

Diagnosis Related Groups–Based Payment to Hospitals for Inpatient Stays

Background

Diagnosis related groups (DRGs) provide a flat per-discharge (or per-death) payment that varies based on diagnoses, severity, and whether and what procedures were performed. DRGs are used for two purposes: In some systems, DRGs are a measure for assessing hospitals' case mixes and activities. In other systems, including Medicare, DRGs are used as an additional payment method. The basic setup for DRG-based hospital payment includes the following elements:

- a patient classification system to group patients with similar clinical characteristics and relatively homogeneous resource consumption into hundreds of DRGs;
- hospital cost information used to determine DRG weights, usually based on relative average treatment costs of patients falling within each DRG;
- a standard monetary conversion factor, used to convert DRG weights into base payment rates for each DRG;
- actual payment rates, obtained by adjusting the DRG base rates for structural differences across hospitals (e.g., wage rates, teaching status, rural area designation) and further resource-consumption variables (e.g., length of stay, readmissions, use of high-cost drugs or services).

Hospitals are paid based on the number and the type of DRGs they produce. The approach assumes that hospitals treat a random variation of patients such that, on average, patients who are more costly than their DRG payment rate are offset by patients who are less costly. Creating more DRG categories to reflect severity differences would decrease perhaps-unrealistic assumptions about random variation, as this would more accurately account for the systematic variations in costs associated with different clinical conditions.

Different payers adopt different DRGs to affect the actual incentives hospitals face. These differences do not alter basic incentives but rather represent operational differences. For example, across countries and payers most DRG weights and payments are based on average costs. However, it is possible to introduce normative rather than empirically based standards for modifying empirically derived weights thought to distort behavior.

Most DRG payment systems include outlier payments as insurance against incentives to avoid or prematurely discharge costly or potentially costly patients (called "outlier cases," based on length of stay or actual computed costs). Outlier payments also protect hospitals from losses related to a "bad draw" of exceptionally costly patients relative to their DRG payment rates. To prevent a skew in calculation of average DRG costs, most DRG systems exclude outlier cases from the determination of average costs and provide separate outlier payments—these payments usually kick in only after a cost or length of stay threshold, generally far higher than the average for the DRG, is reached. Outlier payment therefore reflects to a limited extent the actual cost incurred by the hospital for extreme cases, rather than the cost of an average case, to balance the cost-containing objectives of DRGs with practical concerns about payment fairness.

Key Objectives

Medicare adopted DRGs as an alternative to so-called cost-based payment to fundamentally change hospitals' incentives to reduce costs associated with an inpatient stay. Given that a prospective payment based on a patient's principal diagnosis, the hospital has an incentive to eliminate unnecessary services and to reduce the length of stay. In contrast to the United States, many developed countries introduced DRGs not as a replacement for cost-based reimbursement, but rather as a substitute for hospital global budgets to promote and reward hospital activity. Under some forms of global budgeting, hospitals with a guaranteed budget could adopt a complacent attitude about attracting patients, thereby producing queuing or waiting periods for elective services.

Strengths

- Because the payment amount per principal diagnosis is fixed, hospitals have strong incentives to reduce costs per stay.

- Payers can achieve savings over time because hospitals' responses to DRG incentives lower average costs per case, which in turn permits lower DRG payment levels.
- Hospitals may improve care quality because they will typically improve internal care pathways and reduce lengths of stay (longer stays can be associated with greater iatrogenic harm and hospital-acquired infections).
- DRGs may be more market-oriented than other hospital payment systems because hospitals may improve quality and efficiency by treating patients for which the hospital has a competitive advantage.
- Having a uniform, standard classification system facilitates transparency and permits interhospital comparisons by payers and consumers.
- DRGs eliminate the need to review the appropriateness of every service provided during a patient's stay, so monitoring can focus on the appropriateness of the stay.
- Most health systems and an increasing number of U.S. payers now use DRGs; new approaches to promoting quality and cost containment can be transferred into improved DRG model designs.
- Hospitals paid under DRGs by Medicare would see a common payment model if private payers adopted the same approach, thereby eliminating conflicting incentives with per diems (the predominant method of hospital payment used by insurers).

Weaknesses

- With a fixed payment per case, hospitals retain an incentive to increase the number of patients hospitalized, even when outpatient management is acceptable or preferred.
- Hospitals benefit from increasing revenues per patient, most easily achieved by changing coding practices of diagnoses and procedures ("DRG creep") or by providing services that lead to reclassification of patients into higher-paying DRGs.
- In comparison to other methods for paying hospitals, DRGs are more complex, requiring coding expertise, data systems, and active oversight of coding by payers.

- In commonly used DRG designs, performing a surgical procedure produces a substantially higher payment net of cost for the same diagnosis without a procedure. Thereby, clinical decision-making is potentially skewed to favor procedures when medical management might suffice.
- Hospitals have an incentive to select profitable, low-cost patients ("cream-skimming") in each DRG and transfer or avoid unprofitable, higher-cost patients.
- Hospitals may discharge prematurely, compromising quality yet rewarding hospitals if the patients are readmitted (unless the DRG design does not permit a new payment for readmission within a specified time period, e.g., 30 days).
- Hospitals may transfer patients to other hospitals or postacute care facilities, generating overpayments from the artificially low length of stay. Payers can follow Medicare's lead by reducing the payment when such a transfer occurs early in a hospital stay, though that adds yet more administrative complexity.