Indirect Medical Education (IME): Current Medicare policy, concerns, and considerations for revising

Alison Binkowski and Jeff Stensland

September 6, 2019

Roadmap

① **IME background**

② IME concerns and potential revisions

③ IME illustrative revised policy

IME is one of two types of medical education payments to acute care teaching hospitals

Indirect medical education (IME): Supports teaching hospitals' higher costs of patient care not otherwise accounted for in the IPPS; payments made as IPPS adjustments

Direct graduate medical education (DGME): Supports direct GME costs, such as resident stipends; payments outside of IPPS

Source: MedPAC analysis of IPPS teaching hospital cost reports with a midpoint in fiscal year 2017 and a length of 10-14 months.

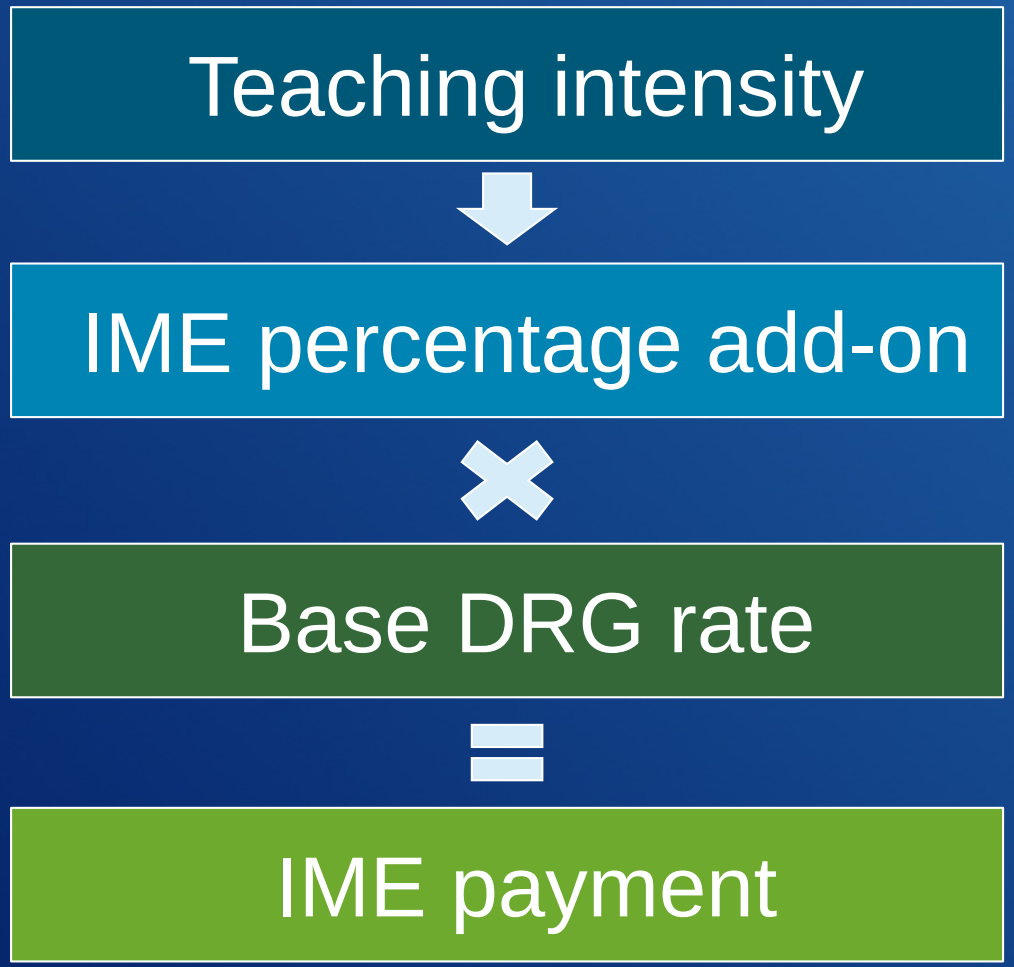
Results preliminary; subject to change

Treatment of IME varies across inpatient operating and capital PPS

	Inpatient operating PPS	Inpatient capital PPS
IME adjustment required?	Yes, formula and level specified in law	Secretary's discretion
IME adjustment implemented?	Yes	Yes, different formula than inpatient operating
IME level changed since enactment?	Yes, originally set at twice empirically justified level, gradual reductions	No

No IME adjustment in outpatient PPS

IME payments based on a hospital's teaching intensity and calculated as percentage add-on



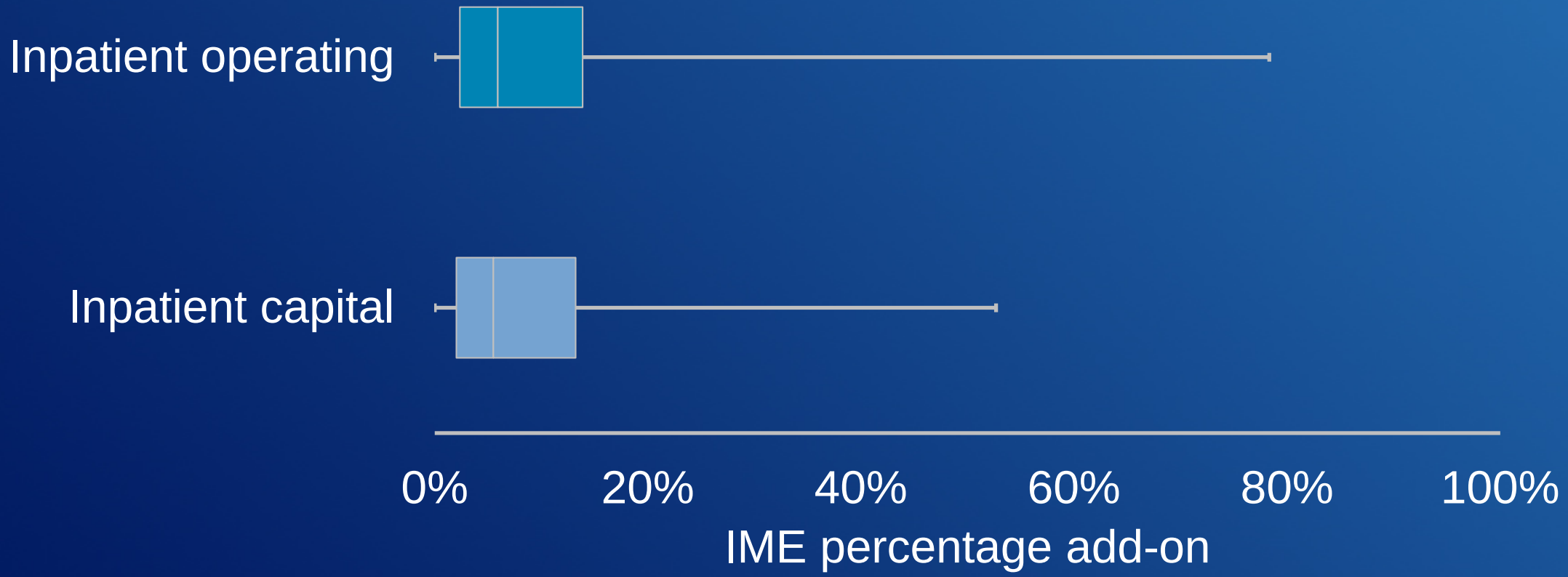
IME policies under the inpatient operating and inpatient capital PPSs differ

	Inpatient operating PPS	Inpatient capital PPS
Teaching intensity	Residents-to-bed ratio (RBR)	Residents-to-average daily census (RADC)
Numerator	Allowable resident FTEs (3 yr avg)	*Same*
Denominator	Inpatient beds	Average daily inpatient census
Maximum	Prior year RBR	1.5
Percentage add-on to base rate	$1.35 * [(1 + RBR)^{0.405} - 1] + 0.66 * [(1 + RBR\_MMA)^{0.405} - 1]$	$\boldsymbol{e^{(0.2822 * RADC)} - 1}$
Treatment of FFS and MA	Medicare pays IME for both FFS and MA patients	Medicare pays IME for FFS MA plans may pay IME for MA

Note: FTEs (full-time equivalents), RBR_MMA (resident-to-bed ratio among residents in additional slots added through the redistribution in the Medicare Modernization Act), FFS (fee for service), MA (Medicare Advantage).

Source: MedPAC summary of 42 CFR 412 § 105 and § 322.

IME percentage add-ons vary substantially, as result of variation in teaching intensity

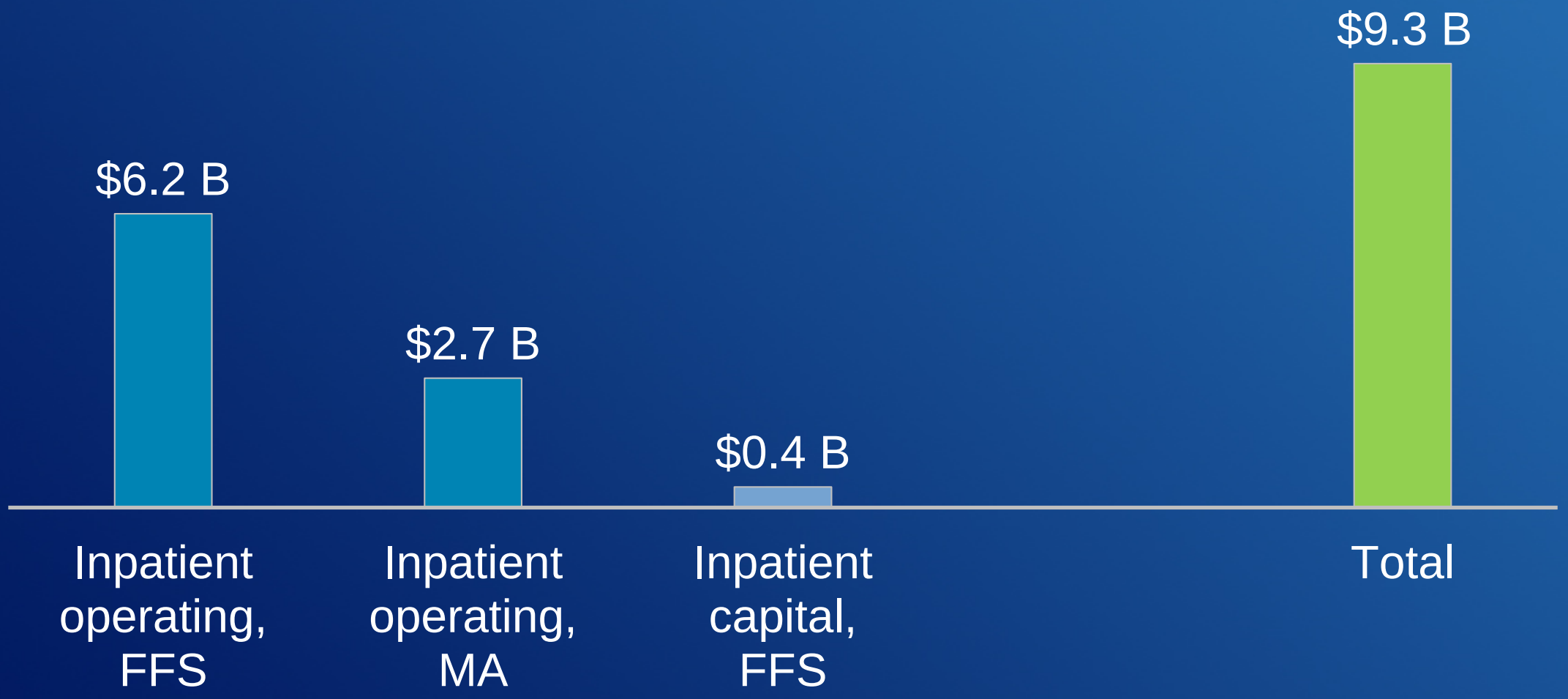


Note: IME (indirect medical education). The box represents the interquartile range (the range that the middle 50 percent of teaching hospitals fall into), the line in the box represents the median, and the whiskers show the minimum and maximum.

Source: MedPAC analysis of IPPS teaching hospital cost reports with a midpoint in fiscal year 2017 and a length of 10-14 months.

Results preliminary; subject to change

IME percentage add-on to inpatient operating rates accounts for nearly all IME payments

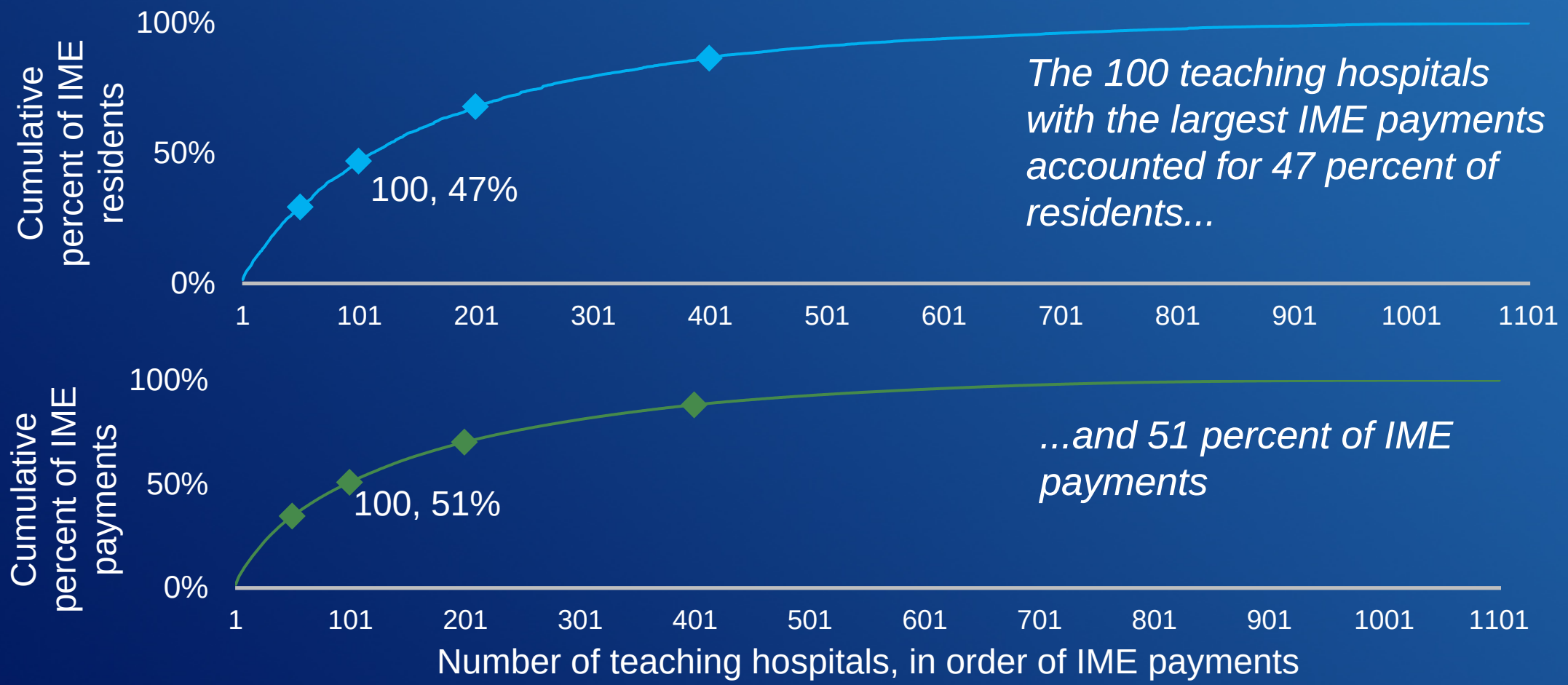


Note: IME (indirect medical education), FFS (fee-for-service), MA (Medicare Advantage).

Source: MedPAC analysis of IPPS teaching hospital cost reports with a midpoint in fiscal year 2017 and a length of 10-14 months.

Results preliminary; subject to change

Residents and IME payments concentrated in subset of teaching hospitals



Note: IME (indirect medical education).

Source: MedPAC analysis of IPPS teaching hospital cost reports with a midpoint in fiscal year 2017 and a length of 10-14 months.

Results preliminary; subject to change

Roadmap

① IME background

② **IME concerns and potential revisions**

③ IME illustrative revised policy

The Commission and others have noted several concerns with IME policy

Clinical setting	Inpatient only
Payment level	Above justified level in inpatient, none in outpatient
Tie to performance	None
Treatment of FFS and MA	Inconsistent

To address concerns and inconsistencies, could transition to revised IME policy

Clinical setting	Inpatient only	→	Inpatient and hospital outpatient
Payment level	Above justified level in inpatient, none in outpatient	→	At justified level in each setting
Tie to performance	None	→	Performance-based teaching payments
Treatment of FFS and MA	Inconsistent	→	Consistent (Medicare pays IME for both)

➔ Revisions could maintain aggregate medical education payments while aligning IME payments with the settings in which care is provided

Revising IME policy would involve key implementation decisions

Measuring MA outpatient use

Could require hospitals to submit informational outpatient claims
➔ *Would support more accurate IME payments and be valuable data source to validate encounter data*

Until available, could estimate
(E.g., FFS outpatient * MA/FFS inpatient ratio)

Measuring teaching intensity

Could construct inpatient + outpatient measure
(E.g., residents-to-average daily total equivalent census)

Revising IME policy would involve key implementation decisions (continued)

Maintaining budget neutrality

Could maintain aggregate payments to teaching hospitals by adding new performance-based program that rewarded teaching hospitals meeting educational standards

- Standards could be established by the Secretary, after consultation with stakeholders
- Level of payment could be tied to performance

➔ Support workforce skills needed in a delivery system that reduces cost growth while maintaining or improving quality

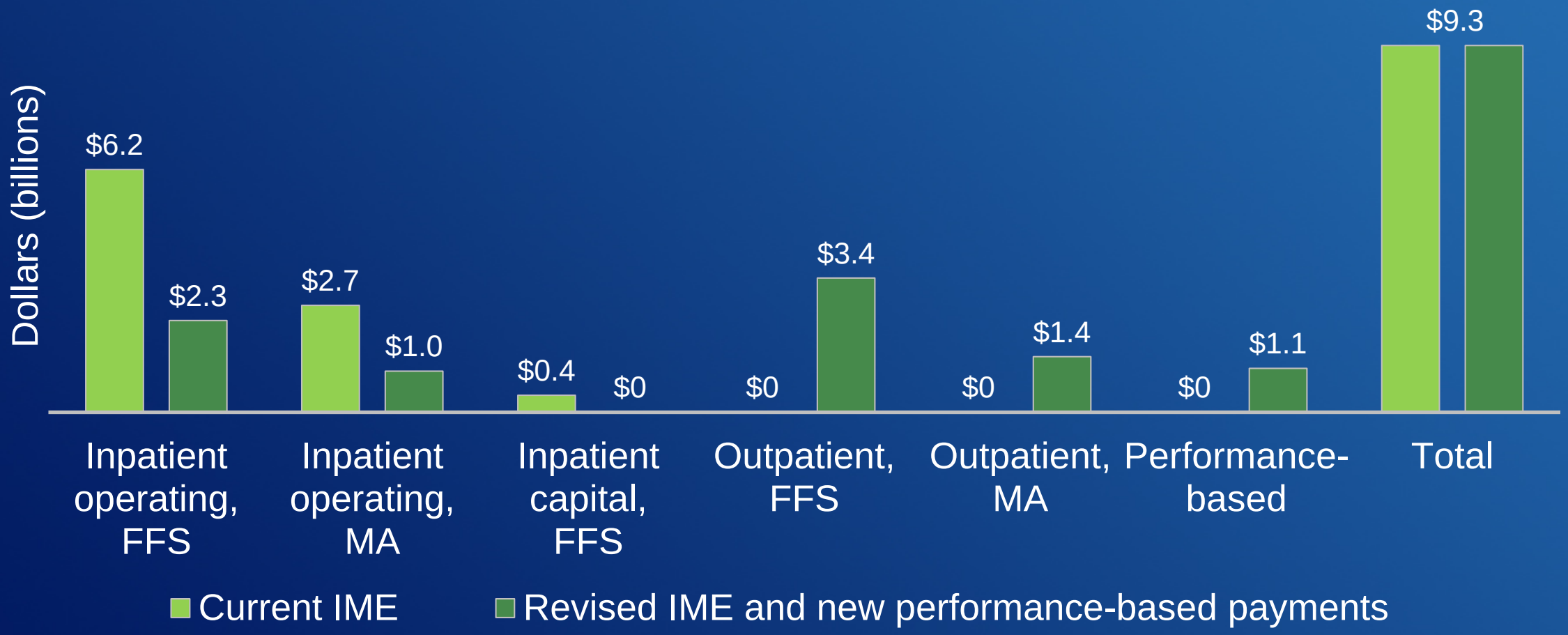
Roadmap

① IME background

② IME concerns and potential revisions

③ **IME illustrative revised policy**

Aggregate medical education payments would be maintained, but change across settings



Note: IME (indirect medical education), FFS (fee-for-service), MA (Medicare Advantage).

Source: MedPAC analysis of IPPS teaching hospital cost reports with a midpoint in fiscal year 2017 and a length of 10-14 months.

Results preliminary; subject to change

Revisions would materially affect hospitals' IME, but small effect on overall Medicare payments

- Many teaching hospitals would have material changes in their IME payments, consistent with
  - Wide variation in ratio of hospitals' inpatient-to-outpatient use
  - Reduction in aggregate IME and shift to performance-based

  ➔ More outpatient-centric teaching hospitals and those with better performance would have largest increases in payments
- However, most teaching hospitals' overall Medicare payments would change by < 2 percent (+/-)
- Financial impacts could be mitigated through transition policies

Summary and discussion

Current IME policy does not reflect the increasing shift towards hospital outpatient care nor the empirically-justified effect of residents on patient care costs

Discussion

- Move to empirically justified inpatient-outpatient IME policy
- Maintain aggregate payments to teaching hospitals
- Develop new performance-based medical education payments
- Require submission of information-only MA outpatient claims

Next steps