

Severity-Based DRGs: How Will They Affect Your Bottom Line?

Experts are calling it the biggest change in the Medicare payment system since the term “DRG” was coined in the 1980s. The Centers for Medicare and Medicaid Services (CMS) is changing to a more cost-based reimbursement system that takes severity of illness into account. As a result, hospitals that care for a lot of high-acuity, resource-intensive patients should see their Medicare payments increase. At the same time, clinical service lines (namely surgical) that have benefited from inflated payments in the past may see their payments decrease.

What Exactly Is Changing About Medicare?

CMS critics have long argued that the old DRG system financially penalized some hospitals for taking on more acute or complicated patients—while financially encouraging other organizations to specialize in treating less costly conditions. The new cost-based, severity-based DRG approach is an attempt to correct these problems, and create a more just and accurate payment system.

Before	Now
<p>Charge-based. CMS reimbursed hospitals a predetermined, fixed amount for the majority of patient services. These predetermined amounts were based on average hospital charges, or the dollar amounts listed on a hospital’s chargemaster for various services and supplies. Hospital charges do not necessarily represent the “true” cost of treatment, due in large part to the hospital industry’s tendency over the years to adjust charges across the board, or by service.</p>	<p>Cost-based. CMS is rebasing DRG payments using hospitals’ estimated costs (versus charges) for providing different types of services. As a result, Medicare payments should better reflect the cost of caring for patients.</p>
<p>Based on diagnosis. CMS uses diagnosis-related groups (DRGs) to determine reimbursement rates. The DRG system classifies inpatients based on their diagnosis. The original DRG system included 538 codes related to patients’ symptoms, injuries, diseases, and conditions.</p>	<p>Takes severity of illness into account. CMS has added 207 new Medicare severity-adjusted DRGs (or MS-DRGs for short). This increases the total number of DRGs to 745. The MS-DRGs include many of the original DRGs, which have been split into separate DRGs based on major complications or comorbidities.</p>
<p>Covered hospital-acquired complications. CMS has typically reimbursed hospitals for the cost of treating patients who develop infections or other complications while in the hospital.</p>	<p>Covers conditions present on admission. Hospitals must report conditions that (a) are high-cost or high-volume or both, (b) result in assignment to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. Beginning next year, hospitals will not receive additional payment for treating patients who developed certain conditions after admission.</p>

Timeline of Medicare Changes

Effective Oct. 1, 2006 (FY07)

- > CMS announces a three-year phase in for new cost-based DRGs. In FY07, CMS reimbursed hospitals based on a blend of one-third cost and two-thirds charges.

Effective Oct. 1, 2007 (FY08)

- > CMS introduces Medicare severity-adjusted DRGs (MS-DRGs), with a two-year phase in. During this first year, hospitals are being paid based on 50 percent MS-DRG weighting and 50 percent traditional DRG relative weighting.
- > The second year in the three-year transition to cost-based DRGs. Hospitals are now being reimbursed based on two-thirds cost and one-third charges.
- > CMS launches present on admission requirements. Acute care hospitals must begin reporting on select conditions. (See “Was the Condition Present on Admission?” on page 11).

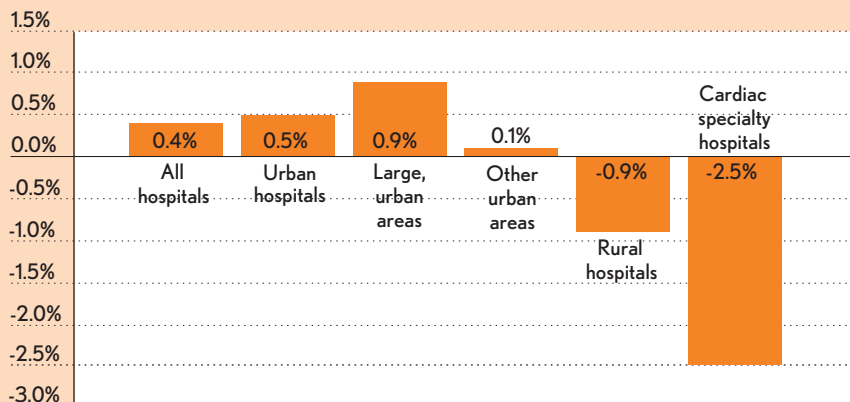
Effective Oct. 1, 2008 (FY09)

- > The final year in the transition to a new cost-based, severity-based DRG system. CMS will determine payments based entirely on hospital costs rather than charges. In addition, hospitals will be paid based on 100 percent MS-DRG relative weighting.
- > CMS begins penalizing hospitals for not preventing infections and other complications after patients are admitted. (See “Was the Condition Present on Admission?”).

Some Hospitals to Gain, Some to Lose

Hospitals can expect their average Medicare payment per case to go up or down in FY08, depending on their mix of services. Rural and cardiac specialty hospitals can expect payments to go down somewhat, while urban and teaching hospitals (which traditionally care for more acute patients) can expect to see their total Medicare payments rise. Hospitals should see more dramatic changes in FY09, when the transition to the new DRG system is complete.

CMS estimated impact of FY08 transitional changes*

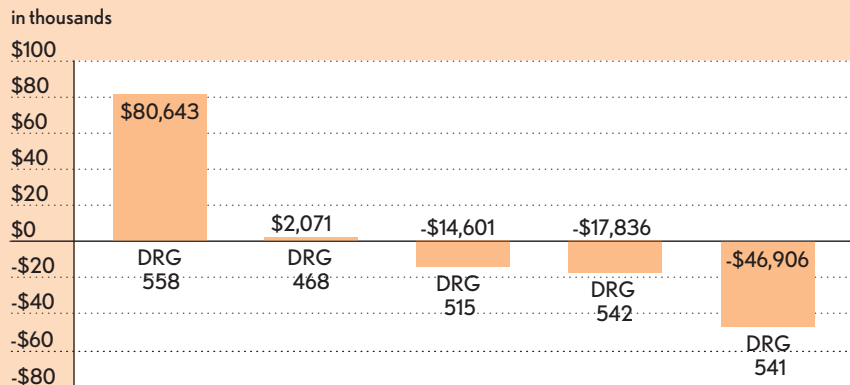


*The FY08 transitional changes include the move toward severity-based DRGs and the move toward cost-based payment.

Source: "Medicare: Hospital Inpatient Prospective Payment Systems and 2008 FY Rates," *Federal Register*, August 22, 2007, pp. 47568-48175. (Available at www.gpoaccess.gov.)

Some Services Will See Payments Decline

The following chart profiles the DRG weight shift for five historically profitable Medicare DRGs. It is critical that hospital executives, including nursing leaders, examine the impact of this new payment system on all product lines. The proposed DRG payments will be impacted by both the switch to MS-DRGs and the transition to cost-based weights. The impact of these two significant policy changes must be profiled at the facility level to fully understand the financial impact.



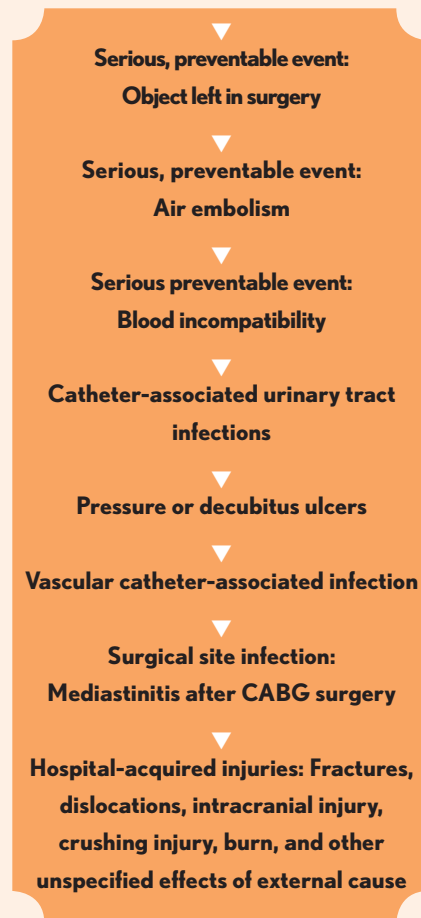
2007 DRG	Definition	Map to new MS-DRG(s)
558	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent Without Maj Cv Dx	247
468	Extensive OR Procedure Unrelated to Principal Diagnosis	981/982/983
515	Cardiac Defibrillator Implant Without Cardiac Cath	226/227
542	Trach with MV 96+Hrs or Pdx Exc Face, Mouth and Neck Without Maj OR	004
541	Ecmo or Trach w MV 96+Hrs or Pdx Exc Face, Mouth and Neck with Maj OR	003

*The payment impact is calculated using the unadjusted operating and capital amounts for 2007 and 2008; claim volume is based on the 2006 MedPAR File. CMS has built a 2.4% reduction in payment into the 2008 proposed rates to account for behavioral offset or CMI creep due to adaptations to the MS-DRG system.

Source: Cleverley & Associates. Reprinted with permission.

Was the Condition Present on Admission?

In less than one year (Oct. 1, 2008), hospitals will no longer receive Medicare payments for treating certain types of hospital-acquired infections and injuries. Cases in which patients developed any of the following eight conditions will not be assigned to a higher-paying DRG *unless* the conditions were present on admission (and the hospital documents that).



In addition, CMS is currently exploring whether to add the following conditions to the above list, effective next October: ventilator-associated pneumonia, *Staphylococcus aureus* septicemia, and deep vein thrombosis/pulmonary embolism. CMS is also considering adding the following three conditions to the list at some future date: methicillin-resistant *staphylococcus aureus*, clostridium difficile-associated disease, and wrong surgery.

Source: "Medicare: Hospital Inpatient Prospective Payment Systems and 2008 FY Rates," *Federal Register*, August 22, 2007, pp. 47568-48175. (Available at www.gpoaccess.gov.)