# National health care payment ushers in the epoch of the DRG/DIP 2.0

16 January 2025

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To promote the diversified composite payment model, the National Healthcare Security Administration (NHSA) successively issued several policy measures during 2019 to 2020, including the “Technical Specifications for Grouping and Payment of China Healthcare Security Diagnosis Related Groups (CHS-DRG)” , the “Sub-grouping Plan of CHS-DRG (Version 1.0)”, the “Technical Specifications for Diagnosis-Intervention Packet (DIP) Payment in National Healthcare Security” and the “DIP Disease Grouping Database (Version 1.0)”. In 2021, the NHSA further issued the “Sub-grouping Plan of CHS-DRG (Version 1.1)”.

By the end of 2023, over 90% of medical insurance regions had adopted DRG or DIP payment approach. However, many local authorities, health care institutions and professionals expressed concerns about the accuracy of the grouping, arguing it did not reflect true clinical situations. In response to these concerns, the NHSA conducted a statistical analysis of the historical data from medical institutions, engaged in interdisciplinary clinical evaluations and gathered feedback and recommendations from various departments and health care organizations. In July 2024, the “DRG Payment Grouping Plan (Version 2.0)” and the “DIP Payment Disease Database (Version 2.0)”–collectively referred to as “DRG/DIP 2.0”–were launched.

This article outlines the significant changes associated with DRG/DIP 2.0 and provides an analysis of the implications of these adjustments.

## Key changes to the DRG/DIP 2.0

### 1. Fine-grouping scheme and disease database

DRG 2.0

The grouping scheme of DRG 2.0 emphasizes optimization and enhancement across 13 disciplines, including joint and complex surgeries, thereby rendering the grouping scheme more logical and scientifically sound. By analyzing clinical feedback, DRG 2.0 has restructured the framework of the grouping scheme into 26 Major Diagnostic Category (MDC), elevated the Adjacent Diagnosis Related Group (ADRG) to encompass 409 groups and expanded the Diagnosis Related Groups (DRGs) to a total of 634 groups. This revision has led to an increase in both surgical and non-surgical groups while simultaneously decreasing the number of internal medicine diagnosis group.

Furthermore, DRG 2.0 incorporates a novel algorithm based on big data AI genetics, employs a multidisciplinary collaborative argumentation model and adjusts the groupings in accordance with anesthesia risk grading. This approach aims to enhance the accuracy of the Complications and Comorbidities (CCs) and Major Complications and Comorbidities (MCCs) classifications to better align with clinical practices.

Table 1: Changes in DRG 2.0 and DRG 1.1 grouping scheme

| | DRG 1.1 | DRG 2.0 | Quantity variation |
|---|---|---|---|
| Adjacent Diagnosis Related Group（ADRG） | 376 | 409 | +33 |
| Diagnosis Related Groups（DRGs） | 628 | 634 | +6 |
| *-Surgical Procedure Group* | *235* | *251* | *+16* |
| *-Non-Operating Room Procedure Group* | *34* | *57* | *+23* |
| *-Internal Medicine Diagnosis Group* | *359* | *326* | *-33* |
| Complication and Comorbidity（CC） | 16,595 | 8,009 | -8,586 |
| Major Complication and Comorbidity（MCC） | 4,678 | 4,477 | -201 |

Source: NHSA, EY analysis

DIP 2.0

DIP 2.0 enhances data coverage by aggregating nearly 50 million historical health insurance billing records from approximately 15,000 medical facilities across 91 cities. It also refines the structure of the disease catalog, allowing the disease database to be updated in alignment with advancements in medical technology.



DIP 2.0 has upgraded China's catalog of core diseases to 9,250 groups. Although it has 2,033 fewer groups than DIP 1.0, new diagnostic and therapeutic techniques such as oncology gene therapy, molecular therapy, immunotherapy and partial radiation therapy have been included and the overall coverage of more than 95% of the cases discharged from hospitals is available.

Simultaneously, DIP 2.0 has introduced a new "major diagnosis + major operation + related operation" grouping. It's for cases where related operation resource consumption is over 10% of the original case cost, aiming to make health insurance payments more in line with actual clinical complexity.

## 2. Localities are permitted to modify DRG subgroups and DIP disease classifications

To ensure that the DRG/DIP groupings reflect the realities of frontline diagnosis and treatment, DRG/DIP 2.0 improves these groupings while also decentralizing the authority to adjust DRG subgroups (DRGs) and DIP disease types to the regional medical insurance departments. While maintaining consistency in the grouping rules for Adjacent Diagnosis Related Groups (ADRGs) and DIP Disease Pools at the national level, local authorities can consider the specific clinical circumstances and make necessary adjustments to their local Diagnosis Related Groups (DRGs) and DIP Disease Pools.

## 3. The adjustment increases the proportion of negotiation mechanisms for special cases outside the subgroups

The DRG/DIP 2.0 adjustment encourages medical institutions to accept cases outside the DRG/DIP payment criteria by increasing the allowable special cases to 5% of DRG discharges or 0.5% of DIP discharges, addressing prolonged stays, high costs, new treatments, advanced technologies and complex health conditions.

## Next move

Since its implementation, the DRG/DIP payment program has cut average per patient medical costs and shortened hospital stays, effectively improving patients' health care access. DRG/DIP 2.0 will further drive the coordinated development of health care insurance, health care and pharmaceutical sectors. It will enhance the diagnosis levels, reduce costs and ease patients' access to medical treatment.

### 1. Developing a communication and feedback system to integrate innovative approaches

In the operational execution of DRG/DIP 2.0, local authorities are granted the flexibility to refine subgroupings and disease classifications, while also being encouraged to assess and incorporate special case negotiations into clinical approaches as needed. This process enhances collaboration between health care insurance and medical providers, ensuring that policies are more closely aligned with real-world clinical practices.

Recently, local health care insurance departments have formed multidisciplinary judge committees to actively exchange information with medical institutions, collecting innovative insights on clinical and operational management. These efforts have led to the progressive introduction of localized DRG/DIP 2.0 implementation plans. For example, in Shandong and Sichuan provinces, health care insurance departments have developed region-specific frameworks based on national DRG/DIP guidelines, addressing key areas such as grouping methodologies, weight adjustments and special case negotiations.

| Provinces/regions | Changes in DRG/DIP 2.0 |
|---|---|
| Shandong | ▪ Grouping: clinical experts were consulted based on version 2.0. Subsequently, the three ADRG groups underwent further subdivision, giving rise to 738 DRG groups.<br>▪ Negotiation of weights: via negotiation with the health care structure, the weights of the 331 DRG subgroups were adjusted while adhering to the principle of no change in the total weights. |
| Sichuan | ▪ Grouping: data measurement was conducted, followed by an expert evaluation, leading to the establishment of 809 distinct groups, along with 21 ambiguous categories and 1 special blank group.<br>▪ Special cases for individual deliberation: in addition to guaranteeing the proportion of special cases for single deliberation required by the DRG/DIP 2.0, special provisions for individual deliberation allow certain medical institutions, such as national and regional centers handling complex illnesses, to moderately increase their applications for special cases, as long as the increase does not exceed the local proportion designated for such cases. |

Source: Shandong Provincial Healthcare Security Administration, Sichuan Provincial Healthcare Security Administration, EY analysis

This update encourages local departments to periodically refine payment weights, rates and methods based on clinical feedback from medical institutions. These refinements should fully account for regional differences, variations among health care providers and diverse patient clinical presentations. Additionally, it highlights the importance of enhancing the assessment of special case negotiations and integrating data-supported innovative solutions into clinical pathways. This approach seeks to address concerns for both patients and medical institutions regarding treatment and settlement processes.

## 2. Incentives for innovative diagnostic and treatment programs to ensure accessibility of health care

The recent upward adjustment of the negotiation mechanism percentage for special cases under DRG/DIP 2.0 offers significant advantages for both medical institutions and patients.

1. Protecting the medical rights of patients with prolonged hospitalizations and high medical costs.
2. Encouraging medical institutions to accept complex cases and enhancing clinical practice and research through interdisciplinary collaboration.
3. Advancing the use of innovative technologies and materials in clinical practices.

Additionally, this negotiation mechanism addresses the challenges associated with billing for innovative diagnosis and treatment programs under DRG/DIP 1.0.

**DRG/DIP 1.0**

Health care coverage may restrict physicians in their ability to choose treatment options for their patients. As a result, they might find themselves unable to offer more appropriate and innovative therapies that, despite being endorsed by prominent guidelines, are not currently included in national medical insurance coverage due to their omission from the approved indications, thus making them non-reimbursable through medical insurance.

**DRG/DIP 2.0**

Through the special-case negotiation mechanism, combined with separate payments in different regions, new technologies, innovative drugs/devices and special diseases can be settled separately. This effectively eases medical institutions' concerns when treating patients.

Doctors can comprehensively assess patients' conditions and available clinical means, offer safer and more effective innovative treatment plans and apply for special-case settlement when necessary, ultimately benefiting patients.

## 3. Developing innovative operational management strategies to cut costs and boost efficiency

Since the introduction of DRG/DIP, medical institutions have not only pursued advancements in clinical practices but also explored fresh ideas in operational management. In certain areas, health care facilities have joined forces to implement DRG-based group purchasing. By consolidating the clinical demand from several major medical institutions and factoring in payment benchmarks and market pricing, they have successfully negotiated price reductions, lowered the costs of high-value medical materials. This strategy has not only reduced operational expenses and increased hospitals' net income, allowing them to reinvest in other initiatives, but has also helped minimize patients' out-of-pocket costs during treatment.

# Closing remarks

The newly launched DRG/DIP 2.0 by the NHSA builds on earlier versions with several key enhancements. These include refining disease groups and the diagnostic catalog, granting local authorities greater flexibility in adjusting groupings and expanding the scope of special-case negotiations. The updates in DRG/DIP 2.0 ensure that payment systems better reflect clinical realities, foster the creation of feedback mechanisms between departments, encourage the adoption of innovative treatment approaches and support the exploration of new management models. These efforts are designed to maintain high clinical standards and improve patients' access to quality health care.

For more information, please contact us:


Felix Fei

Life Sciences and Health Care Segment Leader
Managing Partner, Assurance, China Central
Ernst & Young Hua Ming LLP
felix.fei@cn.ey.com

Sharry Wu

Life Sciences and Health Care Segment Leader
Managing Partner, Management Consulting
Ernst & Young (China) Advisory Limited
sharry.wu@cn.ey.com

Michelle Yan

Partner, Consulting
Ernst & Young (China) Advisory Limited
michelle-xx.yan@cn.ey.com

Jeffrey Yu

Partner, Consulting
Ernst & Young (China) Advisory Limited
jeffrey.yu@cn.ey.com

Ronald Wang

Executive Director, Consulting
Ernst & Young (China) Advisory Limited
ronald.wang@cn.ey.com

Green Dang

Manager, Consulting
Ernst & Young (China) Advisory Limited
green.dang@cn.ey.com

Janet Li

Senior Consultant, Consulting
Ernst & Young (China) Advisory Limited
janet.jc.li@cn.ey.com

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