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Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know

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Introduction

In nearly every area of your life, the choices you make today will have a direct impact on options available to you in the future. This includes your medical education.

The AAMC (Association of American Medical Colleges) first developed this brochure in 1997 to help medical students, residents, and advisors understand Medicare payment rules related to graduate medical education. We have updated it based on changes in the law, regulations, and the many questions that we have fielded over the years. After reading it, we hope that you will be in a better position to assess the impact of decisions related to your graduate medical education, from choosing a program, to changing specialties, to pursuing fellowships.

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1. What are Medicare and Medicaid?

Medicare is a federally administered health insurance program for people 65 or older, certain disabled people, and individuals with end-stage renal disease. Medicare Part A pays for inpatient hospital services, skilled nursing facility care, home health, and hospice care. Part B pays for physicians' services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by Part A. Medicare Part C, known as Medicare Advantage, provides beneficiaries with managed care options. Part D provides prescription drug coverage. Medicare payments for graduate medical education are primarily made under Part A.

Medicaid is a health insurance program for low-income families financed jointly by the federal government and each state. The Centers for Medicare and Medicaid Services (CMS) is the federal agency that administers the Medicare program and the federal portion of the Medicaid program.

2. Does Medicare have a role in financing graduate medical education?

Yes. Medicare is the largest single program providing explicit support for graduate medical education (GME). In federal fiscal year 2011, the Medicare program paid hospitals that train residents approximately \$3.2 billion dollars in direct graduate medical education (DGME) funds, out of approximately \$15 billion in DGME-related costs.¹ DGME payments cover a portion of the direct costs of training residents, such as residents' stipends and benefits, teaching physicians' salaries, other direct costs (e.g., a GME office to administer programs, accreditation fees, educational space, etc.), and related overhead expenses. The amount of Medicare DGME payments a teaching hospital receives is related to the share of the hospital's inpatients who are Medicare beneficiaries. All Medicare payments for DGME are paid directly to hospitals that train residents; none are made to the residents themselves. Medicaid also pays hospitals for GME in many states; however, that topic is outside the scope of this brochure.

¹ Note that teaching hospitals also receive Medicare "indirect graduate medical education" (IME) payments, addressed in Question 10.

3. Why is it important for a medical student to understand how Medicare pays hospitals for DGME?

Because Medicare is such a large payer of DGME costs, Medicare's payment requirements are often of great importance to residents and teaching hospitals. As will be explained below, the rules that Medicare establishes to pay hospitals for DGME may limit some residents' opportunities to change from one specialty to another, or may make it more difficult for a physician who wishes to retrain in another specialty to be able to do so. It is important to remember, however, that many factors other than potential reimbursement from the government influence a program's decision about whether to offer a residency position to a particular individual.

4. What do I need to know about how Medicare pays hospitals?

Every hospital that trains residents in an approved residency program is entitled to receive Medicare DGME funding. The amount of DGME payments varies for each hospital. The payments are based on an amount known as the hospital-specific per resident amount (PRA) which, according to law, was determined by CMS for each teaching hospital in the 1980s and is updated each year by an inflation factor. Because DGME payments are based on historical costs, they are not related to the costs the hospital currently incurs for training residents. The amount each hospital receives for DGME is based on the number of residents it is allowed to count, its hospital-specific PRA, and the percentage of its inpatient population that is comprised of Medicare beneficiaries. This is explained in more detail below.

5. Which training programs does Medicare support?

Hospitals are entitled to receive DGME payments for residents who are participating in approved educational activities. Typically, this means the programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the American Dental Association (ADA), and the American Podiatric Medical Association (APMA). A list of ACGME-accredited specialties is available at: www.acgme.org.

Medicare also recognizes programs that lead to board certification by the American Board of Medical Specialties (ABMS). Note, however, that some highly specialized physician training programs, such as transplant training fellowships, do not meet the CMS definition of "approved," because they are not accredited by one of the accrediting bodies and do not lead to board certification. Hospitals will not receive DGME payments for trainees in these programs. A list of ABMS specialty board certificates is available at: www.abms.org.

Also note that the Medicare program no longer supports the years of a training program that extend beyond the minimum accredited length of the program. For example, if a resident trains in a six-year general surgery program, the hospital will only receive DGME payments for the resident's first five years of training, because the minimum accredited length of a general surgery program is five years. CMS states that hospitals will not receive Medicare funding for the period of time extending beyond the accredited length of the program, because residents are no longer training in an accredited program.

6. Are there any limits on the number of residents for which Medicare will pay a hospital?

Yes. Congress passed a law in 1997 that imposes a hospital-specific limit on the number of residents that Medicare will pay for. In general, the limit (often referred to as the hospital's resident "cap") is based on the number of residents that a hospital trained in 1996.

7. How does a hospital count residents to receive money from Medicare?

Residents working in all areas of the hospital complex may be included in a hospital's full-time equivalent (FTE) count for DGME payments. A hospital also may include residents working in a clinical non-hospital site in its FTE count, if it continues to pay the stipends and benefits of the residents while they train in the non-hospital setting. However, regardless of who pays the costs, a hospital may not count any of the time that a resident spends training at another hospital, even if the other hospital does not seek DGME payments from Medicare.

When Medicare counts the number of residents for determining a hospital's DGME payments, each full-time resident is counted (or "weighted") as 1.0 FTE during an initial residency period (IRP). After the IRP, a full-time resident is counted only as 0.5 FTE for Medicare DGME payments. No resident may be counted as 1.0 FTE for more than five years, but there is no limit on the number of years a resident may be counted as 0.5 FTE, as long as the resident continues to train in an approved program.

8. What is an initial residency period, and how is it determined?

The initial residency period (IRP) is the minimum number of years required for a resident to become board eligible in the specialty in which the resident first begins training. The IRP for a specialty is based on the minimum accredited length of a residency program, as determined by the ACGME. Generally, Medicare determines the IRP at the time a resident first enters a training program. **Every resident has just one IRP, and it does not change, even if the resident later changes specialties.**

It is very important to understand that the residency program in which you begin training determines the number of years Medicare will make full DGME payments to the hospital for your training (although the maximum number of years you can be counted as 1.0 FTE is five); any additional years will be funded at the 50 percent level. CMS has not published a list of specialties and IRPs since 1996, but you can find information on the minimum number of years of training required for each approved residency program on the ACGME's Web site at: www.acgme.org.

Here's an example: Dr. Smith begins an internal medicine residency on July 1, 2012. Internal medicine has an IRP of three years. Dr. Smith soon realizes that she'd rather do a surgery residency (which has a five-year IRP) and would like to begin training the following year. However, even if Dr. Smith is accepted into a surgery program and begins that program on July 1, 2013, her IRP remains three years (of which she has already spent one year training in internal medicine). She would be counted as 1.0 FTE during her first and second years of the surgery residency, but only as 0.5 FTE during her third, fourth, and fifth years. The hospital will be paid less for Dr. Smith's last three years of training than it would have been paid for a resident who began training in surgery right out of medical school and had an IRP of five years.

Here are some special IRP-related rules to keep in mind:

- **Residencies that require the completion of a broad-based clinical year:**
 - If a specialty requires a broad-based clinical year of training, and you match simultaneously into both the broad-based year and the specialty program, then your IRP is determined by the specialty program that begins during your second year of training. If, instead, you initially match only into a clinical base year or preliminary year program, your IRP is determined by your clinical base year program—even if you later match into a different specialty.

Here's an example: You simultaneously match into both an internal medicine clinical base-year program and a radiology training program. Your IRP will be based on the minimum number of years required to become board eligible in radiology and will be set at five years. If, instead, you match *only* into an internal medicine clinical base-year program, begin the program, and later are accepted into a radiology program for your post-graduate year-2 (PGY-2), your IRP will be based on the number of years required to become board eligible in *internal medicine*, and will be set at three years.

- If you match into a program that would begin in your PGY-2, and you are able to obtain a preliminary year position for your PGY-1 outside of the match, then your IRP is determined by the specialty in which you will train during your PGY-2.
- **When your first residency is a transitional year:**
 - If the first residency you enter is a transitional year, then your IRP is determined by the residency you enter in your second year of training.
- **Determining the IRPs for certain residency programs:**
 - If you train in an approved geriatric medicine program that requires the completion of two years of training to become board eligible, the two years spent in the geriatric medicine program are treated as part of the IRP.
 - The IRP for a resident in an approved child neurology program is five years.
 - Residents training in an approved preventive medicine residency or fellowship may be counted as a full 1.0 FTE for up to two years beyond their IRP. (Note, however, that if you were to start training in preventive medicine and subsequently changed specialties, you would no longer be eligible for this two-year IRP extension.)
- **If your training started before July 1, 1995:**
 - If you started your residency training before July 1, 1995, your IRP is counted differently. It is the minimum number of years required to be eligible for board certification, plus one year, though it cannot exceed five years.
- **All other subspecialty training:**
 - For all other subspecialty training that is beyond the IRP, each resident or fellow in a subspecialty program is counted as 0.5 FTE.

9. Can you give an example of what these rules mean in determining how much DGME funding the hospital will receive?

For a hospital to calculate its Medicare DGME payments, it must do the following:

1. Count the weighted number of residents the hospital trains according to the law and regulations.
2. Multiply the number of residents by the hospital's PRA.
3. Multiply the product in number two above by Medicare's share of the hospital's number of inpatient days, i.e., the percentage of hospital inpatients who are Medicare beneficiaries. This is called the Medicare patient load.

Here's an example: In 2012, University Hospital has a DGME resident limit of 400 resident FTEs and is currently training 400 resident FTEs. Of these, 300 FTEs are training in their IRP (so, each is counted as 1.0 FTE) and 100 are training beyond their IRP (so, each is counted as 0.5 FTE). The hospital's updated PRA for 2012 is \$90,000. Thirty percent of the hospital's inpatient days are attributed to Medicare beneficiaries.

Medicare will determine University Hospital's DGME payments as follows:

Payment for residents training in their IRP: $(300 \times \$90,000) \times .30 = \$8,100,000$
+ Payment for residents training beyond their IRP: $[0.5(100 \times \$90,000)] \times .30 = \$1,350,000$
TOTAL DGME PAYMENTS = \$9,450,000

10. Does Medicare cover any other teaching hospital costs?

Teaching hospitals also receive an indirect medical education (IME) adjustment from Medicare, but the label for this type of payment is actually a misnomer. These payments are designed to pay teaching hospitals' increased *patient care* costs associated with treating more complex patients, requiring standby capacity in burn and trauma centers, etc., *not* resident training costs.

The IME adjustment is an additional payment for each Medicare inpatient stay. Among other factors, the IME adjustment is based on a hospital's ratio of residents-to-beds (often referred to as the intern and resident-to-bed ratio or IRB ratio). Residents may be counted for the IME adjustment if they are working in the inpatient or the outpatient department of the hospital or in a non-hospital setting, if certain conditions are met. The IRP does not apply to IME payments. Thus, residents continue to be counted as 1.0 FTE for IME payments, even if they are training beyond their IRP for purposes of DGME.

Psychiatric and rehabilitation hospitals are paid differently than acute care hospitals under the Medicare program. These hospitals receive “teaching status adjustment” payments in lieu of IME payments, and the adjustment formula is based on the ratio of residents to the hospital’s average daily patient census rather than beds.

11. I plan to enter a pediatric residency at a children’s hospital. Will the Medicare GME payment rules be the same there?

Because children’s hospitals treat few, if any, Medicare patients, they receive very little funding from the Medicare program for their GME expenses. However, these hospitals are eligible to receive payments through the Children’s Hospitals GME (CHGME) Payment Program, which is funded by general federal appropriations dollars and administered by the Health Resources and Services Administration (HRSA). This program generally follows the Medicare rules in terms of counting residents and setting caps on the number of funded positions. More information on the CHGME program is available on the HRSA Web site at: <http://bhpr.hrsa.gov/childrenshospitalgme>.

12. I completed a year of clinical training after medical school, and now I am fulfilling a military commitment. How does the IRP limit affect me?

Many medical students who have military commitments are required to complete one year of post-medical school training in an accredited program before entering the military. If you are in your first residency program after graduation from medical school, or if you have not exceeded the limits of an IRP in another specialty, you will be counted as 1.0 FTE during the required year of training prior to entering the military. If you subsequently leave the military and enter a residency program, the year of training you previously completed will count towards the IRP.

If the residency year you completed prior to entering the military was in a specific specialty, such as internal medicine, your IRP will be based on the minimum number of years required to become board eligible in that specialty—even though you left the program to complete a military commitment. If your training prior to entering the military was in a transitional year program, then your IRP will be based on the specialty in which you resume training. Any training in a residency program operated by the military that may be counted towards board certification also counts towards the IRP.

13. Does training time for which Medicare does not pay count against my IRP?

Yes. All training time that counts towards certification in a specialty is counted against your IRP for purposes of determining Medicare's DGME payments. So, even if you completed a residency program that Medicare did not support (e.g., a program in another country, or one funded by the Department of Defense), any training you may wish to do later will be considered to be beyond the IRP, and you will be counted as 0.5 FTE for purposes of determining the hospital's Medicare DGME payments.

14. I plan to begin a combined residency training program. What is my IRP?

The answer depends on the type of combined program in which you will be training. If each of the individual programs that makes up the combined program is a primary care specialty—defined by Congress as general internal medicine, general pediatrics, family practice, geriatrics, preventive medicine, obstetrics and gynecology, and osteopathic general practice—then you will count as 1.0 FTE for the minimum number of years required for board eligibility for the longer of the two programs, plus one additional year. For example, if you enter a combined internal medicine-family practice program, both of which will require three years for board eligibility, you will be counted as 1.0 FTE for four years—the three years required for internal medicine, plus one year. For any additional years of training in an approved program, you will be counted as 0.5 FTE.

If you enter a combined program in which one of the two programs is not a primary care specialty, such as internal medicine-emergency medicine, then the rules are different. CMS determines the IRP based on the longer of the two programs. In the internal medicine-emergency medicine example, CMS states that because the IRP for each program taken separately is three years, the IRP for a combined internal medicine-emergency medicine program is three years. You will be counted as 0.5 FTE for the fourth year of the combined internal medicine-emergency medicine program.

15. I have already begun training in a three-year program and want to switch to a longer program. What do I do now?

It is important for both you and the program director to understand fully the financial implications of Medicare's IRP limitation on the institution where you train. The precise financial impact of training a resident beyond the IRP will differ for each hospital and depends on the hospital's PRA and on its Medicare patient load.

Let's look at a sample teaching hospital in 2012:

Sample hospital-specific PRA ... \$100,000
Medicare patient load ... 30%
Medicare DGME payment for 1.0 FTE ... \$30,000
Potential annual loss for 0.5 FTE ... \$15,000

Remember that the rules regarding the IRP apply only to the hospital's Medicare DGME payments. All residents participating in an accredited training program are counted as 1.0 FTE for the IME adjustment, even when they train beyond the IRP. For this reason, a hospital's IME payments, which generally exceed DGME payment amounts, will be unaffected by IRP rules.

Because the financial implications of training beyond your IRP depend on a number of factors and will change from hospital to hospital, both you and the residency director should fully consider the financial impact on the hospital before making any decisions that would affect your future career.

16. What about the time I spend doing research?

For DGME payments, a hospital may count the time a resident spends performing research, including bench research, as long as the research takes place in the hospital and is part of an approved training program. For IME payments, a hospital may only count the time a resident spends performing clinical research that is associated with the treatment or diagnosis of a particular patient.

If you were to take a year away from your residency training specifically to conduct research not required by your residency program, the research year would not count toward your IRP. For example, if you had completed three years of a general surgery program (a program with a five-year IRP), and you stepped away from the program for one year to do research not required by your program, you would still have two years remaining on your IRP when you returned to training after your research year.

If you have any questions about information contained in this publication, please contact Lori Mihalich-Levin at the Association of American Medical Colleges at: 202-828-0490, or lmlevin@aamc.org.