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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 Association of American Medical Colleges (AAMC) 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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This is a publication of the Association of American Medical Colleges. The AAMC serves and leads the academic medicine community to improve the health of all. [aamc.org](https://aamc.org).

## 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 care, and hospice care. Part B pays for physicians' services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies 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 (GME) 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 GME. In federal fiscal year 2016, the Medicare program paid hospitals that train residents \$3.79 billion in direct graduate medical education (DGME) funds.<sup>1</sup> 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), and related overhead expenses. The amount of Medicare DGME payments a teaching hospital receives is based on historic costs and 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 for GME in many states. Although Medicaid GME is outside the scope of this brochure, more information can be found in the AAMC's *Medicaid Graduate Medical Education Payments: A 50-State Survey*.<sup>2</sup>

### 3. Does Medicare make any other special payments to teaching hospitals?

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 — for example, having standby capacity in burn and trauma centers — **not** resident training costs.

The IME adjustment is an additional payment for each Medicare inpatient stay. Simply stated, 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). The IME payment only applies to hospitals that are paid under the Medicare Inpatient Prospective Payment System (IPPS). Psychiatric and rehabilitation hospitals are paid a "teaching status adjustment," which is similar to the IME adjustment. The remainder of this brochure will focus on the DGME payment.

### 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.<sup>3</sup> Every hospital has its own PRA, and many hospitals have two PRAs. Between 1993 and 1995,<sup>4</sup> Congress only updated the PRA for OB/GYN and primary care residencies (general internal medicine, family medicine, general pediatrics, preventative medicine, geriatric medicine, and general osteopathic medicine), meaning that hospitals have a primary care PRA and a PRA for all other specialties.

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 Medicare beneficiaries. This is discussed in greater detail later in this brochure.

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 to retrain in another specialty. 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 an individual a residency position.

## 5. Which training programs does Medicare support?

Hospitals are entitled to receive DGME payments for residents who participate in approved residency programs, meaning programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the American Dental Association (ADA), or the American Podiatric Medical Association (APMA).<sup>5</sup> A list of ACGME-accredited specialties is available at: [acgme.org/specialties](https://www.acgme.org/specialties). Additionally, the ACGME and AOA are currently transitioning to the single GME accreditation system. Beginning July 1, 2020, the ACGME will accredit GME programs at both MD-granting and DO-granting medical schools.<sup>6</sup> Information about the single accreditation system is available at: [acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System](https://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System).

Medicare also recognizes programs that lead to certification issued by a member of the American Board of Medical Specialties (ABMS).<sup>7</sup> Note, however, that some highly specialized physician training programs, such as certain transplant training fellowships, do not meet the CMS definition of “approved,” so hospitals do not receive DGME payments for trainees in these programs. A list of ABMS specialty board certificates is available at: [abms.org](https://www.abms.org).

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

Yes. Congress passed a law in 1997 (Public Law 105-33) that imposes a hospital-specific limit on the number of residents for which Medicare will fund. In general, the limit (often referred to as the hospital’s resident “cap”) is based on the number of residents that the hospital trained in 1996.<sup>8</sup> Medicare will not fund training for residents who are over the cap; if a hospital trains more residents than their cap, it must find sources apart from Medicare to cover the training costs. But even for residents under the cap, a hospital must rely on other sources of funding, as Medicare only pays for a portion of the training costs.

Although a hospital’s DGME cap ordinarily cannot increase, there are several opportunities for upward cap adjustments. For example, urban teaching hospitals are eligible for a cap increase if they rotate residents to train in rural areas through a rural training track (RTT) program.<sup>9</sup> RTTs have specific requirements outside the scope of this document.<sup>10</sup> Additionally, the Balanced Budget Refinement Act of 1999 increased rural hospitals’ 1996 historic caps by 130%.<sup>11</sup> Rural hospitals may increase their caps for new residency programs regardless of whether the programs were formed during the hospital’s cap-building window.<sup>12</sup> The Affordable Care Act also introduced Section 5506, which allows CMS to make additional permanent residency slots available due to hospital closures.<sup>13</sup> Finally, temporary cap adjustments are available when a hospital or residency program closes to ensure that residents affected can complete their training elsewhere.<sup>14</sup>

## 7. How does a hospital count its residents for purposes of Medicare reimbursement?

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 both pays the stipends and benefits of the residents while they train in the non-hospital setting and enters into an annual written agreement with the non-hospital site detailing these payments.<sup>15</sup> 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.**<sup>16</sup>

Each full-time resident is counted (or "weighted") up to 1.0 FTE during an initial residency period (IRP). A hospital may count a resident's time training in the hospital's own settings, as well as non-hospital settings under certain circumstances. If a resident rotates to any sites that the hospital cannot count, then the hospital must proportionally reduce the claimed FTE.

**Here's an example:** If a resident spends 100% of her time at Downtown Hospital, Downtown Hospital may claim her as 1.0 FTE. If another resident spends 25% of his time at Uptown Hospital and the remainder of his time at Downtown Hospital, then Downtown Hospital may only claim him as 0.75 FTE while Uptown Hospital may claim him as a 0.25 FTE.

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

The 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, as determined by the ACGME.<sup>7</sup> Generally, Medicare determines the IRP at the time a resident first enters a residency training program, but the IRP cannot exceed five years. **Every resident has just one IRP, and it does not change, even if the resident later changes specialties.**

It is important to understand that the residency program in which you begin training determines the number of years Medicare will fully fund its share of the training at 1.0 FTE. In other words, the hospital may receive up to Medicare's entire applicable share of the PRA for training a resident within their IRP. **For any additional years of training, the hospital will be able to count the resident as 0.5 FTE and will receive half of Medicare's applicable share of the PRA.**<sup>17</sup> **Only under limited exceptions can a resident be counted as a 1.0 FTE beyond the IRP.**<sup>18</sup> 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 board eligibility for each approved residency program at: [acgme.org/specialties](http://acgme.org/specialties).

**Here's an example:** Dr. Smith begins an internal medicine residency on July 1, 2018. 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, 2019, her IRP remains three years (of which one year has already been used while she trained in internal medicine). She would be counted as 1.0 FTE during postgraduate years (PGYs) 1 and 2 of the surgery residency, but only as 0.5 FTE during her PGYs 3, 4, and 5.

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

- **Residencies that require the completion of a broad-based clinical year<sup>19</sup>:**

- 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, set at four years. Your year in the internal medicine clinical base year program counts as your first year; during your next three years in the radiology program, the hospital will count you as a 1.0 FTE. However, if you instead match only into an internal medicine clinical base year program, begin the program, and later are accepted into a radiology program for your 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<sup>20</sup>:**

- 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. The transitional year will still count as the first year of your IRP.

- **Determining the IRPs for certain residency programs<sup>21</sup>:**
  - If you train in an approved geriatric medicine program, after finishing your first residency program (in internal medicine or family medicine), you must complete two additional years of training to become board eligible. The two years spent in the geriatric medicine program are treated as part of your first specialty's IRP, meaning the resident may be counted as 1.0 FTE for two additional years.
  - The IRP for a resident in an approved child neurology program is five years.
  - During the time a resident is training in an approved preventive medicine residency or fellowship, the resident may be counted as 1.0 FTE for up to two years beyond the IRP, depending on the length of the preventive medicine residency or fellowship.
- **When you train in an approved combined residency program:**
  - A combined training program allows a resident to simultaneously train toward board-eligibility in two specialties. Depending on the types of residencies, the resident's IRP will differ.
  - If each of the individual programs that makes up your combined program is a primary care specialty<sup>22</sup> — defined by CMS as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or 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, but in no case for more than five years.<sup>18</sup> For example, if you enter a combined internal medicine-family practice program, both of which require three years of training 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<sup>22</sup> — but again, never for more than five years.<sup>18</sup> 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. For the fourth year of a combined internal medicine-emergency medicine program, you will be counted as 0.5 FTE.
- **All training (including fellowships) beyond the IRP:**
  - For all other training that is beyond the IRP, including fellowships, a resident is counted by the hospital as 0.5 FTE.<sup>17</sup>

## 9. Can you give an example of what these rules mean in determining how much DGME funding a 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 criteria established by the law and regulations.
2. Multiply the number of residents by the hospital's PRA.
3. Multiply the product from number two (above) by Medicare's share of the hospital's number of inpatient days, i.e., the total number of Medicare inpatients over total inpatients. This is called the Medicare patient load.

**Here's an example:** University Hospital has a DGME resident limit of 400 FTEs. In 2019, it is training 400 resident FTEs. Of these, 300 FTEs are in their IRP (so each is counted as 1.0 FTE), and 100 are beyond their IRP (so each is counted as 0.5 FTE). Half the residents (150 1.0 FTEs and 50 0.5 FTEs) are training in primary care (PC), and the other half are training in nonprimary care (non-PC).

In 1983-84, University Hospital trained residents and received a set PRA based on their DGME costs that were reported to Medicare, which has since been updated for inflation annually. However, between 1993 and 1995, CMS updated only the PC PRA, resulting in different PRAs for PC residents and non-PC residents. The hospital's updated PC PRA for 2019 is \$90,000, and its updated non-PC PRA is \$85,000.

Of the hospital's inpatient days, 30% are attributed to Medicare beneficiaries.

**Medicare will determine University Hospital's DGME payments for 2019 as follows:**

<b>Payment for PC residents training in their IRP</b>	$(150 \times \$90,000) \times .30$	<b>\$4,050,000</b>
<b>Payment for non-PC residents training in their IRP</b>	$(150 \times \$85,000) \times .30$	<b>+ \$3,825,000</b>
<b>Payments for PC residents training beyond IRP</b>	$(50 \times \$90,000) \times .50 \times .30$	<b>+ \$675,000</b>
<b>Payments for non-PC residents training beyond IRP</b>	$(50 \times \$85,000) \times .50 \times .30$	<b>+ \$637,000</b>
	<b>Total DGME Payments</b>	<b>= \$9,187,000</b>

## **10. 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 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 Congress through general federal appropriations dollars and administered by the Health Resources and Services Administration. This program generally follows the Medicare rules for counting residents and setting caps on the number of funded positions. More information on the CHGME program is available at: [bhw.hrsa.gov/grants/medicine/chgme](http://bhw.hrsa.gov/grants/medicine/chgme).

## **11. 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 toward 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 toward board certification also counts toward the IRP.

## **12. Does training time not paid for by Medicare count against my IRP?**

Yes. All training time that counts toward board eligibility in a specialty is counted against your IRP for purposes of determining Medicare's DGME payments. 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.

### **13. 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. Please refer to questions 8 and 9 for related examples of how switching programs may impact funding.

Remember that the rules regarding the IRP apply only to the hospital's Medicare DGME payments. The FTE count for IME is not weighted, meaning all residents participating in an accredited residency program are counted as 1.0 FTE for the IME adjustment.<sup>23</sup> For this reason, a hospital's IME payments, which generally exceed DGME payment amounts, will be unaffected by IRP rules.

### **14. What about 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 take a year away from your residency training specifically to conduct research not required by your residency program, the research year will not count toward your IRP. For example, if you complete three years of a general surgery program (a program with a five-year IRP), and you step away from the program for one year to do research not required by your program, you will still have two years remaining on your IRP when you return to training after your research year.

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If you have any questions about information contained in this publication, please contact the Association of American Medical Colleges at: 202-828-0490 or [GMEquestions@aamc.org](mailto:GMEquestions@aamc.org).

## Notes

1. Based on AAMC analysis of Medicare Cost Reports for fiscal years 2015 and 2016.
2. This publication is updated periodically, with the next publication scheduled for release in 2019.
3. 42 CFR 413.77 Direct GME payments: Determination of per resident amounts.
4. Applies to cost reporting periods beginning on or after Oct. 1, 1993, through Sept. 30, 1995. 42 CFR 413.77(c)(2).
5. 42 CFR 413.78 Direct GME payments: Determination of the total number of FTE residents; 42 CFR 413.75(b) Direct GME payments: General requirements.
6. American Osteopathic Society. Single GME resident FAQs. <https://osteopathic.org/residents/resident-resources/residents-single-gme/single-gme-resident-faqs>. Accessed March 27, 2019.
7. 42 CFR 413.75(b) Direct GME payments: General requirements.
8. 42 CFR 413.79(e) Direct GME payments: Determination of the weighted number of FTE residents; 42 CFR 413.79 (e)(1)(i).
9. 42 CFR 413.79(k) Direct GME payments: Determination of the weighted number of FTE residents.
10. More information on RTTs can be found in the AAMC's *Rural Training Track Programs: A Guide to the Medicare Requirements*.
11. 42 CFR 413.79(c)(2) Direct GME payments: Determination of the weighted number of FTE residents.
12. 42 CFR 413.79(e)(3) Direct GME payments: Determination of the weighted number of FTE residents.
13. Public Law 111-148, Sec. 5506.
14. 42 CFR 413.79(h) Direct GME payments: Determination of the weighted number of FTE residents.
15. 42 CFR 413.78(a)-(g) Direct GME payments: Determination of the total number of FTE residents.
16. 42 CFR 413.78 Direct GME payments: Determination of the total number of FTE residents.
17. 42 CFR 413.79(b)(1)-(2) Direct GME payments: Determination of the weighted number of FTE residents.
18. 42 CFR 413.79(a)(1) - (4) Direct GME payments: Determination of the weighted number of FTE residents. Residents in approved geriatrics or preventative medicine programs may be counted as full 1.0 FTEs up to two additional years beyond the initial residency period limitations.
19. 42 CFR 413.79(a)(10) Direct GME payments: Determination of the weighted number of FTE residents.
20. 42 CFR 413.79(a)(10) Direct GME payments: Determination of the weighted number of FTE residents; 70 Fed. Reg. 47278, 47449-47452.
21. 42 CFR 413.79(a) Direct GME payments: Determination of the weighted number of FTE residents.
22. 42 CFR 413.79(a)(5) Direct GME payments: Determination of the weighted number of FTE residents. Other specialties that may be considered primary care, such as obstetrics and gynecology, are not subject to this provision.
23. 42 CFR 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.



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