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## Medicare Indirect Medical Education (IME) Payments

### Introduction

In addition to providing basic health services to their communities, teaching hospitals are also sites for the clinical education of all types of health professionals, including the training of resident physicians (“residents”). Residents have graduated from a medical school and then go on to complete several years of supervised, hands-on training in a particular area of expertise, such as primary care or surgery. This phase of their training is called “graduate medical education” (GME).

Teaching hospitals also maintain an environment in which clinical research can flourish, and assure all patients have access to highly specialized care, regardless of their ability to pay. Because of their education and research missions, teaching hospitals offer the newest and most advanced services and equipment. Additionally, the residents and supervising physicians at teaching hospitals are available around-the-clock, prepared to care for the nation’s most critically ill or injured patients. These unique teaching hospital missions increase the cost of patient care at these institutions.

Recognizing the differences in the patient care costs between teaching and non-teaching hospitals, the Medicare program includes a special Indirect Medical Education (IME) payment adjustment in its prospective payment system (PPS).

### Purpose of the IME Payment

The Medicare IME payment carries a “medical education” label, but its purpose, as stated by Congress when it created the PPS in 1983, is much broader:

This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Rept, No. 98-25, March 4, 1983 and Senate Finance Committee Rept, No. 98-23, March 11, 1983).

### IME Payment Methodology

For every Medicare case paid under the operating inpatient PPS, a teaching hospital receives an additional payment, calculated as a percentage add-on to the basic price per case. The hospital’s IME payment is determined by inserting its individual intern/resident-to-bed ratio (IRB) into a formula established under Medicare statute. As a hospital’s involvement in GME increases, its percentage add-on to the basic PPS payment also increases. Over 1,100 teaching hospitals receive IME payments. Because teaching hospitals are not paid directly by Medicare for treating managed care patients, an IME payment is calculated by the hospital submitting a “shadow” (no-pay) claim to Medicare that is used to calculate the IME payment.

Teaching hospitals also receive an IME payment associated with Medicare’s capital PPS. This payment is based on a slightly different formula and uses residents-to-average daily census (RADDC) rather than the IRB to measure teaching intensity. This “capital IME” payment is scheduled to be eliminated in FY 2010.

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## Selected Legislative History

The justification for a special payment adjustment for teaching hospitals is rooted in Medicare's cost limits of the 1970s. As payment limits for hospitals' routine costs grew more stringent, government and private researchers consistently showed that teaching hospitals had higher costs than non-teaching hospitals, even after the direct costs of GME were removed from teaching hospitals' cost structures. Researchers found that a hospital's IRB was related to an increase in hospital patient care costs. In 1980, the concept of an "indirect medical education adjustment" was recognized. The Medicare cost limits for routine patient care provided at teaching hospitals were increased to incorporate a differential based on the IRB in each teaching hospital. In 1982, The Tax Equity and Fiscal Responsibility Act (TEFRA) (P.L. 97-248) established an adjustment for teaching hospital costs.

In December 1982, when the Secretary of Health and Human Services (HHS) proposed a new Medicare payment system, the resident-to-bed adjustment to the TEFRA cost limits was converted to a PPS payment, called the IME adjustment, to recognize the higher costs of teaching hospitals:

The indirect costs of graduate medical education are the higher patient care costs incurred by teaching hospitals with medical education programs....It is also true that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens...there is no question that hospitals with teaching programs have higher patient care costs than hospitals without (Secretary of the Department of Health and Human Services, Hospital Prospective Payment for Medicare: A Report to Congress, December 1982, pages 48-49).

The HHS Secretary estimated that Medicare inpatient operating cost per case increased approximately 5.79 percent with each 10 percent increase in the number of residents per hospital bed. However, two months after the Secretary's report, the Congressional Budget Office (CBO) presented an impact analysis showing the proposed DRG-based payment system would have adversely affected 71 percent of teaching hospitals if the IME adjustment were set at 5.79 percent. The Administration proposed to double the adjustment to 11.59 percent for each 10 percent increase in the IRB. Congress supported this modification of the empirical estimate and included the IME adjustment in the PPS legislation.

As more current and refined information became available, the IME adjustment was recalculated and lowered. The original adjustment of 11.59 percent was reduced to 8.7 percent in 1986 when better data became available. It was reduced by an additional 0.6 percentage point to finance part of the disproportionate share hospital (DSH) adjustment, resulting in an IME adjustment factor of 8.1 percent in 1986. With enactment of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), the IME adjustment remained at 7.7 percent from October 1, 1988 until October 1, 1997 when it was reduced to 7.0 percent as a result of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33).

The BBA included a schedule for reducing IME payments by 28.75 percent over a four-year period, from 7.7 to 5.5 percent. The schedule was altered by the Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113), the Beneficiary Improvement and Protection Act (BIPA) of 2000 (P.L. 106-554), and most recently, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173). The BBA reduced the IME percentage add-on from 7.7 percent in FY 1997 to 7.0 percent in FY 1998 and 6.5 percent in FY 1999. The BBRA and BIPA maintained the IME adjustment at 6.5 percent in FYs 2000, 2001 and 2002 before reducing it to 5.5 percent in FY 2003 and thereafter. The MMA increased the IME adjustment from 5.5 to 6.0 percent on April 1, 2004; to 5.8 percent in FY 2005; and to 5.55 percent in FY 2006. In FY 2007, IME payments were reduced to 5.35 percent before being set at 5.5 percent in FY 2008 and beyond.

The BBA also made changes in how residents are counted for the IRB, the key variable in the IME formula. Beginning in FY 1998, hospitals were permitted to count residents in non-hospital settings for IME payment purposes if the hospital incurred all, or substantially all, of the costs for the training program in that setting and met certain other requirements. In addition, a limit was placed on the number of full-time equivalent (FTE) residents in allopathic and osteopathic training programs that a hospital could include in its IRB, based on the number of residents counted during the hospital's most recent cost report period ending on or before December 31, 1996. In addition, a hospital's IRB could not exceed the hospital's previous year ratio. The BBA also required residents to be counted using a three-year rolling average. Finally, the BBA provided that teaching hospitals could receive IME payments associated with their Medicare managed care patients.