

**Medicare Hospital Prospective Payment System
How DRG Rates Are Calculated and Updated**

August 2001

OEI-09-00-00200

**Office of Inspector General
Office of Evaluation and Inspections
Region IX**

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INTRODUCTION

When Medicare was established in 1965, Congress adopted the private health insurance sector's "retrospective cost-based reimbursement" system to pay for hospital services. Under this system, Medicare made interim payments to hospitals throughout the hospital's fiscal year. At the end of the fiscal year, the hospital filed a cost report and the interim payments were reconciled with "allowable costs" which were defined in regulation and policy. Medicare's hospital costs under this payment system increased dramatically; between 1967 and 1983, costs rose from \$3 billion to \$37 billion annually.¹

In 1982, Congress mandated the creation of a prospective payment system (PPS) to control costs. Congress looked at the success of State rate regulation systems in controlling costs and mandated the implementation of a prospective payment system model that had been successful in several States.² This system is a per-case reimbursement mechanism under which inpatient admission cases are divided into relatively homogeneous categories called diagnosis-related groups (DRGs). In this DRG prospective payment system, Medicare pays hospitals a flat rate per case for inpatient hospital care so that efficient hospitals are rewarded for their efficiency and inefficient hospitals have an incentive to become more efficient.

Congress gave the Department of Health and Human Services (HHS) primary responsibility for setting and updating hospital payment rates under PPS.³ Later, Congress created the Prospective Payment Assessment Commission (ProPAC) to participate with HHS in setting and updating the DRG rates.⁴ Since its implementation, the DRG-based prospective payment system and the updating processes have experienced continual structural shifts and modifications. The processes by which the DRG codes are updated raises considerable issues with significant implications for the structure and funding of our national health care system.

The following White Paper explains the PPS system, examines the process by which DRG codes are updated, and identifies the factors influencing the DRG prospective payment and classifications systems:

- C Part I provides a summary of the evolution of the system including a discussion on how and why the system was created.
- C Part II provides an overview of the PPS including examples and illustrations.
- C Part III explains the processes for updating DRG codes and weights.
- C Part IV contains a discussion of current issues that merit further consideration.

PART I: The Evolution of DRGs

The Retrospective Payment System

From fiscal years 1967 to 1984, hospitals were paid on the basis of the actual cost for providing services to Medicare beneficiaries.⁵ Under this system, each hospital submitted a report called a “cost report” which itemized expenditures incurred in the hospital’s prior accounting period or “fiscal year.” During this period, Federal policy-makers viewed the health care system as wasteful, as the inflationary costs from this system were enormous.⁶ The following table shows the increase in total Medicare expenditures from 1967 to 1985:

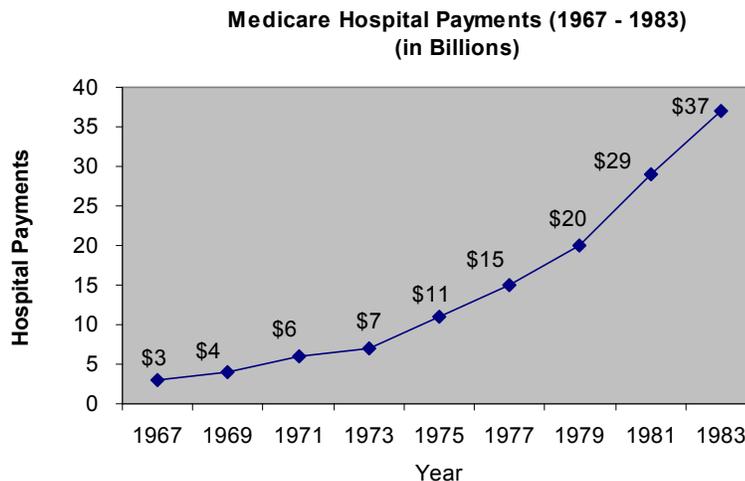
Medicare: Enrolled Population and Expenditures 1967 and 1985⁷

Year	Number of Enrollees	Expenditures	Percent of Health Care Expenditures
1967	19.5 million	\$4.7 billion	9.2%
1985	31.1 million	\$72.3 billion	16.9%

Two factors were blamed for the rapid growth in expenditures:

1. Payment methodologies that paid providers based on their charges for providing services and consequently created an incentive to provide more services;
2. Increases in costly medical technology.⁸

The following table shows Medicare hospital payments from 1967 to 1983.⁹



From 1970 to 1980, Medicare hospital payments increased by 88 percent. After the implementation of the PPS, the rate of growth for Medicare hospital payments steadily declined until 1987. In 1987, the administrative payment system was changed. This resulted in an increase in the payment rate. Also, in 1987, legislative changes increased the amount of reimbursement to hospitals for medical education, capital costs, and disproportionate share payments.¹⁰ From 1985 to 1990, the payment rate decreased by 52 percent, and from 1990 to 1995 the payment rate decreased by 37 percent.¹¹

The Prospective Payment System

In response to payment growth, Congress adopted a prospective payment system to curtail the amount of resources the Federal Government spent on medical care for the elderly and disabled. The Social Security Amendments of 1983 mandated the PPS payment system for hospitals, effective in October of Fiscal Year 1983.¹²

The system was intended to motivate hospitals to change the way they deliver services. With DRGs, it did not matter what hospitals charged anymore -- Medicare capped their payments.

Congress had four chief objectives in creating the PPS:

1. To ensure fair compensation for services rendered and not compromise access to hospital services, particularly for the more seriously ill;
2. To ensure that the process for updating payment rates would account for new medical technology, inflation, and other factors that affect the cost of providing care;
3. To monitor the quality of hospital services for Medicare beneficiaries; and
4. To provide a mechanism through which beneficiaries and hospitals could resolve problems with their treatment.¹³

Congress gave primary authority for implementing the system to the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA). It also assigned responsibilities to outside, independent organizations to ensure that the medical profession, hospital industry, and Medicare beneficiaries had the opportunity to provide input on the creation and implementation of the system.

The Role of the Prospective Payment Assessment Commission (ProPAC)

In 1986, Congress created the ProPAC to participate in setting and updating the DRG rates.¹⁴ This congressional commission was given the responsibility to evaluate the performance of the executive and legislative branch on the management of the PPS. The commission was comprised of 17 experts in health care delivery, finance, and research who were appointed by the Director of the congressional Office of Technology Assessment.

The ProPAC had two statutory responsibilities:

1. To recommend mechanisms for updating hospital payment rates to the Secretary; and

2. To recommend necessary changes in DRGs to the Secretary, including the advisability of establishing new DRGs, modifying existing ones, or changing the relative weights.¹⁵

To ensure that ProPAC had the requisite information to perform these responsibilities, Congress mandated that ProPAC have access to all relevant information, data, and research. Congress also mandated a formal schedule of public communications between ProPAC and the Department with respect to the annual updating of hospital payment rates.¹⁶ As regulated by the Balanced Budget Act of 1997, ProPAC and the Physician Payment Review Commission merged to become the Medicare Payment Advisory Commission (MedPAC). The ProPAC's statutory duties are retained in MedPAC's statutory mandates.¹⁷

The Role of Peer Review Organizations

Congress required HHS to contract with peer review organizations to monitor:

1. the validity of diagnostic information supplied by hospitals for payment purposes;
2. the completeness, adequacy, and quality of care provided to Medicare beneficiaries;
3. the appropriateness of admissions and discharges; and
4. the appropriateness of care in "outlier" cases in which additional Medicare payments were made.¹⁸

The basic responsibility of peer review organizations is to ensure that Medicare hospital services are appropriate, necessary, and provided in the most cost effective manner. The peer review organizations have considerable power to force hospitals' to comply with HHS admission and quality standards. They may deny payment to hospitals where abusive practices are found and, in some instances, report such practices to HHS for further enforcement action.

PART II: Developing and Rating DRG Codes

A key part of PPS is the categorization of medical and surgical services into diagnosis-related groups (DRGs). The DRGs “bundle” services (labor and non-labor resources) that are needed to treat a patient with a particular disease. The DRG payment rates cover most routine operating costs attributable to patient care, including routine nursing services, room and board, and diagnostic and ancillary services.¹⁹ The CMS creates a rate of payment based on the “average” cost to deliver care (bundled services) to a patient with a particular disease. The DRG rates do not expressly include direct medical education costs, outpatient services, or services covered by Medicare Part B.²⁰ For fiscal year 2002, there are 499 DRGs with a prospective price based on the average resources used in treating patients under the specific DRG.²¹

DRG Classification System

The DRGs classify all human diseases according to the affected organ system, surgical procedures performed on patients, morbidity, and sex of the patient.²² The classification also accounts for up to eight diagnoses in addition to the primary diagnosis, and up to six procedures performed during the stay.²³ For example, a trauma patient with broken limbs and organ injuries involving multiple body systems would receive a principal diagnosis for the most severe condition. The physician also would record additional diagnosis and procedures used to treat this patient.

The Claims Process

The classification process begins with the physician’s documentation of the patient’s principal diagnosis, secondary diagnosis and other factors affecting the patient’s care or treatment (referred to as complications and co-morbidities).²⁴ This information is submitted to the hospital’s medical records department where a medical record coder assigns diagnostic and procedures codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9). The hospital then sends the data electronically to its fiscal intermediary on a claim form known as a UB-92.²⁵ The fiscal intermediary is a private company that has contracted with Medicare to process bills and pay claims for Medicare Part A services.

The fiscal intermediary inputs these data into its claims processing system, referred to as the Medicare Code Editor. The system is designed to screen all cases and sort out those cases that require further review before classification into a DRG. Following this screening process, the fiscal intermediary, using an automated algorithm called “Grouper,” groups all discharge cases into one of 25 Major Diagnostic Categories (MDCs) before assigning it to 1 of the 499 DRGs.²⁶ Most of the MDCs are based on the body system involved and disease types. For example, MDC 1 involves diseases and disorders of the nervous system and MDC 2 involves diseases and disorders of the eye. A few MDCs involve more than one organ system. For example, MDC 22 is the classification for burns and involves more than one

organ system, such as the respiratory and circulatory systems. The fiscal intermediary electronically submits a data file (referred to as the Medicare Provider Analysis and Review file) to CMS containing all the charge data that has been assigned to each DRG.²⁷

DRG Weights

The CMS assigns a unique weight to each DRG. The weight reflects the average level of resources for an average Medicare patient in the DRG, relative to the average level of resources for all Medicare patients.²⁸ The weights are intended to account for cost variations between different types of treatments. More costly conditions are assigned higher DRG weights. For example, the fiscal year 2001 DRG weights range from .5422 for a concussion (DRG 32) to 1.4966 for viral meningitis (DRG 21) to 19.0098 for a heart transplant (DRG 103).²⁹

Calculating DRG Weights

The methodology for calculating the DRG weights has been refined over time, but the core process remains the same. Patient charges are standardized to remove the effects of regional area wage differences, indirect medical education costs, and additional payments to hospitals that treat a large percentage of low income patients (referred to as “disproportionate share payments”). Cost of living adjustments are removed for hospitals in Alaska and Hawaii.³⁰ The average standardized charge for each DRG is calculated by summing the charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.³¹ Statistical outliers – those cases outside three standard deviations of the average charge for each DRG, are eliminated. The average charge for each DRG is re-computed and then divided by the national average standardized charge per case to determine the weighting factor.³²

DRG Payment Factors

All services provided by the hospital, except physician services, must be furnished by the hospital directly or through arrangements with another in order to receive payment under the PPS.³³ Each hospital knows its payment rate prior to the beginning of its fiscal year. To arrive at a basic price for a given service for a particular patient, each Medicare patient discharged by a PPS hospital is first assigned to a DRG that has a corresponding DRG weight. The DRG weight is multiplied by the hospital’s payment rate per case. All hospitals are reimbursed on the basis of one of two Federal rates--“large urban” or “other.”³⁴ These rates are adjusted to reflect differences in prevailing wage rates.

The DRG payments are further adjusted to take into consideration four factors which are considered to reflect more accurately the costs of services provided by hospitals:

1. Application of a Wage Index

Salaries generally represent the largest component of hospital costs. Prevailing salary levels vary substantially among different areas of the country. Use of a single national or regional DRG payment for all hospitals, without any consideration of prevailing wages, would

severely penalize hospitals located in high-wage areas and unfairly benefit hospitals located in low-wage areas. The CMS adjusts Federal DRG rates to reflect prevailing wages in the local area which is defined as either large urban, or other. The CMS publishes annually an index of prevailing relative wages for each area. As a result, DRG payments in high-wage areas are greater than DRG payments in low-wage areas.³⁵

2. Indirect Medical Education Costs

Teaching institutions are assumed to have higher costs than other institutions due to extra tests and procedures performed for teaching purposes and the treatment of more serious cases. Accordingly, the DRG payments for these hospitals are increased by a percentage based on the ratio of interns and residents to hospital beds.³⁶

3. Cost Outliers

Medicare makes additional payments for cases with extremely high overall costs, commonly referred to as “cost outliers.” The CMS annually establishes the limits that must be met to qualify for “cost outlier” payments. If the cost of a particular case exceeds the limits, the hospital may qualify for a cost outlier payment. Cost outlier payments are not automatic; a hospital must make a specific request and must identify the actual costs associated with each outlier case.³⁷

4. Disproportionate Share Payments

Disproportionate share hospitals are hospitals that treat a large percentage of low income patients, including Medicaid and Medicare beneficiaries. The CMS makes additional payments to hospitals that qualify to account for the cost of treating this population.³⁸

Other Special Payment Factors

In addition to the four factors discussed above, there are other factors considered in calculating DRG payments depending on whether the hospital is considered a sole community hospital, a Medicare dependent rural hospital, or a regional referral hospital. In each instance, there are special payment rules. A hospital may be designated as a sole community hospital if, among other things, it is (1) located more than 35 miles from another hospital, (2) the sole source of inpatient hospital services in a geographic area, or (3) designated by the Secretary as a “critical access hospital.”³⁹ A Medicare dependent rural hospital is one that depends on Medicare for at least 60 percent of its patient days or discharges. A regional referral hospital is one that serves as a referral center for other hospitals in its area.⁴⁰ These hospitals are reimbursed according to the payment rate for large urban areas.

Congress recognized that the DRG system does not adequately capture the costs for some specialized hospitals. Accordingly, some hospitals are exempt from the system. These include psychiatric, cancer, long-term care, children’s, and rehabilitation hospitals. However, PPS systems are currently being developed for rehabilitation and long-term care hospitals.⁴¹

Calculating DRG Payments

Calculating DRG payments involves a formula that accounts for the adjustments discussed in the previous section. The DRG weight is multiplied by a “standardized amount,” a figure representing the average price per case for all Medicare cases during the year. The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban, or other area. The labor component is then adjusted by a wage index.⁴² If applicable, cost outlier, disproportionate share, and indirect medical education payments are added to the payment.

The following case study illustrates how DRG payments are calculated:

Payment Case Study

Sara, a 72 year old widow, fell off of her front porch. An ambulance transported her to Generic Hospital, a Medicare-certified hospital in San Francisco. She is diagnosed with an open fracture of the left femur requiring surgical intervention. In addition, the physician determines from her medical history that she has non-insulin dependent diabetes with associated peripheral vascular disorders

Step 1: Calculating the Standard Rate

The PPS rate calculation begins with the “standardized amounts.” The standardized amounts are composed of a labor and a non-labor component. The large urban rates are used because San Francisco is in the large urban category.

Generic Hospital’s **Standard Federal Rate** this year consists of the two categories of base operating costs, adjusted for large urban areas:

Labor related	\$2,809.18
Non-labor related	\$1,141.85

Step 2: Adjusting for the Wage Index Factor

The labor-related portion of the standardized amount is adjusted for area differences in wage levels by using the wage index factor. The wage index is calculated from a cost of living adjustment and earnings by occupational category. This year, the wage index for San Francisco is 1.4193.

The labor portion of the Standardized Federal Rate is multiplied by the wage index factor to adjust Generic Hospital's DRG base rate:

$\$2,809.18 \times 1.4193 = \$3,987.07$ (adjusted labor rate for San Francisco)
 $\$3,987.07 + \$1,141.85 = \$5,128.92$ — Generic Hospital's Adjusted Base Rate

Step 3: Adjusting for the DRG Weight

The DRG weight reflects the level of treatment expected for an average patient in this DRG. The relative weight for the hip and femur procedure is 1.8128. This weight is multiplied by the labor and non-labor components calculated in step 1.

Based on the ICD-9 codes, this case was classified as surgical MDC 8, Hip and Femur Procedure, except that the femur is not a major joint, Sara is older than age 17, and she has comorbidities or complications (Diabetes).

$$(\$3,987.07 + \$1,141.85) \times (1.8128) = \$9,297.71$$

Step 4: Disproportionate Share Payment

Medicare-contracted hospitals that provide a disproportionate percentage of care to Medicaid or Medicaid eligible patients who are not eligible for Medicare Part A may qualify for PPS adjustments. The CMS applies this payment adjustment to the Generic Hospital's DRG revenue for inpatient operating costs.

Generic Hospital qualifies as a *Disproportionate Share Hospital* and receives additional funds. This rate is 0.1413. Generic's base payment rate is multiplied by this rate.

$$(\$9,297.71) \times (1 + 0.1413) = \$10,611.47$$

Step 5: Indirect Medical Education Payment

Teaching hospitals that have medical residents may receive an added payment. This payment is based on the number of full-time equivalent residents, number of hospital beds, and number of discharges. The base payment rate is multiplied by the adjustment factor for Indirect Medical Education plus the Disproportionate Share Hospital (DSH).

The adjustment factor for Indirect Medical Education is 0.0744. This rate is added to the DSH factor plus 1 to give the Hospital an adjustment rate of:

$$1 + 0.1413 + 0.0744 = 1.2157.$$

The payment the hospital can expect to receive for this case is:

$$\$9,297.71 \times 1.2157 = \$11,303.23$$

Step 6: Outlier Payments

The CMS provides an additional payment for beneficiaries whose lengths of stay or costs exceed the threshold rate.

The hospital cost for Sara's care was \$9,983.64. She stayed in the hospital for 5 days. The hospital was paid \$11,303.23 by Medicare. If the cost of her care had exceeded the payment rate by \$14,050, Generic Hospital could request an outlier payment.

PART III: Updating DRG Classifications and Weights

Updating the PPS is a complex and lengthy process. It is a two-part process in which CMS has primary responsibility for creating or modifying new DRGs and making necessary changes to the relative weights, and MedPAC makes recommendations to CMS and Congress on how to update the PPS.

The Social Security Act requires CMS to adjust the DRG classifications and relative weights annually.⁴³ Throughout the calendar year, CMS receives comments from the public and other interested parties. In December and January, CMS compiles a list of issues to be addressed through the updating process. CMS awarded a contract to Minnesota Mining and Manufacturing (3M) Corporation, a company specializing in health information systems development to maintain and update the DRG classification.⁴⁴ The 3M Corporation addresses those issues related to updating the DRG classification.⁴⁵ CMS internally handles issues related to updating the DRG weights. In May, CMS publishes its proposed updates in the Federal Register for public comment. It is required to respond to each comment received. In August, CMS publishes its final updates, which are effective in October of that year.⁴⁶

The process involves: (1) updating and reclassifying existing DRG codes, as well as creating new codes; (2) updating the DRG weights; and (3) adjusting the wage index. The updates are performed to account for:

1. inflation, hospital productivity and new technology,
2. changes in resource consumption due to technology and other factors, and
3. changes in treatment patterns, technology and other factors that may change the use of hospital resources.⁴⁷

The CMS Process

CMS reclassifies the DRGs and recalibrates the DRG weights to decide what changes are necessary to compensate adequately for costs under PPS. The recalibration and reclassification processes are integrally related. The reclassification update occurs first, followed by recalibration of the weights.

Updating DRG Codes

The process by which the DRG codes are updated is called reclassification. It involves not only an assessment of the appropriateness of the DRG assignment within MDCs, but it also entails reclassifying the codes to account for new medical technologies and treatment patterns.

The 3M Corporation provides CMS with recommendations for modifications to the DRG system including changes to the DRGs based on new ICD-9 codes.⁴⁸ Using a sample of Medicare cases from a 2-year old MedPAR file, 3M performs statistical analyses to

determine whether potential DRG modifications are warranted. The analyses determine whether the cases of patients classified within a DRG have a similar pattern of resource intensity and whether they contain similar characteristics based on common organ systems (commonly referred to as “clinical coherence”).⁴⁹

Examples of DRG modifications may include adding new MDCs, creating new DRGs, redesigning classes of DRGs, or splitting DRGs to increase classification specificity. When such modifications are implemented, they are tracked for 2 years to determine whether they are appropriate. In 1998, CMS implemented a final rule in which it reclassified the DRGs for burn cases to account for the variation in resources associated with the different severity levels of burn patients.⁵⁰ This reclassification was done after a 2-year review of the cases within the DRG. The review assessed whether or not changes in resource use were valid.

Updating DRG Weights

The process by which the DRG weights are updated is referred to as recalibration. Through recalibration, CMS updates the DRG system to account for changes in medical practices, technology, and the range of cases within the DRGs (commonly referred to as “case complexity”). Recalibration ensures that the weights accurately reflect the value of resources used for each patient classification. The Social Security Act requires CMS to recalibrate the DRG weights in a manner that maintains “budget neutrality” of the total program. Budget neutrality requires that the estimated payments for the hospital benefit are not greater or less than 25 percent of the payment amounts that would have been payable for the same services in Fiscal Year 1984.⁵¹

DRG recalibration follows the reclassification updates. The CMS recalibrates the DRGs from bills received from all hospitals that are under PPS. The recalibration process begins when all the cases in the Medicare Provider Analysis and Review file are regrouped using the DRG reclassification updates. A national standardized average charge is created by performing a statistical analysis to remove the differences in area wage levels, indirect medical education and disproportionate share hospitals payments and the cost-of-living adjustment factor for hospitals in Alaska and Hawaii.⁵² An average standardized charge is calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. Cases above or below the average standardized charge by a specified amount (statistical outliers) are eliminated. After eliminating the statistical outliers, the average charge for the DRG is then re-computed and divided by the national average standardized charge to determine the relative weight for each DRG.⁵³

Updating the Wage Index

The CMS is required to make annual updates to the wage index.⁵⁴ This process involves adjustments to the standardized amounts in hospital wages in different geographic areas throughout the country. The standardized amounts are adjusted by a factor that reflects the relative hospital wage level in a given geographic area compared to the national average

hospital wage level.⁵⁵ The CMS must base the updates on several factors, which include a survey of wages and wage-related costs of short-term, acute care hospitals. The survey measures the salaries, paid hours of employment by occupational category, home office costs and hours, and certain contract labor costs and hours. The update to the wage index excludes the wages and wage-related costs for skilled nursing facility and home health services as well as the wages for other provider areas which are not subject to PPS.⁵⁶

Medicare Payment Advisory Committee's Process

MedPAC's (formerly ProPAC) involvement in the updating process is mandated by statute.⁵⁷ The Commission has 17 members (appointed by the Comptroller General of the General Accounting Office) who bring a wide range of expertise in the financing and delivery of health care services. The Commission is supported by a full-time executive director and a staff of approximately 30 analysts. Analysts typically have backgrounds in economics, health policy, public health or medicine.⁵⁸ The Commission's recommendation process begins in June when it meets to set its policy agenda for the coming year. During the summer months, Commission staff conduct research on the issues set forth in its policy agenda. Beginning in September, the Commission begins a series of 2 day public meetings to discuss the results of its research and to formulate recommendations to CMS and Congress.⁵⁹

The Commission releases its recommendations in two reports, which are required by statute to be issued in March and June of each year. MedPAC's recommendations may involve specific issues related to the DRG updating process or more global considerations related to PPS and Medicare payment policy. The MedPAC does not embark upon a systematic review nor does it use the CMS methodology to update DRG classification and weighting factors. Through its reporting and recommendation processes, it conducts broader analysis related to Medicare payment. Over the years, MedPAC has (1) looked at issues related to improving the quality of care, (2) made recommendations for developing prospective payment systems for various provider categories, and (3) suggested ways to improve payments for end-stage renal diseases services. Recently, however, the MedPAC has focused on specific issues pertaining to the DRG updating process.

MedPAC's June 2000 Recommendations for Updating PPS

In its June 2000 report to Congress, MedPAC specifically outlined recommendations for updating and refining the DRG classification and weighting methodologies. MedPAC recommended updating the system by:

1. changing the DRG definitions to account more completely for severity differences among patients,
2. altering the methods currently used to calculate the DRG weights, and
3. changing the method of financing extra payments for outlier cases.⁶⁰

The MedPAC recommended refinement of the DRG definitions and relative weights to improve payment accuracy. It recommended that CMS adopt the All Patient Refined

Diagnosis Related Groups patient classification system. This system differs from the current DRG system in how information about patients' secondary diagnoses is reported on hospital claims. It also recommended calculating the DRG weights using hospital-specific relative values.

The MedPAC maintains that the use of refined DRGs and weights based on hospitals' relative values would more accurately reflect the relative costliness of typical cases in each DRG. It conducted an evaluation of its proposed changes and the current DRG classification and weighting system.⁶¹

The CMS Response to MedPAC's Recommendations

CMS responds to MedPAC's recommendations in the same manner that it responds to the general public's comments — through the public comment process in the Federal Register. CMS systematically responds to each MedPAC recommendation. Some of the recommendations are implemented, others are not. Some of MedPAC's recommendations would require legislative changes which are beyond CMS' control. In response to MedPAC's June 2000 recommendation that the Secretary should adopt the All Patients Refined Diagnosis Related Groups, CMS agreed that this change would reduce discrepancies between payments and costs, but declined to adopt such a change because it would not be able to predict with accuracy how such a change may affect coding behavior. Furthermore, CMS believes that such a change would require specific legislative authority.⁶²

PART IV: Issues for Consideration

Previous Issues Considered by the Office of Inspector General

Over the years the Office of Inspector General has studied numerous issues related to the DRG-PPS including reports on:

- CI Overpayments for patient transfers under the PPS system;
- CI Improper Medicare payments to hospitals for nonphysician outpatient services;
- CI Monitoring of DRG upcoding;
- CI Monitoring of hospital payments for specific DRGs; and
- CI The effects of the PPS on access to skilled nursing facilities.

Current Issues for Consideration

Factors such as technology development, access to and timeliness of information, and the coding of the DRGs have an impact on the future of PPS. The following issues have been identified as areas for further consideration:

1. Do annual updates adequately reflect changes in technology?
2. Does CMS' 2-year forecasts of the market basket of costs adequately adjust for inflation?
3. Do current review processes adequately verify the validity of diagnostic information supplied by providers?
4. Are the non-MedPAR data sources adequate for updating the DRGs?
5. Does the budget neutrality requirement constrain CMS' ability to update the DRG classifications and weights?

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41. See generally 42 C.F.R. §412.23.

42. 42 C.F.R. §§412, 413.
43. 42 C.F.R. §412.10(a).
44. See, *Health Care Financing Administration Awards Contract to 3M for Maintenance and Update of the Diagnosis Related Groups and Related Software Systems* at, http://www.3M.com/market/healthcare/his/us/news/news-archive/june_1999.html.
45. Telephone Interview with Amy Gruber, Program Analyst, Centers for Medicare & Medicaid Services, in Baltimore, MD (Apr. 27, 2001).
46. Id.
47. 42 C.F.R. §412.60(e). (2000).
48. Telephone Interview with Amy Gruber, Program Analyst, Centers for Medicare & Medicaid Services, in Baltimore, MD (Apr. 27, 2001).
49. 42 C.F.R. §412.10(b)(1) (2000).
50. 64 Fed. Reg. 41489, 41494 (Jul. 30, 1999).
51. 42 U.S.C. §1395ww (2000).
52. 42 C.F.R. §412.62(h)(i) (2000).
53. 64 Fed. Reg.41489, 41499 (Jul. 30, 1999).
54. 42 U.S.C. §1886(d)(3)(E) (1993).
55. 65 Fed. Reg. 47055, 47070 (Aug. 1, 2000).
56. Id.
57. Social Security Act, 42 U.S.C. §1805(a) (1997).
58. Pub. L. 105-33, Title IV §4022(c), 111 Stat. 355 §1395(b)(6) (1997).
59. Medicare Payment Advisory Commission, *Report to Congress: Improving Medicare's Payment for Inpatient Care and for Teaching Hospitals*, at 54 (June 2000).
60. Id.
61. Id.
62. Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2001 Rates, 65 Fed. Reg. 47025, 47103 (Aug. 1, 2000).