

DRG-Based Hospital Payment System Design and Related Issues

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1300-1700

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Many OECD countries have recently or soon plan to implement a DRG-based prospective hospital payment system in an attempt to meet a number of policy goals, including: 1) a better allocation of payments and revenues across services and hospitals; 2) financial incentives to improve “technical efficiency” at the individual hospital level; 3) an increase in overall system efficiency in order to meet regional or country-level expenditure caps; and 4) other social/policy goals. Most of the OECD systems recently implemented have followed the US Medicare model for structuring and developing per DRG payments. While the Medicare Prospective Payment System (PPS) has achieved a degree of success in restraining hospital expenditures, the system suffers from some deficiencies relating to resource allocation for an All-Payer population (PPS was designed for an elderly population), alignment of incentives across hospitals and payers, and other payment equity considerations. For over 35 years the Maryland All-Payer Hospital Rate Setting system has been an innovator in the area of DRG-based prospective hospital payment system. While the Maryland system has many features that are similar to the Medicare PPS, it was designed to cover an All-Payer population and be responsive to unique regional and hospital-specific circumstances. The Maryland System is the first system to incorporate the use of All Patient Refined (APR) DRGs into its payment methodologies. The System also employs a unique payment structure that more effectively aligns the incentives of both hospitals and payers. The structural aspects of the system lend themselves to the implementation of hospital rate setting in a more equitable and responsive way, and generally allows for the more appropriate allocation of revenues (to match reasonable and efficient resource use) across services, hospitals and regions. This half-day training session will present a description of the structural components of the Maryland Payment System, contrasting it with the Medicare PPS. It will also discuss specific technical issues and considerations in the implementation of prospective DRG-based payment such as data requirements (cost and case mix data), structural design considerations, the mechanics of rate setting and key issues in DRG rate development (weight development, DRG creep, coding issues, and outlier exclusions), with illustrations of actual experience with Maryland hospital data. The presentation will also touch on options for integrating quality measures into an All-Payer Hospital DRG-Based payment structure. This session is appropriate for individuals involved in

hospital payment design or those interested in learning more about state of the art hospital payment design and alternative approaches to hospital payment design.

Course Outline:

1) Economic Rationale and Policy Objectives of a Prospective Hospital Payment System (15 min)

2) Overview Key Payment System Features (30 minutes)

- Data requirements
- Establishing the structure of payment
- Setting base rates for each hospital
- Annual updating of base hospital rates
- On-going monitoring, compliance and control
- Link to regional or country global hospital expenditure limits

3) Payment System Design and Incentive Considerations (30 minutes)

- Unit of payment vs. unit of constraint
- Bottom-up rate development vs. top-down rate development
- Payment structure options (per service, per day, per case, per capita)
- Data Requirements (cost and volume data and case mix data)
- Payment Design options (unit of payment vs. unit of constraint)

4) Data Requirements (30 minutes)

- Cost/volume data and output measures – collection and primary uses
- Case mix data and coding – collection and primary uses
- Other data requirements

5) Key DRG Payment Issues (60 minutes)

- Mechanics of a All-Patient DRG hospital payment and constraint system
- Weight Development considerations and issues
- DRG coding practices and DRG creep and policy responses
- Exclusions, trims methodologies and other potential adjustments to payments

6) Other Related Issues – Outpatient Payment Design and Quality Reimbursement (30 minutes)

7) Summary (15 minutes)