Becoming a New Teaching Hospital

A Guide to the Medicare Requirements

November 2014
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America’s teaching hospitals are committed to educating the next generation of physicians through excellent and essential clinical training. Typically, teaching hospitals and their associated ambulatory settings provide this clinical educational environment for the training of resident physicians (residents). Residents have graduated from medical school (referred to as their undergraduate medical education, or UME) and spend several years, generally ranging from three to seven years, receiving instruction and participating in the supervised care of patients in a medical specialty such as internal medicine or neurosurgery. This phase of their training is referred to as graduate medical education (GME).

Hospitals that train residents benefit the communities they serve and value their educational missions. Teaching hospitals find that educating residents provides their institutions with a learning environment for all employees, as learners prove to be catalysts for adopting the latest research and best patient-care practices. They often benefit in other ways from the presence of residency programs as well, for example, by recruiting medical staff from among their program graduates. Teaching hospitals also are recognized in their communities and nationwide for the value they provide both in educating residents and in providing high-quality care for vulnerable patients.

While the benefits are extensive, teaching hospitals incur real and significant costs beyond those customarily associated with providing patient care. Since its inception, the Medicare program has been committed to paying its share of these added costs, recognizing that physician training is essential to the treatment of Medicare beneficiaries. As a teaching hospital, your institution will be eligible for two types of payments under the Medicare program. The first type, Direct Graduate Medical Education (DGME) payments, are intended to cover Medicare’s share of your hospital’s costs that are directly related to educating residents. These costs include expenses such as resident stipends and benefits, the salaries and benefits of physicians who teach, supervise, and evaluate residents, and the costs of maintaining a dedicated GME office.

The label for the second type of payments, Indirect Medical Education (IME) payments, is actually a misnomer, in that these payments are not designed to pay for your hospital’s resident training costs. Although they have an “education” label and are calculated using a formula that takes into account the hospital’s ratio of residents to beds, these payments compensate your hospital for the “indirect” patient care costs associated with having a teaching program. Teaching hospitals tend to have higher patient-care costs than non-teaching hospitals—costs associated, for example, with treating more complex patients, with requiring standby capacity in burn units and trauma centers, and with some inefficiencies in care when learners are involved. This guide will explain in much greater detail these two types of Medicare payments with an “education” label and will explain how these payments will be calculated for your hospital.

If your institution is beginning to think about becoming a teaching hospital that receives funding from the Medicare program for an education mission, or if you are a medical school seeking to develop education partnerships with non-teaching hospitals, we encourage you to begin the planning process several years in advance of taking on your first resident. Building residency programs requires careful planning and important collaboration among all stakeholders, including the potential future teaching hospital, area medical schools, the accrediting body, and the federal government (specifically, the Centers for Medicare and
Medicaid Services (CMS), which oversees Medicare payment policy. The Association of American Medical Colleges (AAMC) encourages you to read this guide, learn from existing teaching hospitals, consult with outside legal counsel, and discuss your plans with your Medicare fiscal intermediary or Medicare administrative contractor (MAC). The decisions you make now about your residency training programs will affect your hospital’s ability to be reimbursed by Medicare for the entire life of these training programs—so now is the time to be purposeful and strategic in your planning.

Please note, this guide represents the AAMC’s best interpretation of the rules and regulations governing Medicare DGME and IME payments and has not been approved or endorsed by CMS or any other government agency.

What this guide will cover:

- What it means to be a “new” teaching hospital for Medicare purposes (and why being “new” matters);
- The types of residency training programs Medicare will pay for;
- How long the Medicare program will pay for a particular resident;
- The two types of payments Medicare makes that have an education label (referred to as DGME payments and IME payments) and how these payments will be calculated for your hospital;
- The limit or “cap” on the number of residents Medicare will pay for and how that cap will be set at your hospital;
- How Medicare will reimburse your hospital during the first five years of being a teaching hospital, before a resident cap is established;
- The implications of being a hospital that accepts rotating residents versus being a “new” teaching hospital; and
- Other important tips to keep in mind as you build your program.

What this guide will not cover:

- Residency program accreditation requirements;
- Details about what training activities are not included in the resident full-time equivalent (FTE) count for Medicare payment purposes;
- Advice on budgeting for your residency training programs;
- Medicare funding of provider-operated nursing and allied health programs;
- Medicaid GME payments (available in certain states); or
- Funding through Veterans Affairs (VA) or Department of Defense (DoD) residency training programs.
What does it mean to be a “new” teaching hospital?

In 1997, for cost containment purposes, Congress imposed a limit or “cap” on the number of residency positions (also referred to as residency slots) the Medicare program will fund. Medicare reimbursement for hospitals that were already training residents in 1996 was capped at the level of training those hospitals conducted in 1996. Congress did not, however, prohibit hospitals that were not training residents as of 1996 from becoming teaching hospitals reimbursed by the Medicare program. A “new” teaching hospital may establish its own resident cap (through a process described below) and may be reimbursed by Medicare for Medicare’s share of the hospital’s training costs.

For the Medicare program to consider your hospital a “new” teaching hospital (i.e. one eligible for Medicare funding), the hospital must have reported no allopathic or osteopathic residents on its most recent Medicare cost report ending on or before December 31, 1996 (if the hospital existed then), and started training residents in a newly accredited program after January 1, 1995. You may not simply transfer an existing residency training program from another hospital to your hospital and still be considered a “new” teaching hospital eligible to establish a resident cap and receive Medicare funding. (E.g., a sponsoring school of medicine may not simply close a program in one hospital and move the program to your hospital.)

To determine whether your hospital is in fact starting a “new” program or is simply transferring a program to your hospital from another hospital, CMS will look not only at the accreditation date of the program and the language in the accreditation letter but also will consider factors that include, but are not limited to:

- Whether the program director is new;
- Whether the teaching staff is new;
- Whether the residents have come from an existing residency program;¹
- The relationship between the hospitals (for example, common ownership or a shared medical school or teaching relationship);
- The degree to which the hospital with the original program continues to operate its own program in the same specialty;
- Whether the program has been relocated from a hospital that closed;
- If the program was relocated from a closed hospital, whether the program was part of the closed hospital’s full time equivalent (FTE) resident cap determination; and
- Whether the program is part of any existing hospital’s FTE cap determination.

CMS does not specify precisely what combination of these factors will contribute to a program’s failure to be deemed a “new medical residency training program.”² Rather, the determination will be made case-by-case. Remember, however, that if CMS finds that your institution is not offering a “new” medical residency training program, the Medicare program will not make payments for your program.

¹ CMS specifically raised this issue in the FY 2013 Inpatient Prospective Payment System Final Rule and reminded hospitals “that filling a program with transfer residents from other hospitals’ existing residency training programs may jeopardize the program’s status as ‘new’.” 77 Fed. Reg. 53258, 53420-53421 (Aug. 31, 2012).
² A more extensive discussion of CMS’ perspective on these factors is located at 74 Fed. Reg. 43754, 43908 (Aug. 27, 2009).
What types of residency training programs will Medicare pay for?

The Medicare program will only reimburse teaching hospitals for interns, residents, and fellows who are in “approved medical residency training programs.” Before discussing the definition of an “approved” program, it is helpful to define a few basic terms:

- **Intern**: Typically, interns are simply residents in their first year of residency training.
- **Resident**: Residents are trainees (including interns) who have completed medical school and are training in a clinical program for which they will become eligible for specialty certification. For purposes of the Medicare program, the term “resident” means an intern, resident, or fellow who participates in an approved program.
- **Fellow**: Fellows are trainees in specialty and subspecialty programs who have already completed their initial residency period (discussed below); fellows are counted for Medicare DGME payment purposes using special rules.

An “approved” program for interns, residents, and fellows is one that is approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the American Dental Association (ADA), or the American Podiatric Medical Association (APMA), or one that leads to board certification by the American Board of Medical Specialties (ABMS).

Some highly-specialized physician training programs—for example, certain transplant training fellowships—do not meet the above definition of “approved,” however, because they are not accredited by one of the four listed accreditation bodies and do not lead to board certification. For trainees in these programs, a hospital may receive reimbursement through Medicare Part B reasonable cost payment. Even then, the Medicare program will provide partial Medicare Part B reasonable cost payment (up to 80 percent of the cost of resident salaries and benefits after the Medicare beneficiary pays the Part B deductible) only if the trainees are not fully licensed in the state where they are participating in an unapproved program.3 Alternatively, if the physician has the appropriate training and is licensed, the physician may bill for services under the Medicare Physician Fee Schedule (MPFS).

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3 See a further discussion of this issue at 75 Fed. Reg. 50042, 50290 - 50291 (Aug. 16, 2010).
How long will the Medicare program continue to pay for a particular resident?

The Medicare program sets a limit on the number of years it will fund a resident in an “approved” program at “full freight.” Medicare counts a trainee as one full time equivalent (1.0 FTE) resident for what is known as the “initial residency period” (IRP)—the minimum accredited length for each allopathic specialty, as listed in the program requirements on the ACGME’s website (www.acgme.org), or, for osteopathic programs, as listed on the American AOA’s website (www.osteopathic.org). The IRP for internal medicine is three years, for example, and the IRP for surgery is five years.

Keep in mind, however, that one resident trainee will not equal a full FTE, given both that residents are unlikely to spend 100 percent of their time in a single hospital and its associated ambulatory clinics and that certain categories of time (e.g., certain research time) must be excluded from the hospital’s FTE count.

If a resident continues to train in an approved program beyond the IRP—most often to participate in an approved fellowship program such as cardiology or neurology—Medicare counts the resident at only fifty percent for DGME payment purposes (discussed below). For IME payment purposes, the resident will continue to count as 1.0 FTE. The maximum number of years Medicare will count any resident as 1.0 FTE is five years, although that period may be extended for up to two additional years for training in a geriatric, child neurology, or preventive medicine residency or fellowship.

The IRP for an individual resident is set when the resident begins training and does not change, even if the resident changes specialties. For example, if a resident begins training in an internal medicine program (IRP = three years) and decides in the second year to transfer to a surgery program (IRP = five years), the resident will only count as 0.5 FTE for DGME purposes for the last two years of the five-year surgery training program, because the IRP was set at three years when the resident first began training.

For residents in “combined” residency programs, in which residents complete training in two specialties simultaneously (for example, internal medicine and pediatrics), the Medicare program will count the residents as 1.0 FTE for the number of years of formal training required to satisfy the initial board requirements of the longer program. If all of a resident’s combined training programs are for primary care or obstetrics and gynecology, the Medicare program will count the resident as 1.0 FTE for the number of years required for certification in the longer of the programs plus one year.

Finally, there are special rules for when the IRP will be set for residents in transitional year and preliminary year programs—rules that depend on whether the resident simultaneously matches into both the transitional year and a specialty program. (Please see the table in the Appendix and its accompanying Federal Register references for more information on these situations.)

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4 Also note that for Medicare payment purposes, the resident count is based on where residents train and not on the sponsor of the program. For additional information on counting resident time, see Chapter 5, under “Rotations to Other Hospitals and Ambulatory Sites during the Five Year Cap-Building Window.”
What payments will Medicare make to reimburse my hospital for training residents?

The Medicare program makes two types of payments to teaching hospitals that have an “education” label: direct graduate medical education (DGME) payments and indirect medical education (IME) payments.

**DGME Payments**

*What do DGME payments cover?*

DGME payments are intended to cover Medicare’s share of your hospital’s costs that are directly related to educating residents. These costs include: resident stipends and fringe benefits, salaries and fringe benefits of supervising faculty, other direct costs (for example, a GME office to administer the program or programs, accreditation fees, educational space, etc.), and allocated overhead costs. The Medicare program spends approximately $3 billion annually on DGME payments to teaching hospitals nationwide.

*How will my hospital’s DGME payments be calculated?*

Medicare makes DGME payments to each hospital that trains residents in an approved residency program based on a hospital-specific per resident amount (PRA), a measure of your hospital’s Medicare utilization, and the count of residents the Medicare program will fund (discussed in Chapter 5). CMS will assign your new teaching hospital a PRA equal to the lower of your actual DGME costs per resident or the weighted mean PRA of the teaching hospitals in the same geographic wage area as your hospital. If there are fewer than three teaching hospitals in your geographic wage area, then CMS will use your Census region instead.

To determine your hospital’s actual DGME costs per resident, CMS will use the cost information you provide on your Medicare hospital cost report for the first cost reporting period when you begin to train residents at your hospital and will divide that cost information by the number of FTE residents training in your hospital that year. (If residents are not on duty during the first month of the cost reporting period during which you begin your training program, CMS will use the cost information you provide on your Medicare hospital cost report for the first cost reporting period immediately following the cost reporting period when you begin training residents.) (See Chapter 6 for additional discussion of how DGME payments are made during the first five years of your program.) For this reason, your hospital should be vigilant about maintaining strict documentation of all resident costs, particularly during the first year. Once CMS establishes your hospital’s PRA, it is permanent and is updated annually by an inflation factor. This PRA will not change, even if your GME costs increase faster than inflation.

The amount of payment your hospital receives for a particular resident will also depend on whether the resident is in the initial residency period or beyond, and whether the resident spends any time at other hospitals or in sites that CMS determines do not count toward DGME payment.

So, for simplicity’s sake, if residents in their initial residency period spend all of their time at your hospital (or at an associated ambulatory site) and your hospital continues to pay the stipends and benefits for those residents, CMS will calculate the amount of DGME payments your hospital will be paid for each resident (up to the resident “cap” discussed below) by multiplying your hospital’s PRA by its Medicare share (equal to the ratio of Medicare inpatient days (including Medicare Advantage days) divided by total inpatient days).
For example, if your PRA is set at $90,000 and your Medicare share is 40 percent, your DGME payment will be $36,000 per 1.0 FTE resident:

\[0.40 \times \$90,000 = \$36,000\]

Fellows training beyond the IRP are counted at 50 percent for DGME payment purposes. Using the same facts, the DGME payment for a fellow would be $18,000:

\[(0.40 \times \$90,000) \times 0.50 = \$18,000\]

Also keep in mind that if one of your residents rotates to another hospital, only that other hospital may receive DGME payments for the time spent at the other hospital, even if that hospital is not incurring any direct costs associated with that resident. (See Chapter 5 for further discussion related to rotating residents.)

Note: You may have heard that PRAs are set at a higher rate for primary care residents than for residents training in other specialties. This is true only for teaching hospitals with programs that began before 1995, because Congress only updated primary care PRAs (and not nonprimary care PRAs) for inflation in 1994 and 1995. As a new teaching hospital, your institution’s PRA for residents and fellows in all specialties will be the same.

**IME Payments**

*What do IME payments cover?*

IME payments are intended to compensate teaching hospitals for the “indirect” patient care costs associated with having a teaching program, to provide payments for the clinical environment where teaching occurs. Teaching hospitals generally have higher patient-care costs than non-teaching hospitals, because they tend to treat patients with more severe illnesses whose complexities are not captured by the per-case Medicare severity diagnosis-related group (MS-DRG) payment system. These hospitals assure all patients have access to highly specialized care, regardless of their ability to pay, and they maintain an environment in which clinical research can flourish. Additionally, teaching hospitals incur other operating costs that are difficult to quantify, such as standby capacity and lower productivity (resulting from time spent teaching, residents’ ordering additional tests, etc.), as well as offering the newest and most advanced services and equipment. These unique teaching hospital missions increase the cost of patient care at these institutions. The Medicare program spends approximately $6.5 billion annually on IME payments to teaching hospitals nationwide.

*How will my hospital’s IME payments be calculated?*

Your operating IME payments will be paid as a percentage add-on to your basic Medicare per case MS-DRG payments. (To receive this add-on payment for Medicare managed care patients you will need to submit “shadow” MS-DRG claims.) The IME adjustment that Medicare will make to your MS-DRG payments is based on a formula set forth in the Medicare statute and relies on your hospital’s intern and resident-to-bed (IRB) ratio to measure teaching intensity and a multiplier set by Congress. Each hospital is subject to a cap on the number of residents it may count in the numerator of the IRB ratio. After an initial period (described in more detail in Chapter 7), the IRB ratio itself is also capped at the lower of the current year or prior year IRB ratio. Unlike for DGME payment purposes,

5 Note that the portion of this payment that represents the hospital’s Medicare Advantage days is then reduced by a certain amount (currently 14.13 percent) to fund Medicare’s nursing and allied health education program payment “pool.”
however, fellows training beyond the IRP are not weighted at 50 percent for IME payment purposes, so each fellow will count as 1.0 FTE in calculating your hospital’s IRB.  

The formula for the IME adjustment is:

\[ \text{Multiplier } c \times ((1+\text{IRB})^{0.405} - 1) \]

where the Multiplier “c” is currently set by Congress at 1.35.

Policymakers sometimes will refer to the multiplier itself or to the percentage increase in payments that reflects IME payments. In this context, the formula means that a teaching hospital will receive approximately a 5.5 percent increase in MS-DRG payments for every 10-resident increase per 100 beds.

Note: Your hospital also will receive a relatively small IME adjustment to its capital inpatient payment rates. This capital IME payment uses a residents-to-average daily census (RADC) ratio rather than the IRB ratio to measure teaching intensity. It is calculated using the formula \[ e^{0.2822 \times \text{RADC}} - 1 \], where \( e \) is the base of natural logarithms, equal to approximately 2.718. Medicare spends approximately $385 million per year on capital IME payments. For capital IME payment purposes, the RADC ratio may not exceed 1.5.

**Example of an IME Operating Payment Calculation:**

Assume:

- Your hospital has a resident count of 170 intern, resident, and fellow FTEs;
- Your hospital has 666 beds; and
- CMS makes a payment to your hospital for MS-DRG 227 (cardiac defibrillator implant without cardiac cath and without major complications or co-morbidities) at an FY 2015 payment rate of $31,963.

To determine the IME percentage add-on, use the formula \( \text{Multiplier } c \times ((1+\text{IRB})^{0.405} - 1) \):

\[ 1.35 \times ((1 + (170/666))^{0.405} - 1) \times 100 = 13.00\% \]

Apply the IME percentage add-on to that particular case:

Payment for MS-DRG 227 × IME % = IME Payment

\[ $31,963 \times 13\% = $4,155.19 \]

Thus, your hospital will receive an additional payment of $3,896.75 for this case, to compensate for the additional patient care costs associated with being a teaching hospital.  

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6 Note that there are specific rules regarding how the bed count is determined for purposes of the IRB ratio that are beyond the scope of this guide (for example, the bed count is actually a calculation of available bed days, neonatal and hospice beds must be excluded from the count, etc.). Your hospital should consider inviting its Medicare intermediary or contractor for a site visit prior to the start of any residency programs, so that the hospital and the intermediary can establish, in advance, an available bed count and avoid potential future disagreements about this subject.

7 Note that this example, designed to illustrate how to calculate an IME payment, is overly simplistic. In reality, the MS-DRG payment rate would be wage-adjusted prior to the addition of the IME payment, and the hospital may receive other payments in addition to this amount (e.g., disproportionate share hospital (DSH) payments and outlier payments).
**The Special Cases of Children’s Hospitals, Critical Access Hospitals, Psychiatric Facilities, and Rehabilitation Facilities**

Children’s hospitals are not reimbursed through the Medicare program, because these hospitals typically do not care for Medicare beneficiaries, but the rules governing Children’s GME (CHGME) payments tend to mirror Medicare’s GME payment rules. CHGME payments are also funded through an annual appropriations process rather than through the Medicare Trust Fund.

Critical access hospitals (CAHs) that train residents receive neither DGME nor IME payments, and the Medicare program does not place a “cap” on the number of residents that train at CAHs. Instead, CAHs are reimbursed at 101 percent of their allowable teaching costs, which include costs for the residents’ stipends and fringe benefits and teaching physician salaries and fringe benefits, as well as other direct and indirect costs.

Distinct part psychiatric and rehabilitation units and freestanding psychiatric and rehabilitation facilities also have separate rules for their education payments. Although these units receive DGME payments based on a per resident amount, they receive a “teaching status adjustment” based on their RADC instead of an IME payment based on their IRB ratio. CMS also sets separate resident caps for these facilities for the “teaching status adjustment” payment.
How will Medicare set the “cap” on the number of residents Medicare will pay for at my hospital?

Since 1997, Congress has placed a limit or “cap” on the number of FTE residents each hospital may claim for DGME and IME payment purposes. (The only exceptions to this limitation are for dental and podiatric residents, for which Medicare imposes no cap.) Each teaching hospital that has its own, separate Medicare provider number has its own cap that is permanent unless changed by Congress.8

Because the cap Medicare assigns to your hospital is your hospital’s permanent cap, it is extremely important for you, as a new teaching hospital, to think carefully through your long-range plans to sponsor or host residency programs before accepting your first resident.9 You should think not only about your initial number of residents and number of residency programs but also about your ultimate desired number of residents and programs. If, for example, you decide to start small now and discover in several years that you would like to expand your programs or add new ones, it will already be too late for you to receive additional Medicare funding for additional residents.

The Medicare program will grant your institution a five-year window to establish your permanent cap.10 (During this five-year period, you will be paid based on your actual resident FTE count and will not be held to any limit on resident FTEs.) Your five-year window will open when you first begin to train residents in your first new residency program. The window will close at the end of the fifth program year of your first new program, and your permanent cap will be effective on the first day of the hospital cost reporting period that coincides with or follows the start of the sixth program year of the first new program you started.11

Your resident cap will equal the sum, for all programs, of the largest number of FTE residents in any postgraduate year (PGY) during the fifth year of the cap-building window, multiplied by the IRP for that residency program.12 If residents train at more than one hospital during the cap-building window, then the above calculated cap is multiplied by a quotient of the number of FTE residents in the new program who trained at the new teaching hospital during the cap-building period, divided by the total number of FTE residents in the new program who trained at all hospitals during the five-year cap-building window.13

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8 Note that although each hospital has two caps, one each for DGME and IME, for simplicity this document refers to “cap” in the singular.

9 The only exception to the establishment of a permanent cap is for rural hospitals, which may add to their cap in the future for additional new programs but not for expansions of existing or previously existing programs.

10 Note that new teaching hospitals that started training residents before October 1, 2012, only had a three-year window to establish a resident cap. CMS increased the cap-building window from three years to five years in the FY 2013 Hospital Inpatient Prospective Payment Systems (IPPS) final rule (77 Fed. Reg. 53258, 53416–53424 (Aug. 31, 2012)), after the provider community expressed concern that three years did not provide sufficient time to reflect the number of FTE residents the new programs actually would train once fully grown.

11 Note that for new programs started before October 1, 2012, CMS’ policy was for the permanent cap to be effective on the first day of the sixth program year of the first program you started.

12 The resident cap will be limited to the number of accredited slots for each program.

13 In adopting this new apportionment rule, CMS explained that considering all five years of the cap-building period, rather than focusing only on the fifth year, provides a more complete picture of the new program’s actual residency rotations, which may be divided among participating hospitals and likely fluctuate from year to year. 77 Fed. Reg. 53258, 53422 (Aug. 31, 2012).
Put more simply, you may use the following six steps to determine the cap that will be set for each program at a new teaching hospital. To determine the new teaching hospital’s total cap, perform these steps separately for each program and then sum the results:

- **Step 1:** Calculate each individual hospital’s TOTAL FTEs in the program over all five years.
- **Step 2:** Sum all totals from step 1 to get total FTE time spent in all hospitals over five years.
- **Step 3:** Looking only at the fifth year, calculate total FTEs for each PGY year; select highest PGY year.
- **Step 4:** Take lower of step 3, or the hospital’s number of accredited slots per year.
- **Step 5:** Take step 4 × minimum accredited length of the program.
- **Step 6:** Take step 5 × (step 1 hospital at issue ÷ step 2).

**Example:**

- New teaching hospital A receives approval to start an accredited family medicine program (IRP = 3 years, limited to 15 residency positions, 5 positions per year) and an accredited surgery program (IRP = 5 years, limited to 20 residency positions, 4 positions per year). Hospital A decides to start the family medicine program in Year 1 and the surgery program in Year 4.

- Residents in both family medicine and surgery programs rotate to Hospital B, an existing non-rural teaching hospital with an established resident cap.

### Hospital A New Family Medicine Program FTE Count

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Hospital A’s Family Medicine FTE 5 year total = **36.95**

### Family Medicine FTEs Rotating to Hospital B

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Hospital B’s Family Medicine FTE 5 year total = **20.85**

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14 Note that this is the same example CMS presented in the FY 2013 IPPS final rule. 77 Fed. Reg. 53258, 53418–53419 (Aug. 31, 2012). For CMS’s discussion of this example, please refer to this final rule.
### Hospital A New Surgery Program FTE Resident Count

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Hospital A's Surgery FTE 5 year total = **11.00**

### Surgery FTEs Rotating to Hospital B

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Hospital B's Surgery FTE 5 year total = **3.80**

### Setting Hospital A's Cap

For the family medicine program:

- **Step 1:**
  - Hospital A: Total FTEs in the program over five years = 0.75 (Year 1) + 5.40 (Year 2) + 9.80 (Year 3) + 10.30 (Year 4) + 10.70 (Year 5) = 36.95 FTEs
  - Hospital B: Total FTEs in the program over five years = 3.75 (Year 1) + 4.20 (Year 2) + 4.80 (Year 3) + 4.30 (Year 4) + 3.80 (Year 5) = 20.85 FTEs

- **Step 2:** Total FTE time spent in both hospitals over five years = 36.95 (Hospital A) + 20.85 (Hospital B) = 57.80 FTEs

- **Step 3:** Total FTEs for each PGY year, during the *fifth* year of the cap-building window and select the highest sum:
  - PGY 1 = 4.20 (Hospital A) + 0.60 (Hospital B) = 4.80 FTEs
  - PGY 2 = 3.70 (Hospital A) + 1.20 (Hospital B) = **4.90 FTEs (highest number)**
  - PGY 3 = 2.80 (Hospital A) + 2.00 (Hospital B) = 4.80 FTEs

- **Step 4:** Take lower of step 3 (4.90 FTEs) or hospital’s number of accredited slots per year (5 FTEs) = 4.90 FTEs

- **Step 5:** Take step 4 (4.90 FTEs) × minimum accredited length of program (3 years) = 14.70 FTEs

- **Step 6:** Take step 5 (14.70 FTEs) × (step 1 Hospital A (36.95 FTEs) ÷ step 2 (57.80 FTEs)) = 14.70 × 0.64 = **9.41 FTEs for family medicine**
For the surgery program:

- **Step 1:**
  - Hospital A: total FTEs in the program over five years = 0 (Year 1) + 0 (Year 2) + 0 (Year 3) + 4.10 (Year 4) + 6.90 (Year 5) = 11.00 FTEs
  - Hospital B: total FTEs in the program over five years = 0 (Year 1) + 0 (Year 2) + 0 (Year 3) + 1.70 (Year 4) + 2.10 (Year 5) = 3.80 FTEs

- **Step 2:** Total FTE time spent in both hospitals over five years = 11.00 (Hospital A) + 3.80 (Hospital B) = 14.80 FTEs

- **Step 3:** Total FTEs for each PGY year, during the fifth year of the cap-building window and select the highest sum:
  - PGY 1 = 4.20 (Hospital A) + 0.60 (Hospital B) = **4.80 FTEs (highest number)**
  - PGY 2 = 2.70 (Hospital A) + 1.50 (Hospital B) = 4.20 FTEs
  - PGY 3 = 0.00 (Hospital A) + 0.00 (Hospital B) = 0 FTEs
  - PGY 4 = 0.00 (Hospital A) + 0.00 (Hospital B) = 0 FTEs
  - PGY 5 = 0.00 (Hospital A) + 0.00 (Hospital B) = 0 FTEs

- **Step 4:** Take lower of step 3 (4.80 FTEs) or hospital’s number of accredited slots per year (4 FTEs) = 4.00 FTEs

- **Step 5:** Take step 4 (4.00 FTEs) × minimum accredited length of program (5 years) = 20.00 FTEs

- **Step 6:** Take step 5 (20 FTEs) × (step 1 Hospital A (11 FTEs) ÷ step 2 (14.80 FTEs)) = 20 × 0.74 = **14.80 FTEs for surgery**

CMS will then add together the caps of each training program to determine Hospital A’s permanent unweighted cap:

9.41 family medicine FTEs + 14.80 surgery FTEs = **permanent cap of 24.21 FTEs**

*Note:* Although the hospital’s Medicare residency cap is established based on program-specific information, the permanent cap it is assigned is not program specific. Once a hospital’s cap is established, the hospital may use those Medicare-funded slots for any approved residency program.

**Rotations to Other Hospitals and Ambulatory Sites during the Five-Year Cap-Building Window**

Note that in determining FTE counts, you may not count a resident who is in a training program at your hospital during the five-year cap-building period for any time the resident spends training in another hospital. For example, if a resident in your emergency medicine program spends 3 months of the year at a trauma center at a hospital across town, you may not count that resident for a full FTE but rather only 0.75 FTEs (subtract out 3/12 of the year). Be sure to plan for these rotations at other hospitals and consider the apportionment rules set forth above when you consider establishing a cap for Medicare payment purposes,
as your FTE cap ultimately could be set at a number much smaller than the number of “bodies” enrolled in your accredited programs.

Conversely, you may not count toward your cap any residents who are rotating into your hospital from existing teaching facilities. Those resident FTEs are already accounted for in the existing teaching hospitals’ caps and may not be counted in building your hospital’s cap.

Finally, note that while your hospital may count the time your residents spend training at clinical ambulatory sites if your hospital pays the residents’ stipends and benefits while they train at those sites, there are other types of training and training sites that are not counted for Medicare funding purposes, which may further reduce your actual FTE count for cap-setting purposes.15

15 For example, research time must be excluded for IME purposes, and training in a site where clinical care is not delivered—such as a public health department—may not be counted for either DGME or IME purposes.
generally speaking, the dgme and ime payments your hospital receives during the first five years the hospital is training residents (the cap-building years) will be calculated in the same manner as they are calculated in all subsequent years.

for your hospital’s dgme payments, as discussed, your hospital’s bra will be determined based on the hospital’s first full cost reporting period with residents. (and, as discussed, your hospital’s bra will ultimately be the lower of your actual bra or the weighted mean bra of all hospitals in the same geographic wage area based on the most recently settled cost reports.) you should note, however, that any graduate medical education related costs the hospital incurs while training residents during the cost reporting period prior to this base period will be reimbursed on a reasonable cost basis.

example:

if your hospital was not previously involved in resident training, begins training residents july 1, 2012, and has a december 31 fiscal year end, cms will look to the gme cost information your hospital provides on its medicare cost report covering the period of january 1, 2013, to december 31, 2013, and will divide that cost information by the number of fte residents training in your hospital that year to determine the bra. for any gme related costs (for example, resident salaries and fringe benefits, teaching salaries, gme program administration costs, etc.) the hospital incurs from july 1, 2012, through december 31, 2012, the medicare program will pay its share of these costs on a reasonable cost basis.

it is important to note that your hospital’s fte count will be calculated differently in the early years of your training programs than in later years, when it will be determined—for both dgme and ime purposes—based on a three-year rolling average. new program fte residents are exempt from this rolling average until the beginning of the hospital cost reporting period that coincides with or follows the start of the sixth program year of the first new program. until then, your hospital’s fte count will be determined based on the fte count for that year alone and will not be subject to a cap. the cap on the irb ratio based on the lower of the current year or prior year’s ratio also does not go into effect until the beginning of that same hospital cost reporting period.

example:

assume your hospital with a cost reporting period of july 1–june 30 is beginning an internal medicine program in your first cap-building year (july 1, 2015–june 30, 2016) and a psychiatry residency program in your third cap-building year (july 1, 2017–june 30, 2018). your hospital’s fte resident cap, three-year rolling average, and irb ratio cap will all go into effect on july 1, 2020, which is the cost reporting period that coincides with or follows the start of the sixth program year of the first program started.

16 you may wish to contact your fiscal intermediary or medicare administrative contractor to discuss such issues as pass-through payment options for the hospital’s first year of dgme and ime payments as well as the possibility of modifying the structure of the hospital’s medicare cost report to appropriately capture all direct gme costs (e.g., associated administrative and general expenses).

17 note that for new programs started before october 1, 2012, cmsg’s policy was to exempt fte residents from the rolling average for the minimum accredited length of the specific type of residency program.
What if my institution does not want to become a teaching hospital (at least not just yet) but wants to allow other residents to rotate through the hospital?

Will Medicare reimburse my hospital for these residents?

Even if your hospital decides not to become a new teaching hospital as the Medicare program defines it, permitting residents to participate in rotations at your hospital has certain implications within the Medicare program. (Also, if you are a current teaching hospital or in fact are planning to become a teaching hospital, you should consider sharing this information with the non-teaching hospitals to which you are planning to rotate your residents.) How you structure your resident rotation arrangements now can affect your ability to be paid by the Medicare program as a teaching hospital in the future.

If your hospital is not currently a teaching hospital but decides to permit residents to do rotations at your hospital, what is “triggered” from a Medicare reimbursement perspective depends on the teaching status of the hospital that is sending resident rotators to your hospital.

If the residents who rotate to your hospital are based at an existing teaching hospital (i.e., one that already has a resident cap established by the Medicare program):

- The existing teaching hospital may elect to “loan” you several of its DGME and IME cap slots under what is known as a “GME affiliation agreement.” If the hospital loans you resident cap slots, you will be paid by the Medicare program for these slots. Payments for DGME will be based on your own PRA (calculated as discussed above) and payments for IME will be based on your own IRB.

- If the existing teaching hospital does not loan you any of its DGME or IME cap slots, you will not be reimbursed by Medicare for the training that takes place in your hospital (other than for the training of dental and podiatry residents, whose training is not subject to resident caps).

- Regardless of whether the teaching hospital loans you any cap slots and whether you receive any Medicare funding, CMS has indicated that your hospital’s PRA will be “triggered” from the time the first resident rotates to your hospital—and will become permanent. CMS’ interpretation would mean that if, for example, the residents’ home teaching hospital continues to incur the cost of resident stipends and benefits, and your hospital reports on its cost report that it incurred “no expenses” relating to training the rotating residents, CMS would set your hospital’s PRA permanently at zero. As a result, your hospital would never be able to receive DGME payments through the Medicare program—even if your hospital decides to start a residency training program at some point in the future.

If the residents who rotate to your hospital are based at a new teaching hospital (in its five-year cap-building period):

- The new teaching hospital does not yet have a resident cap and has no slots to “loan” to your hospital. Nevertheless, you will in fact receive Medicare reimbursement for these residents, but it will be because you have just (intentionally or not) become a “new teaching hospital” yourself. This is because you are training residents in a “new training program”—even if that program is not your hospital’s program.

Relevant regulations do not state this position explicitly, and there are certainly arguments based on the Social Security Act and CMS regulations that would favor an alternate reading of this policy.
• According to CMS, rotating residents in your hospital under this scenario triggers both the establishment of a PRA and a resident cap for your hospital. Your hospital’s PRA will date back to the date the residents first began training in your hospital, but your hospital’s five-year cap-building window begins on the date the first residents in that program began training at the residents’ home teaching hospital.

• For example, if Hospital A, a new teaching hospital, began an internal medicine residency program on July 1, 2013, and residents from that program complete rotations in Hospital B for the first time in August 2015 (assume this is the first time Hospital B has ever permitted resident rotations and internal medicine is the only program with rotators at Hospital B), the five-year window for Hospital B to establish its residency cap closes on June 30, 2018. Thus, Hospital B’s resident cap will be set based on the number of internal medicine residents training in the hospital in only three years, and Hospital B will never have a chance to increase its resident cap in the future, even if it begins new residency programs several years later.

• Also, just as in situations where resident rotators come from an existing teaching hospital, CMS has indicated that your PRA will be “triggered” from the time the first resident rotates to your hospital—and will become permanent. Again, if the residents’ home teaching hospital continues to incur the cost of resident stipends and benefits, and your hospital reports on its cost report that it incurred “no expenses” relating to training the rotating residents, CMS has indicated that the Agency will set your hospital’s PRA permanently at zero. Thus, your hospital will never be able to receive DGME payments through the Medicare program—even if your hospital decides to start a residency training program at some point in the future.
What other helpful tips can you give me as my institution thinks about becoming a new teaching hospital?

We hope this information has helped give you a feel for Medicare reimbursement for graduate medical education as a new teaching hospital. We leave you with several more practical tips to keep in mind as you begin planning your training programs:

- As we have noted throughout this guide, it is extremely important to consider your short-term and long-term objectives at the outset, because many decisions you make today will affect your ability to receive Medicare funding long into the future.

- If you are a new urban teaching hospital, CMS will never permit you to enter into a Medicare GME affiliation agreement (i.e., to share cap slots across hospitals) unless entering into the agreement would result in an increase in your cap (i.e., your hospital receives cap slots from another hospital). In other words, CMS does not permit you to establish a new program just so you can give away your cap slots to another hospital. (Rural hospitals are excluded from this restriction.)

- When your new caps are established, it is often the case that your DGME cap will be different from—and higher than—your IME cap. This is because there are different rules about how you may count DGME resident training time versus IME resident training time. The health reform law helped to narrow the gap between time that can be counted for DGME and IME purposes, but differences remain.

- You will also notice that your hospital’s DGME and IME caps will not be set as whole numbers of residents. The cap determination is based on resident FTE time, not the number of individual residents, so the fractions are a result of deducting “non-countable” time from the total count of individual residents in establishing your cap.

- Review carefully the appropriate accrediting body’s institution and program-specific requirements, because your hospital and each training program will require accreditation from the outset. You should also discuss potential new training programs with the accrediting body.

- Consider your status as a new teaching hospital in the context of funding received from other payers (e.g., your state Medicaid program and commercial insurers), and consider how costs that are not reimbursed by Medicare and other payers will be covered.

- As mentioned above, get legal counsel and discuss your intentions with your Medicare contractor. We believe this primer outlines the main points regarding how the Medicare program funds graduate medical education, but your decisions have permanent implications and should be verified by experienced legal counsel and discussed with your Medicare contractor.

If you have questions relating to the information contained in this guide or other questions about Medicare payments for graduate medical education, please contact Lori Mihalich-Levin in Health Care Affairs at the AAMC, at 202-828-0599 or at lmlevin@aamc.org.
APPENDIX: Relevant Citations

DGME Payments

- Social Security Act § 1886(h): Payments for Direct Graduate Medical Education Costs
- 42 C.F.R. § 413.75: Direct GME payments: general requirements
  - See § 413.75(b) for regulatory definition of an "approved medical residency program"
- 42 C.F.R. § 413.76: Direct GME payments: calculation of payments for GME costs
- 42 C.F.R. § 413.77: Direct GME payments: determination of per resident amounts
  - See § 413.77(e) for discussion of how per resident amount is set for new teaching hospitals
- 42 C.F.R. § 413.78: Direct GME payments: determination of the total number of FTE residents
  - See § 413.78(b) for principle that a hospital may not claim the time spent by residents training at another hospital
- 42 C.F.R. § 413.79: Direct GME payments: determination of the weighted number of FTE residents
  - See § 413.79(a) for a definition of “initial residency period”
  - See § 413.79(d) for rules regarding the 3-year rolling average for hospital’s FTE resident count
  - See § 413.79(e) for rules regarding how a new program establishes its cap
  - See § 413.79(e)(1)(iv) for prohibition on new urban teaching hospital’s joining a GME affiliation agreement unless it would result in an increase in the new urban teaching hospital’s cap
  - See § 413.79(e)(3) for provision permitting rural hospitals to increase their caps for new programs (but not for existing programs)
  - See § 413.79(l) for a definition of a “new medical residency training program”
- 42 C.F.R. § 413.87: Payments for Medicare+Choice nursing and allied health education programs
  - See § 413.87(f) for CMS’ method of reducing Medicare Advantage portion of DGME payment to fund the nursing and allied health education programs “pool”

IME Payments

- Social Security Act § 1886(d)(5)(B)
- 42 C.F.R. § 412.105: Special treatment: Hospitals that incur indirect costs for graduate medical education programs
- 42 C.F.R. § 412.322: Indirect medical education adjustment factor (i.e. the capital IME adjustment)

CMS Alignment of Effective Date for Caps, 3-year Rolling Average, and IRB Ratio Cap

CMS Clarification of Definition of “New Medical Residency Training Program”


CMS Modification of New Training Program Cap Building Window from Three Years to Five Years


Residents Not in Approved GME Programs: Part B Reasonable Cost Payments

- 42 C.F.R. § 415.202: Services of residents not in approved GME programs

Critical Access Hospitals: Education Payments Made at 101 Percent of Costs

- 42 C.F.R. § 413.70: Payment for services of a CAH

Psychiatric and Rehabilitation Facilities: Teaching-Status Adjustment

- 42 C.F.R. § 412.424(d)(1)(iii): Teaching adjustment (for inpatient psychiatric facilities)
- 42 C.F.R. § 412.624(e)(4): Adjustments for teaching hospitals (for rehabilitation facilities)

Setting Initial Residency Periods for Transitional and Preliminary Year Residents

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Sources:

- 42 C.F.R. § 413.79(a)(10)