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

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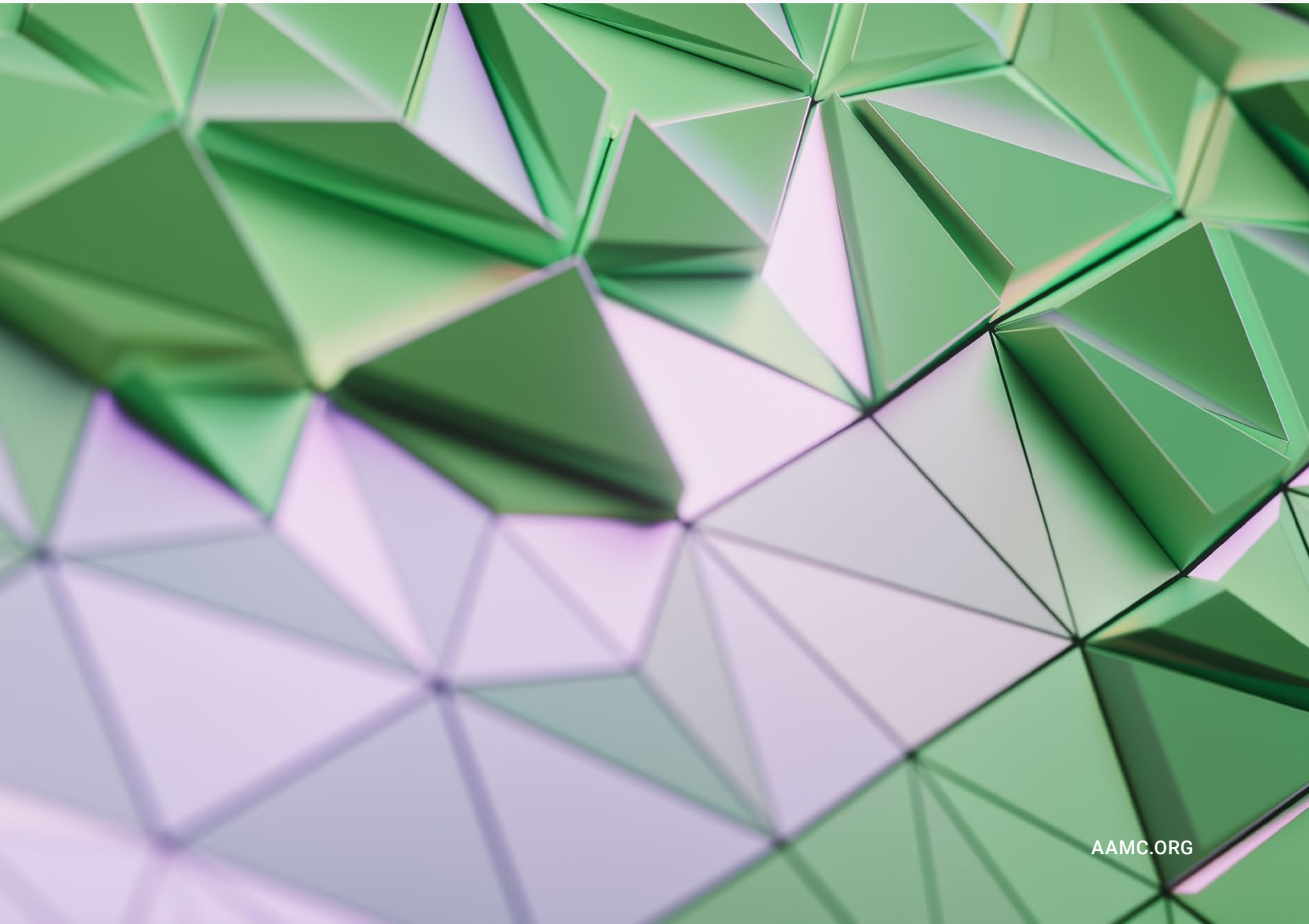

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Introduction

This updated guide helps explain the Medicare reimbursement rules related to graduate medical education (GME), and it incorporates recent changes in law and regulation. This guide helps its readers be in a better position to assess the impact of decisions related to their GME, from choosing a program to changing specialties and pursuing fellowships.

1. What are Medicare and Medicaid?

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

Medicaid is a joint program between the federal government and states that helps cover medical costs for individuals with limited income and resources. While the federal government provides general rules for states to follow, each state develops and runs its own Medicaid program.[1] The Centers for Medicare & 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 single largest, public program providing explicit support for GME. In federal fiscal year 2022, the Medicare program paid hospitals that train residents $5.88 billion in direct GME (DGME) funds.[2] DGME reimbursements 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 that administers programs, accreditation fees, educational space), and related overhead expenses. The amount of Medicare DGME reimbursements that 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 reimbursements 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 2023 AAMC report, *Medicaid Graduate Medical Education Payments: Results From the 2022 50-State Survey*.[3]

3. Does Medicare make any other payments unique 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 adjustments are designed to offset teaching hospitals' increased *patient care* costs associated with more complex conditions; for example, higher patient acuity, burn and trauma centers having standby capacity, or teaching institutions offering specialized services and treatment programs. IME reimbursements are **not** designed to offset 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 resident-to-bed ratio (often referred to as the intern-and-resident-to-bed or "IRB" ratio). The IME adjustment 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. Teaching health centers and children's hospitals have separate funding mechanisms that are authorized by Congress and administered by the Health Resources and Services Administration (HRSA).

The remainder of this brochure will focus on the Medicare DGME reimbursement.

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 reimbursement varies for each hospital based on the number of resident full-time equivalents (FTEs). The payments are based on an amount known as the hospital-specific per resident amount (PRA), which, according to law, was determined by the CMS for each teaching hospital that was training residents in the 1980s, and it is updated each year by an inflation factor.[4] Every hospital has its own unique PRA, and many hospitals have two PRAs; between 1993 and 1995,[5] Congress applied the inflationary increase only to the PRA for OB-GYN and primary care residencies (i.e., general internal medicine, family medicine, general pediatrics, preventative medicine, geriatric medicine, and general osteopathic medicine), meaning that some hospitals, especially older teaching hospitals, have a primary care PRA and a PRA for all other specialties. A hospital with two PRAs has a higher primary care PRA.

Because DGME reimbursements are based on historic costs, they are not reflective of the costs that the hospital is currently incurring for training residents. The amount each hospital receives for DGME is based on the number of residents it is allowed to count, its PRA, and the percentage of its inpatient population that is Medicare beneficiaries. This is discussed in greater detail later in this brochure.

As 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 they 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 can influence a program's decision about whether to offer a residency position.**

5. Which training programs does Medicare support?

Hospitals are entitled to receive DGME reimbursements for residents who participate in approved residency programs; i.e., those accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association, or the American Podiatric Medical Association.[6,7,8] A list of ACGME-accredited specialties is available at: acgme.org/specialties. In July of 2020, the American Osteopathic Association and the ACGME completed a years-long transition to a single accreditation system for GME training; as a result, the ACGME is now the sole accreditor for both MD and DO programs.

Medicare also recognizes certain training programs that lead to certification issued by a member of the

American Board of Medical Specialties (ABMS).[9] Note, however, that some highly specialized physician training programs, such as certain fellowships, do not meet the CMS definition of "approved," so hospitals do not receive reimbursement for trainees in these programs. A list of ABMS specialty board certificates is available at: abms.org.

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

Yes. The Balanced Budget Act of 1997 (Public Law 105-33) imposes a hospital-specific limit on the number of resident FTEs that 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.[10] Medicare will not reimburse hospitals for any resident training that exceeds the cap; if a hospital trains more residents than its cap allows, it must find alternative financial resources to cover the remaining 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 cap ordinarily cannot increase, there are several opportunities for upward cap adjustments; for example, a teaching hospital is eligible for a cap increase if it participates in a Rural Track Program (RTP).[11] (RTPs have specific requirements outside the scope of this document; please see the AAMC's *Rural Track Programs: A Guide to the Updated Medicare Requirements*.[12]) Additionally, the Balanced Budget Refinement Act of 1999 increased rural hospitals' 1996 historic caps to 130%.[13] A rural hospital may increase its cap when it starts a new residency program.[14] The Patient Protection and Affordable Care Act Public Law 111-148 (ACA) introduced Section 5506, which gave the CMS continuing authority to redistribute the residency slots from teaching hospitals that close.[15] Two programs, Section 422 of the Medicare Modernization Act Public Law 108-173 and Section 5503 of the ACA, redistributed unused slots from certain hospitals. The Consolidated Appropriations Act, 2021, and the Consolidated Appropriations Act, 2023, added 1,000 and 200 new Medicare-supported GME slots, respectively. Temporary cap adjustments are available when a hospital or residency program closes, to ensure that affected residents can complete their training elsewhere.[16]

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

Residents working in all areas of the hospital complex must be included in a hospital's FTE count.[17] A hospital may also include in its FTE count residents who are working in clinical, nonhospital sites, if it pays for the residents' stipends and benefits.[18] Regardless of who pays the costs, however, **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 reimbursements from Medicare.[19]**

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

Here's an example: It's important to understand that a resident is not counted as 1.0 FTE at one hospital if their work time is spent in more than one hospital. That is, if a resident spends 100% of her time at Hospital A, Hospital A may claim her as 1.0 FTE; if another resident spends 25% of his time at Hospital B and the remainder of his time at Hospital A, then Hospital A may only claim him as 0.75 FTE, while Hospital B may claim him as 0.25 FTE. No resident may be counted as more than 1.0 FTE across all training sites.

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

The initial residency period (IRP) is the minimum number of years required to become board-eligible in the specialty in which the resident first begins training, as determined by the residency program's accrediting body (ACGME for instance).[9] 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.**

The DGME payment is based on a "weighted" FTE count, meaning each resident captured on the CMS cost report carries their corresponding weighting factor of either 1.0 or 0.5. It is important to understand that the residency program in which the resident begins training determines the number of years Medicare will fully support its share of the training using a weighting factor of 1.0; in other words, the hospital may receive up to the entirety of Medicare's applicable share of the PRA for training a resident within their IRP. For any additional years of training in an approved program, the hospital will be able to count the resident using a weighting factor of 0.5 and will receive half of Medicare's applicable share of the PRA.[20] Only under limited exceptions can a resident be weighted as 1.0 beyond the IRP.[21] It is common shorthand for people to refer to residents within their IRP as 1.0 FTEs, and those training beyond the IRP as 0.5 FTEs. The CMS has not published a list of specialties and IRPs since 1996, but information on the minimum number of years of training required for board eligibility for each approved residency program is available at: acgme.org/specialties.

Here's an example: Dr. Smith begins an internal medicine residency on July 1, 2024. 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 as a Postgraduate Year (PGY) 1 on July 1, 2025, her IRP remains three years (of which one year has already been used while she trained in internal medicine). Her FTE count would be weighted by a factor of 1.0 during PGYs 1 and 2 of the surgery residency, but weighted by a factor of only 0.5 during PGYs 3, 4, and 5.

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

… for residencies that require the completion of a broad-based clinical year[22]:

- If a specialty requires a broad-based clinical year of training, and a resident matches simultaneously into both the broad-based year and the specialty program, then the IRP is determined by the specialty program that begins during the second year of training. If, instead, the resident initially matches only into a clinical base-year program or preliminary-year program, the IRP is determined by the resident's clinical base-year program — even if they later match into a different specialty.

Here's an example: A resident simultaneously matches into both an internal medicine clinical base-year program and a radiology training program. The IRP will be based on the minimum number of years required to become board-eligible in radiology, which is set at four years. The year spent in the internal medicine clinical base-year program counts as the first year; during the next three years in the radiology program, the hospital will use the weighting factor of 1.0. If, however, a resident matches only into an internal medicine clinical base-year program and begins the program, then later is accepted into a radiology program for PGY 2, the IRP will be based on the number of years required to become board-eligible in internal medicine at three years.

- If a resident matches into a program that begins in PGY 2, and they are able to obtain a preliminary-year position for PGY 1 outside of the match, then their IRP is determined by the specialty in which they will train during PGY 2.

… for when the first residency is in a transitional-year program[23, 24]:

If the first residency entered into is a transitional year, then the IRP is determined by the first residency that leads to board eligibility. Any time spent in a transitional-year program will still count toward the resident's IRP.

Here's an example: If a resident first matches into a transitional-year program and continues to train in it for the second year, then they match into an internal medicine residency program as a PGY-1 resident, this resident will have one year of IRP remaining. For PGYs 2 and 3, the resident will be considered outside of the IRP and will be weighted as 0.5 for Medicare DGME reimbursement.

… for determining the IRPs for certain residency programs[25]:

- If the resident trains in an approved geriatric medicine program after finishing the first residency program in internal medicine or family medicine, they 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 the first specialty's IRP, meaning that the resident may be weighted as 1.0 for two additional years.

- The IRP for a resident in an approved child neurology program is five years.

- During the time that a resident is training in an approved preventive medicine residency or fellowship, the resident may be weighted as 1.0 for up to two years beyond the IRP, depending on the length of the residency or fellowship.

… for when the resident trains 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 make up the resident's combined program is a primary care specialty[26] — defined by the CMS as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice — the resident will be weighted as 1.0 for the minimum number of years required for board eligibility for the longer of the two programs, plus one additional year. No resident may be weighted as within their IRP (using a factor of 1.0) for more than five years.[21]

Here's an example: If a resident enters a combined internal medicine-family practice program, both of which individually require three years of training for board eligibility, the resident will be using a weighting factor of 1.0 (the three years required for internal medicine, plus one year). For any additional years of training in an approved program, the resident will be counted using a weighting factor of 0.5.

- The rules are different for a resident who enters a combined program in which one of the two individual programs is **not** a primary care specialty, such as internal medicine-emergency medicine. The CMS determines the IRP based on the longer of the two programs,[26] but again, never more than five years.[21] In the internal medicine-emergency medicine example, the CMS states that because the IRP for each individual program is three years, the IRP for a combined internal medicine-emergency medicine program is three years; for the fourth year of this program, a resident is counted using a weighting factor of 0.5.

… for all training beyond the IRP:

For all other training that takes place beyond the IRP, including fellowships, a resident is weighted by the hospital as 0.5.[20]

9. 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 postmedical-school training in an accredited program before entering the military. If a resident is in the first residency program after graduating from medical school, or if the resident has not exceeded the limits of an IRP in another specialty, the resident will be weighted as 1.0 during the required year of training, prior to entering the military. If the resident subsequently leaves the military and enters a residency program, the previously completed year of training will count toward the IRP.

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

10. Does the training time that is not paid for by Medicare count against my IRP?

Yes. All training time that counts toward board eligibility in a specialty is counted against the resident's IRP for purposes of determining Medicare's DGME reimbursements. Even if an individual completes a residency program that Medicare did not support (e.g., a program in another country, one funded by the Department of Defense, or one supported under HRSA's Teaching Health Center Graduate Medical Education Program), any training that the individual may wish to do later will be considered to be beyond the IRP, and they will be weighted as 0.5 for purposes of determining the hospital's Medicare DGME reimbursements.

11. 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 the resident and the program director to fully understand the financial implications of Medicare's IRP limitation on the training institution. The precise financial impact of training a resident beyond the IRP will differ for each hospital and depends on the hospital's PRA and its Medicare patient load. Please refer to Questions 8 and 12 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 reimbursement. The FTE count for IME is not weighted, meaning all residents participating in accredited residency programs are counted up to 1.0 FTE for the IME adjustment.[27] For this reason, a hospital's IME adjustments, which generally exceed DGME reimbursement amounts, will be unaffected by IRP rules.

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

To calculate its Medicare DGME reimbursement, a hospital must do the following:

1. Count the weighted number of residents being trained 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 Step 2 (above) by Medicare's share of the hospital's number of inpatient days (i.e., the total number of Medicare inpatient days incurred by the hospital divided by inpatient days for all inpatients). This result is the "Medicare patient load."

Here's an example: University Hospital has a DGME resident cap of 400 FTEs. In 2025, it is training 400 residents; of these, 300 residents are in their IRP (so each has a weighting factor of 1.0), and 100 residents are beyond their IRP (so each has a weighting factor of 0.5). Half of the residents within their IRP and half of the residents outside their IRP (150 and 50, respectively) are training in primary care (PC) specialties, and the other half are training in nonprimary care (non-PC) specialties.[28]

In 1983-84, University Hospital trained residents and received a set PRA based on their DGME costs that were reported to Medicare; this PRA has since been updated for inflation annually. Between 1993 and 1995, however, the CMS updated only the PC PRA, resulting in different PRAs for PC and non-PC residents. The hospital's updated PC PRA for 2019 is $90,000, and its updated non-PC PRA is $85,000. Thirty percent of the hospital's inpatient days is attributed to Medicare beneficiaries. Medicare will determine University Hospital's DGME adjustments for 2025 as follows:

Reimbursement for PC Residents Training in Their IRP	(150 x $90,000) x .30		**$4,050,000**
Reimbursement for Non-PC Residents Training in Their IRP	(150 x $85,000) x .30	+	**$3,825,000**
Reimbursement for PC Residents Training Beyond Their IRP	(50 x $90,000) x .50 x .30	+	**$675,000**
Reimbursement for Non-PC Residents Training Beyond Their IRP	(50 x $85,000) x .50 x .30	+	**$637,500**
	Total DGME Reimbursement	=	**$9,187,500**

13. I plan to enter a pediatric residency at a children's hospital. Will the Medicare GME reimbursement 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. Some of these hospitals, however, 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 HRSA. This program generally follows the Medicare rules for counting residents and setting caps on the number of funded positions. There are specific requirements for receiving CHGME funding; for example, the hospital must be a freestanding children's hospital that is not paid under the inpatient prospective payment system. More information on the CHGME program is available at: bhw.hrsa.gov/grants/medicine/chgme.

14. How is my research time factored into DGME reimbursements?

For DGME reimbursement, a hospital may count the time a resident spends performing research, including bench research, if it takes place in the hospital and is part of an approved training program. For IME adjustments, 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 a resident takes a year away from their residency training specifically to conduct research that is not required by the residency program, the research year will not count toward the IRP. If a resident, for example, completes three years of a general surgery program (a program with a five-year IRP) then steps away from the program for one year to do research not required by the program, they will still have two years remaining on their IRP when they return to training after the research year.

For any questions regarding the information contained in this publication, please contact the AAMC at GMEquestions@aamc.org.

Notes

1 U.S. Dept. of Health and Human Services. What's the difference between Medicare and Medicaid? Accessed January 21, 2025. https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html

2 Based on AAMC analysis of Medicare Cost Reports for fiscal years 2021 and 2022.

3 AAMC. *Medicaid Graduate Medical Education Payments: Results From the 2022 50-State Survey.* AAMC; 2023. Accessed January 14, 2025. https://store.aamc.org/medicaid-graduate-medical-education-payments-results-from-the-2022-50-state-survey.html

4 Direct GME Payments: Determination of Per Resident Amounts. 42 CFR §413.77.

5 Applies to cost reporting periods beginning on or after October 1, 1993, through September 30, 1995. See: Direct GME Payments: Determination of Per Resident Amounts. 42 CFR §413.77(c)(2).

6 Direct GME Payments: Determination of the Total Number of FTE Residents. 42 CFR §413.78.

7 Direct GME Payments: General Requirements. 42 CFR §413.75(b).

8 Physician Services in Teaching Settings: Definitions. 42 CFR §415.152(1).

9 Direct GME Payments: General Requirements. 42 CFR §413.75(b)(2).

10 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(e).

11 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(k).

12 AAMC. *Rural Track Programs: A Guide to the Updated Medicare Requirements.* AAMC; 2023. https://store.aamc.org/rural-track-programs-a-guide-to-the-updated-medicare-requirements.html

13 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(c)(2).

14 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(e)(3).

15 Patient Protection and Affordable Care Act, Pub L No. 111-148, Sec. 5506.

16 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(h).

17 Medicare program; changes in payment policy for direct graduate medical education costs. *Fed Regist*. 1989;54(188):40299.

18 Direct GME Payments: Determination of the Total Number of FTE Residents. 42 CFR §413.78(a)-(g).

19 Direct GME Payments: Determination of the Total Number of FTE Residents. 42 CFR §413.78.

20 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(b)(1)-(2).

21 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. See: Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(a)(1)-(4).

22 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(a)(10).

23 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(a)(10).

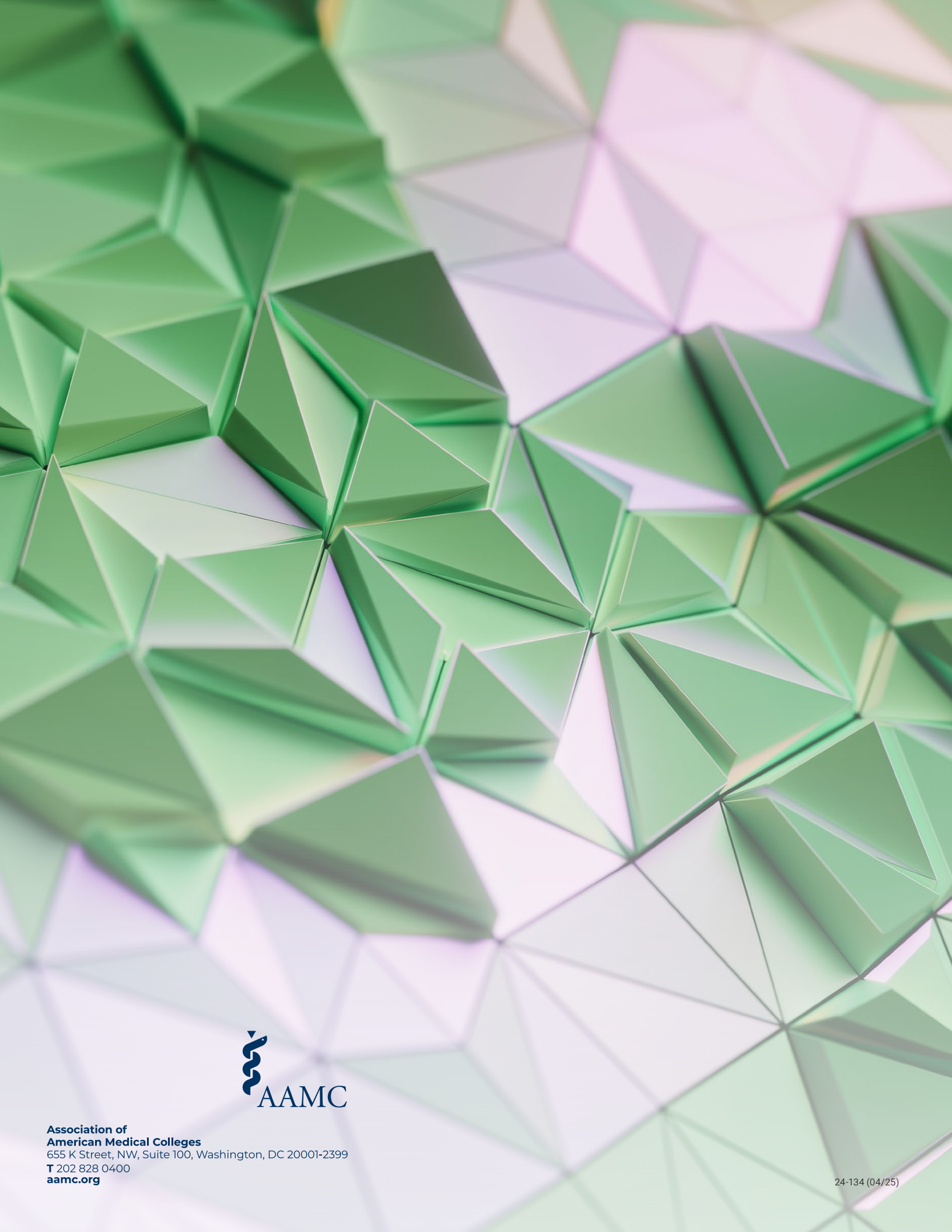
24 Medicare program; changes to the hospital inpatient prospective payment systems and fiscal year 2006 rates. *Fed Regist*. 2005;70(155):47278-47707.

25 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(a).

26 Direct GME Payments: Determination of the Weighted Number of FTE Residents. 42 CFR §413.79(a)(5).

27 Special Treatment: Hospitals That Incur Indirect Costs for Graduate Medical Education Programs. 42 CFR §412.105.

28 In response to the holding in *Hershey v. Becerra*, the CMS changed the rules for counting residents toward the hospital cap in the FY 2023 [Hospital Inpatient Prospective Payment System (IPPS)] Final Rule. Prior to this rule change, the CMS had a somewhat complicated formula that ensured a hospital could not claim more resident FTEs than its cap. This calculation was commonly referred to as the "fellow penalty," because hospitals that were training residents beyond their IRP would translate into a downward adjustment below their allowed FTE cap. The new rule allows hospitals to claim the weighted FTE count if it is below the FTE cap, and to use the FTE cap if the weighted FTE count is greater. See: FY 2023 IPPS Final Rule 87 FR 49066 (Aug. 10, 2022) and *Milton S. Hershey Med. Ctr. v. Becerra*, C/w 19-cv-3763 (D.D.C. May 17, 2021).



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