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

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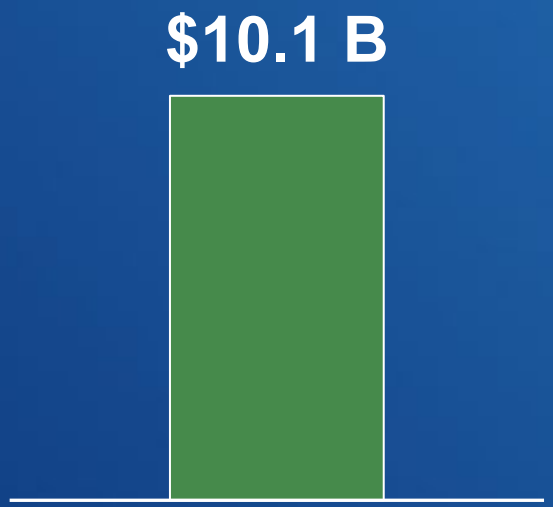
IME is the larger of two types of medical education payments to IPPS teaching hospitals

2019

Teaching hospitals

DGME payments

- Supports *direct* costs, such as resident stipends



IME payments

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

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

Revising IME policy could address key concerns with current policy

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)	✓ Yes*
Costs of treating MA beneficiaries?	~ Inconsistent	✓ Yes

** The transition to empirically justified IME payments should be constructed to minimize adverse effects on teaching hospitals, such as by maintaining aggregate IME payments equal to current policy until such time that they match empirically justified levels*

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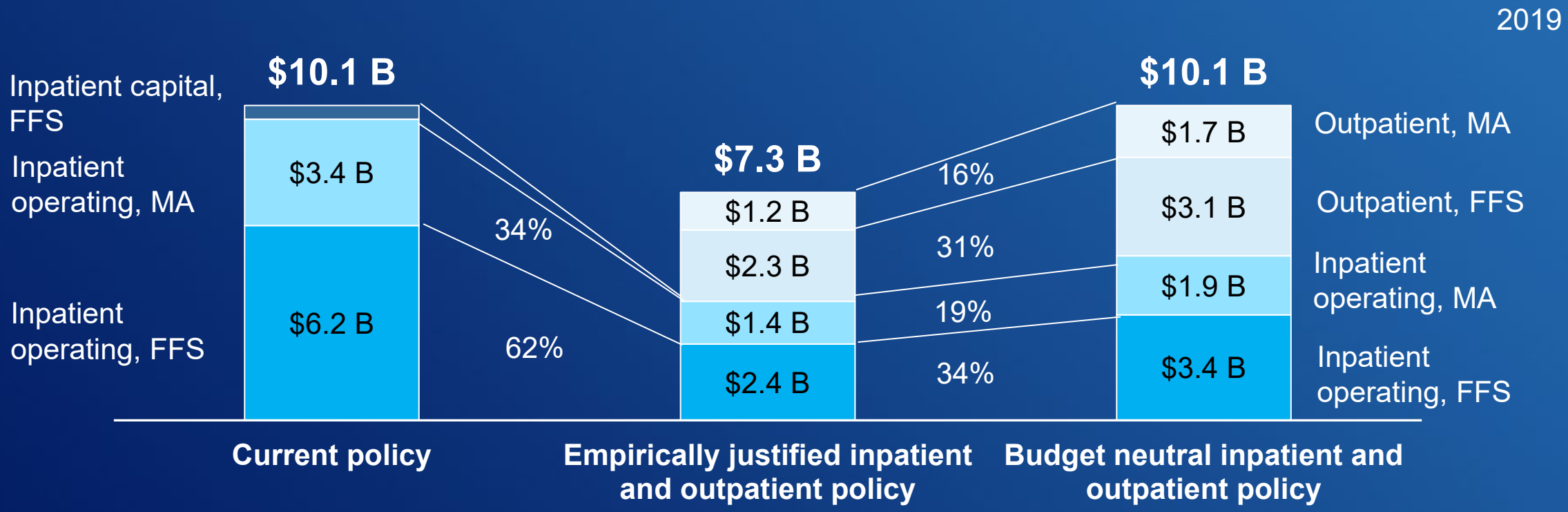
Note: IME (indirect medical education); PPS (prospective payment system); MA (Medicare Advantage).

Revised IME policy would change teaching hospitals' financial incentives

	Current policy	Revised policy
Incentive to provide care in inpatient settings, even when could be safely provided in outpatient settings?	✘ Yes (only inpatient services receive IME, and levels are higher than added costs)	✓ No (teaching hospitals' added costs would be included in Medicare's payment regardless of setting)

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.

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Results preliminary; subject to change

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

Selected teaching hospital groups	Percentage change in total FFS payments 2019		
	Aggregate	25th percentile	75th percentile
For-profit	-0.1%	-0.1%	0.7%
Nonprofit	-0.2	-0.3	0.4
Government	0.2	-0.4	1.1
Urban	-0.1	-0.3	0.5
Rural	+0.0	-0.1	0.6
Low share of low-income patients	+0.0	-0.2	0.4
High share of low-income patients	-0.1	-0.4	0.9
Small (< 150 beds)	0.6	-0.1	1.2
Highest resident-to-bed ratio	-0.5	-1.6	0.9

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

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*

Summary

- Current IME policy is outdated
- Transitioning to an empirically justified inpatient and outpatient IME policy would better reflect teaching hospitals' additional costs
- Having the Congress grant CMS flexibility to implement through rulemaking would allow stakeholders to provide input, such as on whether to waive beneficiary cost sharing on outpatient IME payments

➔ Consistent with MedPAC's 2010 recommendations, policy makers should continue to explore opportunities to address broader concerns with graduate medical education, including using Medicare's funding to support future workforce needs.