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10 tips for survival under MS-DRGs

The phase-in of Medicare severity-based diagnosis-related groups (MS-DRGs) began in October 2007 and will be complete in FY09. The new system replaces the previous schedule of 538 DRGs with 745 new severity-adjusted DRGs. Reimbursement under the MS-DRG system depends on patients' comorbidities or complications.

AT A GLANCE

Many hospitals view MS-DRGs as a threat because their financial protocols do not equip them for this new approach. By viewing MS-DRGs as an opportunity rather than a threat, hospital finance managers can employ techniques to help their organizations succeed under the new science of cost intelligence.

The concept of DRGs has been developed and implemented worldwide to facilitate clinical benchmarking. But the version of DRGs that has existed in the United States since 1983 has led to cross-subsidies, created a risk of undertreatment, and fostered "cherry picking," the practice of seeking low-severity patients with correspondingly low resource requirements. In contrast, reimbursement in the new MS-DRG system will correlate more closely with resource consumption, as severity-based reimbursement redefines the granularity of clinical pathways and measures them with a severity scale. So the new MS-DRGs may be viewed—conceptually, at least—as a more equitable approach to funding.

However, many hospitals view MS-DRGs as a threat because their financial protocols do not equip them for this new approach. Clearly, hospitals that have not learned to code using the dynamics of severity risk are experiencing declines in reimbursement under MS-DRGs.

How can hospitals survive—or even thrive—under MS-DRGs? There are 10 things hospital CFOs should keep in mind when using the new science of cost intelligence.

10 Approaches to Surviving Under MS-DRGs

Survival technique no. 1: *Choose to view MS-DRGs as an opportunity rather than a threat.* Conceptually, DRGs provide a sensible approach to understanding cost. They should be an integral part of the cost management process. DRGs

provide a metric for benchmarking patient cases, physician performance, and hospital performance. Calculating DRG costs is a requisite part of determining cost by procedure. By understanding the true cost of DRGs, hospitals will be able to understand how resources are consumed, where costs exceed acceptable levels and norms, how costs exceed negotiated prices, and where and how losses are incurred and profits are made. This knowledge is the basis of intelligent cost management.

Survival technique no. 2: *School yourself in the new science of cost intelligence.* Cost intelligence is predicated on a thorough understanding of the "causes" of cost, cost variability, and factors that can be influenced to control cost. Benchmarking based on facts, not arbitrary allocations, is an integral element of cost intelligence. Hospitals should develop an in-depth understanding of their costs and manage resources optimally to deliver the best value to patients and optimize their own returns. Cost intelligence is a dynamic science; costs are continually changing due to changes in volume, equipment purchases, depreciation, and other factors.

Survival technique no. 3: *Use MS-DRGs to analyze and understand costs.* Hospitals that don't understand their true DRG costs may be delivering services at a loss and not even know it. Few hospitals are using proper activity-based costing solutions to analyze and understand costs. Using wrong cost allocations leads to cross-subsidization and fosters strategies focused on the wrong products and services, capital investment in the wrong areas, and incorrect pricing strategies, among other problems. MS-DRGs will necessitate a new understanding of costs supported by sound activity-based costing principles.

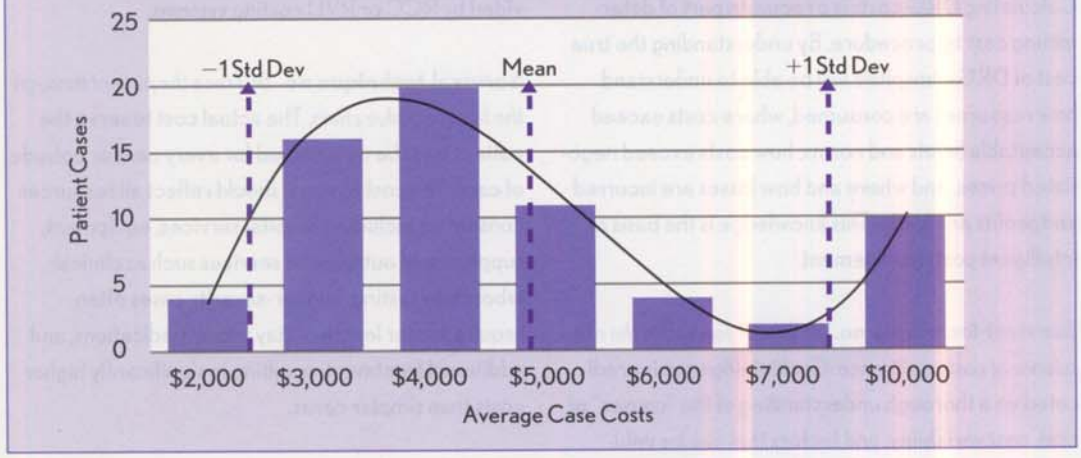
Survival technique no. 4: *Replace current cost methodologies and tools with activity-based costing, where possible.* The vast majority of cost accounting systems in use by U.S. hospitals today are deeply flawed. Relative value units (RVUs) and ratio of cost to charges (RCC) do not reflect the real costs consumed in producing outputs. They represent merely a simplistic method of apportioning costs. A DRG costing solution should drill down to the details for proper analysis, providing insight to case managers, clinicians, and finance managers alike. These details should be the real costs—not the meaningless averages provided by RCC or RVU costing systems.

Survival technique no. 5: *Trace the patient through the hospital value chain.* The actual cost to serve the patient must be determined for every case or episode of care. The cost to serve should reflect all resources consumed, including hospital services, equipment, supplies, and outsourced services such as clinical laboratory testing. Higher-severity cases often require longer length of stay, more medications, and additional treatment, resulting in significantly higher costs than simpler cases.

Survival technique no. 6: *Investigate cost outliers on the high and low ends to reveal the hospital's true cost control issues.* Consider the cost profile of a DRG, as shown in the exhibit on page 54. In most cases, cost falls along an almost normal curve. In this example, the average cost for the DRG is almost $5,000. Plus or minus one standard deviation ($2,500) yields a range from $2,500 to $7,500. Therefore, cases that cost $2,000—as well as those that cost $10,000—fall outside the normal distribution and merit close examination to determine appropriate preventative action. The low-cost cases may indicate undertreatment, which could result in future complications such as readmissions and other quality issues. The high-cost cases may reflect poor cost control, ineffective treatment, or simply incorrect coding. Statistical means may be compared and rankings may be compiled by provider to evaluate effectiveness and provide genuine cost intelligence. Bottom line: If the mean for a DRG is higher than the reimbursement level, the DRG will be delivered at a loss.

Survival technique no. 7: *Increase the depth of coding at your organization.* Severity granularity of MS-DRGs will shift reimbursement to hospitals serving more severely ill patients—and it can also lead to other, unexpected losses. Hospitals that code for severity will receive more reimbursement than hospitals that continue to code using existing DRGs. Conversely, hospitals treating fewer severely ill patients will receive fewer funds. As a result, hospitals should increase the depth of coding just to maintain the status quo under MS-DRGs.

COST PROFILE OF A DRG



The data illustrated at right show that if the mean for a DRG is higher than the reimbursement level, the DRG will be delivered at a loss.

Adjusting for severity will effectively eliminate cherry picking. However, it is important to realize that the MS-DRG reimbursement shift goes beyond severity. The new framework can cause a shift toward one service line, such as orthopedics, and away from another, such as cardiology. This can lead to unexpected losses because of fixed overhead costs or underutilized equipment, for example. The remedy requires true activity-based costing to determine actual costs associated with DRGs.

Survival technique no. 8: *Understand that the impact of MS-DRGs will be pervasive and will resonate throughout the hospital.* Most hospitals will find that significant changes in service line profitability measurement, administrative infrastructure, accounting systems, IT capabilities, and operating procedures are needed to address the impact of MS-DRGs. Coders should receive training to understand the optimal use of MS-DRGs. Increased clinical documentation requirements under MS-DRGs make accuracy more important and coding errors more costly. Additionally, hospitals would be wise to renew their commitment to reducing unnecessary costs.

Survival technique no. 9: *Pay close attention to clinical benchmarking data.* Clinical benchmarking will be more important than ever under MS-DRGs. Financial managers need to know about physicians who consistently have cases that fall outside financial norms or protocols, thereby detracting from a hospital's long-term financial health. Internal and external benchmarking by physician, hospital, and time period will be facilitated by the process of identifying true case costs for MS-DRGs. Calculating true DRG costs can help clinicians understand the impact of their patient care decisions in the context of the big picture.

Keep in mind that the urgency of the need for physician benchmarking under MS-DRGs does not diminish the importance of respecting physician privacy. Physicians' names should be divulged only on a need-to-know basis. Ideally, each physician should receive information about his or her own case costs and comparison data for the peer group's top and bottom quartiles. This approach is relatively nonthreatening and is likely to result in greater physician acceptance and engagement in the benchmarking process. Cost intelligence should be provided to physicians and other clinicians in an accessible format with easy-to-use technology.

Survival technique no. 10: *Merge clinical and financial protocols.* Clinical protocols (also known as clinical guidelines or pathways) identify, summarize, and evaluate the best evidence and most current data about disease prevention, diagnosis, prognosis, therapy, risk/benefit analysis, and cost-effectiveness. Clinical protocols also address clinical practice issues and identify the outcomes associated with various options. The goal of clinical protocols is to enhance quality of care, reduce risk, and achieve the optimal balance between cost and medical parameters such as effectiveness, specificity, and sensitivity.

Many hospitals have adopted detailed clinical protocols that define the best procedure techniques, drugs, medical equipment, postoperative care, and length of stay. Yet finance managers often do not play a significant role in formulating financial protocols. Finance managers should initiate an interactive process with clinicians and case managers to formulate financial protocols, aided by the results of past protocol applications, including how these applications may have resulted in losses to the hospital and where prices need to be renegotiated. The right cost-to-serve structure should form an integral part of clinical protocols.

Benefits of Maximizing the MS-DRG Opportunity

Understanding true DRG costs will enable hospitals to make a stronger argument for fair reimbursement while acknowledging and remediating their own performance shortcomings in light of benchmarking information. Financial protocols should be linked with the new reimbursement regimen and variances should be reported and managed. Capital costs may be integrated into cost calculations, as appropriate.

Coupling DRG cost analysis derived from activity-based costing with outcomes analysis provides the foundation for improving clinical protocols and ensuring profitability. It provides valuable insights into quality, productivity, resource consumption, capacity utilization, and effectiveness, as many of these elements are captured in the patient value chain. Cost intelligence provides a sound basis for benchmarking to identify underperforming clinicians, poor facility utilization, excessive spending, incorrect coding, and pricing policies that result in cross-subsidization. In the last analysis, cost intelligence is probably the closest a hospital can come to integrating the performance objectives of clinicians and finance managers. ●

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