Revising Medicare's indirect medical education payments to better reflect teaching hospitals' costs

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IME is the larger of two types of medical education payments to IPPS teaching hospitals

2019

1,100

Teaching hospitals

$3.8 B

DGME payments

- Supports *direct* costs, such as resident stipends

$10.1 B

IME payments

- Supports *indirect* costs of *inpatient* care not otherwise accounted for

90,000

Supported residents

Note: IME (indirect medical education), DGME (direct graduate medical education); IPPS (inpatient prospective payment system). Analysis restricted to IPPS hospitals with complete cost reports having a midpoint in fiscal year 2019. Payment amounts reflect Medicare payment rates; the Medicare program pays these rates minus any applicable beneficiary cost-sharing responsibilities.
Source: MedPAC analysis of hospital cost reports.

Results preliminary; subject to change

Medicare's treatment of teaching hospitals' IME costs varies across the three hospital PPSs

IME payments	Inpatient operating PPS	Inpatient capital PPS	Outpatient PPS
Authority	Specified in statute	Flexibility in statute; added through rulemaking	Flexibility in statute; *not* added
Measure of teaching intensity	Specified in statute: Residents per inpatient beds ratio (RBR)	Residents per average daily inpatient census (RADC)	--
For care of MA beneficiaries?	Specified in statute to be paid by Medicare program	Not directly paid by Medicare program	

Note: IME (indirect medical education), PPS (prospective payment system), MA (Medicare Advantage).
Source: MedPAC summary of public laws (42 USC 1395ww(d)(5)(B), (d)(11), (g), 1395w-23(k)(4), and 1395l(t)(2)(E)) and regulations (42 CFR 412.105, 412.322, and 422.306(c).

Key concerns with current IME policy

Reflects…	Current policy
Range of settings in which residents train?	✘ No (inpatient only)
Effect of residents on costs?	✘ No (higher than empirical levels for inpatient; zero for outpatient)
Costs of treating MA beneficiaries?	~ Inconsistent

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Note: IME (indirect medical education); PPS (prospective payment system); MA (Medicare Advantage).

Revising IME policy to address key concerns

Reflects…	Current policy	Revised policy
Range of settings in which residents train?	✘ No (inpatient only)	✓ Yes (inpatient and outpatient)
Effect of residents on costs?	✘ No (higher than empirical levels for inpatient; zero for outpatient)	✓ Transition to yes without reducing aggregate IME payments
Costs of treating MA beneficiaries?	~ Inconsistent	✓ Yes

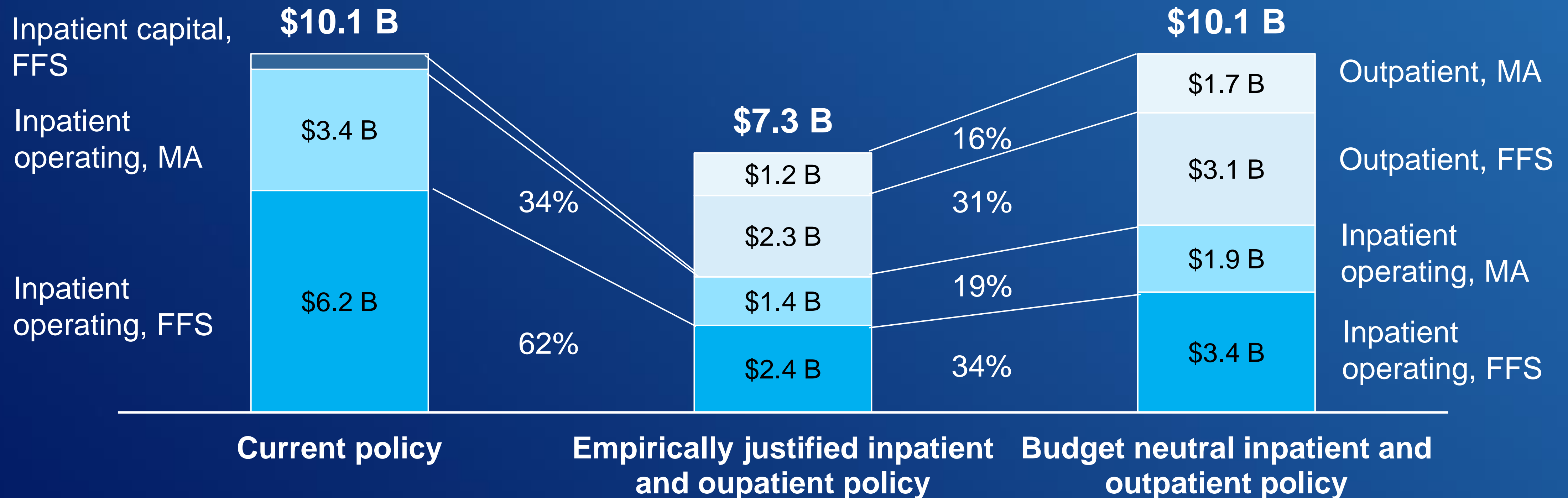
Note: IME (indirect medical education); PPS (prospective payment system); MA (Medicare Advantage).

Illustrative budget-neutral inpatient and outpatient IME policy

Feature	Illustrative revised IME policy
Included services	Inpatient and outpatient services to FFS or MA beneficiaries, exclusive of separately payable drugs and devices
Teaching intensity	Resident-to-patient ratio (patients = average daily inpatients + outpatient equivalents)
IME adjustment	Empirically justified estimates of teaching hospitals' additional costs not otherwise accounted for in PPS
Budget neutrality	Adjust empirical IME payments such that aggregate IME payments are not reduced relative to current policy

Note: IME (indirect medical education); FFS (fee-for-service); MA (Medicare Advantage); PPS (prospective payment system).

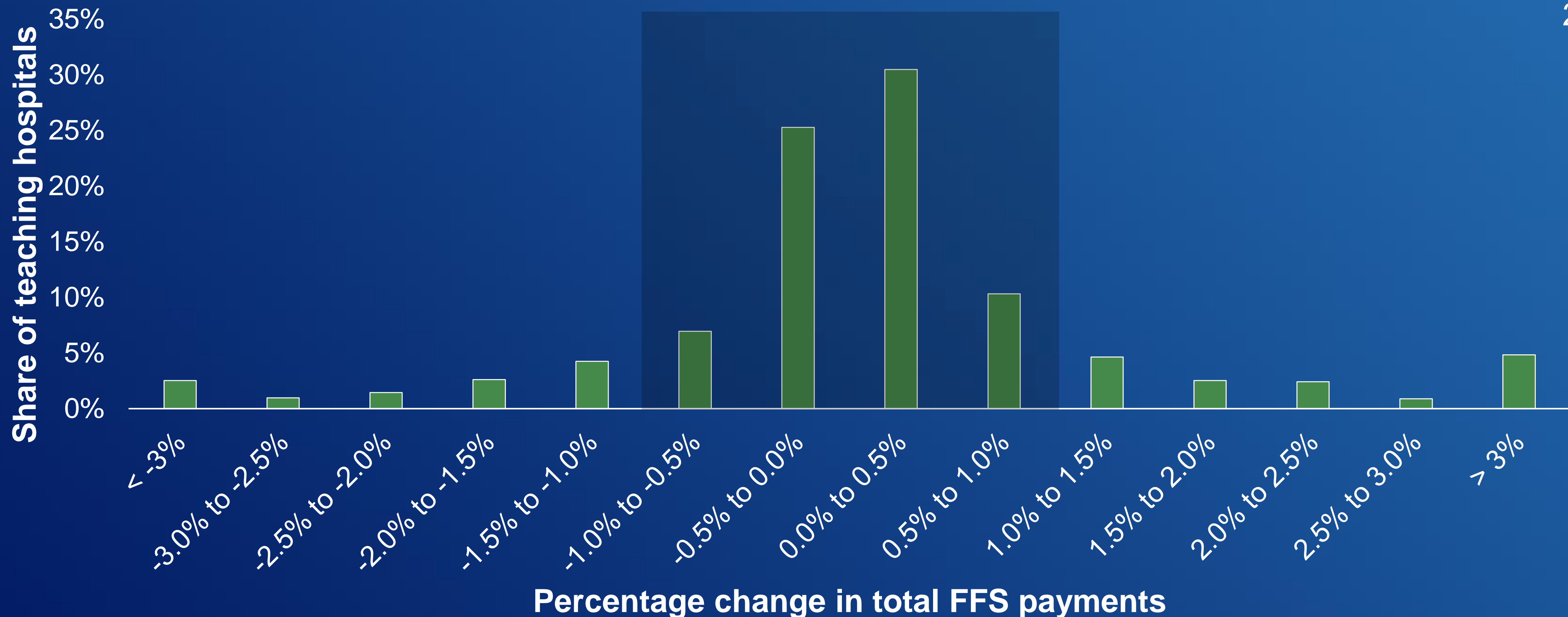
Revised IME policy would maintain aggregate IME payments but redistribute towards outpatient care



Notes: IME (indirect medical education), FFS (fee-for-service), MA (Medicare Advantage). Under the illustrative revised IME policy, the Medicare program would make IME payments for IME-eligible inpatient and outpatient services provided to Medicare FFS or Medicare Advantage beneficiaries; each teaching hospital's teaching intensity is calculated as its ratio of allowed residents to all-payer average daily inpatients plus outpatient equivalents; and the levels of the IME adjustments are set at their empirical levels multiplied by a budget neutrality adjustment such that aggregate IME payments are the same as under current policy. Results include inpatient prospective payment system hospitals with complete cost reports having a midpoint in fiscal year 2019. Components may not sum to total due to rounding and components shown.
Source: MedPAC analysis of Medicare cost report data from CMS.

Results preliminary; subject to change

Revised IME policy would result in a small change in total FFS payments for most teaching hospitals



Notes: IME (indirect medical education), FFS (fee-for-service). Under the illustrative revised IME policy, the Medicare program would make IME payments for IME-eligible inpatient and outpatient services provided to Medicare FFS or Medicare Advantage beneficiaries; each teaching hospital's teaching intensity is calculated as its ratio of allowed residents to all-payer average daily inpatients plus outpatient equivalents; and the levels of the IME adjustments are set at their empirical levels multiplied by a budget neutrality adjustment such that aggregate IME payments are the same as under current policy. "Percentage change in total FFS payments" calculated as change in inpatient and outpatient Medicare FFS payments (including uncompensated care payments) under the revised policy (relative to current policy). Results include inpatient prospective payment system hospitals with complete cost reports having a midpoint in fiscal year 2019.
Source: MedPAC analysis of Medicare cost report data from CMS.

Results preliminary; subject to change

Revised IME policy would shift payments towards teaching hospitals currently underpaid

		Medicare services provided in outpatient settings	
		Low	**High**
Residents-per-patients relative to residents-per-beds	**High**	Minimal change in IME payments	*Increases* in IME payments
	Low	*Decreases* in IME payments	Minimal change in IME payments

➔ IME payments shifted towards teaching hospitals that:

- Are, or will become, more outpatient-centric, and
- Have high residents per *patients* relative to residents per *beds*

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Revised IME policy would result in small change in IME and total FFS payments for most groups

2019

Selected teaching hospital groups	Percentage change: IME FFS payments	Percentage change: Total FFS payments (inpatient and outpatient)
For-profit	-1.7%	-0.1%
Nonprofit	-3.5	-0.2
Government	2.8	0.2
Urban	-2.2	-0.1
Rural	0.9	+0.0
High share of low-income patients (> 42%)	-2.7	-0.1
Small (< 150 beds)	17.7	0.6
Large (> 400 beds)	-4.2	-0.3

Notes: IME (indirect medical education); FFS (fee-for-service); MA (Medicare Advantage). "Total FFS payments" includes those for inpatient and outpatient services as well as uncompensated care payments. Results for inpatient prospective payment system hospitals with complete cost reports having a midpoint in fiscal year 2019.
Source: MedPAC analysis of Medicare cost report data from CMS.

Results preliminary; subject to change

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Summary

- Current IME policy is outdated.
- Transitioning to an empirically justified inpatient and outpatient IME policy would better reflect teaching hospitals’ additional costs while not reducing Medicare’s aggregate support to teaching hospitals.
- Congress could grant CMS flexibility on implementation, including whether to:
  - Phase in revised IME policy for subset of teaching hospitals more substantially affected
  - Waive beneficiary cost sharing on outpatient IME payments