UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

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HUMAN RESOURCES DIVISION

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JUNE 15, 1983

RELEASED

The Honorable John Heinz
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

Subject: Comments on a Health Care Financing Administration Regional Office Report on New Jersey's Diagnostic Related Group Prospective Reimbursement Experiment (GAO/HRD-83-63)

Your February 17, 1983, letter forwarded a copy of a report by the Health Care Financing Administration's (HCFA's) New York Regional Office on New Jersey's Diagnostic Related Group (DRG) hospital prospective payment experiment. Your letter states that the New Jersey system has had an unanticipated impact on reimbursement, produced an unexpected administrative burden, altered and increased the need for utilization review and financial audits, and required a lengthy implementation process. You asked us to comment on the report's findings and recommendations and to assess their relevance to the administration's proposed Medicare hospital prospective payment system. A Medicare prospective payment system that differs in several important ways from the administration's proposal was recently enacted into law. (Social Security Amendments of 1983, Public Law 98-21, Apr. 20, 1983.)

The administration's proposed bill was very general and would have granted the Secretary of the Department of Health and Human Services (HHS) broad authority to design, implement, and operate the system. Therefore, whether the proposal, if enacted, would have addressed the problems discussed in the HCFA Regional Office report would have depended largely on actions taken by HHS in establishing and operating the payment system. The Congress included features in Public Law 98-21 which attempt to address concerns like those expressed in the HCFA Regional Office report.

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## BACKGROUND

Medicare generally pays hospitals on a reasonable cost basis; that is, hospitals are paid their actual costs of providing patient care as long as costs meet Medicare's definitions of allowability and reasonableness, and as long as they neither exceed 120 percent[1] of the average costs per discharge of comparable hospitals nor increase from prior costs per discharge by more than an annually fixed percentage.[2] During fiscal year 1982, Medicare paid over $32 billion to hospitals, and such expenditures have increased an average of 19 percent per year since 1979. While the general rate of inflation as measured by the Consumer Price Index slowed to 3.9 percent in 1982, hospital costs rose 12.6 percent under this index.

The Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248, approved September 3, 1982, required HHS to submit a report to the Congress about a potential prospective payment system for hospitals and other providers. Under a prospective system providers are told in advance what they will be paid and normally the payment level is not retrospectively adjusted to reflect actual costs.

In a December 1982 report, HHS recommended to the Congress a hospital prospective payment system for Medicare covering routine and ancillary service costs and submitted proposed legislation on February 22, 1983, to implement this system. The proposal provided for payments based on the patient's diagnosis. The DRGs to be used were developed by Yale University, which grouped diagnoses by physiological system and severity of illness. The grouping of diagnoses was designed to include those cases which are closely related in the extent of resources expected to be devoted to treating the patients.

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[1]For hospital cost report years ending in fiscal year 1983. For reporting years ending in fiscal years 1984 and 1985, this percentage was scheduled to decrease to 115 and 110 percent, respectively. However, Public Law 98-21 makes this reimbursement limit inapplicable after fiscal year 1983.

[2]The allowable increase is defined as the percentage increase in an economic index designed to reflect changes in hospital operating costs plus 1 percent. This limit acts as an upper limit on payments for fiscal years 1984-86 under the revised reimbursement system in Public Law 98-21.

The amount Medicare would pay would be the national average Medicare cost per discharge, adjusted for local wages, for the DRG into which the patient's diagnosis falls. Although not specifically stated in the administration's proposed legislation, HHS' report to the Congress indicates that capital and education costs would continue to be reimbursed on a reasonable cost basis. The rates paid by Medicare would be payment in full to the hospital which could not charge the beneficiary except for Medicare's coinsurance and deductibles for inpatient hospital services.

The administration's proposal provided for an annual adjustment of the fiscal year 1984 payment rate, but was not specific about how payment levels would be adjusted in the future. It did state that payment levels were to be updated periodically and that HHS could consider such factors as the increase in the costs of goods and services purchased by hospitals, improved hospital industry productivity, and technological changes.

The Congress, in enacting Public Law 98-21, adopted a prospective payment system based on DRGs which substantially modified the administration's proposal. The legislation requires the Secretary of HHS to develop a national and nine regional DRG rates, each having an urban and rural rate adjusted for local wages. The prospective payment system would be phased in over a 3-year period. Generally, the amount each hospital would be paid is based on a proportion of the national and regional payment rate and a portion based on the costs incurred by the hospital.[3] The prospective payment rate applies to hospitals located in the 50 States and the District of Columbia except for psychiatric, rehabilitation, children, or long-term care hospitals, or a distinct psychiatric or rehabilitation unit in a hospital. Capital and educational expenses would be paid on a cost basis, but HHS is to report to the Congress by October 1984 on a suggested method for including capital costs in the prospective payment rates.

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[3]The DRG prospective payment rate would be phased in as follows.

| Fiscal year | Percent of payment to hospital based on Cost | Census Region DRG rates | National DRG rates |
|---|---|---|---|
| 1984 | 75 | 25.0 | 0 |
| 1985 | 50 | 37.5 | 12.5 |
| 1986 | 25 | 37.5 | 37.5 |
| 1987 | 0 | 0 | 100.0 |

The law requires the Secretary of HHS to adjust the DRG payment rates each year and to make other adjustments as necessary. To assist the Secretary in adjusting the DRG rates a Commission was created to review the use of new technologies and treatment modalities and to recommend changes to the rates based on its evaluation.

## ISSUES REPORTED BY HCFA'S NEW YORK REGIONAL OFFICE ON NEW JERSEY'S PROSPECTIVE PAYMENT SYSTEM

A prototype DRG-based prospective payment system was developed in New Jersey under a $5.3 million grant from HCFA. The New Jersey system was phased in over several years beginning with 26 hospitals in 1980. As of December 1, 1982, New Jersey's system covered 99 acute care general hospitals and applied to all payors. To obtain uniform data on which to set prospective rates, New Jersey required hospitals, beginning in 1975, to file uniform cost reports. Thus, the first step for most New Jersey hospitals was developing a substantial data base that incorporated financial data and clinical information. Reportedly, considerable resources were expended to improve hospital medical record departments to support each hospital's data base and to help assure the accuracy of DRGs assigned to patients for payment purposes.

HCFA's New York Regional Office prepared a report (dated Aug. 9, 1982) on New Jersey's prospective payment experiment which identified issues the Office believed should be addressed by any proposal for a national DRG prospective payment plan. HCFA headquarters staff reviewed the Regional Office report and advised the Regional Office in October 1982 that a complete evaluation of the New Jersey experiment is scheduled to begin after its completion in December 1983.

The observations and recommendations made by the HCFA Regional Office related to two main areas:

--The need for a utilization review mechanism to assure quality of care and accurate reporting of diagnoses for payment purposes.

--Suggested modifications to New Jersey's payment system if it were to be used nationwide.

These areas are discussed in the following sections.

## Utilization review mechanism needed

The HCFA New York Regional Office noted three areas where potential problems could arise that indicated the need for a reliable utilization review mechanism. The first of these was the potential for hospitals to manipulate diagnosis reporting in order to maximize Medicare payments under a DRG system. The Regional Office report noted two studies which indicated the potential for hospitals to maximize payments by reporting high paying diagnoses or combinations of diagnoses.

A study conducted by the University of California at San Francisco Department of Medicine showed that, by reporting for payment purposes as the principal diagnosis the higher paying of either the principal or secondary diagnosis, the University's hospital would have received 14 percent more in 1978 if it were under a DRG payment system similar to New Jersey's. A computer program was designed which selected automatically the sequencing of diagnoses that ensured maximum payment. In 23 percent of the cases, reporting the actual secondary diagnosis as the principal diagnosis for billing purposes would have increased the DRG payment.

The HCFA New York Regional Office also conducted a study to determine the accuracy of diagnosis reporting at selected New Jersey hospitals. The results reported were:

--Review of a sample of 276 Medicare and Medicaid claims from three hospitals indicated that 28 (10 percent) of the claims appeared to have inappropriate DRGs. The billed DRG in all 28 cases resulted in higher payments than would have been obtained using the DRGs the Regional Office believed were appropriate.

--The Regional Office looked at the Professional Standards Review Organizations' (PSROs')[4] retrospectively monitored claims from the same three hospitals. The PSROs

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[4]PSROs are responsible for making medical necessity and appropriateness determinations for Medicare inpatient hospital services and can perform this function for Medicaid at each State's option. The Tax Equity and Fiscal Responsibility Act of 1982 replaced the PSRO program (effective Oct. 1, 1983) with the Utilization and Quality Control Peer Review Organization Program (referred to as PRO). The PROs would have similar responsibilities to those of the PSROs for Medicare and could carry out utilization review functions for other payors.

reviewed a sample totaling 150 claims (all payors) and disagreed with the DRGs reported by the hospitals in 22 cases (15 percent).

The second area of potential problems noted by the Regional Office indicating a need for utilization review involved assuring appropriate utilization of services and quality of care. The Regional Office pointed out that a DRG-based prospective payment system introduces a new incentive to hospitals, namely providing the least costly care to patients by avoiding unnecessary care. This incentive carried to the extreme could result in adverse impacts on quality of care. Possible examples cited in the report included manipulating ancillary services and premature discharges to minimize costs and increasing admissions to maximize payments. The Regional Office believed that, if any of these actions occurred, quality of care could be adversely impacted.

The third area of potential problems related to DRG outliers which are cases where the patients' length of stay or other factors differ substantially from the norm for the DRG involved. The Regional Office was concerned about the percent of cases falling into the outlier category in New Jersey--an estimated 30 to 35 percent of all inpatient cases in 1982 were expected to be outliers. The Regional Office believed monitoring of outlier cases was needed because of the significant impact on payments these cases have because hospitals receive additional payments for such cases.

Based on these observations the Regional Office recommended that

--hospitals be given very specific instructions on diagnoses designation and sequencing and that review of this area be emphasized,

--a more innovative approach to utilization review and quality assurance than that used in New Jersey be adopted, and

--a monitoring system for outliers be established to minimize the number of cases falling into this category or alternately paying outliers on a cost rather than a charge basis.

In a recent report[5] we expressed similar concerns about the potential problems that could arise under a DRG-based prospective payment system and the need to have a utilization review mechanism to control abuse. We stated that the administration's proposed DRG prospective payment system included provisions which could (1) allow for manipulating admissions and diagnostic coding to increase total reimbursement and (2) result in adverse impacts on the quality of care provided to Medicare beneficiaries. Therefore, it is necessary to maintain a PSRO/PRO type function at least until it can be demonstrated that these potential problems do not arise under the proposed hospital payment system. In addition, we noted several instances in the December 1982 HHS report to the Congress on the proposed prospective payment system which identified potential problems and which we believe pointed out the need for a PSRO/PRO type function. These areas included:

--The proposed system might encourage hospitals to release patients prematurely which in turn might result in otherwise unnecessary readmissions and a second payment.

--The proposed system might encourage hospitals to transfer unnecessarily a patient to another provider or to reduce the provision of important ancillary services to minimize costs.

--There is an incentive in the proposed system for unnecessary admissions.

--There is an incentive under the proposed system for hospitals to report higher level diagnoses in order to obtain higher payments.

The administration proposed eliminating both the PSRO program and the requirement that hospitals not covered by a PSRO establish utilization review committees. Also, the President's budget for fiscal year 1984 does not provide any funds for a PRO program. Thus, there would not have been a required program of physician review of the medical necessity and appropriateness of inpatient hospital services under Medicare.

The administration's proposed legislation for a DRG prospective payment system did not address the mechanisms to be used to control against the problem areas raised by HCFA's New

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[5]"GAO Staff Views on the President's Fiscal Year 1984 Budget Proposals" (GAO/OPP-83-1, Mar. 4, 1983), pages 69-72.

York Regional Office, by HHS' report to the Congress on the proposed prospective system, and by us in our March 4, 1983, report. However, the Congress in enacting Public Law 98-21 addressed these concerns. The law requires hospitals to contract with the PRO covering its area, if one has been designated, by October 1, 1983, in order to receive Medicare payments. If a PRO had not been designated for a hospital's area by October 1, 1984, the hospital could not receive payments from Medicare. PROs are to review (1) the validity of diagnostic information provided by hospitals; (2) completeness, adequacy, and quality of care provided; (3) appropriateness of admissions and discharges; and (4) appropriateness of care for outlier cases. If the PRO program is implemented (required under Public Law 97-248 on Oct. 1, 1983) and PROs are effectively performing the functions listed above, the concerns expressed by HCFA's New York Regional Office and by us should be addressed.

Suggested modifications to New Jersey's payment system if it applied nationwide

The HCFA New York Regional Office report made suggestions for modifications to New Jersey's DRG payment system if it was to be applied nationwide. The suggestions fell into four areas: (1) treatment of bad debts, (2) appeals for changes in reimbursement, (3) payments for outliers, and (4) the need for cost reports and audits of them.

The Regional Office was concerned about the impact that including a factor in payments to cover hospitals' bad debts could have on payments and how changing economic conditions could affect the level of bad debts. Under Medicare's cost reimbursement system, the only bad debts recognized as costs were those directly related to Medicare patients; that is, unpaid Medicare deductible and coinsurance amounts. The prospective payment system enacted by the Congress continues Medicare's prior policy on bad debts, so we believe they should not significantly affect the new payment system.

The Regional Office was also concerned about the number of payment rate appeals occurring under New Jersey's system because most providers covered by it in 1981 appealed their initially set rates. While New Jersey's rate-setting system involved a number of steps which could result in appeals of payment rates, the Medicare DRG payment system enacted by the Congress does not permit appeal of the payment rates. Thus, the concerns of the Regional Office about the administrative burden of payment rate appeals should not be as significant a problem under Medicare's revised hospital payment system.

Regarding payments for outlier cases, the Regional Office made two recommendations that

--the number of cases falling in the outlier category be held to a minimum (it was expected that 30 to 35 percent of the cases in New Jersey would be classified as outliers) or

--outlier cases be paid on the basis of costs rather than hospital charges as was done in New Jersey because charges normally exceed costs and paying charges would increase Medicare payments.

The administration proposed that only cases which exceeded a DRG's average length of stay by 30 days or more be classified as outliers; discharges with very short lengths of stay would be paid the DRG rate.[6] This was expected to result in about one-half of 1 percent of the cases falling in the outlier category.

The law as enacted requires that additional payments for outlier cases be not less than 5 percent nor more than 6 percent of total DRG payments.[7] Therefore, outlier payments are supposed to be held, under Medicare's system, to a percentage substantially below that experienced in New Jersey.

The administration's proposed legislation did not state how additional payments for outlier cases would be calculated. The law as enacted does not state how such payments are to be calculated, but does provide that they shall approximate the marginal cost of care beyond the point which makes the case fall into the outlier category. We are concerned that hospitals not be able to increase payments by keeping patients longer than necessary

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[6]New Jersey uses a relatively complex system to classify outliers under which meeting any of seven criteria puts a case in the outlier category. Cases are classified as outliers if, for example, they significantly vary from the average length of stay on either the high or low side.

[7]The conference report (H. Rept. No. 98-47) on Public Law 98-21 stated that the conferees were equally concerned that adjustments may be required for cases which have an unusually short length of stay or which are significantly less costly than the DRG payment. The Secretary of HHS is required to report in the annual report on the prospective system on how to address such low cost cases.

in order to receive an outlier payment. If hospitals only receive, as an outlier payment, the additional costs directly related to care provided after a case reaches the outlier cutoff point--that is, marginal costs--as required by the law, this should not provide an incentive to retain patients longer than necessary or enable hospitals to gain from outlier cases.

Finally, regarding the need for cost reports and audits of them, the Regional Office expressed its concerns that Medicare payments under the New Jersey DRG system had exceeded the amounts that would have been paid under Medicare's cost reimbursement system. The Regional Office stated that it had anticipated that payments would increase and that the percentage increase might not be excessive considering that payments included a factor for uncompensated care (bad debts) and that the payment methodology had changed. However, the Regional Office was concerned that the two hospital cost report audits which had been done indicated that at least initially the New Jersey system may be quite costly. The Regional Office said it was developing an audit program so that HCFA could be furnished hard data on such things as actual costs, cost shifting, and data collection. The Regional Office was also concerned about whether sufficient funds would be provided to carry out the audit program. It recommended that the need for auditing and commitment of funds be built into the design of any new national DRG prospective payment system.

As we have stated in the past,[8] we believe that prospective payment systems should be based on the costs which would be incurred by an efficient and economical provider to deliver needed care. For the Medicaid program, the Congress has required the States to have reimbursement systems for hospitals and nursing homes which meet similar requirements. We also believe that to determine the cost level at which efficient and economical providers can deliver needed services and to ascertain changes in this level over time, it is necessary to obtain, through audited cost reports, data on actual reasonable and allowable costs incurred by at least a statistically reliable sample of providers.

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[8]For example, see "Information on Prospective Reimbursement Systems" (GAO/HRD-82-73, May 10, 1982) and testimony before the Subcommittee on Health, Senate Committee on Finance, on the data used by HCFA in preparing its proposal to establish a prospective reimbursement system for the End-Stage Renal Disease Program, March 15, 1982.

During the hearings on the bills which eventually resulted in the enacted DRG prospective payment system, concerns about the accuracy of the data bases which will be used to set the DRG payment rates were expressed. Public Law 98-21 requires hospitals to continue submitting cost reports through fiscal year 1988. Also, during fiscal years 1984-86, hospitals will continue to be paid by Medicare partially on a cost basis so auditing of cost reports should continue. In addition, Public Law 97-248 authorized an additional $45 million per year during fiscal years 1983-85 for Medicare claims paying agents to be used exclusively for cost report auditing and medical reviews ($23 million of the $45 million appropriated for fiscal year 1983 has been allocated to cost report auditing).

Finally, Public Law 98-21 requires that payments to hospitals not exceed what would have been paid under the reimbursement system in existence before the revised system for fiscal years 1984 and 1985; that is, the rate of increase limit on payment per discharge established by Public Law 97-248 (see p. 2). Therefore, the tools (cost reports) shall be available to determine the impact the revised system has on hospital costs in such areas as those raised by the Regional Office. Also, cost report auditing should continue to be performed and funds should be made available for this purpose. In addition, the utilization review program which the Congress mandated for the DRG system should provide the information needed by the Government to address many of the questions raised about the current data bases and to help assure that DRG payment rates accurately reflect the costs which would be incurred by efficient and economical providers to furnish needed service. Thus, assuming that the utilization review program is effectively implemented and that costs reports are adequately audited, the Government should, in the future, have better data bases on which to establish prospective DRG payment rates.

## OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to address the concerns expressed by HCFA's New York Regional Office in a report regarding its experience with the DRG experiment in New Jersey in view of (1) the prospective system proposed by the administration for Medicare and (2) the prospective payment system enacted into law. We interviewed knowledgeable officials, including New Jersey State officials responsible for operating, monitoring, and evaluating the New Jersey program. We interviewed HCFA officials both in the New York Regional Office and at headquarters. Also, we talked with a consultant doing work on the New Jersey program and an intermediary responsible for New Jersey

hospitals in order to evaluate the recommendations made by HCFA's New York Regional Office. In addition, we reviewed articles in medical publications specifically dealing with utilization of hospital services and the New Jersey experiment. We also reviewed the administration's report to the Congress, congressional committee and conference reports, and the Social Security Amendments of 1983, Public Law 98-21, to determine whether the law addressed the concerns of HCFA's Regional Office. As requested by your office, we did not obtain comments from HHS on this report.

Except as noted above our work was done in accordance with generally accepted government audit standards.

Unless you publicly announce its contents earlier, no further distribution of this report will be made for 21 days. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel
Director