Myths and Facts: Medicare Funding for Graduate Medical Education

**MYTH:** Medicare pays the full cost of training a resident.

**FACT:** Medicare direct graduate medical education (DGME) payments only cover “Medicare’s share” of the costs directly related to resident training.

Medicare DGME payments offset about 20 percent of the total costs associated with training residents at teaching hospitals. DGME payments are based on the percentage of patients at an institution who are Medicare beneficiaries. The greater the percentage of Medicare patients, the greater the level of Medicare support.

In 2012, the total direct costs of training residents exceeded $16 billion, but Medicare DGME payments, which are largely based on estimated physician training costs in 1983, totaled only $3.3 billion. The additional costs are covered by clinical revenue of teaching hospitals—support that already is threatened by cuts to reimbursement.

**MYTH:** Only teaching hospitals can receive Medicare DGME payments.

**FACT:** Federally qualified health centers (FQHCs) and rural health centers (RHCs) also can receive Medicare DGME payments if they train and bear the costs of training residents.

When residents are trained at FQHCs and RHCs, those centers may receive Medicare DGME payments as long as they pay the residents’ stipends and benefits for the time the residents train at their facilities. The direct payments they receive are meant to help defray the same costs covered by DGME payments to teaching hospitals, including resident stipends and benefits, teaching physician salaries and fringe benefits, and facility overhead. Critical access hospitals (CAHs), which also serve rural communities, receive special teaching payments as well. These payments cover 101 percent of a CAH’s reasonable teaching costs.

**MYTH:** Medicare indirect medical education (IME) payments are payments for training residents.

**FACT:** Despite having the word “education” in its title, Medicare IME payments are intended to offset a portion of the additional costs teaching hospitals incur to maintain specialized services and treat the most complex, acutely ill patients. These services are critical for the health of the community and crucial for the environment in which health professionals must be trained. A hospital’s IME payments are made per Medicare discharge, not per resident.

All doctors must be able to recognize and manage the most serious illnesses and injuries, regardless of where or in which specialty they eventually practice. To provide these training opportunities, teaching hospitals must maintain specialty services like trauma centers, burn units, and neonatal intensive care units. Often, they are the only providers offering this care in their communities. For example, AAMC-member teaching hospitals represent just 5 percent of all hospitals, yet provide nearly one-quarter (23 percent) of all clinical care and more than one-third (37 percent) of all hospital charity care. They maintain more than two-thirds (68 percent) of all burn care unit beds, more than one-third (37 percent) of neonatal intensive care beds, and more than three-quarters (79 percent) Level 1 regional trauma centers.

The unique attributes of teaching hospitals (e.g., expertise and technology for the most acutely ill and injured patients, residency training programs) are expensive to maintain and represent costs not explicitly reimbursed by most payers. By helping offset a portion of those costs, Medicare IME payments allow teaching hospitals to maintain their missions of clinical care, community service, education, and research.
MYTH: Teaching hospitals should increase the number of residency positions without receiving additional federal support.

FACT: Reductions in hospital reimbursement and other emerging fiscal pressures likely will force teaching hospitals to reduce the number of residency positions.

Cuts to Medicare and other clinical reimbursements jeopardize the ability of teaching hospitals to cross-subsidize with clinical revenue the 10,000 residency positions they operate without Medicare support (positions over the “Medicare cap”). In light of this, further expansion without new Medicare support is highly unlikely.

Likewise, proposals to undermine Medicare GME support would weaken the nation’s physician training capacity at a time when the country needs more doctors. According to an August 2013 survey by the ACGME,1 83 percent of respondents (from both teaching hospitals and medical schools) already are engaged in leadership-level discussions about how they would reduce residency positions if Medicare GME support was cut.

The survey posed three scenarios under which Medicare GME funding could be reduced, and respondents reported those actions would trigger program reductions/eliminations across training programs in both primary and specialty care. The results indicate that GME cuts could lead to up to 75 percent of teaching hospitals reducing or eliminating training programs.

MYTH: Funding for Medicare GME disproportionately benefits a few states, leaving other regions with a shortage of physicians.

FACT: The level of Medicare GME funding in a particular geographic area reflects the number of teaching programs, residents, and Medicare beneficiaries, and the complexity of services in that region. GME support is not directed to one region at the expense of another.

Although nothing prohibits the development of new teaching hospitals in any part of the country and nothing would preclude those programs from seeking Medicare GME support, some regions have invested in far fewer training programs than others. These regions rely upon other parts of the country to train the physicians they need. For example, because Idaho and Montana have very few teaching hospitals, they have relied upon training programs in California, New York, Massachusetts, Michigan, Texas, and other states to produce their primary and specialty care physicians. As such, any change in GME policy has the potential to impact all states, regardless of how many teaching hospitals or trainees a state might have.

Personal decisions about lifestyle, family, and career plans are factors that shape where and in which specialty a physician chooses to practice. Efforts to attract physicians to shortage areas must address these factors.

Similarly, any reduction in Medicare support for the unique services available at teaching hospitals jeopardizes every American’s ability to access potentially lifesaving care when they need it most.

For more information, visit www.aamc.org/advocacy/gme.