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Paradigm Lost: The Strategic Impact of Revised DRG Payments

By Preston Gee, for HealthLeaders News, July 13, 2006

We are on the eve of a seismic change in revenue reimbursement for hospitals with the expected reconfiguration of diagnostic related groups as recalibrated by the Centers for Medicare and Medicaid Services. The new configuration is a modification to the Inpatient Prospective Payment System. Surprisingly, other than running the numbers and issuing a cursory first-pass analysis, many hospitals and health systems are not undergoing or undertaking the kind of in-depth review and on-deck evaluation that the kind of recalculation that the IPPS rebasing should merit. When all is said and done, healthcare leaders need to recognize that much of their world is about to change—prompting a veritable paradigm shift in long-range planning considerations.

The decline of the “Core Four?”

One example of this significant transition is the impact on the high-focus four service lines that typically constitute the bulk of operating revenues and contribution margins. It has been widely held for the past few years that, for hospitals, the “Pareto Group” (those areas where the 80/20 rule applies) that commands management’s attention and prompts intense competition includes the cardiovascular, orthopedic, neurosciences and general surgery service lines. For many mid- to large-scale hospitals, these four typically accounted for between 60 percent and 75 percent of the critical financial and market share metrics that hospital executives track.

That managerial maxim may be about to change. For example, one large system in Texas--that just calculated the impact of IPPS on its reimbursement once the new program is implemented--estimated that the cardiovascular service line will realize a 30 percent reduction in its total revenue. Other across-the-board reimbursement calculations (for cardiology) range from The Advisory Board’s estimate of a 9 percent overall reduction to a leading systems projection of 40 percent to 50 percent for some specialty hospitals.

Although the other key lines--ortho, neuro and general surgery--will not be hit quite as hard, they will no doubt feel the pain of the surgical strikes. All this has major implications, since hospitals for the past five to ten years have expended disproportionate capital and management time on these service lines. With their cachet and contribution now expected to diminish some--although admittedly they will still be major players--the emphasis may need to turn to other areas of the hospital’s portfolio that have long been considered economic second-tier services and/or third-rate margin contributors

Margin makeover

One of these areas obviously is the entire milieu of medical diagnoses. Partly as a result of portfolio grids and strategic planning matrices, the medical service lines have been considered important, but not necessarily essential. Many were viewed as overall drains on the system, and depending on the market, they were either relegated to a second-tier consideration or even evaluated for eventual reduction and jettisoning.

With the revised payments, all bets are off—or at least some of them—as it relates to the relative financial and operational value of the medical segment of the service-line portfolio. One example of this is the entire service line of oncology, which looks to gain significantly from the revised IPPS calculations. Obviously, the broader categories of general medicine and other previously lower-margin areas will also undergo marked amelioration in reimbursement.

This translates into some interesting planning dynamics, as executives may need to rethink their previously crafted strategies on market segmentation and service expansion. For example, in some markets, the Medicare segment is experiencing an increasingly difficult time accessing primary care, as more physicians close their practices to the over-65 population. While this is somewhat understandable given the untenable payment levels the government has enacted, it creates a significant problem for many hospitals. Medicare enrollees in smaller and mid-size markets are migrating to metropolitan areas where the over-supply of physicians usually fosters increased access to care. These migrating seniors, who are then referred to medical specialists in the metropolitan areas, often elect to be hospitalized in the metropolitan setting, thus leaving the hospitals in their locale in the lurch when it comes to Medicare patients. With the rebasing initiative, some of these hospitals may need to consider upstream solutions to the primary care shortage by subsidizing senior centers or geriatrician clinics to retain this segment of the population which now has more reasonable reimbursement levels for general medicine.

The salience of service lines

The imminent adoption and implementation of the IPPS changes underscore one very important strategic consideration and managerial approach, which is the inherent value of a service-line orientation. Those organizations that have incorporated the structure of service-line management with defined data parameters, specific performance metrics and well-defined managerial accountability will be better positioned to navigate the IPPS transition and adjust to the revised reimbursement guidelines.

And by this time in the preparation cycle, organizations have both been warned, and been provided ample lead time to make the necessary adjustments. When DRGs were first introduced in the mid-1980s, very few organizations in the healthcare realm (at least hospitals) had the advantage of having a service-line structure. However, over two decades have passed, and many organizations have astutely recognized that a service-line structure enables an organization—whether large or small—to more adroitly and nimbly make the transition to a new set of operational and financial parameters.

This is a critical lesson that other sectors of American industry (and international firms) have learned well. The same can be said for progressive and strategy driven health systems. The service-line structure offers organizations in transition (especially in payment transition) the optimal operational structure to both assess the financial impact, as well as map out future strategy. Some hospital executives have commented that “when all is said and done this [IPPS] should be budget neutral for most hospitals.” While that may be true, there is a vast shift in the financial relevance between the service lines. A hospital’s strategy should take into account that shifting relative value and reflect the revised importance of each service line under the new configuration. Those hospitals that have good data and have service-line directors or managers who are ultimately accountable for their areas will be best-positioned to adjust and to map out a new strategic course under the new reimbursement guidelines.

Pulling up and drilling down

Whether one views the forthcoming impact of the rebasing initiative as significant or nominal, there is additional value to the change. Basically, as with any sweeping change that pervades the industry, it is an opportune time to pull up and evaluate not only the Medicare payment structure for its strategic implications, but the entire pricing structure for an organization as well. The reality is that shifting government reimbursement, transparent pricing, and strategically-targeted revenue cycle management practices (strategic pricing) are all inter-related. Savvy and sophisticated health leaders will seize this opportunity to evaluate their organization’s overall pricing structure and strategy and make the necessary and financially-beneficial adjustments.

Market pricing is very much one of the key items that needs to be addressed at the senior level. This narrow window of opportunity/transition provides leaders in the C-suite the platform to navigate this sea change with an entirely different view toward the horizon and a renewed focus on customer orientation and market-driven strategy. In essence, this rebasing initiative provides an excellent opportunity for all hospitals and health systems to fully evaluate their cost structure and to document their pricing approach and algorithms. The rapidly emerging trend toward transparent pricing (or perhaps more aptly termed, “market pricing”) synchronizes appropriately with the IPPS initiative to step back and evaluate the entire pricing configuration. Fundamentally, we are entering a time when progressive hospitals will realize the emergence of the customer and the diminishment of the charge master--as the winds of market change prompt the need for a new managerial model and approach.

Healthcare executives that are attuned to the shifting sands of the market environment will seize this opportunity and re-evaluate their entire pricing structure by pulling up from their historical approach and drilling down into the fine detail of how they determine their prices and how this should optimally be performed under the emerging construct of a market-driven environment. These planning-centric, forward-thinking organizations will capitalize on these significant changes to ensure future long term viability.