Commentary

Who Bears Legal Liability Under DRG Management?

As recently as February 1985, the American Medical Association (AMA) stated that medical malpractice claims are causing a financial crisis within the health care arena. Americans enjoy the highest standard of medical care in the world, yet here exists the highest number of malpractice suits. In 1984, 16% of practicing physicians faced lawsuits, an increase of 20% over 1983 (*1*).

"Ninety-plus percent are totally without merit," said Dr. James Sammons, executive vice president of the AMA and chairman of a task force on malpractice. "The strange irony of it all is, it's the good guys who get sued, the specialist in the field. They're at the greatest risk (2)."

"This," said Dr. Sammons, "has lead to defensive medicine. If you're living under the threat that every time you turn around you're going to be sued, whether it's legitimate or not, you're going to make decisions to protect yourself (2)."

In early 1983, President Reagan signed into law a piece of legislation known to health care practitioners as the Prospective Payment Plan, designed to regulate Medicare payments to hospitals. Payments are based on a classification system known as Diagnosis Related Groups (DRGs) that are intended to improve efficiency within the health care delivery system. This law has brought numerous changes in the way hospitals are being managed. What were once known as profit centers (i.e., Radiology, Laboratory, etc.) are now seen as cost centers for the hospital (*3*). Now it is desirable for hospitals to minimize the use of hospital-based diagnostic services in an effort to contain the cost of a hospital stay. Herein lies the problem of practicing "defensive medicine." Physicians are faced with demanding patients expecting perfection in this era of high technology, while health care managers are trimming budgets and struggling to operate within the government guidelines to keep the hospital solvent.

As hospital managers strive to operate more efficiently and cut costs to remain solvent, physicians are asked to minimize the use of diagnostic and therapeutic services. This policy may increase individual physician liability. Who will ultimately bear the burden of rising malpractice awards?

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HISTORY OF THE PROSPECTIVE PAYMENT SYSTEM AND DRG

Increasing federal deficits and the imminent insolvency of the Hospital Insurance Trust Fund, which funds Medicare, has forced the government to review and embark on a plan to save the Trust Fund from bankruptcy by controlling the rising costs of health care. During the administration of President Carter, numerous proposals to revise the reimbursement process, develop more competitive plans, and create incentives for patients to choose more economical health care received considerable attention (*4*).

In 1980, the price tag for health care in the United States was $223 billion, an increase of 15% over 1979. Of this total expenditure in 1980, Federal Medicare and Medicaid payments accounted for 23%, representing a figure five times the 1970 cost of $10 billion (*5*). The largest expenditure for Medicare is hospital in-patient care (representing 67% of the total Medicare cost); traditionally characterized by cost-based reimbursement, medicine has displayed several inherent problems identified by the government as follows (*6,7*):

1. Insufficient incentives to control costs.
2. Lack of rewards for efficiency.
3. Costly intrusive regulatory structure.
4. Unacceptable increases in hospital expenditures.

The Reagan Administration drafted and Congress passed new cost-containment legislation in 1981 and 1982. With a federal deficit of nearly $200 billion, drastic measures to curtail the health care costs were inevitable. In response to this budget crisis, Congress approved The Omnibus Budget Reconciliation Act of 1981 and The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which caused significant restructuring of the type and level of reimbursement allowed to hospitals under the Federal Medicare and Medicaid Programs.

On April 20, 1983, President Reagan signed into law a third bill, The Social Security Amendments Act of 1983. This bill contained a plan known as the Prospective Payment System (PPS) which was designed to regulate Medicare hospital payments. The plan is based on a payment formula derived from a hospital classification system known as DRGs. This system was developed by researchers at Yale in the late 1970s.

The PPS establishes the total reimbursement a hospital will receive from Medicare for treating patients. Reimbursement

is predicated on which of the 467 DRGs the patient is assigned to at the time of discharge. Hospitals incurring costs less than the DRG price are allowed to keep the savings; conversely, costs exceeding the DRG price must be absorbed by the hospital. This system became effective on October 1, 1983, with a few exceptions. The law allows states to apply for waivers from the PPS. If the state meets 12 specific requirements, the Secretary of Health and Human Services may at his/her discretion grant a waiver. Four states, New Jersey, New York, Massachusetts and Maryland, have successfully applied for and received waivers.

The PPS, being phased into action over a period of three years, will be in full effect by October 1, 1986. The law has specified that the following studies be submitted to Congress by the Health Care Finance Administration (HCFA):

1. Annually submitted updates.
2. Potential impact of PPS on skilled nursing facilities—due December 1983.
3. Capital cost study—due October 1984 (not yet released).
4. Study of the extension of PPS to an all-payor system—due January 1985.
5. Study of the impact of PPS on hospital cost information systems—due April 1985.
6. Study on hospitals exempt from PPS—due December 1985.
7. Study of extension of PPS to physician reimbursement—due July 1985.

Fearful that hospitals will shift costs to them, major insurance carriers and other health care consumers have taken steps to implement their own reimbursement systems similar to the DRG system.

The full impact of the PPS will not be known until it is completely implemented in October of 1986. Despite the extensive complex legislation taken to restructure the Medicare reimbursement program, the government still projects that the Hospital Insurance Trust Fund will be insolvent by the mid-1990s.

MANAGEMENT UNDER PPS

It has been estimated that as many as 20% of the existing hospitals in 1983 will be bankrupt by the time the PPS is fully implemented (*12*). The picture is clear to hospital management: If hospitals are to survive, they must reduce the cost of treating patients. It is a well-established fact that physicians control approximately 70% of a hospital's operating cost in the following ways:

1. The number and type of admissions.
2. The length of a patient stay.
3. The use of hospital-based services (i.e., x-rays, laboratory tests, respiratory therapy).

Administrators are exploring ways to implement controls in areas that will financially benefit the hospital. Under consideration are the following methods which are also relevant to nuclear medicine:

1. Decreased use of in-patient ancillary services.
2. Elimination of multiple studies that offer only a marginal increase in diagnostic confidence.
3. Promotion of cost-effective, time-efficient procedures.
4. Expansion of the hospital workday and week.
5. Employment of less costly physicians.
6. Rationing of in-patient ancillary services.

However, this plan of action encompasses a multitude of problems for physicians practicing "defensive medicine" because physicians are being asked to decrease the length of hospital stays and to perform diagnostic work-ups prior to admission.

It has been suggested that, by implementing the PPS, hospital administrators and boards of directors will view only the bottom-line financial results and a deemphasis on quality of patient care will quickly evolve. Congress has taken steps to eliminate this problem by requiring all hospitals to enter an agreement with a Utilization of Quality Care Peer Review Organization (PRO) by October 1, 1984. A PRO is charged with analyzing: the validity of patient diagnosis, the appropriateness of hospital admissions and discharges by reviewing outlier cases (atypical patient cases), and the assessment of the quality of patient care.

The number of physicians has been rapidly increasing since 1970. In 1966, there were 144 physicians per 100,000 population. By 1980, that number increased to 205 physicians per 100,000 population. An oversupply of 70,000 physicians by 1990 and 140,000 by the year 2000 has been predicted by the Graduate Medical Education National Advisory Committee (*4*).

The emphasis to hire less costly physicians has implied an initial degradation of quality. Administrators, however, are hoping that through the use of a properly structured PRO, the predicted surplus of physicians will promote keen competition and higher standards of quality care.

It is difficult for hospital administrators to deny the diagnostic services ordered by a physician. However, if the service is not available, studies cannot be performed within a reasonable time frame. Consequently, diagnoses are made without the benefit of otherwise useful procedures. Management has begun to staff ancillary services on a basis of "average" activity levels rather than the traditional "peak load" accommodations. This strategy is designed to decrease a department's ability to handle unexpected heavy work loads, thereby rationing service availability. On the other hand, incentives to speed the time to diagnosis means longer hours open and a faster turnaround time. There is also a need to give referring physicians a full range of services to maintain patient flow, and the JCAH requires access to nuclear medicine services.

ADDRESSING LEGAL LIABILITY

Is the 20% increase of suits filed in 1984 a reflection of what is developing as a result of the government's efforts to curtail medical costs? The reasons and supporting testimony will not be fully known until the suits have come to trial.

In view of the increasing medicolegal action, pressure is put on hospitals to provide services in a timely fashion. Patients, who are unable to receive a necessary procedure and

subsequently suffer, will seek litigation, and cost hospitals perhaps more than they originally saved through rationing. The legal community has increased its efforts to encourage patients to bring legal action if the patient suspects he has been denied services and suffered needlessly.

The medical community is showing signs of fighting back. The AMA has formed a special task force to address the professional liability crisis and has developed an action plan to include the following:

1. Education and communication to accurately document problems and make issues clear to the public.
2. Judicial reform of state and federal tort to assure equitable and adequate compensation for injuries attributed to medical negligence.
3. Risk control and quality review to collect and analyze information on quality care, provide information on practice management, and strengthen peer review.
4. Endorsement of high quality medicine in the face of government and management efforts to control costs by pressuring physicians to order fewer tests, provide less care, and admit patients less frequently.

As of March 1985, physicians can now check potential patients against existing court records for previous malpractice and negligence suits. This measure is all in an effort to curtail the "professional plaintiffs" who repeatedly use unsuspecting well-meaning practitioners for personal gain.

James S. Terry, historian of the State University of New York's Health Sciences Center, has said, ". . . the goals of tort law have been deterrence of negligence, compensation of injured persons, and retribution against wrong-doers. But there is ample evidence that it no longer fulfills any of these goals adequately. Even worse, it may be unjust, and it is certainly inefficient. Perhaps we should take a long hard look at what we expect of doctors and how we handle unfortunate outcomes of medical care. Perhaps it would be better to abandon the negligence-based medical tort altogether and listen to proposals for "no-fault" systems (*2*)."

In summary, the conflict has just begun. Patients, with increasing expectations of the health care delivery system, are being awarded compensations in the millions of dollars. Hospitals are succumbing to government pressure to implement cost restraints, and physicians are struggling to practice "defensive medicine." This does represent a "Catch-22." The only true benefactor of this situation may ultimately be the legal practitioners who are litigating medical malpractice cases on a contingency consignment basis.

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