HRSA
Health Resources & Services Administration

Federal Office of Rural Health Policy

Notice of Funding Opportunity

Application due April 10, 2025

Rural Residency Planning and Development (RRPD) program

Opportunity number: HRSA-25-007

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Contents

Before you begin

If you believe you are a good candidate for this funding opportunity, secure your SAM.gov and Grants.gov registrations now. If you are already registered, make sure your registrations are active and up-to-date.

SAM.gov registration (this can take several weeks)

You must have an active account with SAM.gov. This includes having a Unique Entity Identifier (UEI).

See Step 2: Get Ready to Apply

Grants.gov registration (this can take several days)

You must have an active Grants.gov registration. Doing so requires a Login.gov registration as well.

See Step 2: Get Ready to Apply

Apply by the application due date

Applications are due by 11:59 p.m. Eastern Time on April 10, 2025.

To help you find what you need, this NOFO uses internal links. In Adobe Reader, you can go back to where you were by pressing Alt + Left Arrow (Windows) or Command + Left Arrow (Mac) on your keyboard.

Step 1: Review the Opportunity

In this step

Basic information

Health Resources and Services Administration (HRSA)

Federal Office of Rural Health Policy

Policy Research Division

Creating new, sustainable residency programs to improve access to health care in America's rural communities.

Summary

The Rural Residency Planning and Development (RRPD) program improves and expands access to health care in rural areas by developing new sustainable rural residency programs, including rural track programs (RTPs). Under the program, we provide start-up funding to grant recipients to create rural residency programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

These residency programs are then sustained long-term through viable and stable funding mechanisms, such as Medicare, Medicaid, and other public or private funding sources.

Ultimately, this funding opportunity aims to address physician workforce shortages and challenges faced by rural communities.

Funding details

Application type: New

Expected total available funding in FY 2025: $11,250,000

Expected number and type of awards: 15 grants

Funding range per award: Up to $750,000 per grant

We plan to fund awards fully in Year 1 for the three-year period of performance (August 1, 2025, to July 31, 2028).

The program and awards depend on the appropriation of funds and are subject to change based on the availability and amount of appropriations.

Have questions? Go to Contacts and Support.

Key facts

Opportunity name: Rural Residency Planning and Development Program

Opportunity number: HRSA-25-007

Announcement version: New

Federal assistance listing: 93.155

Statutory authority: 42 U.S.C. § 912(b)(5) (§711(b)(5) of the Social Security Act)

Key dates

NOFO issue date: January 10, 2025

Informational webinar: January 23, 2025

Application deadline: April 10, 2025, at 11:59 pm ET

Expected award date is by: July 1, 2025

Expected start date: August 1, 2025

See other submissions for other time frames that may apply to this NOFO.

Eligibility

Who can apply

You can apply if you meet all the eligibility criteria for funding under this notice.

Types of eligible organizations

These types of domestic* organizations may apply:

- Public or private institutions of higher education, as part of a graduate medical education (GME) consortium, including:
  - Schools of allopathic medicine
  - Schools of osteopathic medicine
  - Historically Black Colleges and Universities (HBCUs)
- Rural hospitals
- Rural community-based ambulatory patient care centers, including Rural Health Clinics
- Native American tribal governments
- Native American tribal organizations

*"Domestic" means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Individuals are not eligible applicants under this NOFO.

Completeness and responsiveness criteria

We will review your application to make sure it meets these basic requirements to move forward in the competition.

We will not consider an application that:

- Is from an organization that does not meet the eligibility criteria.
- Does not include all required attachments and narrative sections including a sustainability plan.
- Is not responsive to the purpose of the program, the sustainability plan requirements, or requirements for attachments.
- Fails to propose a new rural residency program in a qualifying medical specialty with greater than 50% of training at rural training sites.

- Requests funding above the award ceiling shown in the funding range.
- Is submitted after the deadline.

Application limits

You may not submit more than one application. If you submit more than one application, we will only accept the last on-time submission.

Cost sharing

This program has no cost-sharing requirement. If you choose to share in the costs of the project, we will not consider it during merit review. We will hold you accountable for any funds you add, including through reporting.

Program description

Purpose

The purpose of the Rural Residency Planning and Development (RRPD) program is to improve and expand access to health care in rural areas by developing new sustainable rural residency programs, including rural track programs (RTPs).

These residency programs must achieve accreditation from the Accreditation Council for Graduate Medical Education (ACGME). Newly created rural residency programs will increase the number of future physicians training in rural areas, and ultimately the number of physicians practicing in rural areas with the goal of addressing the physician workforce shortages in rural communities.

The RRPD program provides start-up funding to create new rural residency programs in qualifying medical specialties that will be sustainable long-term through viable and stable funding mechanisms, such as Medicare, Medicaid, and other public or private funding sources. Qualifying medical specialties are family medicine, internal medicine, preventive medicine, psychiatry, general surgery, and obstetrics and gynecology.

For this notice of funding opportunity (NOFO), rural residency programs:

- Are accredited physician residency programs.
- Train residents in clinical training sites that are physically located in a rural area as defined by HRSA's Federal Office of Rural Health Policy (FORHP) [1] for greater than 50 percent of their total time in residency.
- Focus on producing physicians who will practice in rural communities.

The purpose of the RRPD Program is to fund the development of new rural residency programs in qualifying medical specialties. For this funding opportunity, we consider "new" programs to include both programs seeking accreditation for the first time and existing programs that apply for a permanent complement increase to train additional residents at new rural training site(s) as part of an RTP. To be responsive to the program purpose and be considered for funding, you must propose a new rural residency program in a qualifying medical specialty. For this funding opportunity, we do not consider the following to be new programs:

- Programs that have received accreditation or a permanent complement increase for their proposed rural residency program before the application due date.
- Programs seeking to increase resident full-time equivalents at an existing RTP site without adding a new rural training site.

Program pathways

There are two pathways for this program. In your application, you will specify to which pathway your proposed residency program corresponds.

Pathway 1: General primary care and high-need specialty

This pathway supports developing new rural residency training programs that focus on training to meet significant rural health needs.

The qualifying specialties in this pathway are family medicine, internal medicine, preventive medicine[2], psychiatry, and general surgery.

Pathway 2: Maternal health and obstetrics

This pathway supports developing new rural residency programs with a focus on training to provide high-quality, evidence-based maternity care and obstetrical services in rural areas.

Qualifying specialties in this pathway are obstetrics-gynecology and family medicine with enhanced obstetrical training.

Enhanced obstetrical residency training must provide family medicine residents with extensive clinical experience in comprehensive maternity care, as outlined in ACGME's program requirements. This includes dedicated training on labor and delivery.

These programs must have faculty with clinical expertise to prepare family medicine residents for the independent practice of obstetrics in rural communities.[3]

Program goals

The program's goal is for each recipient to establish a new rural residency program in a qualifying specialty by the end of the period of performance.

These programs must be accredited by ACGME and sustainable long-term through viable stable funding streams, such as Medicare, Medicaid, and other public or private funding sources.

Funded rural residency programs will effectively train physicians to practice in and meet the clinical needs of rural populations. As a result, we expect a markedly higher proportion of graduates from these programs to enter careers serving rural populations when compared to traditional urban-based residency programs across the nation.

Program objectives

To achieve this goal, you must achieve the following objectives if funded:

- Develop a new rural residency program that is accredited by ACGME.

- Finalize a validated sustainability plan that includes ongoing funding streams to sustain long-term resident training after the program is established.
- Develop a structured plan to track and publicly report on resident career outcomes after graduation for at least 5 years after the first graduating class to assess retention in rural communities.

Background

One in five Americans live in rural communities.[4] Compared to their urban counterparts, people living in rural communities have higher rates of chronic conditions and preventable hospitalizations.[5] They also lack access to timely care.[6] In fact, 71 percent of areas designated as primary medical health professional shortage area (HPSA) are in rural or partially rural areas.[7]

At the same time, national trends show the demand for physicians will continue to grow, outpacing the projected supply. Recent data from HRSA's Bureau of Health Workforce projects a shortage of 139,940 physicians across primary care and non-primary care specialties by 2036.[8] The maldistribution of the physician workforce contributes to these shortages. Urban areas have more physicians, while rural and underserved communities experience the greatest need for health care providers.

Retaining and recruiting physicians continues to remain a critical issue for rural communities. One proven strategy is rural residency training. A recent study found that rural exposure during family medicine residency training is associated with a five- to six-fold increase in choosing rural practice.[9] A second study found rural training is more strongly associated with rural practice than having a rural background.[10] Despite the demonstrated successes of rural training, research finds persistently limited opportunities for physician residents to train in rural areas. According to the U.S. Government Accountability Office, only 2 percent of residency training occurred in rural areas between 2014 to 2015 and 2019 to 2020. Instead, residency training is highly concentrated in urban areas, particularly in the southern and northeastern regions.[11]

Rural residency programs often face financial, human resource, and organizational capacity constraints. These include lack of sustainable financing, limited faculty support, and difficulties recruiting residents. Due to these challenges, few new residency programs started in rural areas in the past. In recent years, HRSA-funded grantees have shown that rural residency programs can overcome these challenges through strong partnerships, community champions, and start-up resources. Further, current Medicare graduate medical education (GME) payment policy includes several provisions that can provide new Medicare GME funding for new residency programs in rural facilities. These Medicare GME payments can be an important part of a program's financial sustainability.

This program came out of the urgent need to develop new rural training opportunities. HRSA's Federal Office of Rural Health Policy (FORHP) administers the program in consultation with HRSA's Bureau of Health Workforce (BHW). HRSA funded its inaugural cohort in FY2019 and additional cohorts in FY2020–24. HRSA has made 85 RRPD program awards across 38 states and 1 territory to develop rural residencies, including rural track programs, in the six qualifying specialties.

As of October 1, 2024, 47 program recipients have created new rural residency programs for a total of 587 approved residency positions. Forty-four of these residency programs have matriculated more than 460 physician residents. To navigate the complexities of accreditation and GME financing, all recipients are required to collaborate with the HRSA-funded RRPD Technical Assistance Center and attend a 2-day annual RRPD program meeting throughout the duration of their period of performance.

Please see helpful websites for additional resources and our glossary of important program definitions.

Program requirements and expectations

We expect all applicants funded under this funding opportunity to develop strong and sustainable residency programs in qualifying medical specialties. To achieve that goal, you must meet critical milestones for each of the program objectives during the three-year period of performance.

In addition to achieving accreditation, you must also finalize a validated sustainability plan and develop a structured plan to track and report your residency program's graduate outcomes.

Program milestones

We expect recipients to meet the following critical milestones for each objective of the program:

Objective 1: Residency program development

- Appoint a residency program director or identify a residency program director in development by the end of the first year (July 31, 2026).
- Submit the ACGME application for the new rural residency program or rural track program by the end of the second year (July 31, 2027).
- Establish a new ACGME-accredited rural residency program or rural track program by the end of the period of performance (July 31, 2028).
- Begin training first resident class no later than the first academic year (AY) after the RRPD period of performance ends (AY2029).

Objective 2: Program sustainability

- Finalize detailed pro forma for program sustainability by the end of the first year (July 31, 2026).

Objective 3: Graduate tracking plan

- Finalize and submit detailed graduate outcome tracking plan by the end of the second year (July 31, 2027).

Program sustainability

You are expected to finalize a validated sustainability plan that includes ongoing funding streams to sustain long-term resident training through one or more of the following options:

- Qualifying under current regulatory authority for viable Medicare payments for GME, such as Indirect Medical Education (IME) or Direct Graduate Medical Education (DGME) payments, for hospitals starting a new residency training program.
- Expanding a rural track program to a new rural site in accordance with Medicare regulations that qualifies for viable IME or DGME payments.[12]
- Qualifying for Medicaid GME, other state, public, or private support.
- Combining multiple funding streams (for example, a hospital may have a mix of Medicare and other public funding).

Medicare sustainability options

If your sustainability plan relies on Medicare GME, you must select one or more of the following options:

Option 1 – Rural hospital “new” residency program

Rural teaching hospitals may be eligible to receive an increase in their Medicare FTE resident cap if they start a new medical residency training program in the rural hospital.

For example, a rural hospital with an accredited family medicine residency program may be eligible for an increase in its resident caps if it starts training residents in a new psychiatry program.

Current Medicare regulations do not provide cap increases when a rural hospital expands the number of FTE residents in an existing program, or if an existing residency program is transferred to a new training site.

Option 2 – Medicare FTE resident cap expansion for rural track programs

Urban and rural hospitals that establish a rural track program or add an additional rural site to an existing rural track program that is accredited by the ACGME may qualify for an adjustment to their GME FTE resident caps.

Effective for cost reporting periods on or after October 1, 2022, a rural track program is an ACGME-accredited program in which residents train for greater than 50 percent of their residency training in a rural area (as defined at 42 CFR 412.62(f)(iii)).

This regulation defines rural areas as areas outside of a metropolitan statistical area.[13]

Option 3 – Establishing a Medicare FTE resident cap for the first time

Rural hospitals that have not yet triggered their per resident amount (PRA) and do not yet have GME FTE resident caps set ("never claimers") are eligible to select this option.

To demonstrate that the PRA has not yet been triggered, rural hospitals must demonstrate that no prior residency training has taken place in their hospital and no previous caps have been set through a careful examination of past cost reports since 1996.[14]

Option 4 – Medicare FTE cap adjustment for rural reclassified hospitals

Inpatient Prospective Payment System (IPPS) hospitals located in an urban area, but reclassified as rural under 42 CFR 412.103, may be eligible to receive an increase in their Medicare IME resident cap when they begin a new residency program.[15]

However, they are not eligible for a Medicare DGME cap increase unless they serve as the urban partner in a rural track program.

When participating in a program that is simultaneously a rural track program and a new residency program, a rural reclassified hospital serving as the urban partner in the rural track program could be eligible for a DGME rural track program cap increase and an IME new program cap increase. (See Option 2 – Medicare FTE resident cap expansion for rural track programs.)

Current Medicare regulations do not provide IME cap increases when a hospital expands the number of FTE residents in an existing program.[16]

IME for rural reclassified hospitals may be a viable sustainability funding stream as part of a larger sustainability plan but may not be sufficient by itself to ensure program sustainability.

If your sustainability plan relies on the rural reclassified status of a hospital outside of the rural track program model, you must include other funding sources as part of the overall sustainability plan.

Option 5 – Medicare reasonable cost payments for Critical Access Hospitals

Critical access hospitals (CAHs) may be a training site for a rural residency program. Because these are not IPPS hospitals, typical GME formulas are not involved in their Medicare payments.

Instead, a CAH's GME payment is based on 101 percent of reasonable costs that the CAH itself incurs for the residency program, pro-rated for Medicare patient share.

These payments are usually not sufficient by themselves to ensure program sustainability, since the allowable teaching costs incurred by CAHs when pro-rated for Medicare patient share are unlikely to fully cover their direct teaching costs.

If you therefore plan to use GME payments to a CAH as a part of your sustainability plan, you must include additional realistic, long-term funding sources to adequately ensure program sustainability.

Critical Access Hospitals may also participate in residency training as part of a larger GME consortium. Under current regulation, IPPS hospitals may claim residents' time at a Critical Access Hospital, considering this hospital as a nonprovider site for GME purposes. The IPPS hospital must cover the residents' salary and benefits while they train at the CAH. Typically, under this option, IPPS hospitals and CAHs develop funds flow agreements to help cover the costs associated with hosting the residency training. If a CAH is serving as a nonprovider site as part of your GME consortium, you should use the most appropriate sustainability option from Medicare sustainability options 1, 2, or 3.

Non-Medicare sustainability options

Option 6 – Other public or private funding

Rural residency programs may also be supported by funding sources other than Medicare.

Examples include ongoing funding from Medicaid, state sources, or other public or private funding streams.

Graduate tracking plan

If funded, you must develop and submit a structured plan to track and publicly report on resident career outcomes after graduation. Outcomes must be tracked for at least 5 years after the first graduating class to assess retention in rural communities.

To consistently track graduates, you must identify and establish data collection elements for the graduate tracking plan.

At a minimum, the graduate tracking plan must accurately collect the following graduate outcomes:

- National Provider Identifier (NPI).
- Practice locations.
- Medical specialty/sub-specialty.
- Employment status (part-time or full-time).

Examples of other information you might collect include:

- Patient population served.
- Service time committed to the care of safety net patients.
- Part or full-time clinical practice status.
- Services offered.
- Proportion of clinical time in inpatient and outpatient settings.
- Additional training opportunities pursued after residency completion.

You must also track program performance data and should consider adding these measures to your plan for tracking graduate outcomes.

Refer to the Annual Performance Report Program Manual for examples of program performance data.

Award information

Funding policies and limitations

Policies

- We will only make awards if this program receives funding. If Congress appropriates funds for this purpose, we will move forward with the review and award process.
- We distribute the full award amount in the first year of the three-year period of performance. While you must allocate the award funding across each of the three years, the budget does not need to be evenly split across the three-year period of performance and can vary based on your program's needs.
- If we receive more funding for this program, we may:
  - Fund more applicants from the rank order list.
  - Extend the period of performance.
  - Award supplemental funding.

General limitations

- For guidance on some types of costs we do not allow or restrict, see Project Budget Information in Section 3.1.4 of the Application Guide. You can also see 45 CFR part 75, or any superseding regulation, General Provisions for Selected Items of Cost.
- You cannot earn profit from the federal award. See 45 CFR 75.400(g).
- Congress's current appropriations act includes a salary limitation, which applies to this program. As of January 2024, the salary rate limitation is $221,900. This limitation may be updated.

Program-specific statutory or regulatory limitations

You cannot use funds under this notice for the following:

- Acquiring or building real property.
- Major construction or major renovation of any space. (Minor renovations or alterations are allowable.)

See Manage Your Grant for other information on costs and financial management.

Indirect costs

Indirect costs are costs you charge across more than one project that cannot be easily separated by project. For example, this could include utilities for a building that supports multiple projects).

To charge indirect costs you can select one of two methods:

Method 1 – Approved rate. You currently have an indirect cost rate approved by your cognizant federal agency at the time of award.

Method 2 – *De minimis* rate. Per 2 CFR 200.414(f), if you have never received a negotiated indirect cost rate, you may elect to charge a *de minimis* rate. If you choose this method, costs included in the indirect cost pool must not be charged as direct costs.

This rate is 15% of modified total direct costs (MTDC). See 2 CFR 200.1 for the definition of MTDC. You can use this rate indefinitely.

Program income

Program income is money earned as a result of your award-supported project activities. You must use any program income you generate from awarded funds for approved project-related activities. Find more about program income at 45 CFR 75.307.

Step 2:
Get Ready to Apply

In this step

Get registered

SAM.gov

You must have an active account with SAM.gov to apply. This includes having a Unique Entity Identifier (UEI). SAM.gov registration can take several weeks. Begin that process today.

To register, go to SAM.gov Entity Registration and select **Get Started**. From the same page, you can also select the Entity Registration Checklist to find out what you'll need to register.

When you register or update your SAM.gov registration, you must agree to the financial assistance general certifications and representations. You must agree to those for grants specifically, as opposed to contracts, because the two sets of agreements are different. You will have to maintain your registration throughout the life of any award.

Grants.gov

You must also have an active account with Grants.gov. You can see step-by-step instructions at the Grants.gov Quick Start Guide for Applicants.

Find the application package

The application package has all the forms you need to apply. You can find it online. Go to Grants Search at Grants.gov and search for opportunity number HRSA-25-007.

After you select the opportunity, we recommend you select the Subscribe button to get updates.

Application writing help

Visit HHS Tips for Preparing Grant Proposals.

Visit HRSA's How to Prepare Your Application page for more guidance.

See Apply for a Grant for other help and resources.

Join the webinar

For more information about this opportunity, join the webinar:

- Thursday, January 23, 2025
- 2 p.m. ET
- Join at this Zoom link.

If you are not able to join through your computer, you can call in:

- **Phone Number:** 833-568-8864
- **Meeting ID:** 160 387 3976
- **Passcode:** 95106394

We will record the webinar. If you are not able to join live, you can replay it on our website.

Have questions? Go to Contacts and Support.

Step 3: Prepare Your Application

In this step

Application contents and format

Applications include five main components. This section includes guidance on each.

Application page limit: 60 pages

Submit your information in English and express whole number budget figures using U.S. dollars.

Make sure you include each of these:

Components	Submission format
Project abstract	Use the Project Abstract Summary form.
Project narrative	Use the Project Narrative Attachment form.
Budget narrative	Use the Budget Narrative Attachment form.
Attachments	Insert each in the Attachments form.
Other required forms	Upload using each required form.

Required format

You must format your narratives and attachments using our required formats for fonts, size, color, format, and margins. See the formatting guidelines in Section 3.2 of the Application Guide.

Project abstract

Complete the information in the Project Abstract Summary form. Include a short description of your proposed project. Include the needs you plan to address, the proposed services, and the population groups you plan to serve. For more information, see Section 3.1.2 of the Application Guide.

Additionally, in the project abstract section of your form, include the following items in list format first, followed by the narrative content indicated:

- Eligible entity/facility type (for example, rural hospital. See Eligibility.)
- Program pathways. Select one or both:
  - General Primary Care and High Need Specialty pathway residency
  - Maternal Health and Obstetrics pathway residency
- Residency medical specialties

- Residency format. Select one:
  - Rural residency program (non-RTP)
  - New rural track program, or RTP (new program accreditation)
  - Rural track program expansion (adding new rural training site or sites to existing program)
- Sponsoring institution name, location, and ACGME sponsor program code (if applicable)
- Rural target county or counties
- Funding amount requested
- Program sustainability option (refer to Program Sustainability.)
- Projected total number of residents
- Expected ACGME accreditation and first resident matriculation dates
- Funding priority points requested, if applicable. (See Attachment 9 and Selection process.)
- List of recent HRSA awards received within the last 5 years, if applicable, by program name and grant number (for example, Rural Residency Planning and Development Program, Grant No. P13RH99999)

Project abstract narrative content

- Provide a brief overview of the project, including description of geographic area, target patient population and needs, consortium members (if applicable) and clinical collaborations (for example, training partners and types of clinical facilities).
- Include specific measurable objectives and expected outcomes of the project and how you will accomplish what you propose (i.e., the "who, what, when, where, why, and how" of the project).

Project narrative

In this section, you will describe all aspects of your project. Project activities must comply with the nondiscrimination requirements.

Use the section headers and the order listed.

Introduction

See merit review criterion 1: Need

- Briefly describe the purpose of your project.
- Identify specific goals, objectives, and expected outcomes.
- Summarize how your project will address population health needs and expand your project's proposed medical specialty in your target area.

Need

See merit review criterion 1: Need

Summarize the health workforce and health care needs of the target area served by your proposed project. Focus this section on assessing the current health care infrastructure (such as GME landscape) and describing the resources needed to develop a new rural residency program.

Use and cite demographic data whenever possible to support the information provided.

Specifically, you must:

- Describe the geographic area where you plan to start the new rural residency program and explain why you chose this target area.
- Describe the unmet health care needs that the residency program will address. Whenever possible, include data on the demographics, social determinants of health, health disparities, and health care needs of the population served, as well as barriers to accessing care.
- Describe the area's health workforce shortages and need for physicians in your proposed medical specialty. Include current (within 3 years) information and data demonstrating the need for the proposed specialty in the target area.
- Indicate the presence of geographic or population Health Professional Shortage Areas (HPSA) for primary care or mental health.
- Describe the rural health care delivery system and the specific needs of the facility or facilities hosting your proposed rural residency program. Include information on the organization's structure and the clinical and faculty capacity needed to support the new rural residency program.
- List any residency programs (existing or in development) in the proposed qualifying medical specialty that serve the target area where the proposed new rural residency program will be located.
- Describe any progress made towards developing a rural residency program.

- Describe existing residency program collaborations and efforts to develop clinical training sites and to support preceptor development and retention.
- Describe any consultations with the State Office of Rural Health related to the planning and development of the new rural residency program. You must also at a minimum include the required letter of intent and any response received as Attachment 8.

Letter of Intent: Notify the State Office of Rural Health in any state where you have proposed to conduct rural training of your intent to apply to this program. For a list of the state offices,[17] visit the National Organization of State Offices of Rural Health (NOSORH) member list. We recommend making every effort to contact your state office early in the application process to advise them of your intent to apply.

- If you are pursuing the Maternal Health and Obstetrics Pathway, you must also:
  - Describe gaps in the obstetrics services and existing resources available to care for individuals and families with high-risk factors in pregnancy.
  - Include current state or county-level data on demographics, social determinants of health, and health disparities faced by the target population. Discuss their maternal health needs, including prevention and treatment of risk factors during pregnancy, such as diabetes, heart disease, hypertension, obesity, depression, and opioid use disorder (OUD) and substance use disorder (SUD). You may use maternal health indicators from HRSA's Maternal and Infant Mapping Tool.

Approach

See merit review criterion 2a: Approach

Tell us how you'll address your stated needs and meet the program's goals, objectives, requirements, and expectations. See Program goals, Program objectives, and Program requirements and expectations sections.

Describe how your approach will bridge any gaps identified in the Need section.

Specifically, tell us how you will:

- **Achieve ACGME accreditation** for the new rural residency program or permanent complement increase for the new rural track program expansion in a qualifying specialty no later than the end of the period of performance (July 31, 2027). Describe:
  - Your program's proposed sponsoring institution and whether it has received institutional accreditation. If not yet accredited, describe your plans to achieve institutional accreditation.

  - Your program's proposed clinical training sites. Provide a table in Attachment 1 that includes all your proposed clinical training facilities and demonstrates that greater than 50% of the training will take place in facilities physically located in rural areas as defined by HRSA's Federal Office of Rural Health Policy (FORHP).
  - Your plan to make sure your clinical capacity meets ACGME program accreditation requirements, including enough dedicated supervisory faculty, adequate patient care volume, and appropriate resident training time in relevant medical specialties and subspecialties (such as obstetrics training). If a clinical training partner addresses gaps in existing clinical capacity to meet ACGME requirements and provides significant support, you must submit a Letter of Agreement from the clinical partner describing their committed resources and clinical capacity in Attachment 5.
  - Your sponsoring institution's plan to ensure required organizational capacity and program governance structure meet both ACGME sponsoring institution and program accreditation requirements, including hiring non-faculty staff, and acquiring access to electronic health records, library services, learning management systems, etc.
  - Your plan to appoint a residency program director by the end of year 1 of the grant (if not already hired), and your faculty recruitment and development plan, including recruiting specialty faculty to meet ACGME requirements for the proposed specialty.
  - Your curriculum and training plan, including incorporation of interprofessional training, culturally and linguistically appropriate care, and training to address the health inequities and disparities of the patient population in the rural target area. Your curriculum plan must lead to successful board certification of graduates and readiness for clinical practice following completion of training.

- **Enroll residents in training** no later than the academic year immediately following the end of the program period of performance (AY2029). Describe your plan to:
  - Recruit and support a diverse cohort of high-quality residents, including outreach to medical students with rural and disadvantaged backgrounds.
  - Recruit and train at least the minimum number of residents required to achieve and maintain accreditation for the proposed specialty.
  - Promote retention among residents and graduates to practice in rural communities.
- **Track residents' career outcomes** for at least 5 years after the first graduating class from the rural residency program. Describe how you'll:

    - Develop, enhance, or leverage a graduate tracking system to track and publicly report (e.g., on your program website) on graduates' career outcomes and retention in rural and underserved areas. At a minimum, the graduate tracking plan should accurately collect the following information about graduates:
        - National Provider Identifier (NPI).
        - Practice locations.
        - Medical specialty/sub-specialty.
        - Employment status (part-time or full-time).

- **Describe a plan to disseminate reports**, products, or project outputs so project information may inform other rural residency programs to pursue this model as a strategy for training physicians likely to seek rural practice.
- **Describe innovative approaches** or unique program characteristics that would enhance the quality of rural residency training to meet the needs of the targeted rural area, such as:
    - Patient care or health care delivery strategies (e.g., patient-centered medical homes, telehealth, etc.).
    - Integrating interprofessional education and practice.
    - Integrating oral health.
    - Providing mental health and SUD treatment.
    - Incorporating public health emergency preparedness and response training.
- If you are pursuing the Maternal Health and Obstetrics Pathway, you must also:
    - Describe the type of training sites for obstetrics training and the range of services at the clinical training sites, including ambulatory care for maternal health in the locality of the program. Include the number of anticipated vaginal deliveries and C-sections per year, as applicable.
    - If applicable, describe how you plan to enhance the family medicine residency program in maternal health and obstetrical training, referencing current ACGME requirements. Describe how you'll meet these requirements to train family medicine residents for the independent practice of obstetrics in rural communities.[18]
        - Describe the number of preceptors and faculty members that provide maternal health care and the types of maternity and obstetrics services they perform in sites where the residents will train.
        - Clearly identify the percentage of time and types of maternal health/obstetrics services the residents will perform or experience while training in rural communities.

High-level work plan

See merit review criteria 2b: Work plan

- Describe how you'll achieve each of the program goals and objectives identified in the Project Narrative Approach section during the period of performance.
- Provide a timeline that includes each activity and identifies the faculty/staff or key collaborator who is responsible for each. Key faculty/staff identified in the work plan must correspond with the staffing plan in Attachment 3. Provide Letters of Agreement from all key collaborators in Attachment 5.
- Identify how key stakeholders will help plan, design, and carry out all activities, including developing the application. Discuss the extent to which these contributors reflect the populations and communities served. Provide Letters of Agreement from all GME consortium members in Attachment 5.
- Explain how the work plan is appropriate for the program design and how the targets fit into the overall timeline of the grant.
- Include a more detailed work plan in Attachment 2. You should use this plan to achieve each of the program goals and objectives listed in the program description's Purpose section. A sample work plan is included in Appendix B for your reference.

Resolving challenges

See merit review criterion 2c: Resolving challenges

Discuss challenges that you are likely to encounter when implementing your work plan and explain approaches that you'll use to resolve them.

Specifically, you must:

- Discuss challenges and barriers in implementing your work plan to achieve program goals and objectives. Examples include inadequate clinical experiences or patient volumes for residents, recruiting specialty and subspecialty preceptors needed to meet ACGME requirements, and financial sustainability issues. Propose reasonable strategies to address these challenges.
- Discuss any expected internal challenges (such as managing expectations among clinical training partners) and external challenges (like regulatory changes) that may directly or indirectly affect the development of the rural residency program. Provide strategies for how you will overcome them.
- Describe challenges incorporating interprofessional health care, innovative approaches, and culturally and linguistically appropriate care in the program curriculum. Propose resolutions to these challenges.

- Describe challenges recruiting a diverse cohort of high-quality residents. Discuss strategies to overcome recruitment challenges.

Include references to ACGME program requirements wherever possible when addressing any challenge related to meeting accreditation requirements.

Performance reporting and evaluation

See merit review criteria 3a: Evaluation measures

Describe your proposed plan to monitor ongoing processes and progress towards meeting project goals, objectives, and expected outcomes.

Performance measurement and reporting

See reporting manual for performance measure requirements and examples of reporting forms.

- Describe how you will collect, and report required performance data accurately and on time.
- Describe how you will manage and securely store data.
- Describe how you will monitor and analyze performance data to support continuous quality improvement. Specifically, describe a plan to collect and report on the following performance measures for your residency program, in addition to the plan for tracking characteristics of graduates, practice locations, and intent to be employed in rural areas required in the Approach section:
    - Accredited positions
    - Admissions
    - Residents by:
        - Year of training
        - Age
        - Gender
        - Race
        - Ethnicity
    - Location of training
    - New curriculum development
    - Faculty development
- If funded, you must report on selected characteristics of residents during the period of performance. Refer to the Annual Performance Report Program Manual

for examples of performance data. You must provide a table of anticipated values for the following initial outputs in your application:

- Number and type (i.e., model and specialty) of newly established rural residency programs.
- Number of residents each rural residency program can support in the first year.
- Number of residents each rural residency program will support once fully established (longer-term goal).
- Number and type of existing clinical training sites for residents.
- Number and type of newly established clinical training sites for residents.
- Number of faculty and staff trained to teach, support, and administer the curriculum at each rural residency program site.
- Number and type of existing collaborations (e.g., non-clinical training site) that support the rural residency program.
- Number and type of newly established collaborations (e.g., non-clinical training site) that support the rural residency program.

Program evaluation

Describe the plan for the program performance evaluation that will meet ACGME accreditation requirements and promote continuous quality improvement. Include:

- Clearly defined, viable metrics, including descriptions of the inputs (e.g., key personnel, collaborators, and other resources), key processes, and meaningful expected outcomes of the funded activities.
- The evaluation barriers and your plan to address them.
- The evaluation capacity of your organization and staff. Describe experience, skills, and knowledge.

See Reporting for more information.

Program sustainability

See merit review criteria 3b: Program sustainability

You must propose a clearly defined, fact-based, validated sustainability plan to support the long-term financial sustainability for the new rural residency program beyond the RRPD period of performance. You must:

- Describe a financial sustainability plan by selecting one or more of the sustainability options described in this NOFO to support the costs of your new rural residency program. Describe any financial investments you have already made. See the Program sustainability section of Program requirements and

expectations for sustainability options. Your financial sustainability plan must describe funding sources and clinical revenue that are available or projected for the long term. New rural residency programs may seek various funding sources to ensure long-term sustainability for their program, including qualifying under current regulatory authority for Medicare GME payments or other public or private support.

- Demonstrate a stable future financial outlook for the sponsoring institution and the clinical training partners involved in the new rural residency program. In Attachment 5, the Letters of Agreements from collaborators should clearly describe future financial outlook, resources, and commitment to support the program long-term.
- Discuss any foreseeable challenges and barriers (such as reliability of state or private funding sources) to your proposed sustainability plan, and how you will address these challenges and barriers.
- Hospitals that either do not qualify for Medicare GME funding or receive partial GME funding (like Critical Access Hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, or Rural Emergency Hospitals) must describe a strong sustainability plan that includes sufficient ongoing funding streams to sustain long-term resident training once the program is established.
- Provide all required documentation for selected sustainability options that demonstrates that the proposed sustainability plan is reasonable, feasible, and will result in long-term financial sustainability.

Applications that lack a program sustainability plan narrative and the required supporting documentation in both Attachments 1 and 6 for the chosen sustainability options are not complete and responsive. We will not consider applications that do not meet the Completeness and Responsiveness Criteria outlined in this NOFO.

Specifically, you must include the following documentation where relevant. For further reference, please see the program sustainability options checklist.

Rural status documentation in Attachment 1

If your sustainability plan relies on Medicare sustainability options 1 or 2, you must provide documentation that demonstrates that greater than 50 percent of total resident training will take place in a clinical training site, such as a hospital, clinic, or similar physically located in a rural area. This must be in accordance with both FORHP's definition and CMS's definition of "rural."

Hospitals located in an urban county that have reclassified as rural under 42 CFR 412.103 are rural for IME, but not DGME. (See Option 4: Medicare FTE cap adjustment for rural reclassified hospitals.)

To determine if a hospital is located in a county that is rural, review the FY2025 IPPS Final Rule's "County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals File" that is available at FY 2025 IPPS Final Rule.

If your sustainability plan does not rely on Medicare sustainability options 1 nor 2, you must provide documentation that demonstrates that greater than 50 percent of total resident training will take place in a clinical facility physically located in a rural area that meets FORHP's definition of rural. Use the Rural Health Grants Eligibility Analyzer to check the rural status of the training sites.

For FY2025 grants, there are 17 counties that were considered fully within FORHP-designated rural areas in FY2024 that are no longer fully rural due to updates from the Office of Management and Budget (OMB). While either some or all areas in these 17 counties will not appear as rural in the Rural Health Grants Eligibility Analyzer, reference to these counties in your application will qualify as eligible FORHP-designated rural areas for the purposes of this NOFO. If a rural site qualifies because it is located in one of these 17 counties, you must account for the change in rural status in future years in your sustainability plan.

See Attachment 1: Rural Status.

Medicare sustainability documentation

Options 1, 2, 3, or 4: Documentation for Medicare sustainability

Provide documentation that demonstrates that the rural hospital (or the urban hospital in the case of a rural track program) is eligible for Medicare GME funding.

To do so, provide the following documentation in Attachment 6:

- Letter from hospital's chief executive officer or other leadership confirming, through careful examination of past Medicare cost reports since 1996, that:
  - The proposed new rural residency program or RTP is eligible to qualify for Medicare GME funding.
  - The hospital has not hosted pre-planned and scheduled residency training in past cost reports that are settled but are within the 3-year reopening period.
  - The hospital does not have a Medicare FTE cap set for the proposed new rural residency program or RTP (new or additional rural site).
- If proposing **Medicare sustainability option 3**, the letter must also confirm that the hospital has not previously triggered the DMGE PRA.

- If proposing **Medicare sustainability option 4**, the letter must also confirm that the hospital is rurally classified under 42 CFR 412.103.

Option 5: Documentation for Medicare sustainability

For a sustainability plan that relies on Medicare sustainability option 5: Medicare reasonable cost payments for Critical Access Hospitals, provide the following attestation documentation in Attachment 6:

- Letter from hospital's chief executive officer or other responsible leadership confirming that:
  - The hospital is a Critical Access Hospital.
  - Careful examination of past Medicare cost reports and hospital financial records has demonstrated that the proposed new rural residency program can be sustained through payments for reasonable costs and other public or private funding streams.
- If your sustainability plan relies on option 5, you must also submit additional information under Option 6: Other public and private funding.

You may evaluate Medicare eligibility using the two HCRIS data files posted on the CMS website, which contain hospital Medicare cost report GME data.

You can use the RRPD-TA Center's Rural GME Hospital Analyzer tool (registration required) as a starting point to understand potential sustainability options for your proposed program. This tool is for information purposes only.

You must include additional documentation including your own analysis of the hospital's records to determine Medicare GME eligibility for the purpose of this application.

Option 6: Documentation for other public or private funding

If you propose a sustainability plan that relies on non-Medicare public funding, you must demonstrate the long-term viability of the funding and clearly describe the funding mechanism in Attachment 6:

- Application process (competitive vs. noncompetitive).
- How your program qualifies for the funding.
- The anticipated award date and the expected amount, duration, and availability of the funding.

If you propose a sustainability plan that includes private funding for ongoing support of your residency program, you must demonstrate the long-term viability of the funding and must provide a letter of agreement from the funder in Attachment 6, including:

- The level of commitment to the sustainability of the program.
- Funding amount and duration of funding.
- Potential future funding support (if applicable).

See Attachment 6: Program sustainability documents.

Program sustainability options checklist

In addition to describing the program sustainability within the project narrative, all applications must include attachments 1 and 6 to be considered complete and eligible for review. These required attachments must include different information for each of the program sustainability options the applicant selects. A checklist of the required information and documents follows.

For all options, Attachment 1 must include:

- A table of all proposed training sites that includes the following key information:
  - Site name and address
  - County name and state
  - County rural or urban status in the FY 2025 IPPS Final Rule
  - Site rural status in the Rural Health Grants Eligibility Analyzer
  - Site Classification
  - Projected percentage of resident training time at each site
- An attestation that the program will train residents in rural areas for greater than 50 percent of the total residency training time. See the following individual options for rurality requirements.

Table 1: Requirements for each sustainability option

If you choose:	In Attachment 1, provide proof that rural training sites meet:	Include the following required documentation in Attachment 6:
Option 1: Hospital "new" residency program	• CMS definition of rural. • FORHP definition of rural.	• Submit an attestation letter from the hospital CEO or other leadership confirming that: ◦ The proposed rural residency program is a new program or specialty for purposes of Medicare GME funding, ◦ The hospital has not hosted pre-planned and scheduled residency training in the proposed specialty in past cost reports that are settled but within the 3-year reopening periods, and ◦ The hospital does not have previously set Medicare FTE resident caps for the proposed program.
Option 2: Medicare FTE resident cap expansion for RTPs	• CMS definition of rural. • FORHP definition of rural.	• Submit an attestation letter from the hospital CEO or other leadership confirming that: ◦ Proposed RTP (new or additional rural site) is eligible for Medicare GME funding, ◦ The hospital has not hosted pre-planned and scheduled residency training in past cost reports that are settled but within the 3-year reopening periods, and ◦ The hospital does not have previously set Medicare FTE resident caps for the proposed RTP.
Option 3: Establishing a Medicare FTE resident cap	• FORHP definition of rural.	• Submit an attestation letter from the hospital CEO or other leadership confirming that: ◦ The proposed rural residency program is new for purposes of Medicare GME funding, ◦ The hospital has not hosted pre-planned and scheduled residency training in past cost reports that are settled but within the 3-year reopening periods, and ◦ The hospital does not have previously set Medicare resident FTE caps or previously triggered DMGE PRA.
Option 4: Medicare FTE cap adjustment for rural reclassified hospitals	• FORHP definition of rural.	• Submit an attestation letter from the hospital CEO or other leadership confirming that: ◦ The hospital is rurally classified under 42 CFR 412.103,

If you choose:	In Attachment 1, provide proof that rural training sites meet:	Include the following required documentation in Attachment 6:
		◦ The proposed rural residency program is a new program or specialty for purposes of Medicare GME funding, ◦ The hospital has not hosted pre-planned and scheduled residency training in the proposed program in past cost reports that are settled but within the 3-year reopening periods, and ◦ The hospital does not have previously set Medicare FTE resident caps for the proposed program.
Option 5: Medicare reasonable cost payments for CAHs	• FORHP definition of rural.	• Submit an attestation letter from hospital's CEO or other responsible leadership confirming that: ◦ The hospital is a CAH, and ◦ Through careful examination of past Medicare cost reports and hospital financial records the proposed new rural residency program can be sustained through payments for reasonable costs and other public or private funding streams. • Submit additional sustainability information/documentation under Option 6: Other public and private funding.
Option 6A: Non-Medicare public funding	• FORHP definition of rural.	• Submit a document that demonstrates the long-term viability of the funding and clearly describe the funding mechanism, including: ◦ Application process (competitive vs. noncompetitive), ◦ How your program qualifies for the funding, and ◦ The anticipated award date and the expected amount, duration, and availability of the funding.
Option 6B: Private funding	• FORHP definition of rural.	• Submit Letter of agreement from the funder, including: ◦ The level of commitment to the sustainability of the program, ◦ Funding amount and duration of funding, and ◦ Potential future funding support (if applicable).

Note: HRSA welcomes applicants selecting more than one option to strengthen their sustainability plan, as appropriate. Regardless, you must identify and provide all required documentation for all options selected.

Organizational information

See merit review criteria 4: Resources and capabilities and 5: Support requested

- Briefly describe your mission, structure, and the scope of your current activities. Explain how they support your ability to achieve project outcomes and meet program expectations.
- Discuss how you'll follow the approved plan, account for federal funds, and record all costs to avoid audit findings.
- If funds will be sub-awarded or expended on contracts, explain how your organization will ensure these funds are properly used and monitored. Discuss policies and procedures in place that meet or exceed the requirements in 45 CFR part 75 regarding sub-recipient monitoring and management.
- Describe how you'll routinely assess the unique needs of the people who live in the community you serve.
- Describe your organizational profile, budget, partners, and key processes.
- Describe your key staff's experience, skills, and knowledge as it relates to the proposed project.
- Include a project organization chart in Attachment 7. The chart must identify and show relationships between the applicant organization, the residency program sponsoring institution, and all relevant collaborators, including clinical training partners involved in the development and operation of the new rural residency program.
    - If your organization is located in an urban area, you must demonstrate that you can train residents in rural facilities, by either:
        - Operating a clinical site in a rural area as defined by HRSA's FORHP; or
        - Demonstrating that you are part of a consortium where at least one consortium member operated a clinical training site in rural area.
    - Include Letters of Agreement with all key collaborators, clinical training sites, and the sponsoring institution, if different from the applicant organization, in Attachment 5.
- If your organization is applying as part of a GME consortium, you must:
    - List all members of the GME consortium.
    - Identify key personnel and responsibilities of each consortium member involved with the grant.
    - Explain the flow of grant funds between members of the consortium (if applicable).

- Describe your organization's experience developing rural residency programs. Discuss how the expertise of collaborators will contribute to successfully implementing a new rural residency program.
- Include the staffing plan and job descriptions for key faculty/staff in Attachment 3.
- Include biographical sketches for each person occupying the key positions in Attachment 4.

Budget and budget narrative

See merit review criterion 5: Support Requested

Your budget should follow the instructions in Section 3.1.4. Project Budget Information - Non-Construction Programs (SF-424A) of the Application Guide and the instructions listed in this section. Your budget should show a well-organized plan.

HHS now uses the definitions for equipment and supplies in 2 CFR 200.1. The new definitions change the threshold for equipment to the lesser of the recipient's capitalization level or $10,000 and the threshold for supplies to below that amount.

The total project or program costs are all allowable (direct and indirect) costs incurred for the HRSA award activity or project. This includes costs charged to the award and non-federal funds used to satisfy a matching or cost-sharing requirement (which may include maintenance of effort, if applicable).

The budget narrative supports the information you provide in Standard Form 424-A. See other required forms. It includes an itemized breakdown and a clear justification of the costs you request. The merit review committee reviews both.

As you develop your budget, consider:

- If the costs are reasonable and consistent with your project's purpose and activities.
- The restrictions on spending funds. See Funding policies and limitations.
- You cannot use funds under this notice for the following:
  - Resident salaries and benefits.
  - Ongoing operating costs of the residency program.
  - Ongoing support for resident training (e.g., as a program sustainability plan).
  - Fees to ACGME, except for the ACGME initial accreditation fee.

To create your budget narrative, see detailed instructions in Section 3.1.5 of the Application Guide.

Attachments

Place your attachments in order in the Attachments form. See the application checklist to determine if they count toward the page limit.

Attachment 1: Rural status

Provide a table of all proposed training sites that includes the following key information:

- Site name and address.
- County name and state.
- County rural or urban status in the FY 2025 IPPS Final Rule.
- Site rural status in the Rural Health Grants Eligibility Analyzer.
- Site classification.
- Projected percentage of resident training time at each site.

Site classification

For site classification, choose one or more of the following:

- Critical Access Hospital (CAH)
- Sole Community Hospital (SCH)
- Medicare Dependent Hospital (MDH)
- Rural Referral Center (RRC)
- IPPS "Never Claimer"
- Established teaching hospital
- Indian Health Services (IHS) hospital
- Non-hospital site (like a federally qualified health center, rural health clinic, or another clinic)

You may register to use the RRPD-TA Center's Rural GME Hospital Analyzer tool as a starting point to determine site classification for your proposed training sites. This tool is for information purposes only.

Include an attestation that the program will train residents in rural areas for greater than 50 percent of their total residency training time.

You must provide proof of rural designation for all rural training sites that meet the FORHP definition of rural by using the Rural Health Grants Eligibility Analyzer. For FY2025 grants, there are 17 counties that were considered fully within HRSA-designated rural areas in FY2024 that are no longer fully rural due to updates from the Office of Management and Budget (OMB). While either some or all areas in these 17 counties will

not appear as rural in the Rural Health Grants Eligibility Analyzer, reference to these counties in your application will qualify as eligible HRSA-designated rural areas for the purposes of this NOFO.

Include a screenshot or printout of the Eligibility Analyzer result for each rural training site or of the list of 17 eligible counties, as applicable. In some cases, a location may be considered rural by FORHP that is not in a rural county according to CMS. If you propose a sustainability plan that includes certain Medicare GME funding options, you must demonstrate that the rural clinical training site where greater than 50 percent of the training will occur is in a rural county according to CMS.

To determine if a hospital or other training site is located in a county that is rural for CMS IPPS wage index purposes, download and review the FY 2025 "County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals File" that is available on the FY2025 IPPS Final Rule home page. Counties without a CBSA or CBSA Name listed in Columns D and E are considered rural for CMS purposes.

Attachment 2: Work plan

Attach the project's work plan. Make sure it includes everything required in the Project narrative High-level work plan section.

Attachment 3: Staffing plan and job descriptions

See Section 4.1.vi of the Application Guide.

Include a staffing plan that shows the staff positions that will support the project and key information about each. This should include all key staff that are necessary for the success of the project. At a minimum, this must include your proposed project director, your residency program director, and residency program coordinator. The residency program director is not required to be the project director for the grant.

Justify your staffing choices, including education and experience qualifications, and your reasons for the amount of time you request for each staff position.

Attach a one-page job description for each key staff position in the staffing plan. It must include the role, responsibilities, and qualifications.

Also include a description of your organization's timekeeping process to ensure that you will comply with the federal standards related to documenting personnel costs.

Attachment 4: Biographical sketches

Include biographical sketches for people who will hold the key positions you describe in Attachment 3.

Each biographical sketch should be no more than two pages. Do not include non-public, personally identifiable information. If you include someone you have not hired yet, provide a letter of commitment from that person along with the biographical sketch.

Include the following in each biographical sketch:

- **Name**
- **Position title**
- **Education or training**, beginning with baccalaureate or other initial professional education, such as nursing. Include postdoctoral training and residency training if applicable.
    - **Institution** and location.
    - **Degree** (if applicable), date of degree (MM/YY), and field of study.
    - **Section A: Personal statement (required):** Briefly describe why the individual's experience and qualifications make them particularly well suited for their role in the project that is the subject of the award.
    - **Section B: Positions and honors (required):** List in chronological order previous positions, concluding with the present position. List any honors. Include present membership on any Federal Government public advisory committee.
    - **Section C: Peer-reviewed publications or manuscripts in press in chronological order (optional):** Limit the list of selected peer-reviewed publications or manuscripts in press to no more than 10 items. Do not include manuscripts submitted or in preparation. The individual may choose to include selected publications based on date, importance to the field, or relevance to the position. Citations that are publicly available in a free, online format may include URLs along with the full reference (note that copies of publicly available publications are not acceptable as appendix material).
    - **Section D: Other support (optional):** List both selected ongoing and completed projects during the last 3 years (federal or non-federal support). Begin with any projects relevant to the project proposed in this application. Briefly indicate the overall goals of the projects and responsibilities of the Key Person identified on the Biographical Sketch.

Attachment 5: Agreements with other entities

Provide any documents that describe working relationships between your organization and others you refer to in the proposal (e.g., clinical training sites).

Documents that confirm actual or pending contracts or agreements should clearly describe the roles of subrecipients and contractors and any deliverable.

Make sure you sign and date any letters of agreement.

You may call these documents letters of agreement, memorandums of understanding, or other names that are meaningful to you and others you work with.

Attachment 6: Program sustainability documents

Provide documentation that supports the residency program sustainability plan during and after grant funding (for example, qualifying under current regulatory authority for Medicare GME or other public or private support).

For required documentation for all program sustainability options, refer to the project narrative's program sustainability section.

We will review the sustainability documentation in this attachment to ensure it is complete and responsive based on the sustainability options you describe in your narrative. We will not consider applications with incomplete or non-responsive documentation.

Attachment 7: Project organizational chart

Provide a one-page diagram that shows the project's organizational structure. This diagram must include the sponsoring institution, clinical training partners, GME consortium members (as applicable), or other key collaborations.

Attachment 8: State Office of Rural Health letters of intent

Provide a copy of the letter or email sent to the State Office of Rural Health describing your project **and** any response received from them.

You must notify the office in the state(s) where you are proposing to conduct rural training of your intent to apply to this program.

For a list of the state offices, visit the National Organization of State Offices of Rural Health website.

Attachment 9: Funding priority documentation (optional)

If it applies, provide a statement that you qualify for funding priority and identify the priority. We strongly recommend you include the following language to identify your funding priority requests:

For Priority 1

"[Your organization's name] is requesting funding priority 1 for geographic distribution. Our proposed new [rural residency program or RTP expansion] will train residents for greater than 50 percent of total training time in [rural county Y] in [state Z]."

Clearly explain the applicable location if your rural training site is in a different state from the applicant organization's primary address.

For Priority 2

"[Your organization's name] is requesting funding priority 2 for maternal health. The proposed new rural residency program will train residents for the independent practice of obstetrics in rural communities through (select one):

- An obstetrics-gynecology [rural residency program or RTP expansion]
- A family medicine [rural residency program or RTP expansion] with enhanced obstetrical training."

> If you are proposing a family medicine with enhanced obstetrics program, you must describe in the Project Narrative and in Attachment 9 how the program will train residents for the independent practice of obstetrics in rural communities.

You may request one or both funding priorities as applicable. If you request funding priorities for both geographic distribution and for maternal health, you must ensure that your application and **Attachment 9** clearly demonstrate that you are requesting both priorities and your qualification for both priorities.

See Selection process for information about the two funding priorities and how these apply.

Attachment 10 to 15: Other relevant documents (optional)

Include any other documents that are relevant to the application.

These may include other letters of support, proof of nonprofit status, or indirect cost rate agreements. Other letters of support must be dated and specifically indicate a commitment to the project or program (in-kind services, dollars, staff, space, equipment, etc.).

Other required forms

You will need to complete some other forms. Upload the following forms at Grants.gov.

You can find them in the NOFO application package or review them and any available instructions at Grants.gov Forms.

Forms	Submission Requirement
Application for Federal Assistance (SF-424)	With application
Budget Information for Non-Construction Programs (SF-424A)	With application
Disclosure of Lobbying Activities (SF-LLL)	If applicable, with the application or before award

Step 4: Learn About Review and Award

In this step

Application review

Initial review

We will review each application to make sure it meets eligibility criteria, including the completeness and responsiveness criteria. If your application does not meet these criteria, it will not be funded.

We will not review any pages that exceed the page limit.

Merit review

A panel reviews all applications that pass the initial review. The members use the following criteria.

Criterion	Total number of points = 100
1. Need	15 points
2. Response	30 points
3. Impact	35 points
4. Resources and capabilities	15 points
5. Support requested	5 points

Criterion 1: Need (15 points)

See Project Narrative Introduction and Need sections.

The panel will evaluate the application for how well it:

- Explains the problem and its contributing factors.
- Justifies the geographic target area where the proposed rural residency program will be located.
- Describes how the program will address the unmet health care needs of the populations it will serve.
- Demonstrates a significant workforce shortage and need in the proposed qualifying specialty in the target area.
- Uses appropriate data sources to show limited health resources and increased burden of diseases and other conditions among rural residents within these communities (e.g., demographics, health outcomes, health disparities/inequities, barriers to access, etc.).

- Describes the rural health care delivery system and provides details on specific needs of the organization and facilities that will host the proposed program. Demonstrates the organization's structure and capacity to successfully establish the proposed rural residency program.
- Assesses the current GME landscape for the proposed target rural area(s), including existing or developing rural residency programs, and describes the need for a new rural residency program.
- Describes progress towards planning and developing a new rural residency program, including:
  - Any consultations with the State Office of Rural Health.[19]
  - Existing residency program collaborations and efforts to support development of clinical training sites and preceptor development and retention, to deliver high-quality, culturally competent training to residents through academic and community linkages with private sector or safety net providers.

Additionally, the panel will evaluate how well a Maternal Health and Obstetrics Pathway application:

- Describes the need for more obstetrics-gynecology and family medicine physicians with expertise in managing maternal health care in rural areas, who can improve maternal health outcomes with limited resources.
- Describes the social determinants of health and health disparities faced by the target population. Describes their maternal health needs, including the need for training residents to prevent and treat certain high-risk factors in pregnancy (e.g., diabetes, heart disease, hypertension, obesity, depression, OUD/SUD).
- Provides current state or county-level data, such as data from HRSA's Maternal and Infant Health Mapping Tool.

See Program pathways and Project abstract for more information.

Criterion 2: Response (30 points)

See Project Narrative Approach, High-level work plan, and Resolving challenges sections.

2a: Approach (10 points)

The panel will evaluate each application for how well it:

- Describes activities likely to achieve the program goals and objectives stated in Purpose and establish a new rural residency program or RTP in a qualifying specialty and achieve accreditation by ACGME.

- Describes the proposed sponsoring institution, and if applicable the plan to achieve institutional accreditation.
- Describes the proposed training sites and demonstrates in Attachment 1 that greater than 50% of the training will take place in facilities physically located in rural areas as defined by HRSA's Federal Office of Rural Health Policy (FORHP).
- Demonstrates clinical capacity to meet ACGME accreditation requirements by the end of the RRPD grant program period of performance (July 31, 2028). This includes describing dedicated supervisory faculty, adequate patient care volume, and appropriate resident training time in relevant medical specialties and subspecialties (e.g., adequate obstetrics training). If a clinical training partner(s) addresses gaps in existing clinical capacity to meet ACGME requirements, the application must include letters of agreement from the clinical partner demonstrating their committed resources and clinical capacity in Attachment 5.
- Describes how the sponsoring institution will ensure required organizational capacity and program governance structure needed to meet ACGME sponsoring institution and program accreditation requirements, including hiring non-faculty staff, and acquiring access to electronic health records, library services, learning management systems, etc.
- Describes a plan to appoint a residency program director (if not already appointed) by the end of the first year of the grant (July 31, 2026) and a faculty recruitment and development plan, including recruiting faculty with specialty expertise to meet ACGME requirements for the proposed qualifying residency specialty.
- Describes how residency program education will deliver high-quality training and curriculum (e.g., innovative approaches, health equity, emerging patient care strategies, interprofessional education) that will lead to successful board certification and prepare residents to provide high-quality culturally and linguistically appropriate care that address emerging rural population health needs.
- Explains why the project is innovative and provides the context for any innovative approaches described.
- Describes a strategic plan to recruit a diverse cohort of high-quality residents (to begin training no later than AY 2029) who are committed and willing to develop competencies to practice in rural communities.
- Describes a feasible graduate tracking plan to track and publicly report residents' practice locations and retention in rural communities for at least 5 years after the first graduating class from the rural residency program.
- Describes a plan to disseminate reports, products, or project outputs so project information may inform other programs to pursue this model.

Additionally, the panel will evaluate how well a **Maternal Health and Obstetrics Pathway** application:

- Describes how the clinical training sites will support maternal health and obstetrics training, including the number of vaginal deliveries and C-sections, and the range of services needed to develop competency among residents.
- Describes a sufficient number of preceptors and faculty members with maternal health and obstetrics expertise who will train family medicine residents or obstetrics and gynecology residents to practice in rural areas.
- Describes a plan to provide adequate maternal health/obstetrics clinical experience at a rural site(s) capable of supporting the resident complement.
- If proposing a family medicine with enhanced obstetrics program, demonstrates that the proposed family medicine program in the maternal health pathway will meet maternal health and obstetrical training, referencing current ACGME requirements, to train family medicine residents for the independent practice of obstetrics in rural communities.

2b: Work plan (10 points)

The panel will evaluate how well each application:

- Proposes a work plan will support the successful accreditation and establishment of a new rural residency program or RTP that will start training residents no later than the academic year immediately following the final year of the period of performance (i.e., AY2029).
- Provides a detailed and logical work plan that will achieve program goals and objectives identified in the “Approach” section of the project narrative.
- Provides a clear and complete work plan in Attachment 2 describing timeframes, deliverables, and key faculty/staff and collaborators required to execute each activity during the three-year period of performance.
- Clearly identifies key faculty and/or staff responsible for each activity in the work plan, which should correspond with the staffing plan in Attachment 3.
- Clearly identifies activities requiring collaboration with relevant organizations (including sub-award recipients) in the planning, designing, and implementation of the new rural residency program, which should correlate with letters of agreements or memorandum of understanding provided in Attachment 5.
- Explains how the work plan is appropriate for the program design and how the targets fit into the overall timeline of the grant.

2c: Resolving challenges (10 points)

The panel will assess how well the application:

- Demonstrates an understanding of the challenges and obstacles of establishing a new rural residency program and proposes reasonable strategies to address these challenges.
- Describes and demonstrates an understanding of additional challenges both internal and external to the applicant organization that may directly or indirectly affect the development of the program and provide a plan on how these will be resolved.
- Describes challenges with incorporating interprofessional health care, innovative approaches, and culturally and linguistically appropriate care in the program curriculum and proposes resolutions to these challenges.
- Provides strong strategies for overcoming challenges in recruiting a diverse cohort of high-quality residents that will start training no later than the academic year immediately following the final year of the RRPD period of performance (i.e., AY 2029).

Criterion 3: Impact (35 points)

See Project Narrative Performance reporting and evaluation and Program sustainability sections.

3a: Evaluation measures (10 points)

The panel will evaluate how well each application:

- Demonstrates a strong plan to report on measurable outcomes requested to achieve program goals and objectives, which include both:
  - HRSA's performance reporting measures.
  - Applicant's performance evaluation process dedicated to achieving ACGME accreditation.
- Proposes a clearly defined performance evaluation plan that will contribute to continuous quality improvement.
- Demonstrates adequate technical support capacity to conduct performance management and evaluation.
- Proposes reasonable solutions for addressing potential evaluation barriers.
- Includes a logical and well-supported table of anticipated values for the following output measures:
  - Number and type (model and specialty) of newly established rural residency program.

- Number of residents each rural residency program can support in the first year.
- Number of residents each rural residency program will support once fully established (longer-term goal).
- Number and type of existing clinical training sites for residents.
- Number and type of newly established clinical training sites for residents.
- Number of faculty and staff trained to teach, support, and administer the curriculum at each rural residency program site.
- Number and type of existing collaborations (e.g., non-clinical training site) that support the rural residency program.
- Number and type of newly established collaborations (e.g., non-clinical training site) that support the rural residency program.

3b: Program sustainability (25 points)

The panel will assess how well the application:

- Describes a clearly defined, fact-based, reasonable, and validated sustainability plan for the proposed rural residency program to support the residency after the period of federal funding under this award ends.
- Describes a plan for supporting the financial and programmatic sustainability of the new rural residency program. This must include funding sources other than clinical revenue and one (or a combination) of the funding options presented in the Program sustainability section of Program requirements and expectations.
- Identifies challenges and barriers to the proposed sustainability plan and proposes strong resolutions to address these issues to sustain the new rural residency program long-term.
- Describes financial investments already made for the new rural residency program.
- Demonstrates a stable future financial outlook for the sponsoring institution and clinical training partners involved in the new rural residency program. In Attachment 5, letters of agreements from collaborators should clearly describe future financial outlook, resources, and commitment to support the new program long-term.
- Provides strong supporting documentation validating the proposed sustainability plan in Attachment 1 and Attachment 6.

The panel will consider the following for each of the program sustainability options presented in the Project Narrative Program Sustainability Options Checklist.

For all sustainability options, the panel will assess how well the application:

- Explains the funding mechanisms and how the proposed program qualifies for the funding.
- Substantiates that the proposed funding source will sufficiently sustain the proposed rural residency program or RTP for the long term. For example, Sole Community Hospitals typically do not receive full Medicare GME payments and therefore may require additional sustainability funding from other sources beyond clinical operating revenue.

If an application proposes using Medicare sustainability options 1, 2, 3, or 4, the panel will consider:

- How well the application describes a strategy to qualify for these Medicare GME options (i.e., DGME and IME payments) and the viability of the proposed strategy.
- The strength of all required supporting documentation provided in Attachments 1 and 6 demonstrating eligibility for Medicare GME.

If an application proposes using Medicare sustainability option 5, the panel will consider:

- How well the application describes a strategy to create a sustainable rural residency program at a CAH.
- How well the required supporting documentation in Attachments 1 and 6 demonstrate eligibility for cost-based reimbursement as a CAH. **Note: Applications proposing Medicare sustainability option 5 are required to submit additional sustainability information under Option 6: Other public and private funding.**

For applications proposing to use non-Medicare sustainability funds (Option 6: Other public or private funding), the panel will consider how well the application demonstrates:

- For non-Medicare public funding, that the funding stream is viable long term, and that the program is reasonably qualified to obtain the public funding.
- For private funding, that the funding stream is viable long term, and through letters of agreement, the level of commitment of the private funder to the sustainability of the program, including the funding amount, duration of funding, and any potential future funding support.

We welcome you to select more than one sustainability option to strengthen your sustainability plan. Reviewers will consider the quality and extent to which an application that selects a combination of the six options has demonstrated meeting the criteria for each.

Criterion 4: Resources and capabilities (15 points)

See Project Narrative Organizational information.

The panel will assess how well the application:

- Describes the organization's current mission, structure, and scope of current activities for the applicant organization and other key collaborations.
- Describes how the organizational structure, collaborations, and resources will contribute to the organization's ability to successfully develop a new rural residency program and manage all programmatic, fiscal, and administrative aspects of the grant, including properly accounting for federal funds, and documenting all costs to avoid audit findings.
- Provides an organizational chart in Attachment 7 that clearly identifies the applicant organization, the sponsoring institution, and all relevant collaborators, including clinical training partners required for the rural residency program.
    - If the applicant organization is located in an urban area, the application demonstrates that you will be able to train residents in rural facilities by either:
        - Operating a clinical site in a rural area as defined by HRSA's FORHP; or
        - Demonstrating that you are part of a consortium where at least one consortium member operates a clinical training site in a rural area.
    - Corresponding letters of agreement with all primary training partners are included in Attachment 5.
- Describes a comprehensive staffing plan that will contribute to the success of the project in Attachment 3 and demonstrates the aptitude and expertise of faculty and staff to implement the proposed work plan in Attachment 4.
- Demonstrates the adequacy of facilities available to fulfill the needs of the proposed residency program.
- Describes the members of the GME consortium, key personnel, responsibilities of each consortium member involved with the grant, and explains the flow of grant funds between members of the consortium (if the application includes a GME consortium).
- Demonstrates capacity to ensure funds are properly used and monitored, including having policies and procedures in place that meet or exceed the requirements in 45 CFR part 75 regarding sub-recipient monitoring and management (if the application proposes sub awards or contracts).

Criterion 5: Support requested (5 points)

See Budget and budget narrative section and Organizational Information.

The panel will review your application to determine:

- How reasonable the proposed budget is for each year of the period of performance.
- How reasonable costs are and how well they align with the project's scope.
- How sufficient the time is for key staff to spend on the project to achieve project objectives.

We do not consider **voluntary** cost sharing during merit review.

Risk review

Before making an award, we review your award history to assess risk. We need to ensure all prior awards were managed well and demonstrated sound business practices. We:

- Review applicable past performance
- Review audit reports and findings
- Analyze the budget
- Assess your management systems
- Ensure you continue to be eligible
- Make sure you comply with any public policies

We may ask you to submit additional information.

As part of this review, we use SAM.gov Entity Information Responsibility / Qualification to check your history for all awards likely to be more than $250,000 over the period of performance. You can comment on your organization's information in SAM.gov. We'll consider your comments before making a decision about your level of risk.

If we find a significant risk, we may choose not to fund your application or to place specific conditions on the award.

For more details, see 45 CFR 75.205.

Selection process

When making funding decisions, we consider:

- The amount of available funds.
- Assessed risk.
- Merit review results. These are key in making decisions but are not the only factor.
- The larger portfolio of HRSA-funded projects, including the diversity of project types and geographic distribution.
- The funding priorities and special considerations listed.

We may:

- Fund out of rank order.
- Fund applications in whole or in part.
- Fund applications at a lower amount than requested.
- Decide not to allow a recipient to subaward if they may not be able to monitor and manage subrecipients properly.
- Choose to fund no applications under this NOFO.

Funding priorities

This program includes a funding priority, imposed by HRSA policy. A funding priority adds points to merit review scores if we determine that the application meets the listed criteria. Qualifying for a funding priority does not guarantee that your application will be successful.

If requesting funding priorities, indicate which qualifiers are being met in the Project Abstract and **Attachment 9**. HRSA will determine whether you meet one or both of these priorities.

Priority 1: Geographic distribution (2 points)

We will give you a funding priority if you clearly propose to develop a new rural residency program that trains residents for greater than 50 percent of total training time in rural counties located in one of the following priority states or U.S. territories:

- **States:** Alaska, Arizona, Idaho, Indiana, Maine, Montana, North Dakota, Nevada, Oregon, South Dakota, Utah, and Wyoming
- **Territories:** Commonwealth of Puerto Rico, Northern Mariana Islands, American Samoa, Guam, U.S. Virgin Islands, Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau

You must clearly list the state or territory and county of your training sites in your abstract and in **Attachment 9**.

HRSA selected these states and territories because they are in the lowest quartile for residents per capita or have no ACGME accredited residency programs.[20] This funding priority is to improve the geographical distribution of rural residency programs. The maldistribution of residency training across the nation is a key contributing factor for physician workforce shortages and access to health care in rural areas.[21] Several studies show that more than half of the individuals who complete residency training practice in the state where they did their residency training.[22]

If you propose to develop a new rural residency program that trains residents in one of these priority states or territories, but your organizational address is not in a priority state or territory, **you can still qualify for this priority.**

However, you will only qualify if you clearly demonstrate that the program will fulfill the general requirement of this priority to train residents for greater than 50 percent of total training time in rural counties located in a priority state or territory.

You must clearly list the state or territory and county of your training sites in your abstract and in **Attachment 9**.

Priority 2: Maternal health (4 points)

We will give you a funding priority if you clearly identified in your application that you are applying to develop a program in the Maternal Health and Obstetrics Pathway and you propose to create a program that meets either of the two options for this pathway:

- Obstetrics-gynecology rural residency program or rural track program.
- Family medicine rural residency program or rural track program with enhanced obstetrical training that will train residents for the independent practice of obstetrics in rural communities.

The purpose of this funding priority is to improve maternal health and increase obstetrical training in rural areas. Rural counties experience higher infant, neonatal and postnatal mortality rates than large urban counties.[23] The declining access to obstetrical services in rural areas due to obstetric unit closures and lack of practicing obstetricians present a challenge to providing high-quality maternal health services to meet the demands of rural communities.

Special considerations

This program includes special considerations imposed by HRSA. This program includes a special consideration to prevent significant overlap of service areas. Qualifying for special consideration does not guarantee that your application will be successful. We may assess your application based on the following criterion:

- If two or more applicants propose to train residents in the same medical specialty and target area, then only the highest ranked application for that specialty in the target area will receive consideration for award within available funding ranges.
- We will not consider applications proposing a new residency program in a target area currently served by a previously or currently funded RRPD recipient in the same specialty as the proposed program.

You can review the target areas of previous RRPD recipients using the program profiles.

To achieve the distribution of awards as stated, HRSA may need to fund out of rank order.

Award notices

We issue Notices of Award (NOA) on or around the start date listed in the NOFO. See Section 4 of the Application Guide for more information.

By drawing down funds, you accept the terms and conditions of the award.

Step 5: Submit Your Application

In this step

Application submission and deadlines

Your organization's authorized official must certify your application. See the section on finding the application package to make sure you have everything you need.

Make sure you are current with SAM.gov and UEI requirements. When you register or update your SAM.gov registration, you must agree to the financial assistance general certifications and representations, and specifically with regard to grants.

Make sure that your SAM.gov registration is accurate for both contracts and grants, as these registrations differ. See information on getting registered. You will have to maintain your registration throughout the life of any award.

Deadlines

Application

You must submit your application by April 10, 2025, at 11:59 p.m. ET.

Grants.gov creates a date and time record when it receives the application.

Submission method

Grants.gov

You must submit your application through Grants.gov. You may do so using Grants.gov Workspace. This is the preferred method. For alternative online methods, see Applicant System-to-System.

For instructions on how to submit in Grants.gov, see the Quick Start Guide for Applicants. Make sure that your application passes the Grants.gov validation checks, or we may not get it. Do not encrypt, zip, or password protect any files.

Have questions? Go to Contacts and Support.

Other submissions

Intergovernmental review

If your state has a process, you will need to submit application information for intergovernmental review under Executive Order 12372. Under this order, states may design their own processes for obtaining, reviewing, and commenting on some applications. Some states have this process and others do not.

To find out your state's approach, see the list of state single points of contact. If you find a contact on the list for your state, contact them as soon as you can to learn their process. If you do not find a contact for your state, you do not need to do anything further.

This requirement never applies to American Indian and Alaska Native tribes or tribal organizations.

Application checklist

Make sure that you have everything you need to apply:

Component	How to Upload	Included in page limit?
☐ Project abstract	Use the Project Abstract Summary Form.	No
☐ Project narrative	Use the Project Narrative Attachment form.	Yes
☐ Budget narrative	Use the Budget Narrative Attachment form.	Yes
Attachments	Insert each in the Attachments form in this order.	
☐ 1. Rural status		No
☐ 2. Work plan		Yes
☐ 3. Staffing plan and job descriptions		Yes
☐ 4. Biographical sketches		No
☐ 5. Agreements with other entities		Yes
☐ 6. Program sustainability documents		Yes
☐ 7. Project organizational chart		Yes
☐ 8. SORH letters of intent		No
☐ 9. Funding priority documentation		Yes
☐ 10. Other relevant document		Yes
☐ 11. Other relevant document		Yes
☐ 12. Other relevant document		Yes
☐ 13. Other relevant document		Yes
☐ 14. Other relevant document		Yes
☐ 15. Other relevant document		Yes

Component	How to Upload	Included in page limit?
Other required forms*	Upload using each required form.	
☐ Application for Federal Assistance (SF-424)		No
☐ Budget Information for Non-Construction Programs (SF-424A)		No
☐ Disclosure of Lobbying Activities (SF-LLL)		No
☐ Project/Performance Site Location(s)		No
☐ Grants.gov Lobbying Form		No
☐ Key Contacts		No

* Only what you attach in these forms counts against the page limit. The form themselves do not count.

Step 6: Learn What Happens After Award

In this step

Post-award requirements and administration

Administrative and national policy requirements

There are important rules you need to know if you get an award. You must follow:

- All terms and conditions in the Notice of Award (NOA). We incorporate this NOFO by reference.
- The regulations at 45 CFR part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, and any superseding regulations. Effective October 1, 2024, HHS adopted the following superseding provisions:
  - 2 CFR 200.1, Definitions, Modified Total Direct Cost.
  - 2 CFR 200.1, Definitions, Equipment.
  - 2 CFR 200.1, Definitions, Supply.
  - 2 CFR 200.313(e), Equipment, Disposition.
  - 2 CFR 200.314(a), Supplies.
  - 2 CFR 200.320, Methods of procurement to be followed.
  - 2 CFR 200.333, Fixed amount subawards.
  - 2 CFR 200.344, Closeout.
  - 2 CFR 200.414(f), Indirect (F&A) costs.
  - 2 CFR 200.501, Audit requirements.
- The HHS Grants Policy Statement (GPS). Your NOA will reference this document. If there are any exceptions to the GPS, they'll be listed in your NOA.
- All federal statutes and regulations relevant to federal financial assistance, including those highlighted in HHS Administrative and National Policy Requirements.
- The requirements for performance management in 2 CFR 200.301.

Health information technology interoperability

If you receive an award, you must agree to the following conditions when implementing, acquiring, or upgrading health IT. These conditions also apply to all subrecipients.

- Compliance with 45 CFR part 170, subpart B. Make sure your activities meet these standards if they support the activity.
- Certified Health IT for Eligible Clinicians and Hospitals. Use only health IT certified by the ONC Health IT Certification Program for activities related to Sections 4101, 4102, and 4201 of the HITECH Act.

If 45 CFR part 170, subpart B standards cannot support the activity, we encourage you to:

- Use health IT that meets non-proprietary standards.
- Follow specifications from consensus-based standards development organizations.
- Consider standards identified in the ONC Interoperability Standards Advisory.

Non-discrimination legal requirements and assurance

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS-690). To learn more, see the Laws and Regulations Enforced by the HHS Office for Civil Rights.

Contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws or call 1-800-368-1019 or TDD 1-800-537-7697.

The HRSA Office of Civil Rights, Diversity, and Inclusion (OCRDI) offers technical assistance, individual consultations, trainings, and plain language materials to supplement OCR guidance. Visit OCRDI's website to learn more about how federal civil rights laws and accessibility requirements apply to your programs, or contact OCRDI directly at HRSACivilRights@hrsa.gov.

Executive order on worker organizing and empowerment

Executive Order on Worker Organizing and Empowerment (E.O. 14025) encourages worker organizing and collective bargaining to promote equality of bargaining power between employers and employees.

You can support these goals by developing policies and practices that you could use to promote worker power.

Cybersecurity

You must create a cybersecurity plan if your project involves both of the following conditions:

- You have ongoing access to HHS information or technology systems.
- You handle personal identifiable information (PII) or personal health information (PHI) from HHS.

You must base the plan based on the NIST Cybersecurity Framework. Your plan should include the following steps:

Identify:

- List all assets and accounts with access to HHS systems or PII/PHI.

Protect:

- Limit access to only those who need it for award activities.
- Ensure all staff complete annual cybersecurity and privacy training. Free training is available at 405(d): Knowledge on Demand (hhs.gov).
- Use multi-factor authentication for all users accessing HHS systems.
- Regularly backup and test sensitive data.

Detect:

- Install antivirus or anti-malware software on all devices connected to HHS systems.

Respond:

- Create an incident response plan. See Incident-Response-Plan-Basics_508c.pdf (cisa.gov) for guidance.
- Have procedures to report cybersecurity incidents to HHS within 48 hours. A cybersecurity incident is:
    - Any unplanned interruption or reduction of quality, or

    - An event that could actually or potentially jeopardize confidentiality, integrity, or availability of the system and its information.

Recover:

- Investigate and fix security gaps after any incident.

Reporting

If you are successful, you will have to follow the reporting requirements in Section 6 of the Application Guide. The NOA will provide specific details.

You must also follow these program-specific reporting requirements:

- Progress reports each quarter.
- Annual performance reports through the Electronic Handbooks.
- Submission of key parts of your application (project narrative, work plan, staffing plan, sustainability documentation, organizational chart, and budget narrative) to the RRPD Technical Assistance Center within 45 days after the project start date.
- Submission of ACGME documentation confirming application completion and submission in ACGME Accreditation Data System (ADS) within 24 months after the project start date.
- Submission of a graduate tracking plan within 24 months of the project start date.

Contacts and Support

In this step

Agency contacts

Program and eligibility

Jason Steele
Public Health Analyst, Policy Research Division

Attn: Rural Residency Planning and Development Program
Federal Office of Rural Health Policy
Health Resources and Services Administration
Email your questions to: ruralresidency@hrsa.gov
Call: 301-443-2203

Financial and budget

Beverly Smith
Grants Management Specialist

Division of Grants Management Operations, OFAM
Health Resources and Services Administration
Email your questions to: ruralresidency@hrsa.gov
Call: 301-443-7065

HRSA Contact Center

Open Monday – Friday, 7 a.m. – 8 p.m. ET, except for federal holidays.
Call: 877-464-4772 / 877-Go4-HRSA
TTY: 877-897-9910
Electronic Handbooks Contact Center

Grants.gov

Grants.gov provides 24/7 support. You can call 1-800-518-4726, search the Grants.gov Knowledge Base, or email Grants.gov for support. Hold on to your ticket number.

SAM.gov

If you need help, you can call 866-606-8220 or live chat with the Federal Service Desk.

Helpful websites

- HRSA's How to Prepare Your Application page
- HRSA Application Guide
- HRSA Grants page
- HHS Tips for Preparing Grant Proposals
- Health Resources and Services Administration Resources
- Federal Office of Rural Health Policy
- Bureau of Health Workforce
- National Health Service Corps (NHSC)
- Teaching Health Center Graduate Medical Education (THCGME) Program
- Council on Graduate Medical Education
- HRSA Data Warehouse
- Rural Residency Planning and Development Technical Assistance (RRPD-TA)

HRSA is not affiliated with all the following resources, and inclusion of a non-federal resource on this list does not constitute endorsement by HRSA, but you are encouraged to review these resources.

- Accreditation Council for Graduate Medical Education
- Common Program Requirements
    - Specialty-Specific Program Requirements
        - Family Medicine
        - General Surgery
        - Internal Medicine
        - Obstetrics and Gynecology
        - Preventive Medicine
            - Occupational and Environmental Medicine
            - Public Health and General Preventive Medicine
        - Psychiatry
    - ACGME Rural Track Program Designation
    - Institutional Application Process
    - Program Application Information
    - ACGME FAQs and General Accreditation Questions
    - Rural Training Track (RTT) Collaborative

- Rural Health Research Gateway
- Rural Health Information Hub (RHI Hub)
- National Area Health Education Center (AHEC) Organization
- National Organization for State Offices of Rural Health (NOSORH)

Appendix A: Medicare GME Information

The Centers for Medicare and Medicaid Services (CMS) provides Inpatient Prospective Payment System (IPPS) Medicare GME payments to qualifying hospitals to support the indirect (IME) and direct (DGME) costs of an approved medical residency program.

CMS calculates both IME and DGME payments based in part on the number of full time equivalent (FTE) residents a hospital trains. The Balanced Budget Act (BBA) of 1997 established a limit on the number of FTE residents for which each hospital can receive IME and DGME payment. This limitation, one for IME and one for DGME, is based on the number of such FTE residents the hospital trained in its most recent cost report ending on or before December 31, 1996. It is referred to as the "1996 Base Year Resident Cap."

The DGME payment is also based in part on a hospital-specific Per Resident Amount (PRA). Establishment of a hospital's PRA is triggered when the hospital trains a resident or residents in an approved GME program for the first time, regardless of whether those residents are part of a new approved program or an existing approved program and regardless of whether the hospital is the sponsor of the approved program, and regardless of whether the hospital incurs costs for the resident(s). The regulations at 42 CFR 413.77 provide additional information on the establishment of PRAs.

IME is a calculated payment added on to each Diagnosis Related Groups (DRG) payment and includes the Medicare Advantage DRG-equivalents. A hospital's classification type for Medicare payment purposes (e.g., Sole Community Hospitals and Medicare Dependent Hospitals) can have a marked effect on hospital GME payments. Some hospital types may only get only partial IME payments. CAHs are not IPPS hospitals, meaning that CAHs are not paid by Medicare for patient care using the DRG system that IPPS hospitals use. Program Sustainability Option 5 discusses GME payment to CAHs.

For more information about Medicare GME funding for specific hospital types see the glossary in the RRPD-TA Center's Rural GME Hospital Analyzer tool.

On December 27, 2020, Congress passed the Consolidated Appropriations Act (CAA), 2021 (P.L. 116-260) that included major GME provisions that promote physician residency training opportunities and seek to address the health equity gap in rural communities. CMS finalized provisions to implement sections 126, 127, and 131 of the CAA in the FY22 Inpatient Prospective Payment System (IPPS) Final Rule with Comment Period (CMS-1752-FC3) published on December 27, 2021:

- **Section 126** – authorizes the distribution of 1,000 new Medicare-funded GME residency positions to qualifying hospitals in 4 statutorily-specified categories, including hospitals located (or treated as being located) in a rural area starting in FY 2023 with not more than 200 slots being distributed per fiscal year. Refer to CMS FAQs on Section 126.
- **Section 127** – statutorily removes the "separate accreditation" requirement for RTPs and allows both the urban and/or rural hospitals to qualify to receive a rural track FTE adjustment if greater than 50 percent of the training takes place in a rural area, regardless of specialty, if the entire program is accredited by ACGME. Refer to the CMS FAQs on Section 127.
- **Section 131** – authorizes the resetting of low or zero DGME PRAs and low IME and DGME FTE resident caps for certain hospitals starting December 27, 2020, through December 26, 2025. It also requires hospitals to report residents on their Medicare cost reports only when they train at least 1.0 FTE in an approved program (in the absence of a Medicare GME affiliation agreement). Refer to CMS Guidance on Section 131.

Appendix B: Sample Attachment Templates

Sample rural status table

This is a sample rural status table for Attachment 1: Rural status. We share it as an example of the type of table and information required in grant applications for HRSA's RRPD program. Other types are acceptable. See Attachment 1 for more information.

Site Name	Address	County or County Equivalent	CMS Rural Status	FORHP Rural Status	Site Classification	Projected Percentage of Training Time at Site
Site A	Address City, State	X County	Rural	Rural	CAH	51%
Site B	Address City, State	Y County	Urban	Rural	SCH, Never Claimer	29%
Site C	Address City, State	Z County	Urban	Urban	RRC	20%

Sample work plan template

This is a sample work plan template. We share it as one example of the type of work plan required in grant applications for HRSA's RRPD program. Other types are acceptable.

See the Project narrative High-level work plan section and Attachment 2 for more information.

Goal:

Measurable outcomes: Time Frame (Start/End Dates by Month/Year in Project Cycle)

Objective	Key Tasks	Person Responsible	Start Date	End Date
1.				
2.				

Note: You can add as many major objectives as necessary for your program.

Appendix C: Glossary

The following definitions apply to the RRPD Program for the Fiscal Year 2025.

Centers for Medicare & Medicaid Services (CMS) Rural: CMS defines "rural" in accordance with Medicare regulations at 42 CFR 412.62(f)(1)(iii). That is, a rural area is any area outside of an urban area. This excludes hospitals that are physically located in an urban area but reclassify to a rural area under 42 CFR 412.103 and thus are treated as rural for indirect medical education (IME) purposes, but not for direct GME. To determine if a hospital is in a county that is rural for Medicare payment purposes, refer to the FY 2025 "County to CBSA [Core-Based Statistical Area] Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals File" that is available on the FY25 IPPS Final Rule Homepage. Applicants must confirm rural status and examine past Medicare cost reports to determine hospital eligibility status for Medicare GME payment.

HRSA Federal Office of Rural Health Policy (FORHP) Rural: FORHP accepts all non-metropolitan counties as rural and uses an additional method to determine rural census tracts within metropolitan counties. FORHP considers census tracts inside metropolitan counties with the Rural-Urban Commuting Area (RUCA) codes 4-10 to be rural and makes additional adjustments for very large tracts with low population density, for counties with no population living in certain Census-defined Urban Areas, and for geographically isolated tracks due to rugged terrain.[24] Use the Rural Health Grants Eligibility Analyzer to determine whether FORHP considers a geographical area to be rural.

- **Note:** HRSA's definition of rural may differ from CMS, which is an important distinction to understand if developing a financial sustainability plan based on Medicare GME funding.

Graduate Medical Education Consortium: An association between two or more organizations (e.g., academic medical centers, rural hospitals, rural community-based ambulatory patient care centers, universities, and/or medical schools) to form an entity that serves as the institutional sponsor and operator of an accredited residency program(s). At least one consortium member must operate a clinical training site located in a rural area. The relationship between the consortium members must be legally binding and the agreement establishing the relationship must describe the roles and responsibilities of each entity.

National Provider Identifier (NPI): The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The

NPI is a unique identification number for covered health care providers. You can find additional information about NPIs here.

New Medical Residency Training Program: Per 42 CFR 413.79(l), CMS defines a new medical residency program as one that is, "a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995". In determining whether a program is new, CMS will consider the accrediting body's characterization of the program as new and whether the program existed previously at another hospital, as well as factors such as (but not limited to) whether there are new program directors, new teaching staff, and whether there are only new residents training in the program.

Preventive Medicine: ACGME defines Preventive Medicine as the medical specialty in which physicians focus on health promotion and the prevention of disease, disability, and premature death of individuals in defined populations.[25] Preventive medicine focus areas include aerospace medicine, occupational and environmental medicine, and public health and general preventive medicine. For this NOFO, only occupational and environmental medicine and public health and general preventive medicine are qualifying specialties.

Rural Residency Programs: Rural residency programs are ACGME-accredited physician residency training programs that place residents in rural training sites for greater than 50 percent of their total time in residency training and focus on producing physicians who will practice in rural communities.

Rural Track Program (RTP): RTPs are a type of rural residency program. Per 42 CFR 413.75(b) CMS defines RTP as, "an ACGME-accredited program in which residents… gain both urban and rural experience with more than half of the education and training for a resident… taking place in a rural area as defined at 42 CFR 412.62(f)(iii)[26]" effective for cost reporting periods starting on or after October 1, 2022. ACGME's RTP designation identifies RTPs "either with the approval of a permanent complement increase request and the addition/identification of at least one new rural participating site or at the time of program application for accreditation". For the purposes of this NOFO, applicants can propose RTPs that are 1) new programs, or 2) a new rural track program within an existing program by applying for a permanent complement increase with at least one new rural training site through ACGME's RTP designation process.

- **Note:** Historically, the terminology for this program model was referred to as Rural Training Track (RTT) which were limited to separately accredited residency programs with more than half of the training taking place in a rural area.

Target Area: A target area is the specific rural geographic location(s) and communities you plan to serve with the proposed rural residency program. In most cases your target area will be the county or counties where your rural training sites are located.

Endnotes

1. Rurality requirements are more stringent (i.e., CMS rural) for certain sustainability options. To satisfy rurality requirements for this funding opportunity, an application must propose that greater than 50% of the training will take place in FORHP rural areas. Applicants should review the Program Sustainability section carefully and ensure that they include required documentation for the sustainability options they propose. See Appendix C: Glossary for rural definitions. ↑
2. For this NOFO, only occupational and environmental medicine and public health and general preventive medicine are qualifying specialties. Refer to program definitions for more information. ↑
3. Effective July 1, 2024, ACGME revised family medicine program requirements contain updates for maternity care, including robust requirements on comprehensive pregnancy-related care (IV.C.3.i).(2)). Refer to ACGME's Family Medicine Program Requirements for more information. ↑
4. U.S. Department of Health and Human Services, Health Resources and Services Administration. HRSA Defining Rural Population. Retrieved from https://www.hrsa.gov/rural-health/about-us/what-is-rural ↑
5. Streeter RA, Snyder JE, Kepley H, Stahl AL, Li T, et al. The geographic alignment of primary care Health Professional Shortage Areas with markers for social determinants of health. PLOS ONE 24 April 2020 15(4): e0231443. Retrieved from https://doi.org/10.1371/journal.pone.0231443 ↑
6. Ibid. ↑
7. U.S. Department of Health and Human Services, Health Resources and Services Administration Data Warehouse. Accessed June 2024 from https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport ↑
8. U.S. Department of Health and Human Services, Health Resources and Services Administration. Health Workforce Projections, March 2024. Retrieved from https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand ↑
9. Russell, DJ, Wilkinson E, Petterson S, Chen C, Bazemore, A; Family Medicine Residencies: How Rural Training Exposure in GME Is Associated with Subsequent Rural Practice. J Grad Med Educ 1 August 2022; 14 (4): 441–450. doi: https://doi.org/10.4300/JGME-D-21-01143.1 ↑
10. Patterson, DG, Shipman, SA, Pollack, SW, et al. Growing a rural family physician workforce: The contributions of rural background and rural place of residency training. *Health Serv Res* . 2023; 1-7. ↑
11. United States Government Accountability Office. Graduate Medical Education: Programs and Residents Increased during Transition to Single Accreditor; Distribution Largely Unchanged. GAO-21-329. April 2021. Retrieved from https://www.gao.gov/products/gao-21-329 ↑
12. The Consolidated Appropriations Act (CAA), 2021 (P.L. 116-260) authorized changes to Medicare GME regulations that expanded indirect and direct GME payment policies for Rural Track Programs (RTPs). Refer to the implementation of the CAA, 2021 in the FY22 Inpatient Prospective Payment System (IPPS) Final Rule with Comment Period and Program Sustainability for more information. ↑
13. Section 127 of the CAA, 2021, removed the separate accreditation requirement previously applied to RTPs, providing greater flexibilities for urban hospitals and rural hospitals to receive Medicare GME funding for new RTPs and new RTP sites regardless of specialty. Note, however, that current Medicare regulations do not provide cap increases when hospitals expand the number of residents training at an existing participating site of an already established RTP. ↑
14. In past competitions, recipients may have planned to use Section 131 of the Consolidated Appropriations Act as part of their sustainability plan to reset low caps and/or per resident amounts. Under current law, this authority expires in December 2025. Based on program experience, most

recipients take three years to start a new residency program and thus Section 131 resets will not be available as a realistic sustainability option for new applicants for this NOFO. See Appendix A: Medicare GME Information for more information about Section 131. ↑

15. Hospitals located in an urban area and reclassified as rural under 42 CFR 412.103 will not qualify as rural training sites for the purpose of this NOFO unless they are physically located in an area considered rural by FORHP. See Appendix C: Glossary for FORHP rural definition. ↑
16. Centers for Medicare & Medicaid Services. "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." *Federal Register* 86, no. 245 (2021): 73447. Accessed at: https://www.federalregister.gov/d/2021-27523/p-400 ↑
17. U.S. territories do not have State Offices of Rural Health but are eligible to apply. Therefore, U.S. territories are not required to contact a SORH. If you are proposing training sites in territories, you may notify the National Organization of State Offices of Rural Health (NOSORH) of your intent to apply to this program. U.S. territories may submit a notification to and/or letter from NOSORH as Attachment 8 as part of their complete application. ↑
18. Effective July 1, 2023, ACGME revised family medicine program requirements contain updates for maternity care, including robust requirements on comprehensive pregnancy-related care. Per ACGME, "Residents who seek the option to incorporate comprehensive pregnancy-related care, including intrapartum pregnancy-related care and vaginal deliveries into independent practice, must complete at least 400 hours (or four months) dedicated to training on labor and delivery and perform or directly supervise at least 80 deliveries". Refer to ACGME's Family Medicine Program Requirements for more information. ↑
19. This review criterion does apply to U.S. territories. U.S. territories do not have State Offices of Rural Health but are eligible to apply. Therefore, U.S. territories are not required to contact a SORH. ↑
20. Accreditation Council for Graduate Medical Education. Data Resource Book: Academic Year 2022-2023. 2023; 61. Accessed at https://www.acgme.org/globalassets/pfassets/publicationsbooks/2022-2023_acgme_databook_document.pdf ↑
21. Council on Graduate Medical Education. Special Needs in Rural America: Implications for Healthcare Workforce Education, Training, and Practice. July 2020. Accessed at https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/publications/cogme-rural-health-issue-brief.pdf ↑
22. Association of American Medical Colleges. 2023 Report on Residents. November 2023. Accessed at https://www.aamc.org/data-reports/students-residents/data/report-residents/2023/executive-summary ↑
23. 17 Ely D, Hoyert D. Differences Between Rural and Urban Areas in Mortality Rates for the Leading Causes of Infant Death: United States, 2013-2015. NCHS Data Brief No. 300. 2018. https://www.cdc.gov/nchs/data/databriefs/db300.pdf ↑
24. U.S. Department of Health and Human Services, Health Resources and Services Administration. HRSA Defining Rural Population. Accessed at https://www.hrsa.gov/rural-health/about-us/what-is-rural ↑
25. Accreditation Council for Graduate Medical Education. Preventive Medicine. Accessed at https://www.acgme.org/Specialties/Preventive-Medicine/Overview ↑
26. Quoted as appears in the CFR; however, correct citation is 42 CFR 412.62.(f)(1)(iii). ↑