



AAMC

Tomorrow's Doctors, Tomorrow's Cures®

Medicare Payments For Graduate Medical Education



What Every Medical Student, Resident, and Advisor Needs to Know

April 2006

Association of
American Medical Colleges

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ISBN 978-1-57754-051-9

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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. The same is true for 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.

1. What are Medicare and Medicaid?

Medicare is a federally administered health insurance program for people 65 or older and certain disabled people. Part A of Medicare 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 primarily are made under Part A.

Medicaid is a health insurance program for low income families jointly financed 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. In Federal fiscal year 2006 it will pay hospitals that train residents approximately \$2.5 billion dollars for direct graduate medical education (DGME). DGME payments cover a portion of the direct costs of training residents, such as residents' stipends, teaching physicians' salaries, and related overhead expenses. The amount of the Medicare payment is related to the share of a 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 some states, but that topic is outside the scope of this brochure.

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 often are of great importance to residents and teaching hospitals. As will be explained below, the rules that Medicare establishes to pay hospitals for direct graduate medical education 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 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 the way in which Medicare pays hospitals?

Every hospital that trains residents in an approved residency program is entitled to receive Medicare's DGME payment. The amount of DGME payment varies for each hospital, subject to a minimum level. It is based on an amount known as the "hospital specific per resident amount" which, according to law, was determined by CMS for each teaching hospital in the 1980's, and is updated each year by an inflation factor. Since the DGME payment is based on historical costs, it is not related to the costs that the hospital currently incurs for training residents. The amount that each hospital receives for DGME is based on the number of residents it is allowed to count, the hospital specific per resident amount, 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 those residents who are participating in approved educational activities. Typically, this means programs which are accredited by the Accreditation Council on Graduate Medical Education (ACGME) and included in the American Medical Association (AMA) Graduate Medical Education Directory (sometimes called the Green Book). A list of ACGME-accredited specialties is available at www.acgme.org. Medicare also recognizes programs not included in the Green Book but for which an American Board of Medical Specialties organization issues a certificate of competence. A list of ABMS Specialty Board Certificates is available at www.abms.org.

Programs accredited by the American Osteopathic Association, the American Dental Association, and the American Podiatric Medical Association also are recognized.

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

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 is based on the number of residents that a hospital trained in 1996.

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

First, residents working in all areas of the hospital complex may be included in a hospital's full time equivalent (FTE) count for the DGME payment. If certain criteria are met—the site is part of the resident's educational program, there is a written agreement that meets the government's requirements, and the hospital pays "all or substantially all" of the costs for the training time spent outside the hospital—a hospital also may include residents working in a nonhospital site in its FTE count. Regardless of who pays the cost, however, a hospital may not count any time that a resident spends 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 payment, each full-time resident is counted (or "weighted") as a 1.0 FTE during an initial residency period (IRP). After the initial residency period, a full-time resident is counted only as a 0.5 FTE for Medicare's DGME payment. No resident may be counted as a 1.0 FTE for more than 5 years, but there is no limit on the number of years a resident may be counted as a 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. It is based on the minimum accredited length for residency programs as determined by the ACGME. Generally, Medicare determines the initial residency period at the time the 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 that you understand that the residency program in which you begin training determines the number of years in which Medicare will make full direct graduate medical education payments to the hospital for your training (although the maximum number of years you can be counted as a 1.0 FTE is 5); any additional years will be funded at a 50% level. CMS has not published a list of specialties and initial residency periods since 1996. In the Appendix to this brochure, you will find information on the minimum number of years of training required for each approved residency program.

- **Rules for residencies that require the completion of a broad-based clinical year.**

If a specialty, such as radiology, requires a broad-based clinical year of training, and you match simultaneously into both the broad-based year and the specialty program, then the IRP is determined by the specialty program that begins during your second year of training. If you match into a program that begins in your PGY (Post Graduate Year)-2, and 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 are training in your PGY-2.

- **Rules when your first residency is a transitional year.**

If the first residency that you enter is a transitional year, then your IRP is determined by the residency you enter in your second year of training.

- **Special rules for determining the IRPs of certain residency programs.**

- If you train in an approved geriatric program that requires the completion of 2 years of training to initially become board eligible, the 2 years spent in the geriatrics program are treated as part of the IRP.
- The IRP for a resident in an approved child neurology program is 5 years.
- Residents in an approved preventive medicine residency or fellowship may be counted as a 1.0 FTE for up to 2 years beyond their IRP.

- **Rules if your training started before July 1, 1995.**

If you started your residency training before July 1, 1995, your initial residency period is counted differently. It is the minimum number of years required to be eligible for board certification, plus one year, though it cannot exceed 5 years.

For all other subspecialty training that is beyond the initial residency period, each resident or fellow in a subspecialty program is counted as a 0.5 FTE.

Here's an example for a resident who changes training programs. Dr. Smith begins an internal medicine residency on July 1, 2005. Internal medicine has an initial residency period of 3 years. Dr. Smith soon realizes that she'd rather do a surgery residency (which has a 5-year initial residency period) and would like to begin training the following year. However, even if Dr. Smith is accepted into a surgery program, her initial residency period remains 3 years. She would be counted as 1.0 FTE during her first and second year of the surgery residency and 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 for a resident who began training in surgery right out of medical school and thus had an initial residency period of 5 years.

9. Can you give an example of what these rules mean when a hospital is determining how much it will be paid by Medicare for DGME?

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

1. Count the weighted number of residents according to the law and regulations.
2. Multiply the number of residents by the hospital's per resident amount.
3. Multiply the product in #2 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 2006, University Hospital has a resident limit of 400 residents and is currently training 400 residents. Of those, 300 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). Its updated hospital specific per resident amount for 2006 is \$90,000. 30 percent of its inpatient days are attributed to Medicare beneficiaries.

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

$(300 \times \$90,000) \times .30 = \$8,100,000$

$[\$.5(100 \times \$90,000)] \times .30 = \$1,350,000$

TOTAL DGME PAYMENT = \$9,450,000

10. Does Medicare cover any other teaching hospital costs?

Teaching hospitals also receive an indirect medical education (IME) adjustment from Medicare. Medicare provides the IME adjustment to teaching hospitals to recognize their higher costs of inpatient care when compared to nonteaching hospitals. 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 interns and residents-to-beds. 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 nonhospital 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 even if they are beyond the IRP for purposes of DGME.

Psychiatric and rehabilitation hospitals are paid differently under Medicare than acute care hospitals. These hospitals also receive IME payments, but 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 from the Medicare program for GME expenses. However, these hospitals are eligible to receive GME and IME payments via the Children's Hospitals GME 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. 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 initial residency period limit affect me?

Many medical students who have military commitments are required to complete 1 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 have not exceeded the limits of an initial residency period in another specialty, you will be counted as a 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 previously completed will count toward the initial residency period. If the residency year completed prior to entering the military was in a specific specialty, such as internal medicine, your initial residency period will be based on the eligible years for that specialty—even though you left the program to complete a military commitment. If the training prior to entering the military was in a transitional year program, then the initial residency period 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 toward the initial residency period.

13. Does training time for which Medicare does not pay count against my initial residency period limitation?

Yes. It does not matter whether or not Medicare makes any payment towards your training. All training time that counts towards certification in a specialty is counted against your initial residency period for purposes of determining Medicare's DGME payment. So even if you completed a residency program that Medicare did not support, any training which you may wish to do later will be considered to be beyond the initial residency period, and you will be counted as a 0.5 FTE for purposes of determining Medicare's DGME payment.

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

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 a 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 require 3 years for board eligibility, you will be counted as a 1.0 FTE for 4 years—the 3 years required for internal medicine, plus one year. For any additional years of training in an approved program, you will be counted as a 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 initial residency period based on the longer of the two composite programs. In the internal medicine-emergency medicine example, CMS has stated that since the initial residency period for each program taken separately is 3 years, the initial residency period for combined internal medicine-emergency medicine programs is 3 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 3-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 fully understand the financial implications of Medicare's initial residency period limitation to the institution where you train. The precise financial impact of a resident beyond the initial residency period will differ for each hospital and depends on the hospital's per resident amount and on the percentage of inpatient days in each hospital attributable to Medicare beneficiaries. Let's look at a sample teaching hospital in 2006:

Sample hospital specific per resident amount . . .	\$85,000
Average Medicare patient load . . .	30%
Medicare per resident payment . . .	\$25,500
Potential annual loss for a 0.5 FTE . . .	\$12,750

The rules regarding the initial residency period apply only to the hospital's Medicare DGME payment. Residents participating in an accredited training program are counted as 1.0 FTE for the IME adjustment even when they are beyond the initial residency period. For most hospitals, Medicare's IME adjustment exceeds Medicare's DGME payment. So, as a percentage of the hospital's total Medicare payments related to GME, the financial impact of a resident beyond the initial residency period may be small. The impact will also be more or less, depending on the amount a hospital is paid for each resident and the hospital's percentage of Medicare inpatient days. Similarly, a hospital's payment for your training time beyond the initial residency period will be less if the hospital's per resident amount is very low. In short, 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 time that I spend in research?

For DGME, a hospital may count the time a resident spends performing research, including bench research, as long as the research is part of an approved training program. For the IME, 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 have any questions, please contact Ivy Baer at the Association of American Medical Colleges, at 202-828-0490 or ibaer@aamc.org.



YEARS OF TRAINING REQUIRED FOR SPECIALTIES AND SUBSPECIALTIES

The purpose of the chart below is to provide you with information that, in combination with the information provided in this brochure, will help you determine whether you will count as a 1.0 or 0.5 FTE for purposes Medicare's DGME payment

SPECIALTY • SUBSPECIALTY	PREREQUISITE REQUIRED FOR SPECIALTY?	NUMBER OF YEARS REQUIRED FOR PROGRAM COMPLETION
Allergy/Immunology	Must complete IM or Peds	*2
Anesthesiology	Broad-based clinical year	4
• Critical Care		*1
• Pain Management		*1
• Pediatric		*1
• Undersea/Hyperbaric		*1
Colon/Rectal Surgery	Completion 5 year general surgery residency	*1
Dermatology	Broad-based clinical year	4
• Dermatopathology		*1
• Procedural Derm		*1
Emergency Medicine		3
• Medical Toxicology	Completion of ACGME- accredited residency	*2
• Pediatric	Completion of peds or EM residency	*2
• Sports Medicine		*1
• Undersea/Hyperbaric		*1
Family Medicine		3
• Geriatric Medicine		*1
• Sports Medicine		*1

Medical Genetics

2 years if completed an ACGME residency, or have completed 2 or more years of an ACGME-accredited residency; otherwise 4 years

- Molecular Genetic Pathology

*1

Internal Medicine

3

- Cardiovascular disease

*3

- Clinical Cardiac Electrophysiology

*1 (after 3 years of cardiovascular fellowship training)

- Critical Care Medicine

1 or 2

- Endocrinology/ Diabetes, & Metabolism

*2

- Gastroenterology

*3

- Geriatric Medicine

*1

- Hematology

*2

- Hematology/Oncology

3

- Infectious Disease

*2

- Interventional Cardiology 3 years in cardiology

1

- Medical Oncology

*2

- Nephrology

*2

- Pulmonary Disease

*2

- Rheumatology

*2

- Sleep Medicine

*1 (not available until 2006)

- Sports Medicine

*1

Neurological Surgery**	1 year in general surgery or other ACGME-accredited program	6
• Endovascular Surgical Neuroradiology		*1
Neurology	1 broad-based clinical year in general IM	4
• Child Neurology	2 years in peds; PGY-1 in adult neurology and 1 year in peds; or 1 year peds + 1 year basic neuroscience training	5 (Congress determined that IRP is 5 years for child neurology)
• Clinical Neurophysiology		*1
• Neurodevelopmental Disabilities	Completion of 2 years in pediatric residency	*4
• Neuromuscular Medicine	Completion of residency in adult or pediatric neurology or physical medicine and rehab.	*1
• Pain Management		*1
• Sleep Medicine		*1
• Vascular Neurology		*1
Nuclear Medicine	Broad-based clinical year	2 years thru 6/2007; 3 years effective 7/2007
Obstetrics/Gynecology		4
Ophthalmology	Broad-based clinical year	4
Orthopaedic Surgery		5
• Adult Reconstructive Surgery		*1
• Foot & Ankle Surgery		*1
• Hand Surgery		*1
• Musculoskeletal Oncology		*1
• Pediatric		*1
• Spinal		*1
• Sports Medicine		*1

• Trauma	*1
Otolaryngology	5
• Neurotology	*2
• Pediatric	*1
• Sleep Medicine	*1
Pathology	3 or 4 (CMS recognizes 3 years as IRP)
• Blood Banking	*1
• Chemical	*1
• Cytopathology	*1
• Dermatopathology	*1
• Forensic	*1
• Hematology	*1
• Medical Microbiology	*1
• Molecular Genetic Pathology	*1
• Neuropathology	*2
• Pediatric	*1
Pediatrics	3
• Adolescent Medicine	*3
• Cardiology	*3
• Critical Care	*3
• Developmental-Behavioral	*3
• Emergency Medicine	*3
• Endocrinology	*3
• Gastroenterology	*3
• Hematology/Oncology	*3
• Infectious Disease	*3
• Neonatal-Perinatal	*3

• Nephrology		*3
• Pulmonology		*3
• Rheumatology		*3
• Sleep Medicine		*1
• Sports Medicine		*1
Physical Medicine & Rehab	Broad-based clinical year	4
• Pain Management		*1
• Pediatric Rehab		*2
• Spinal Cord Injury		*1
Plastic Surgery**		5 or 6
• Craniofacial	Must complete plastic surgery program or other appropriate surgical program	*1
• Hand	Must complete general, orthopaedic, or plastic surgery residency	*1
Preventive Medicine		3
• Toxicology		*2
• Undersea/Hyperbaric		*1
Psychiatry	If enter as PG-2, must have completed one year in IM, family med, peds, transitional year, or clinical specialty requiring comprehensive and continuous patient care	4
• Addiction		*1
• Child & Adolescent		*2 (after completing PGY-1 and at least 2 years in gen'l psychiatry)
• Forensic		*1
• Geriatric		*1

• Pain Management		*1
• Psychosomatic		*1
• Sleep Medicine		*1
Radiation Oncology	Broad-based clinical year	5
Diagnostic Radiology	Broad-based clinical year	5
• Abdominal		*1
• Cardiothoracic		*1
• Endovascular Surgical Neuroradiology		*1
• Neuroradiology		*1
• Nuclear Radiology		*1
• Pediatrics		*1
• Vascular/Interventional		*1
Surgery		5
• Critical Care		*1
• Hand		*1
• Pediatric		*2
• Vascular		*1
Thoracic Surgery	Completion of general surgery residency	*2 or 3
Transitional Year		1
Urology	Completion of 12 months of general surgery	4
• Pediatric		*1

For specialties in bold, residents generally will be counted as a 1.0 FTE

*Requires the completion of another residency prior to the start of training; generally, residents in a subspecialty will be counted as a 0.5 FTE for purposes of DGME.

**Although specialty requires 6 years for completion, the law requires that a resident not be counted as a 1.0 FTE for more than 5 years.



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