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

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MEDPAC

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

Direct graduate medical education (DGME) payments

$4.0 B

- Supports direct GME costs, such as resident stipends
- Supplemental per-resident payment (outside of PPSs)

Indirect medical education (IME) payments

$10 B

- Supports teaching hospitals' higher costs of inpatient care not otherwise accounted for in the inpatient PPSs
- Calculated as percentage add-on to inpatient PPS payments

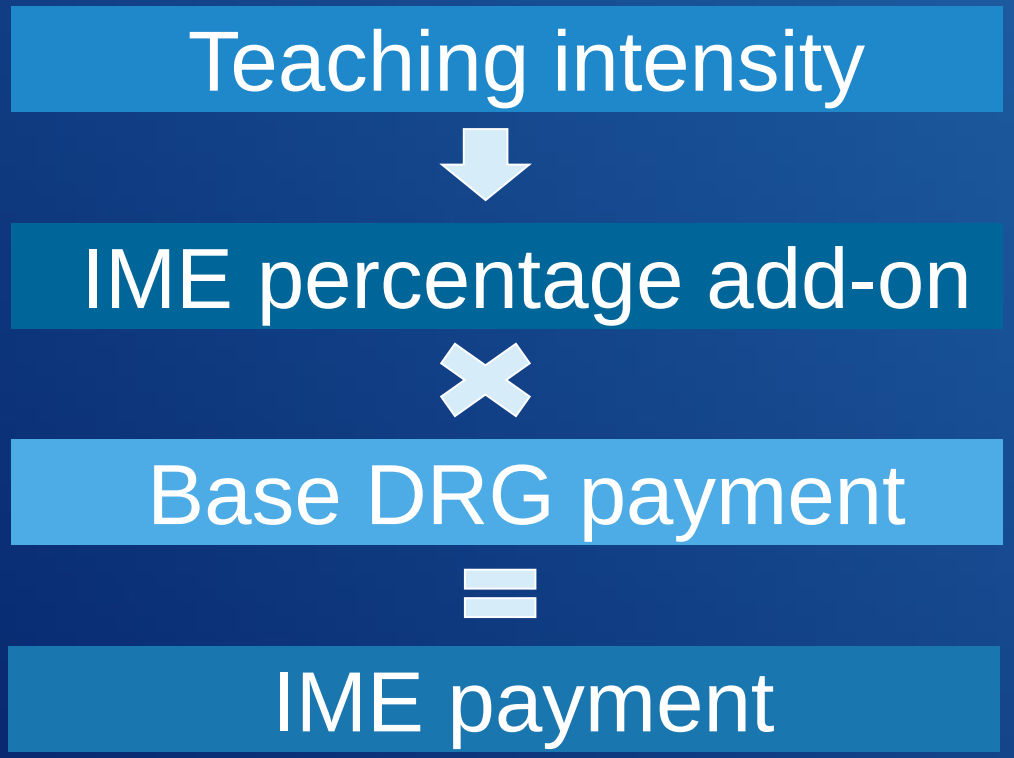
Note: Prospective payment system (PPS). Payment amounts reflect Medicare payment rates (post-sequestration); the Medicare program pays these rates minus any applicable beneficiary cost-sharing responsibilities.
Source: MedPAC analysis of inpatient PPS teaching hospital cost reports in fiscal year 2018.

IME history: IME policy varies across hospital PPSs and does not align with teaching hospitals' costs

IME Adjustment

	Inpatient operating PPS	Inpatient capital PPS	Outpatient PPS
Authority	Specified in statute	Flexibility in statute; added through rulemaking	Flexibility in statute; *not* added
Original level	Twice the estimated effect of teaching on inpatient operating costs	Estimated effect of teaching on *total* inpatient (operating and capital) costs	--
Changes over time	Changes through statute, most recently in 2008, but still well above empirically justified level	None (unchanged since 1992)	--

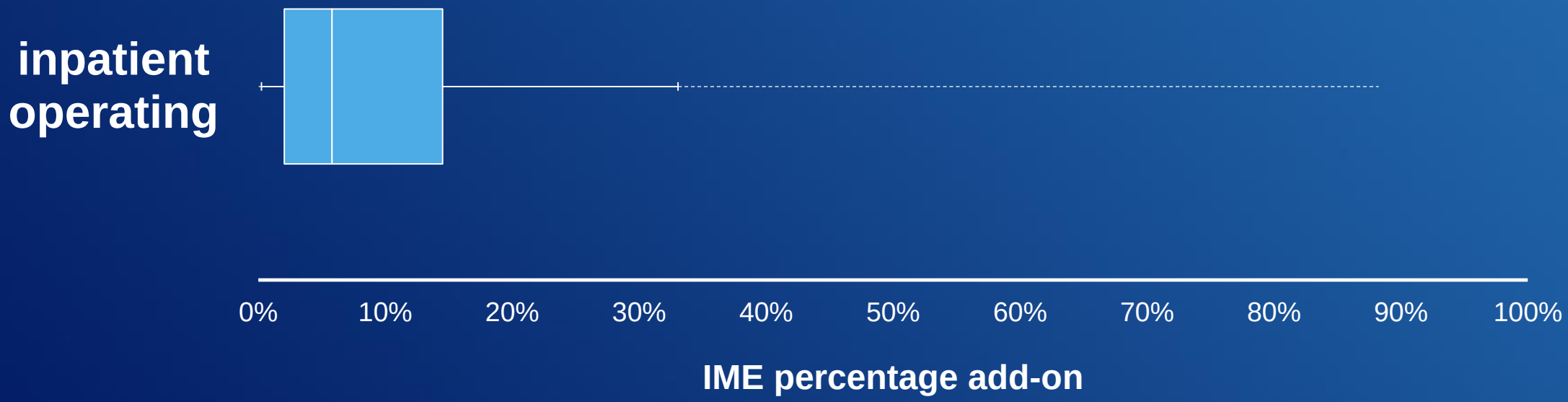
IME adjustment is percentage add-on to base inpatient payments



Inpatient operating: $9.5 B ($6.3 B FFS + $3.2 B MA)
Inpatient capital: $0.4 B

Note: Total IME payments were $10 billion. Components do not sum to total because of rounding.
Source: MedPAC analysis of inpatient PPS teaching hospital cost reports in fiscal year 2018.

IME adjustment varied substantially across teaching hospitals



Note: 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, the solid whiskers represent values within the 5th and 95th percentiles, and the dashed lines represent the top and bottom 5 percent.

Source: MedPAC analysis of inpatient PPS teaching hospital cost reports in fiscal year 2018.

Results preliminary; subject to change

Key concerns with current IME policy could be addressed in revised IME policy

Feature	Current IME policy	Potential revised IME policy
Clinical settings	Inpatient only	Inpatient and outpatient
Payment level	Above empirical level in inpatient, none in outpatient	Initially keep budget neutral to current policy, but distribute across settings proportionally to effect of teaching on costs Transition to empirically justified levels once they exceed current law

IME reform could also address other concerns with current policy and potential reform

IME policy feature	Concern		Revised policy
Treatment of FFS and MA	Inconsistent	→	Consistent (Medicare pays IME for both)
Items, services and locations	IME adjustment could provide adverse incentives	→	Only apply when teaching hospitals have additional costs (e.g., exclude separately payable drugs)
Methodology	Inconsistent and static	→	Within principles, give CMS flexibility to implement and update through rulemaking

Illustrative budget neutral inpatient and outpatient IME policy used in modeling

Feature	Illustrative revised IME policy
Clinical settings	IME payments for both inpatient and outpatient care
Payment level	Initially budget neutral, but distributed proportionally to teaching hospitals' additional costs in each setting
MA	IME payments for care of MA beneficiaries in all settings
Items, services and locations	IME adjustment does not apply to separately payable drugs Given lack of data, modeling did not exclude any locations

Empirical effect of teaching on costs varied across PPSs and differed from current policy

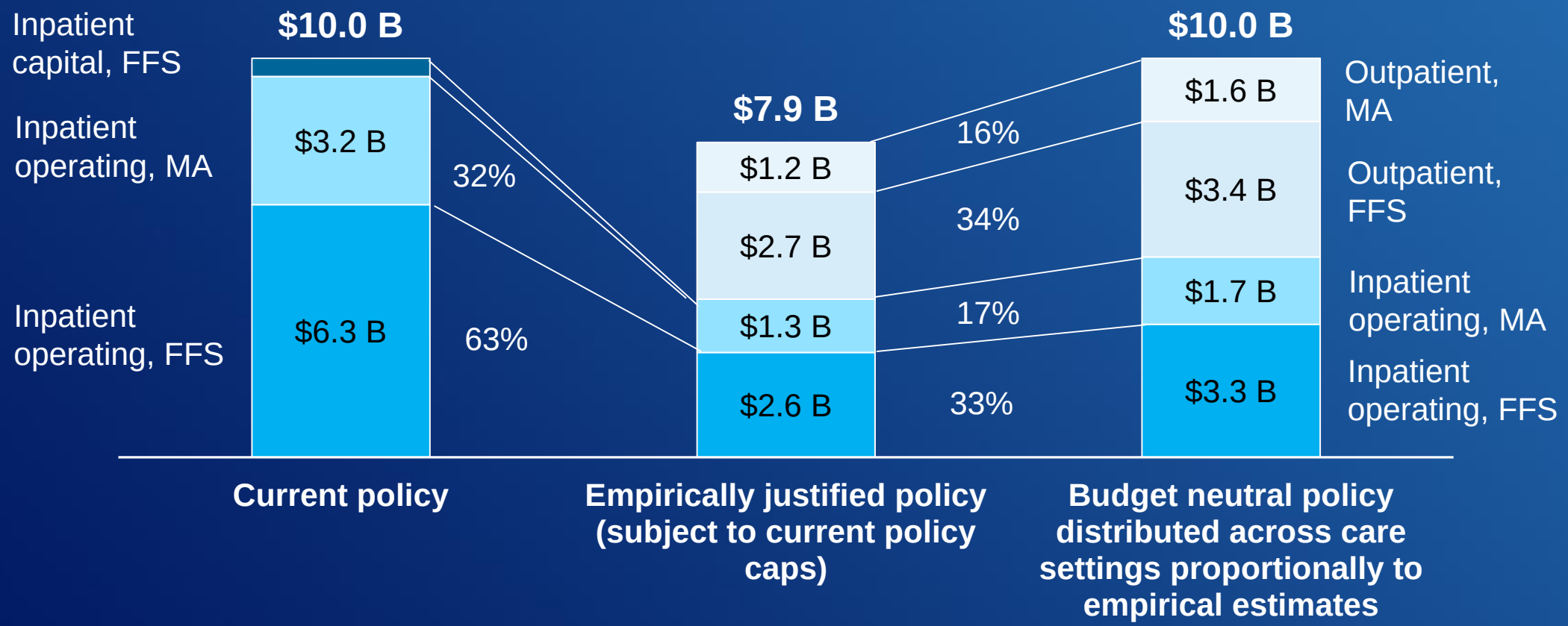
2018

	Median IME adjustment		
	Current policy	Empirically justified policy	Notes
Inpatient operating PPS	5.8%	2.5%	• Empirical IME adjustment less than half of current policy • Consistent with prior MedPAC estimates
Inpatient capital PPS	5.7%	0%	• No significant effect of teaching on capital costs • Consistent with earlier CMS analyses
Outpatient PPS	0%	4.7%	• Larger relationship could be driven by several factors, including the more limited adjustments in the outpatient PPS

Source: MedPAC analysis of inpatient PPS teaching hospital cost reports in fiscal year 2018.

Results preliminary; subject to change

Illustrative revised IME policy would maintain aggregate IME payments but shift towards outpatient care



Note: Components may not sum to total due to rounding and components shown.

Source: MedPAC analysis of inpatient PPS teaching hospital cost reports in fiscal year 2018.

Results preliminary; subject to change

Revised IME policy would redistribute IME payments towards outpatient-centric hospitals

	Percentage change	
Teaching hospital groups	**IME payments (FFS and MA)**	**FFS payments (inpatient and outpatient)**
Very inpatient-centric	-22%	-1.5%
Very outpatient-centric	28	1.5
Other selected groups		
For profit	-13	-0.6
High share of low-income patients	-6	-0.5
Rural	16	0.4
Small (< 150 beds)	14	0.4

Note: Results assume no behavioral change. Very inpatient-centric refers to teaching hospitals in the top quartile of the ratio of inpatient to outpatient PPS base payments (exclusive of separately payable drugs). Highest share of low-income patients refers to hospitals in the top quartile of disproportionate share patient percentage.
Source: MedPAC analysis of inpatient PPS teaching hospital cost reports in fiscal year 2018.

Results preliminary; subject to change

Summary and discussion

Current IME policy does not reflect or support the increasing shift towards hospital outpatient care

Principles for IME reform:

1. Inpatient and outpatient IME payments
2. Initially budget neutral to current policy, but distributed proportionally to teaching hospitals' additional costs in each setting
3. Over time, transition to empirically justified IME payments
4. Medicare program makes IME payments for FFS and MA beneficiaries
5. Only apply IME adjustment to items, services, and locations when teaching hospitals have additional costs not otherwise accounted for (e.g., exclude separately payable drugs and locations where residents do not rotate)

Within these broad principles, grant CMS flexibility to implement and update