Medicare GME implications of newly-approved fellowship programs

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As health care innovation and clinical needs evolve, accrediting bodies have been approving fellowship programs in new subspecialties that previously were not accredited and that may not have led to board certification. Some examples of recently-accredited programs include fellowships in addiction medicine and clinical informatics. These newly-accredited fellowship programs are now considered "approved" programs for Medicare GME payment purposes, which has significant reimbursement implications for hospitals and clinical non-hospital sites where these residents rotate and train.

To receive DGME and IME payments, a fellowship program must meet CMS's definition of an "approved" program. CMS defines approved residency programs as those programs that are: (1) accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the Commission on Dental Accreditation of the American Dental Association or the Council on Podiatric Medical Education of the American Podiatric Medical Association; or (2) result in an American Board of Medical Specialties (ABMS)-approved specialty or subspecialty certification. Thus, a long-standing program may suddenly become "approved" for CMS purposes if it begins to be accredited or to lead to an ABMS certification.

From a Medicare perspective, the key difference between an approved program and an unapproved program is that a hospital may not report the time spent by residents training in unapproved programs on the Medicare GME worksheets of the hospital cost report. Regardless of the site or setting of care, such residents (which include fellows) may furnish physician services, and receive reimbursement for such services under the Medicare physician fee schedule, provided that they are fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed. If a fellow in an unapproved program is not fully licensed in the state where he or she is training, a hospital could receive reasonable cost reimbursement under Part B, provided that the fellow is enrolled and participating in a formally organized, standardized and structured course of study, and that the program has a duration of at least one year.

When a previously-unapproved fellowship program becomes an approved program, the time fellows spend training in that program must now be reported on the hospital's Medicare cost report. Because CMS has structured the GME payment regulations to avoid making double payments, fellows may not continue to independently bill for services provided within the scope of a newly approved fellowship program, nor may hospitals receive reasonable cost reimbursement for fellows in a program that has recently changed status to an approved program.

Additionally, if a hospital has only ever trained fellows in an unapproved program, and then its fellowship program becomes an approved program, the hospital could unintentionally trigger the establishment of its per-resident amount (PRA) and GME FTE Caps. Because the newly accredited fellowship program now satisfies the definition of an approved residency program, the hospital becomes a "new teaching hospital" for GME payment purposes. The risk of triggering a non-teaching hospital's PRA also arises if fellows in a newly approved program rotate to a hospital that has never trained any residents before.

Even existing teaching hospitals training over their GME FTE caps should be conscious of the potential payment implications of changes in the approval status of their fellowship programs. These hospitals must claim fellows in recently approved fellowship programs on their cost report for GME payment purposes. Counterintuitively, reporting these fellows actually could have a detrimental effect on existing teaching hospitals' GME payments . CMS calculates hospitals' weighted DGME caps in way that tends to penalize hospitals for which the proportion of fellows (counted at 0.5 FTEs) compared to total FTE residents (counted at 1.0 FTEs) has increased compared to the base year when the GME FTE caps were set. In short, adding more fellows without adding more non-fellow residents may decrease DGME payments for hospitals training above their caps.

The above are all issues hospitals and fellowship programs may be unaware of as their formerly-unapproved fellowship programs continue to operate as they always have after either becoming accredited or now leading to ABMS board certification. The Dentons team listed above can answer any questions you may have about these potential implications and other GME payment issues that may arise relating to your institution's residency and fellowship programs.

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