The Medicare IME Pool Act of 2015 (H.R. 3292)

Introduced on July 29, 2015, the Medicare IME Pool Act of 2015 (H.R. 3292) would discontinue Medicare add-on payments currently paid to teaching hospitals to offset indirect medical education (IME) costs. The bill also establishes a Medicare IME Pool that would distribute lump sum payments to teaching hospitals according to a new financing methodology. Medicare IME investments would no longer be linked to caring for Medicare beneficiaries or providing specialized services to complex patient populations.

Elimination of IME Add-On Payments

Beginning in FY 2019, teaching hospitals would no longer receive IME payments for Medicare inpatient discharges. Instead, teaching hospitals would receive lump sum payments in regular intervals that mirror the distribution of direct graduate medical education payments. The size of these payments would be determined as described below.

The Medicare IME Pool Act of 2015 does not phase in implementation of this change; it would occur in its entirety in 2019.

Medicare IME Pool

The Medicare IME Pool would be established with a base allocation of $9.5 billion. This amount would be adjusted upwards to account for two factors: establishment of new teaching programs and market basket updates. The funding would not be linked to delivery of services to Medicare beneficiaries.

New Teaching Programs: If a new teaching program is established between 2015 and 2019, the funding in the IME pool would increase by the product of the number (#) of new full-time equivalent (FTE) residents and the Secretary's estimate of the national average IME expenditures per resident. If a new teaching program is established after 2019, the increase in IME pool funding would no longer be based on the Secretary's estimate, but instead on the average per-resident allocation as detailed in the following section.

Market Basket Update: The IME pool amount would be adjusted each fiscal year to reflect the market basket percentage increase applicable to hospital discharges.

Hospital Allocations from the Medicare IME Pool

The Medicare IME Pool would be divided among hospitals in accordance with the proportion of the nation's FTE residents each hospital trains. A hospital's allocation would be derived according to the following formula:

$$\left(\frac{\text{weighted average of Hospital's \# of FTE residents}}{\text{weighted average of total \# of FTE residents nationwide}}\right) * \text{ Total IME Pool Funds } = \text{Hospital's Allocation}$$

This methodology establishes a uniform per-FTE-resident IME amount nationwide and includes no adjustments for hospital case mix, Medicare volume, patient severity, or geographic variations in wages or other operating costs. The formula is not linked to the current distribution of IME payments, resulting in changes in IME funding for nearly every teaching hospital.

The Medicare IME Pool Act of 2015 (H.R. 3292)

The Purpose of Medicare Indirect Medical Education Payments

- Recognizing the differences in the patient care costs between teaching and non-teaching hospitals, Congress created the Medicare IME payment adjustment in its prospective payment system (PPS). Teaching hospitals receive Medicare IME payments to help offset the increased costs associated with caring for sicker and more challenging patient populations than non-teaching hospitals[1].

- Medicare IME payments also are intended to support unique but costly teaching hospital missions that ensure all patients have access to highly specialized care, such as trauma centers, burn units, or specialized stroke centers, while also maintaining an environment in which clinical research can flourish[2].

H.R. 3292 Will Result in Fewer Resources for Treating Sicker Patients

- The Medicare IME Pool Act of 2015 (H.R. 3292) eliminates a critical source of Medicare support for teaching hospital missions and instead creates a new formula that dramatically – and without strong rationale – reduces funding for hospitals that train many residents and care for large numbers of Medicare beneficiaries. Many major teaching hospitals - which treat the most complex patients, respond to community disasters, and undertake innovative research - would be hit the hardest.

- By disregarding the intent of IME payments, the legislation would slash funding for vital care and services available almost exclusively at major teaching hospitals, including Level 1 trauma centers, burn centers, and access to clinical trials.

- Although the bill may intend to create stability and protect IME funding, H.R. 3292 would actually threaten many teaching hospitals' ability to maintain their costly tripartite mission of education, research, and clinical care. A hospital's IME payments would not be linked to treating Medicare beneficiaries or its current or historic payments, and there would be no phasing in of the impact – overnight, many of our nation's leading clinical and research institutions would see unsustainable Medicare cuts.

Medicare Funding Should Stay with Medicare Beneficiaries

- The Medicare IME Pool Act of 2015 would undermine accountability for Medicare GME funding. Under the proposal, Medicare Trust Fund dollars would no longer be linked to providing care to Medicare beneficiaries, compromising a hospital's ability to provide care to an increasingly aging and sicker population.

The Legislation Jeopardizes Training for America's Future Doctors

- Recent workforce projections indicate the nation faces a shortage of between 46,000 and 90,000 physicians by 2025, with shortages most acute in surgical specialties – the result of a growing, aging population. By eliminating the link between patient care and Medicare IME payments, the Medicare IME Pool Act of 2015 would worsen these shortages by forcing teaching hospitals to make difficult choices between maintaining life-saving clinical services for their communities and maintaining their investment in training physicians for the future needs of the nation.

- By dismantling Medicare IME patient care payments and disrupting teaching hospital finances, the Medicare IME Pool Act of 2015 would have significant negative consequences on the future of health care. Devastating cuts to teaching hospitals would threaten the world's best training programs for health professionals and would worsen the doctor shortage.

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[1] House Ways & Means Committee Rept. No. 98-25, March 4, 1983 and Senate Finance Committee Rept. No. 98-23, March 11, 1983.

[2] Grover, A., Slavin, P., Willson, P. 2014. The economics of academic medical centers. New England Journal of Medicine. 370(25): 2360-2.