DRGs—The First Year

MUNICIPAL HOSPITAL BONDS DOWNGRADED: “ONEROUS REIMBURSEMENT ENVIRONMENT”

The Society of Nuclear Medicine’s Executive Director, Henry L. Ernstthal, has been keeping close track of the impact of diagnosis-related groups (DRGs) on the health care profession in general, as well as their implications for the future practice of nuclear medicine. At the Board of Trustees meeting earlier this year, Mr. Ernstthal presented a comprehensive overview of this cost-containment experiment, published here for the interest of Newsline readers.

In the first year, diagnosis-related groups (DRGs) accounted for 25 percent of Medicare funding. Since most hospitals have about 40 percent of their costs reimbursed by Medicare, DRGs control 10 percent of hospital revenue.

The most significant impact, in my mind, is the downgrading in not-for-profit municipal hospital bond ratings—despite the fact that capital costs are permitted to be passed through.

In a recent quarter it was reported that 33 offerings were downgraded, and only eight upgraded. That number was the highest in downgrades for all municipal bond categories, and the reason given by analysts was “increasingly onerous reimbursement environment.”

Should this trend continue, and there’s no reason to believe it will not, there are significant implications for a capital-intensive modality of care such as nuclear medicine. It’s interesting to note that the Health Care Financing Administration (HCFA) was required to report to Congress by October 1, 1984, on capital costs.

That report has not yet been rendered.

In part, as a response to this uncertainty in access to capital markets, there’s a very strong push for merger acquisitions and joint ventures in medical institutions, according to the American Hospital Association (AHA). The benefits include joint funding of advertising, joint purchasing systems, and joint services.

Hospital chains

According to the chairman of the AHA’s Council on Finance, the small health care institution in the future will only be able to exist as part of a chain.

Recently, 26 hospitals each contributed $125,000 to develop a for-profit joint venture, American Health Care Systems, incorporating 233 hospitals in 21 states, 45,000 beds, and combined revenues of $6 billion. This group plans a division to create for-profit health maintenance organizations (HMOs) and prospective payment organizations (PPOs), an arm to raise capital for member institutions, and a lobbying group.

There is also a strong, increased pressure from the business community to deal with the problem of health care costs.

According to a report in Forbes magazine (Oct. 15, 1984), 150 business coalitions have formed to deal with health care, 60 percent of which were established since 1982. Many of these coalitions have no direct input from physicians or hospitals.

These coalitions collect cost information from various institutions and publish data to encourage their employees to seek health care at lower-cost institutions.

Businesses are either renegotiating health care employee benefits or increasing copayments and deductibles.

Another external pressure today on medicine is the federal budget deficit. Although federal health care expenditures are not part of the deficit, there will be pressures to reduce spending. In addition, the public will be relatively indifferent to these budget cuts. Surveys show that the public does not perceive health care as an important issue.

Decline in admissions

According to Hospital Week (Feb. 1, 1985), hospitals experienced a sharp 2.0 percent decline in the overall admissions rate during the third quarter of 1984, sinking to 1978 levels. Length of stay for patients under 65 years of age decreased from 5.7 to 5.6 days; length of stay for patients 65 and older continued its precipitous drop from 8.8 days.

In response to these declines, full-time equivalents decreased 3.2 percent over the five quarters prior to third-quarter 1984, and the trend continues.

Medicaid is considering a DRG approach in 27 states, and they are in use in some areas, including Utah. Other third-party payers are responding furiously to the cost shift.

The Health Insurance Association of America has been publishing ads calling for, in essence, an “all-payer” system. The insurers call it a “fair payment” system, and say it “con-
DRGs...
(continued from page 339)

tains exploding hospital costs."

Blue Cross/Blue Shield in at least four states is negotiating a DRG system. In a particularly interesting development, several major third-party insurance companies have formed joint ventures with, or bought out, consulting firms whose principals participated in the Yale group that developed the DRG system.

We know that the issue of DRGs for physician fees may be addressed directly by Congress next year. In anticipation of that event, HCFA has requested proposals for the development of a relative value scale (RVS). The American Medical Association (AMA) has responded with an offer that would impact all medical procedures in Current Procedural Terminology (CPT-4).

The American College of Surgeons (ACS) and the American College of Physicians (ACP) are jointly responding to the request for proposal as well. Their proposal, they tell me, does not include the development of RVS units relating to nuclear medicine, radiology, and the ancillary services.

If HCFA accepts the ACS and ACP proposal instead of the AMA’s, it is uncertain how that agency will deal with nuclear medicine. There are also serious legal and anti-trust issues relating to RVS.

Loss of local control
One of the significant consequences of chain hospitals is a shift from a local board of trustees to a remote board less amenable to pressure and input from the local community.

There is also a basic power shift involving new decision makers, such as chief financial officers, data processing managers, and purchasing agents. With a large chain, it does not appear that an individual institution, much less an individual department, will be free to make its own purchasing decisions.

As anticipated, there are short-term pressures on the referring physician to be careful in ordering tests. The AMA has adopted a checklist, with such questions as: Are charges printed on order forms for lab tests and x-rays? Do you schedule diagnostic tests or procedures on an outpatient basis whenever feasible? Do you know the costs of the services that you order?

The supplier community is beginning to respond by advertising the cost/benefit of their products.

Nuclear medicine must make the case for cost-effectiveness. I have been unable to find significant work that deals with the cost-effectiveness of nuclear medicine beyond the scope of its replacement for another imaging technique. To survive in this austerity era, we need to look hard at the consequences of a nuclear medicine study in terms of speed to diagnosis, differentiating this specialty from other hospital resources.

[To thoroughly examine the cost-effectiveness of nuclear medicine, the Society’s Executive Committee has decided to support the development of a study by a professional health care consulting firm, and to investigate funding by foundations and government sources.]

32ND SNM ANNUAL MEETING

T
housands of nuclear medicine professionals will attend the Society’s 32nd Annual Meeting, June 2-5, at the Albert Thomas Convention and Exhibit Center in Houston, TX.

Under the direction of Philip O. Alderson, MD, the 1985 Scientific Program Committee has organized nearly 600 peer-reviewed papers, posters, and exhibits into a compendium with subjects ranging from single-photon emission computed tomography (SPECT) to monoclonal antibodies. Based on 1,081 abstracts submitted, up 5.5 percent over last year, the meeting promises a comprehensive view of developments in nuclear medicine not only within the United States but in Europe and Japan as well.

At the heart of the clinical program, a series of continuing education sessions, coordinated by C. Leon Partain, MD, PhD, will include: measuring epithelial and endothelial cell function in the lung with radioaerosols, labeled amines, and other tracers; brain perfusion tomography using two amines, N-isopropyl p-iodoamphetamine and HIPDM labeled with iodine-123; immunotherapy with labeled monoclonal antibodies; and orthopedic application of tomographic bone imaging.

In the chemistry section, radiopharmaceuticals for the heart and brain, receptor binding, and a comparison of fluorine-18 and carbon-11 form the core of the program. Courses on SPECT, NMR, scintillation camera technology, and picture archiving and communication systems (PACS) comprise the physics track. The PACS course will discuss the long-term goal of many investigators, namely, a filmless nuclear medicine and radiology service.