

Navigating the Rapids: How Government Funds Flow to Graduate Medical Education

Mary Jo Wagner , MD, FACEP
Harold A. Frazier , MD, FACS

Jeffrey S. Berger , MD, MBA

The Challenge

Graduate medical education (GME) funding in the United States is complex and can be confusing, even for established leaders. Funds from the federal government play a major role in GME, with federal GME revenues largely fixed for established training hospitals.¹ The challenge for GME leaders and their organization's financial officers is to understand how GME funding is allocated and their role in maintaining fiscal responsibility. This responsibility must be achieved while adequately anticipating community health care workforce needs and communicating about funding limits and opportunities to others, including university and health system leaders, trainees, and faculty.

What Is Known

Roughly two-thirds of the approximately \$20 billion in federal funds allocated for GME is through Medicare, from the Centers for Medicare & Medicaid Services (CMS).¹ This is a mandatory federal outlay to cover Medicare patients' share of medical education. One-quarter of GME funding is Medicaid with state (and federal matching) contributions to GME. Remaining GME funding is via the Health Resources and Services Administration (HRSA) payments for children's hospitals and teaching health centers, US Department of Veterans Affairs (VA), Department of Defense, other federal agencies, and non-profits.

Medicare GME payments are divided into direct graduate medical education (DGME)² and indirect medical education (IME), which are distributed to hospitals, not sponsoring GME institutions. DGME reimbursement is provided to offset expenses including trainee salaries, benefits, administrative, and educational expenses. IME reimbursement is intended to offset hospitals' higher patient care costs experienced by teaching hospitals (such as the standby cost for a trauma service or the increased resource use for complex patients). The DGME is based on an established, institution-specific per resident amount (PRA),³ the full-time equivalent (FTE) complement of residents in the hospital, and the number of Medicare in-patient days recorded on the hospital's cost report. The PRA is established by the allowable expenses reported on the hospital's cost report, based on residents' presence in the hospital. GME reimbursement covers only the

RIP OUT ACTION ITEMS

1. Understand your hospitals' (and affiliates') direct graduate medical education and indirect medical education contributions to graduate medical education (GME).
2. Know your GME cap for direct and indirect funding and create infrastructure for tracking, oversight, and reporting.
3. Strategize for contingencies to grow GME with additional funding from internal, state, or federal sources, and reduce GME positions in low-priority specialties, if necessary.

percentage of Medicare patients in the hospital and is not intended to cover all expenses of trainees.

Upon entering the first year of training, in a program that provides specialty board eligibility, each resident is given a number of years for which they will be eligible for full reimbursement. This is known as the initial residency period (IRP). If total years of training exceed IRP (for those who did an unrequired preliminary year, residents who have changed their specialty training, or fellows who have completed their core residency training), CMS will only reimburse 50% of the DGME funding for that resident, for each year. Geriatric fellowships in several specialties are an exception, funded at 100% DGME for one additional year.

The IME is calculated based on the ratio of trainees to beds. As IME is an addition to the hospital's diagnosis-related group, it is only paid when residents are involved in Medicare patient services billed at the hospital or associated "nonprovider setting," like a clinic. Both the DGME and IME have a capitated "cap" limit on the number of resident FTEs that will be paid to the hospital. FTE funding extends to residents who train in nonprovider settings (outpatient clinics) associated with the institution. If residents have never been on a hospital's cost report in the past, CMS allows 5 years to establish a cap. The Intern and Resident Information System (IRIS) Report is used to convey the actual resident effort for reimbursement that hospitals receive for GME. This is documented in the residency management system of most institutions.

The VA funds proportional salaries and benefits for residents during the time they are working in a VA facility. As the institutional cost of the VA is funded separately, IME-equivalent funds are not available for external residency faculty and administrative costs. Rural training programs, where at least 50% of the resident's

training is affiliated with the rural site, allow the GME cap to be shared by larger hospitals. In addition, time spent by a resident at a *critical access hospital* can be counted as a nonprovider setting on the primary hospital's cost report.

How You Can Start TODAY

1. **Review your IRIS report with leaders.** Identify the connection between each training program's block diagram and the accuracy of the IRIS report. Consider and clarify how vacations, nonclinical activities (eg, research, study rotations, away conferences greater than a day), out-of-system rotations, international electives, and training at more than one location in a day or block are listed. If work hour logging is used to ensure residents are correct on the hospital cost report, confirm that each program monitors the location of residents for review in an audit.
2. **Determine if your hospital is over the CMS funding cap.** If it is, by how many positions? Due to required off-site experiences, resident leaves of absence, and audit corrections, ideally an institution remains a few percent of FTE above its cap to maximize federal funding. Contact your hospital finance office or refer to the following website: <https://www.graham-center.org/maps-data-tools/gme-data-tables.html>. Discuss the cost/benefit (ie, of DGME cap implications) for residency applicants who will exceed their IRP during training at your institution.
3. **Identify how unfunded positions are supported within your institution.** Separate government reimbursement from Medicare clinical payments, endowment money, or from a faculty practice plan's operational funds support residency positions. Optimize the revenue-to-expense ratio of nonaccredited programs that do not receive federal funding and specialty residency programs that have no cap, such as dentistry and podiatry.

What You Can Do LONG TERM

1. **Perform a gap analysis.** Determine which programs may garner internal funding sources or programs that no longer align with institutional or community needs,

if forced to cut FTE. Develop a business case to support right-sizing programs identified in the gap analysis.²

2. **Implement formal oversight** of resident FTE distribution among hospitals with regular review.
3. **Negotiate for IME funds** received by your hospital(s) to support GME activities.
4. **Identify opportunities** to add CMS-funded positions or other federal and state programs that fund GME by identifying specialty or geographical physician shortages, especially for state funding. Federal programs are listed on the DGME CMS website.³
5. **Advocate.** Join national leaders to promote legislative solutions to increase physician training resources.

References and Resources for Further Reading

1. Congressional Research Service. Medicare graduate medical education payments: an overview. Accessed December 16, 2023. <https://crsreports.congress.gov/product/pdf/IF/IF10960>
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3. Centers for Medicare & Medicaid Services. Direct Graduate Medical Education. Accessed June 22, 2023. <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/direct-graduate-medical-education-dgme>



Mary Jo Wagner, MD, FACEP, is Professor of Emergency Medicine, Central Michigan University (CMU) College of Medicine, Chief Academic Officer, and Designated Institutional Official (DIO), CMU Medical Education Partners, Saginaw, Michigan, USA;

Harold A. Frazier, MD, FACS, is Professor of Urology, Associate Dean for Graduate Medical Education, and DIO, The George Washington University School of Medicine and Health Sciences, Washington, DC, USA; and **Jeffrey S. Berger, MD, MBA**, is Professor, Department of Anesthesiology and Critical Care Medicine, The George Washington University School of Medicine and Health Sciences, Washington, DC, USA, and Associate Editor, *Journal of Graduate Medical Education*, Chicago, Illinois, USA.

Corresponding author: Mary Jo Wagner, MD, FACP, Central Michigan University College of Medicine, Saginaw, Michigan, USA, wagne1m@cmich.edu