



Medicare's new payment plan: a mixed blessing. Douglas A. Conrad and Gilbert S. Omenn. *Technology Review* 88.(Nov-Dec 1985): pp50(3). (1852 words)

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IN 1983, the federal government made a fundamental change in the way it reimburses hospitals for the care of Medicare patients. Instead of paying hospitals whatever they say their costs or charges are, the government now pays a fixed sum for a particular diagnosis. Each diagnosis is included in a "diagnosis-related group" (DRG), and that DRG reflects not only the main illness but also complications. For instance, a patient admitted to the hospital for treatment of a heart attack but no other cardiovascular complications would be included in one DRG, while a patient with complications such as heart-rhythm disturbances or congestive heart failure would be included in another, higher-paying DRG.

This method of reimbursement provides hospitals with much-needed incentives to keep their costs down. It has already reduced the length of time patients stay in hospitals and thus is a major step toward economic reform. But it is not without some serious flaws. The new system may actually increase the number of hospital admissions in some cases and shift some types of care to outpatient settings without diminishing their cost. It may also encourage some hospitals to avoid treating acutely ill patients with limited means. And finally, the new system will have a mixed effect on technological innovation, encouraging hospitals to adopt cost-saving technologies while motivating them to continue investing in expensive "magnet" technologies of questionable value.

A Bias Against the Severely Ill

The severity of illnesses among patients within a given DRG varies considerably. Since the government bases payments to hospitals on the average level of resources required for each DRG, hospitals are, in effect, penalized for treating more complex and severely ill cases. According to a recent study, Rush-Presbyterian-St. Luke's Medical Center, a well-known teaching hospital in Chicago, suffered an average loss of \$10,567 for each Medicare patient receiving nonsurgical intensive care. In contrast, the hospital gained an average of \$578 per patient not requiring intensive care. Among patients who underwent coronary-bypass surgery, the hospital realized an average profit of \$10,858 for those not requiring intensive care. But it lost \$674 for every patient with the same diagnosis and treatment who did require intensive care.

To avoid such losses, hospitals somehow will have to "streamline" the care of acutely ill patients. As a complementary strategy, hospitals will seek payments for the more profitable diagnoses to cover such losses. Many private hospitals may simply avoid admitting severely ill Medicare patients, "dumping" them instead on government-funded municipal hospitals. Since the resources of many public hospitals are already badly strained, this bias could well disenfranchise the acutely ill poor and elderly from the benefits of sophisticated medical care.

An increased focus on the severity of illness will also encourage hospitals to invest in sophisticated information systems that identify the severity of illness more precisely. A growing number of hospitals, for instance, are buying software that classifies individual cases by the stage of disease or by their patient-care requirements. Such systems will replace traditional billing systems that do not contain such information.

The new system also appears to encourage surgical rather than nonsurgical treatment. DRG

payments are based on actual hospital charges in recent years. However, these figures are already outdated and do not reflect the shorter lengths of stay many types of surgery now require. Hospitals are being reimbursed for a higher amount than many surgical procedures now cost. For instance, payments for treating patients with heart disease nonsurgically are about one-third those for treating the same patients using coronary-bypass surgery. Hospitals therefore have an incentive to perform such surgery, even though many (perhaps most) patients do not need it.

Even worse, many of the bypass operations are performed in hospitals that do too few cases to be really proficient. Complications may result that not only harm the patient but also increase the resources devoted to caring for that patient. Exacerbating this bias is the structure of fees for physicians, who are paid separately. A recent Medicare study shows that doctors receive \$197 per hour for surgical procedures versus \$50 per hour for nonsurgical treatments. Including all physician services in the DRG prices for inpatient care would eliminate this disparity. Such a step would ensure that doctors share the hospitals' interest in keeping costs down.

Under the new system, teaching hospitals are still reimbursed for their direct costs of providing education, which mainly include the salaries of interns and residents. Since the 7,000 hospitals in the United States include only about 400 teaching hospitals, most hospitals view the \$1 billion now going to teaching institutions as an undesirable claim on a dwindling pool of health-care dollars.

Sen. David Durenberger [R-Minn.] has proposed funding medical education from a "discretionary" budget allocated by the states. However, under this proposal, federal contributions would be cut by about 10 percent. Adopting this plan would also mean that such funding could more easily fall victim to efforts to reduce the federal budget deficit.

We believe that payment for patient care and rigorously accredited medical education should be linked. Patients benefit from the intellectually challenging environment for medical students, residents, and attending physicians in a teaching hospital. When the transition to 100 percent DRG payment rates is completed in 1988, the direct costs of medical education should be built into higher DRG rates for teaching hospitals.

The Technological Incentive

Because hospitals can gain higher profits by doing surgery, we can expect to see an increase in new (and costly) technologies for the operating room. However, DRGS have also encouraged a number of cost-saving technological innovations as alternatives to conventional surgery. For example, a device developed in Germany, called the Dornier extracorporeal shockwave lithotripter, breaks up kidney stones using shock waves rather than surgical incision. The hospitalization time for lithotripsy is less than one-half that of alternative minor surgical procedures, and less than one-third that of major kidney stone surgery. Hence, hospitals may be more inclined to use lithotripsy, when feasible, for inpatient and outpatient care.

Banking on the initial success of the Dornier device, a few American companies have developed new lithotripters that are much less costly but just as effective as the German product. By lowering the DRG payment for this technology, the federal government can make sure that the first-generation West German product is not insulated from U.S. competition.

PTCA--or percutaneous transluminal coronary angioplasty--is another new technology that promises significant savings in cost. PTCA is a nonsurgical alternative to coronary-bypass surgery for heart patients with a blockage in their coronary arteries. It uses a catheter to overcome the obstruction in the clogged artery. The new DRG payment system gives hospitals an incentive to use this new procedure because its cost is about 15 percent less than bypass surgery.

However, some provisions in the DRG system may inadvertently discourage some hospitals from using PTCA. For instance, if PTCA doesn't work for a given patient, bypass surgery may still be

required. In such cases, the hospital will be paid only for the bypass operation even if PTCA was performed during the same hospital stay. That lowers the hospital's incentive to try angioplasty before bypass surgery. It may also encourage hospitals to admit heart patients twice, once for a PTCA and again for a bypass, which of course increases the overall costs of health care.

The DRG system also indirectly encourages hospitals to acquire expensive diagnostic technologies, such as nuclear magnetic resonance (NMR) imaging and CAT scans, both of which scan for abnormal tissue in the body. These machines can cost close to \$1 million each, and their value in diagnosing disease remains unclear. Yet because the DRG system induces hospitals to discharge patients sooner, lowering occupancy rates in the short run, more hospitals will feel impelled to acquire these desirable technologies to attract physicians and, with them, patients.

Because it is such a shock to the status quo, the DRG system is being phased in over four years. For now, the government continues to pay the costs of capital--interest, depreciation, and return on equity for investor-owned hospitals--separately based on a hospital's actual costs. This again encourages hospitals to spend money on medical equipment and buildings rather than relying on human labor and "intellectual software" -- that is, information and brain power. Many hospitals will be more likely to buy expensive machines instead of making much-needed innovations in managing patient care. For instance, many hospitals need to better coordinate patients' discharge plans with home health and nursing-home services.

DRGS do provide a strong incentive for hospitals to combine all their important resources (length of stay, routine and intensive care, x-rays, laboratory tests, and operations) to minimize the resources used per hospitalization. However, integrating several levels of health services--office visits and hospital outpatient and inpatient care--could yield still greater economies. Health maintenance organizations (HMOS), which provide a full range of services in return for a fixed premium, have dramatically demonstrated this fact: their costs are 10 to 40 percent less than those of the traditional health-care system.

The federal government should contract with more HMOS and networks of doctors and hospitals to care for a set number of Medicare patients in return for a fixed premium per enrollee. Medicare officials should also develop incentives for insurance companies to negotiate similar contracts with HMOS and physician-hospital networks. Most insurance companies simply process Medicare claims; they do not bear any underwriting risk for Medicare patients. The revised policy would make carriers--along with doctors and hospitals--responsible for keeping prices below the contracted fee for services. This would lead to significant cuts in costs.

To keep the new system working, DRG rates must be updated regularly. They should cover the full costs of only those new technologies that will be cost-effective in the long term. For example, careful analysis of a technology must show that short-term savings will not be offset by increased admission rates. If frequent use of PTCA leads to more double admissions, the DRG system should not pay for the technique.

By the same logic, DRG prices should fully cover technologies that raise the cost per hospitalization but that lower long-term costs. The Rand Corp. recently analyzed a number of expensive tests designed to clarify the cause of gastrointestinal problems before stomach and esophageal operations. Curtailing such tests might reduce costs per case but also might lead to poorer choices on the type and technique of surgery. That, in turn, could lead to postsurgical complications, more hospitalizations, and higher costs, not to mention poorer health.

Thorough studies to establish the precise costs of efficient, high-quality care are crucial. Only when we know the true costs of treating health problems will we be able to set payment rates that do not encourage surgery and properly compensate for quality care. Such unbiased rates are essential if Medicare policy is to avoid a drift toward procedure-oriented medicine instead of treatment that incorporates human interaction, personal care, and good clinical judgment.

In sum, today's DRG payment plan may increase hospital admissions and shift costs to outpatient settings, offsetting any cost savings that might otherwise result. The existing plan should be viewed only as the first generation in a continuum of innovations in the American health-care system.

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