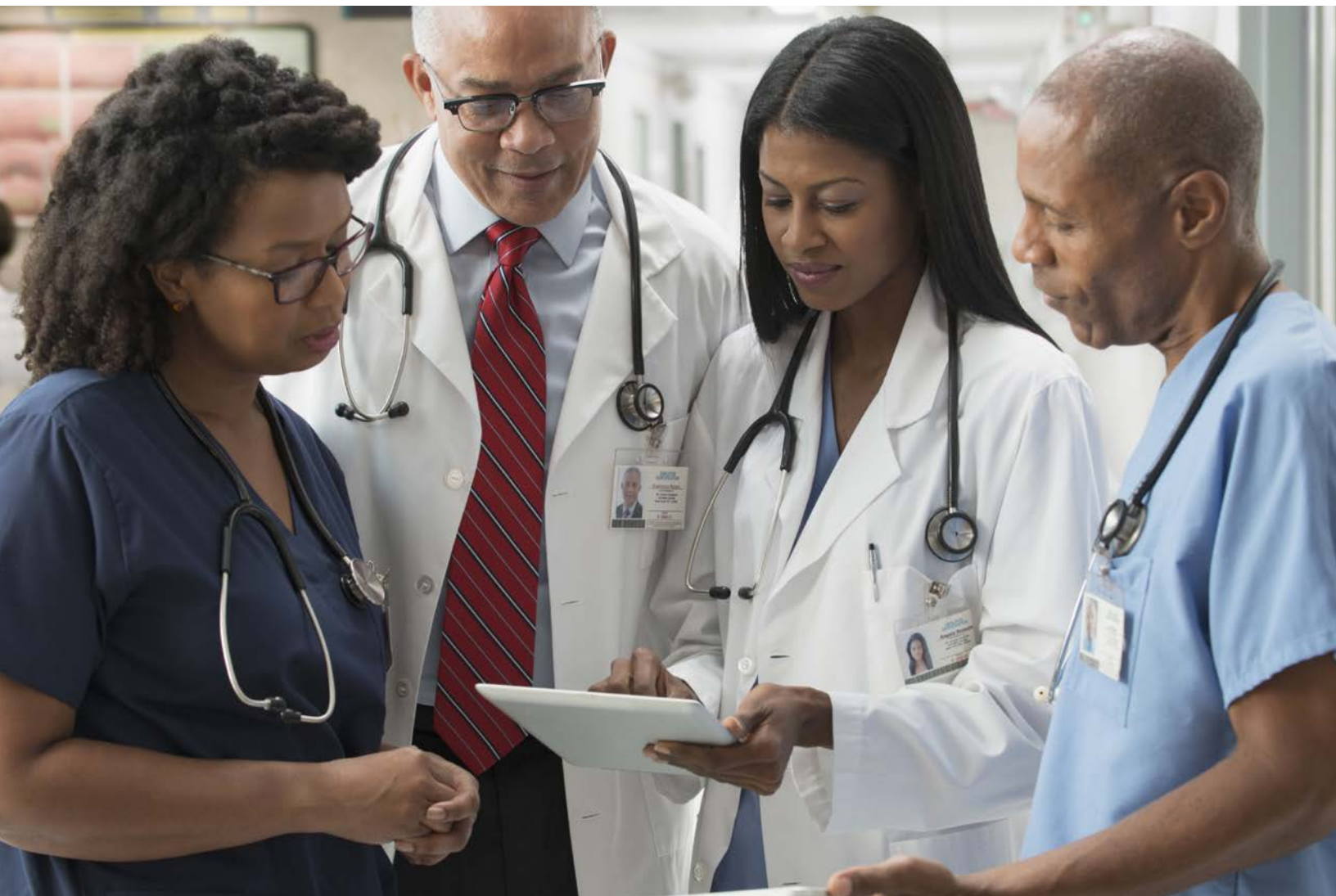


A Fresh Look at Graduate Medical Education and Capital Payments

Are these supplementary payments still relevant in inpatient healthcare policy?



A Fresh Look at Graduate Medical Education and Capital Payments



In this era of value-based purchasing – of getting more value for every healthcare dollar – it is timely to take a fresh look at methods of paying providers that may have been in place for decades. Examples include paying hospitals for capital and graduate medical education (GME). (GME consists of indirect medical education (IME) and direct medical education (DME).) Are these payments still relevant in inpatient healthcare policy? How has the world of Medicaid purchasing changed from 30 years ago, when these supplementary payments began?

The Payment Method Development team at Conduent has been involved in moving eight Medicaid plans to diagnosis-related groups (DRGs) that establish preferred economic incentives. DRGs group clinically similar patients and are used to calculate reimbursements using a predetermined price adjusted for patient acuity. (Fiscal policies account for high- and low-cost outliers.) DRG payment rewards hospitals that provide more efficient patient care while encouraging access to care through higher reimbursement rates for sicker patients.

To understand why Medicare and some Medicaid programs make separate payments for capital and GME, let's go back to 1983. DRG implementation was a thunderclap over the heads of hospitals that were accustomed to being reimbursed for essentially all their costs. Hospitals were very nervous about any changes and successfully lobbied to keep at least capital cost reimbursement for ten years. Furthermore, the initial DRG algorithm was a far less sophisticated measure of patient acuity than the algorithms used today. Concerned that teaching hospitals might be underpaid, legislators took an adjustment factor from a study and doubled it. That became the IME payment. The result was "strictly at hoc," according to a *New England Journal of Medicine* analysis.¹ "It was just an easy way to get substantial support to the teaching hospitals," said one Senate staffer at the time.

Fast-forward 30 years. Medicare still pays separately for capital, although at a flat rate unrelated to a specific hospital's cost. And the IME adjustment persists, despite repeated recommendations from the Medicare Payment Advisory Commission (MedPAC) to reduce it.² Medicare also pays for DME costs separately using a formula tied to actual costs. (The IME adjustment formula has no relation to measured cost.)

Medicaid programs often look to Medicare as a model, but then make adjustments as necessary for the different needs of a Medicaid population. Federal law gives states wide discretion in setting payment methods for services provided by hospitals and many other provider types. In recent years, Medicaid programs nationwide have become increasingly interested in tying payment as closely as possible to value received.

In the District of Columbia, for example, the Department of Health Care Finance (DHCF) re-considered whether its current payments for capital, IME and DME were consistent with value purchasing. The result was a decision to reduce capital, IME and DME payments and redeploy these monies to DRG payments, tightening the link between services provided and payments made. For IME, payments will be reduced in two steps to half of current levels. For capital, no hospital's capital payment will exceed average capital cost across all hospitals. DME payment will have similar limits, except at 200 percent and then 150 percent of average DME cost across all hospitals.

The new approach will improve incentives for efficiency and access (because more money will be available for DRG payments which adjust payment based on patient acuity). It also will be fairer to pay hospitals more similarly for similar patients. Table 1 shows an example of an appendectomy. Although the DRG payment to each of three hospitals is the same, the hospital-specific capital, IME and DME payments create a wide gap. A policy argument can be made for Medicaid programs to support DME. The IME adjustment, however, is even less justified than it was 30 years ago.

Table 1: Effect of Disparate IME, DME and Capital Payments on Inpatient Payment per Stay

Example	Base price	DRG relative weight	DRG base payment	IME	Base price with IME	Adjusted DRG base payment	DME Add-on	Capital add-on	Final Payment
	a	b	c = a x b	d	e = a + d	f = e x b	g	h	i = f + g + h
Hospital X	\$7,000	1.88	\$ 13,160	\$150	\$7,150	\$13,442	\$100	\$800	\$14,342
Hospital Y	\$7,000	1.88	\$ 13,160	\$1,000	\$8,000	\$15,040	\$1,000	\$4,000	\$20,040
Hospital Z	\$7,000	1.88	\$ 13,160	\$4,000	\$11,000	\$20,680	\$3,000	\$8,000	\$31,680

Note: These numbers are fictitious and for the purpose of illustration only using the relative weight for DRG 225-3 Appendectomy. Examples do not include outlier or other adjustor policies.

Additionally, eight Medicaid plans no longer pay GME and several more are considering eliminating GME payments.³ And separate reimbursement for capital is inconsistent with the “price for a product” philosophy that has made DRG payment arguably the most influential innovation in the history of healthcare financing.⁴ Some Medicaid plans have already discontinued capital payments and rolled these monies into inpatient reimbursement. “For DC Medicaid, reducing payments for GME and capital allowed us to add more money to the District-wide base rate,” explained Claudia Schlosberg, acting DC Medicaid Director. “As purchasers, this means we are buying more services with our healthcare dollars.”

You can learn more about us at www.conduent.com/medicaid.
And discover how Conduent creates better outcomes across all parts of the healthcare ecosystem at www.conduent.com/freedomtocare.

1. John Iglehart, “Medicare Begins Prospective Payment of Hospitals,” *New England Journal of Medicine* 308:23(1983).
2. MedPAC, *Aligning Incentives in Medicare*, Report to Congress (Washington, DC: MedPAC, June 2010)
3. Tim Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (Washington, DC: Association of American Medical Colleges, 2013).
4. Kevin Quinn, “After the Revolution: DRGs at Age 30,” *Annals of Internal Medicine* 160:6 (March 18, 2014).

