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IN FOCUS

August 20, 2025

Medicare Graduate Medical Education, 2025

Medicare makes a significant investment in medical residency training (or graduate medical education [GME]). It paid an estimated $21.2 billion in FY2023, primarily to hospitals. The Government Accountability Office has found that Medicare is the largest federal source of GME funding, which also includes Medicaid, the Department of Defense, the Department of Veterans Affairs, Children's Hospital GME, and Teaching Health Center GME.

Given the prominence of Medicare in funding medical residency training, policies that impact Medicare GME can affect the future physician supply and could be used to address identified health care workforce priorities. This In Focus provides an overview of how Medicare pays for GME at hospitals, including eligibility requirements, payment structure, and funding caps. It also highlights selected policy considerations for Congress.

Eligibility for Medicare GME Payments

To be eligible for Medicare GME payments, a teaching hospital, which is often affiliated with a medical school, must have an approved residency program in allopathic (i.e., conventional) medicine or osteopathic medicine, dentistry, or podiatry. Medicare regulations require that programs be accredited. For allopathic and osteopathic programs, the Accreditation Council for Graduate Medical Education (ACGME) is the single accreditation system. (The remainder of this In Focus addresses allopathic and osteopathic residency programs unless otherwise noted.)

What Medicare GME Pays For

Medicare GME payments cover Medicare's share of the costs of a hospital's approved medical residency program. This includes the *direct* costs of operating a residency program, such as resident stipends, supervisory physician salaries, and administrative costs. Medicare GME payments also cover *indirect* costs, namely, the higher patient care costs in teaching hospitals relative to non-teaching hospitals. For example, resident-provided care may be more expensive because of additional tests that residents may order as part of their training. In either case, Medicare payments for direct and indirect costs are not intended to reflect the hospital's full cost of training.

How Medicare Pays For GME

Medicare pays separately for direct and indirect GME costs. Medicare payments for direct costs of GME are called *direct graduate medical education* (DGME) payments. DGME payments are sometimes referred to as "pass-through" payments in that they are not an adjustment to a Medicare payment for an individual hospital discharge. Rather, DGME is an aggregate payment determined by a statutory formula. (See section on "Determining Medicare GME Payment Amounts to Qualifying Hospitals.")

Medicare payments for indirect GME costs are called *indirect medical education* (IME) payments. IME payments are intended to cover the costs of "inefficient" care that may be provided by medical residents. However, since Medicare typically does not provide separate payment for such activities as additional testing, Medicare IME payments are provided as an adjustment or add-on to each Medicare inpatient prospective payment system (IPPS) per-discharge payment for qualifying teaching hospitals. IME payments are determined through a statutory formula.

Both DGME and IME payments generally are based on patient volume or the number of beds and number of residents. (See **Figure 1** and **Figure 2** for information about how each formula uniquely accounts for these factors.)

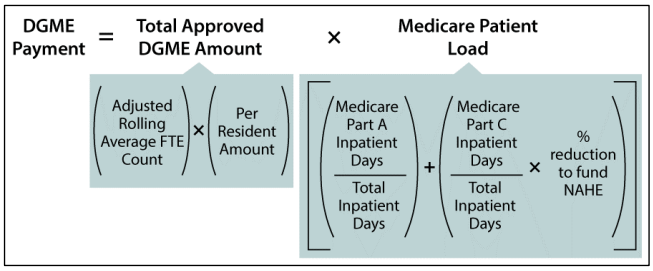
Determining Medicare GME Payment Amounts to Qualifying Hospitals

When Medicare was enacted in 1965, GME payments—like hospital inpatient services—were paid based on a hospital's reported costs, essentially an open-ended commitment by Medicare. Congress later capped Medicare GME payments for allopathic and osteopathic residency programs by limiting the number of resident full-time equivalents (FTEs) and per-resident amounts (PRAs) it would support. The FTE cap is set at the *number* of FTE residents a hospital trained in 1996; the *amount* Medicare pays for an FTE is based on a hospital's costs for a resident FTE in a base year, usually FY1984 or FY1985, updated by the Consumer Price Index for All Urban Consumers (CPI-U), as compiled by the Bureau of Labor Statistics. Newly constructed hospitals or existing hospitals that establish new residency programs for the first time after FY1996 may have their Medicare FTE caps and PRAs established according to criteria specified in statute and regulations.

Direct Graduate Medical Education

DGME payments are the product of a hospital's total approved DGME costs (i.e., a three-year rolling average of FTEs, subject to the FTE cap, multiplied by the PRA) and a hospital's Medicare patient load percentage. A hospital's Medicare patient load is the proportion of Medicare beneficiary inpatient (Part A and Part C) days relative to all-patient inpatient days for the year. The Medicare Part C (Medicare Advantage) portion of a hospital's Medicare patient load is reduced by a Centers for Medicare & Medicaid Services (CMS)-specified percentage to fund nursing and allied health education. The CMS-specified percentage can change each year. (See **Figure 1**.) In FY2023, Medicare paid an estimated $6.1 billion for DGME, supporting 116,431 FTEs—112,230 allopathic and osteopathic medicine, 4,201 dentistry and podiatry.

Figure 1. Medicare DGME Payment Formula



Source: CRS analysis of 42 U.S.C. §1395ww(h)(3) and 42 C.F.R. §§413.75-413.88.

Notes: DGME = direct graduate medical education; FTE = full-time equivalent; NAHE = nursing and allied health education.

The FTE cap and PRA amount are hospital-specific. However, qualifying hospitals may enter into a formal affiliate agreement in which a group of hospitals can share and redistribute FTEs among the hospitals. This allows some affiliated hospitals to reduce their Medicare-supported FTEs to increase another affiliated hospital's FTEs without exceeding the aggregate number of FTEs of the affiliated group (i.e., no net increase in Medicare-supported FTEs).

Indirect Medical Education

IME payments are intended to cover the higher costs of delivering health care services in teaching hospitals relative to non-teaching hospitals. IME payments are adjustments or add-ons to both the operating and capital portions of the Medicare IPPS per-discharge payment. The IME payment adjustment for each portion—operating and capital IPPS payments—is calculated differently. (DGME payments and FTEs also are calculated differently from those for IME.)

The IME adjustment to the operating portion of the IPPS payment is based on a statutory formula. The IME formula (see **Figure 2**) captures for each teaching hospital the ratio of interns and residents to beds (IRB ratio). The formula applies an exponent of 0.405 to the IRB to produce an estimate of the effect of teaching activity on hospital costs. In addition, the formula contains a multiplier (1.35) that is set by Congress in statute. CMS states that this multiplier represents a 5.5% increase in the IME payment for every 10% increase in the IRB ratio.

The IME payment adjustment for the capital portion of the IPPS payment is based on the ratio of residents to average daily census (RADC ratio) and an estimate of the effect of teaching activity on hospital costs (0.2822). (See **Figure 2**.)

In FY2023, Medicare paid an estimated $15.0 billion for IME, supporting 124,034 FTEs—119,328 allopathic and osteopathic medicine, 4,706 dentistry and podiatry.

Figure 2. Medicare IME Operating and Capital Adjustment Formulas

$$\text{IME Operating Adjustment} = 1.35 \times [(1 + \text{IRB})^{0.405} - 1]$$

$$\text{IME Capital Adjustment} = [e^{(0.2822 \times \text{RADC})} - 1]$$

Source: CRS analysis of 42 U.S.C. §1395ww(d)(5)(B) and 42 C.F.R. §412.322(b).

Notes: IRB = interns-and-residents-to-beds ratio; IME = indirect medical education; RADC = residents-to-average-daily-census ratio. Both IRB and RADC ratios are subject to the Medicare graduate medical education cap. Other restrictions to the formulas may apply.

Medicare GME Payments and FTEs

CMS does not publish estimates of Medicare GME payments and the FTEs supported by such payments. **Table 1** contains estimates of payments and FTEs based on analysis of publicly available Medicare cost report data.

Table 1. Estimated Medicare GME Payments and FTEs, FY2023

Payments (billions)			FTEs (count)	
DGME	*IME*	*Total*	*DGME*	*IME*
$6.1	$15.0	$21.2	112,230	119,328

Source: CRS analysis of FY2023 Medicare hospital cost report data.

Notes: Payments include all disciplines; Medicare cost report data do not distinguish payments by discipline. FTE counts are for allopathic and osteopathic residents only.

Increasing Medicare-Supported Residency Positions

There are limited administrative options to increase the number of Medicare-supported residency positions. For example, a hospital with an existing residency program can establish a new program triggering a new PRA and FTE cap; "new" is defined in regulation. A hospital without a residency program can start one, though some of these hospitals may already have a Medicare cap that is smaller than the number of residents the hospitals intend to train. (The Consolidated Appropriations Act, 2021 [P.L. 116-260], allowed some of these hospitals to adjust their caps.) Alternatively, an urban hospital can start a new Rural Training Program to train residents in a rural area. Otherwise, Congress may enact legislation to increase the number of Medicare-supported residency positions, which was done most recently in P.L. 116-260.

Selected Issues for Congress

The National Academies of Sciences, Engineering, and Medicine and the Medicare Payment Advisory Commission (MedPAC), among others, have identified issues that Congress may consider in any potential GME legislation:

- Resident contributions: Medicare GME payments cover the costs of a residency program but are not adjusted for any savings or revenue generated by medical residents.
- Efficiency of IME payments: the IME statutory formula may result in payments that are up to twice the amount that is empirically justified (e.g., MedPAC March 2007, March 2017, and June 2021).
- Start-up barriers: Medicare does not cover up-front costs to establish a new GME program; Medicare GME payments begin when training begins.
- Alignment with workforce needs: Medicare GME generally does not adapt to changes in geographic, settings-of-care, or physician specialty needs and may not incentivize training in priority areas.

For further information, see CRS Report R48636, *Federal Support for Graduate Medical Education*, coordinated by Elayne J. Heisler.

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IF13088

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