Chapter 6

Findings and Conclusions

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DRG EVALUATION ISSUES

Diagnosis Related Groups (DRGs) were developed as a method for characterizing hospitals' case mix using data commonly available on hospital discharge abstracts. Although the motivation behind their original development was unrelated to their use in hospital payment systems, they were ready for implementation at a time when a consensus was developing that hospitals should be paid for their outputs (treated cases) rather than for their inputs (services or days of care). As the only system of case-mix classification currently practical for use with per-case payment, it is understandable that DRGs have been selected for use in the Medicare program.

Nevertheless, it is important for those who would use DRGs to recognize that in their present state of refinement (i.e., the **467** DRG classification) they have been inadequately evaluated for their validity as an indicator of patient resource needs and for their impact on medical technology in per-case payment. In light of the budget crisis facing the part A Medicare trust funds in the upcoming years, to move to DRG payment is reasonable. But given how little anyone knows about what to expect from DRG payment, it is ***critical*** that its implementation be carefully monitored, particularly with respect to its effect on the use and adoption of medical technology.

DRG PAYMENT ISSUES

Although there exists little empirical evidence about the effect of DRG payment on the adoption and use of medical technology, ***potential problems with various aspects of program design can be identified.***

First, just as cost-based reimbursement has created inappropriate incentives regarding the use and adoption of medical technology, so too does DRG payment, but the incentives are new and different. Whereas overuse of inpatient services and too lengthy hospitalization were problems under cost-based reimbursement, underprovision of services and inappropriate admission and discharges may be a problem under DRG payment. These incentives will require programs of quality assurance and utilization review designed specifically to deal with them.

Second the incentives affecting the use of medical technology depend on several important aspects of system design. In particular, the way in which capital costs are treated will affect incentives to use and adopt medical technologies. In drafting the Medicare law, Congress recognized that treating capital costs as a pass-through item is not an optimal longrun approach. Hospitals are **likely to become too capital-intensive over time as a result. The diversity** in hospitals' ages, debt structures, and future needs for expansion or closure all argue for hospital-specific determinations of the capital payment levels. These issues are inevitably intertwined with planning for health facilities and are therefore most amenable to treatment on a State level.

Third, **DRGs must be updated to both reflect and induce desirable technological change if the system is to remain responsive** to the needs of all patients. ***Periodic reestimation of relative DRG rates to reflect changes in the costs of various DRGs is essential to a workable program.*** Reestimation guards against growing divergence in the ratios of DRG cost to DRG price, and it also counteracts the potentially deleterious effects of DRG creep. How frequently such reestimation should occur is a debatable issue. The new Medicare law mandates recalibration at least every 4 years, but this interval may be too long. More frequent, perhaps annual, reestimation has disadvantages in increased administrative burden on program administrators and reporting requirements on hospitals. But these administrative costs

might be offset by the enhanced ability of the Federal Government to capture cost savings as they occur and by the strengthened incentives to adopt cost-saving innovations more quickly. Annual reestimation would also be more effective in controlling the longrun incentives for DRG creep than would infrequent reestimation. Whatever its interval, reestimating relative DRG costs implies the need for a continuing source of cost and charge data to support the process. Plans for altering Medicare billing forms and cost reporting requirements should proceed with these requirements in mind.

Methods for updating DRG rates that are conditional upon technology adoption may be important to stimulate desirable but cost-raising innovations. The adjustment process should allow for differentiation in rates between adopters and nonadopters of new medical technologies whose diffusion needs to be stimulated. Creation of new DRGs and provider appeals represent the only viable conditional adjustment methods, and each of these has shortcomings. In particular, heavy reliance on new DRGs runs the risk in the long run of creating a fee-for-service system in the hospital, the precise opposite of what DRG payment is intended to do. Provider appeals conjure up visions of administrative bureaucracy and delays which detract from the otherwise attractive simplicity of DRG payment. Yet, appeals may bean important vehicle for encouraging new technologies. New Jersey's DRG appeals mechanism should provide some insight into its usefulness in this regard.

The DRG adjustment process requires supporting mechanisms for identifying and assessing new hospital cost-raising technologies. Judgments about the readiness of new technologies for payment under one or more DRGs need to be supported by evidence about their effectiveness, risks, and costs. While the Medicare law established a Prospective Payment Assessment Commission whose purpose, among others, is to collect such information, adequate research resources are necessary to support the process.

The reliance of the DRG classification system on accurate and timely data collection and coding will necessitate improvement of hospital's medical records procedures and performance. Educational programs for physicians, nurses, hospital administrators, and medical records personnel should be initiated. Monitoring of information quality both within hospitals and by the mandated peer review organizations will be necessary.

IMPLICATIONS FOR RESEARCH AND EVALUATION

Although a conclusion of this memorandum is that DRGs are ready for use in per-case payment and that they are currently superior for this purpose to any other measure, the importance of a good case-mix measure in making per-case payment a viable longrun payment strategy implies that research on alternative measures must continue. It is too early to consider DRGs the basis for all future changes in case-mix measurement. The new Medicare law requires the Department of Health and Human Services (DHHS) to study the appropriateness of modifying DRGs to account for illness severity or other factors. This study should be enlightening, but by itself it is not enough. DHHS has an excellent record for support of the development of DRGs and other case-mix measurement techniques. Continued aggressive Federal support for development and refinement of promising alternatives is required to reap real improvements in case-mix measurement techniques.

So little is known about the magnitude of the effects of DRG payment on the utilization of services and technologies in the health care system that systematic study of these effects is needed. Studies need to be designed now to evaluate the effect of DRG payment on rates of admissions, lengths of stay, and the use of ancillary, outpatient, and nonhospital care. The new Medicare law mandates a study of its impact on hospital admissions. Such a study could be part of a larger investigation of the law's effects.

Since the effects of DRG payment on access to and quality of care are unknown at present, these factors should be closely monitored as the Medicare program is implemented. Patterns of service specialization are likely to change, and while these results may have benefits, they may leave pockets of inadequate access in some areas. The hallmark of the Medicare program has been the great increase in access of the elderly to mainstream medical care. The effect of DRG payment on access, particularly through hospitals' decisions to open and close services, merits close scrutiny in the coming years.

The importance of pass-throughs in altering the incentives of hospitals argues for careful study of ways to expand the scope of DRG payment. The Medicare law mandates separate studies of two important elements that are currently pass-through items: capital and teaching costs.

Finally, the remaining questions about the impact of specific elements of program design in altering general hospital incentives provided by per-case payment make study of State-level alternative prospective payment systems an attractive prospect. Although States need not adopt per-case payment, the law encourages them to design systems that they can be reasonably confident will do at least as well as the Medicare system in containing hospital costs. Evaluations of such systems, as mandated in the new law, will provide important information to support future improvements in payment system design.

IMPLICATIONS FOR PAYMENT SYSTEM ORGANIZATION

The relatively untested introduction of a national per-case payment system using DRGs as the case-mix measure is a bold step toward improving the efficiency of hospital care. But the system as designed in the new Medicare law is imperfect, and the details of program administration are still to be worked out. DRGs are the best case-mix indicators currently ready for use in a payment system, but there are other measures under development with equal or perhaps even greater promise. Moreover, there are many potential useful approaches to prospective payment and even to per-case payment. It is therefore fortunate that the new Medicare law does not discourage individual States from establishing alternative prospective payment systems. These alternative systems will allow for experimentation with different payment system configurations, including the use of other case-mix measures as they become ***more*** refined.

By statute, alternative prospective payment systems must cover a high proportion of the State's inpatient admissions. The inclusion of payers in addition to Medicare in prospective payment will strengthen its incentives. Furthermore, there are many components of per-case payment that appear to be suited to decentralized administration. For example, utilization review, provider-initiated appeals, and decisions regarding payment for capital costs are more amenable to decentralized administrative structures.

When these administrative issues are considered in conjunction with the potential for sharing administrative costs with other payers, considerable attention should be given to the possibility that the future of DRG payment rests on the degree to which the States join with Medicare to devise all-payer systems. The incentives analyzed in previous sections would all be strengthened under all-payer systems.