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DRGs at 40 years in the United States

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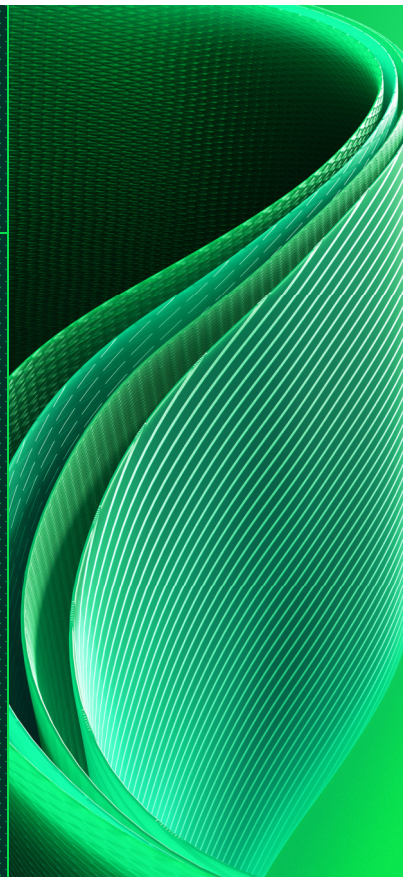

United States – 40 years of DRGs

- Key Concept: A clinically credible management tool facilitating real behavior change and performance improvement

- Crisis Leading to Action: 1982 - Imminent risk of Medicare Hospital Trust Fund insolvency in led to Congressional passage of Medicare Inpatient Prospective Payment System
  - No New Taxes
  - No reduction in Payment Levels
  - Budget Neutral System – designed to provide inherent financial incentives for cost control
  - Reform focused on HOW hospitals were paid instead of HOW MUCH hospitals were paid

20% decrease in projected expenditures without negative impact on patient outcomes

DRG - Pre-Federal Adoption – 1970s

- Prior to 1983
  - Federal government funded state level Medicare payment reform projects in 1970s

    New Jersey and Maryland – All Payer DRG

    Important, refinements/adjustments made during demonstration period:
    - Outlier policies, teaching hospital, disproportionate share, rural/urban concepts refined
  - Regulatory framework and operational experience established prior to federal deployment
  - Nationally deployed 5 months after legislation passage in 1983

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Key Lessons in First Decade

- Origin as a management tool to control the “production process” for cost and quality
  - Use of same tool for payment – was crucial for success
  - When introduced as a management system, hospitals disregarded as payment was cost based
  - Cost based payment provided little reward for efficiency

- When Payment System rewarded efficiency – DRGs could then be used as management tool
  - Enormous variations in costs for similar patients noted which meant opportunities for improvement existed
  - Hospital administrators/leadership empowered to align financial, operational, strategic activities with a common language

- All inclusive, fixed price for each type of inpatient admission
  - Explicit reflection of patient case-mix was critical to adoption
  - DRGs costs could then be used to establish reimbursement standards that balanced interests of public and hospital

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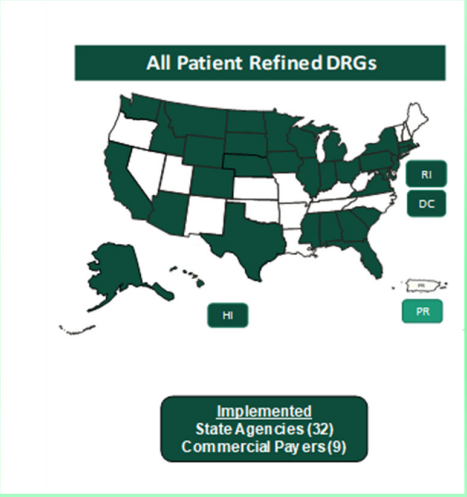
DRGs at 10 and 20 years

- 1982 – HHS Report – “A reasonable price for a known product”

- 2001 CMS report: “Success of any payment system that is predicated on providing incentives for cost control is almost totally dependent on the effectiveness with which the incentives are communicated”
  - Basic structure remained essentially unchanged
  - Known and stable payment environment
  - Equitably distributed and controlled Medicare hospital payments



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DRG - Case Mix Adjustment and Categorical Clinical Models

- Payment system in which providers assume financial risk must be case mix adjusted
  - Otherwise, risk of providers avoiding complex/costly patients

– Categorical nature of DRGs – separation of the clinical model (DRGs) from the payment weights. Noncategorical models – clinical/payment weights are interdependent

– CMS “Separation of clinical and payment weight methodologies allows for stable clinical methodology to be maintained while the payment weights evolve in response to changing practice patterns”
  - Clinical model has been largely stable – consistent/powerful communication tool
  - Payment weights, however, fluctuate to reflect practice patterns

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Summary and Going Forward

Risk Adjustment – Predict impact of case mix and communicate payment incentives

– IPPS designed to impact entire hospital – not subset of patients or clinical scenarios

– Substantive /sustainable behavior change – organization wide

Lesson after 40 years – incentive-based payment system must be designed as a clinically credible management tool that facilitates real behavior change and performance improvement

- Establish a clinically credible performance standard for each type of patient
- Performance determined on the basis of variation to the standard

Going forward –

Extending model to ambulatory setting and inpatient psychiatry,

Integrating outcomes /performance – safety/mortality/adverse events/PROs, and

Expanding scope to post acute

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