

## MEDICARE/MEDICAID

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healthcare financial management association [www.hfma.org](http://www.hfma.org)

## DRG do-over the need for a service-line strategy

**It's no secret: We are within months of another iteration of prospective payment.** And the changes that are to come will likely require hospitals and health systems to seriously reassess their service-line focus.

### AT A GLANCE

- > Hospitals should establish a service-line-focused strategic approach in preparation for the reimbursement changes resulting from CMS's reconfiguration of DRGs.
- > Surgical areas that hospitals have relied upon as primary revenue generators, particularly cardiology, may lose financial strength after the new IPPS is implemented.
- > Hospitals may benefit from increasing their strategic focus on other service lines—particularly medical diagnostic services—that have the potential to contribute more to the bottom line than they have in the past.

The reconfiguration by the Centers for Medicare and Medicaid Services of diagnosis-related groups under the inpatient prospective payment system is intended to establish greater parity between the medical and surgical diagnoses/treatments that occur within a hospital. The general plan (and hope) is that, even with the beefed up number of DRGs (increasing from 526 to 861), most hospitals will experience little change in overall federal reimbursement. Nonetheless, this change—which may go into effect as soon as Oct. 1, 2006—raises significant implications for a hospital's market strategy and organizational response.

In short, as a result of the revised payment structure, hospitals may need to reevaluate the service lines that they have historically tended to identify as core service offerings and to fundamentally alter their traditional strategies regarding these services. While revenues from these services face potential declines, other service lines previously considered to be drains on the system—sometimes termed *loss leaders*—have the potential to emerge in better financial position. Hospital executives therefore should pay close attention to the revised IPPS structure and begin appropriate planning to navigate the new payment path.

Although the announcement of the IPPS revision may seem mundane, and not worthy of much of a response beyond running the numbers and issuing a cursory first-pass analysis, the impact of this change should not be underestimated. Indeed, after the shift in reimbursement architecture, it may be necessary for some healthcare leaders to seriously reconsider their existing strategy and traditional priorities for resource allocation and managerial emphasis.

### Have the Cash Cows Been Milked?

In a traditional portfolio analysis, the high-performing service lines are often called "cash cows." For many hospitals, these lines have historically been cardiology,

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orthopedics, neurosciences, and general surgery. Historically, these high-focus service lines have constituted the bulk of operating revenues and the lion's share of an organization's contribution margin. Given, of course, that circumstances vary by hospital or health system, the collective foursome often account for more than 50 percent of the most important and oft-cited metrics—be they market share or net income.

The new IPPS may soon cause these contributors to top-line revenue and bottom-line impact to change fairly significantly. For example, a large health system in Texas has calculated that after the IPPS is implemented, total revenue from its cardiology service line will decline by about 30 percent. Other predictions of reimbursement changes for cardiology range from The Advisory Board's estimate of a 9 percent overall reduction to another leading health system's projection of a 45 percent decline on some its most profitable procedures.

Orthopedics, neurosciences, and general surgery will not likely be affected as much as cardiology, but their financial positions will not be as strong as they were before the IPPS revision. Because of the disproportionate focus on these lines during the past decade, the implication for strategy—as well as for capital expense and managerial effort—is no small thing. Undoubtedly, these service lines will still account for a significant share of revenue and bottom-line impact, but their loss of cachet and contribution should be factored into an organization's overall projections and planning.

## Of Margins and Medicine

With the future for their traditional “cash cows” in doubt, hospital strategists should be alert to the potential rise in relevance and profitability of other service lines that historically have been considered second tier, tending to receive lower emphasis. Hospital leaders should prepare to focus more managerial attention on these areas.

Consider, for example, the area of medical diagnoses. Under current reimbursement, medical service lines have not typically received as much capital and managerial interest as their surgical counterparts. They often have been seen as low-margin areas—even economic drains on the organization. In recent years, hospitals have sought ways to limit their involvement with, and contribution from, these service lines. Strategies have ranged from consolidation to jettisoning of individual departments.

With the revised payment schedule, however, the relative value of these service lines may increase. Based on initial estimates, for example, reimbursement for oncology may gain some ground. The revised payment architecture also holds the promise of increased reimbursement in the broad-based category of general medicine, as well as in other previously low-margin (or at least lower-margin) diagnoses segments.

## Strategic Implications

So what do these shifts mean for strategists and the planning process? In simplest terms, the IPPS is likely to fundamentally change the way many healthcare executives view their portfolio of services. At the very least, the revised IPPS should be an integral consideration in an organization's planning efforts and exercises as it maps out its strategy for the next three to five years. The implications can be far-reaching in terms of demographic considerations and market segmentation strategies.

Consider the market segment of mature Americans, for example. Today, in many markets, the Medicare-age population is facing increasing difficulty obtaining access to primary care services. This situation poses a challenge to hospitals in such markets in that it may prompt increased out-migration by the Medicare patients to areas where access is easier

## ABOUT THE IPPS REVISIONS

The proposed rule, issued April 12, 2006, by the Centers for Medicare and Medicaid Services, describes the most significant revisions to the inpatient prospective payment system since its implementation in 1983. To find out more about the proposed changes, read *HFMA Highlights: Inpatient Hospital PPS Proposed Rule for FY 2007*. To access this member-only document, go to [www.hfma.org](http://www.hfma.org), and search on “Inpatient Hospital PPS” (quotes needed).

and physicians are in greater supply. Particularly vulnerable to such a trend are hospitals in smaller or midsize communities that are in relatively close proximity to a metropolitan area.

**HFMA COMMENTS**

On June 12, HFMA sent a letter to Mark McClellan, CMS administrator, commenting on the proposed changes to the inpatient prospective payment system. To read the letter, go to [www.hfma.org](http://www.hfma.org) and search on “Comment letter on FY 07” (quotes needed).

The obvious dilemma for a hospital’s executive team in such a scenario is that the exodus of primary care services leads to increased referrals to specialists outside the area and subsequent loss of hospital admissions to competitors also outside the area. To stem this erosive trend, some hospitals have established senior centers or geriatric practices to continue to attract the senior population in their area to their facilities. This upstream strategy has not garnered much attention up until this point, as many executives have concluded that the Medicare population may not be in the best payer category because the propensity of these patients has been to access lower paying medical diagnostic services. That assumption may need to be revisited under the new reimbursement structure.

**It Takes a Service-Line Approach**

From a strategic vantage point, the ability to prepare effectively for the new IPPS guidelines depends on a well-organized and data-driven service-line managerial structure. Progressive hospitals and health systems that have already incorporated a smoothly running service-line approach will likely be in a better position to evaluate the impact of the revised payment structure and maneuver effectively under the new guidelines. They will be able to immediately assign responsibility for assessing the projected effect of the rebasing initiative to the managers or directors accountable for each service line. That is the inherent

beauty and integral value of a service-line structure: It allows for a thorough evaluation of and rapid response to changes in the market—whether they emerge from competitive forces or external factors.

Furthermore, in this iteration of federal prospective payment, hospitals can have little excuse for not anticipating changes and adjusting accordingly. When prospective payment was initially introduced in the mid-1980s, few—if any—organizations in the healthcare sector had the advantage of having a strategic business unit approach to managing their operation and monitoring the market. This time, however, with multiple warnings and myriad market shifts, several innovative organizations have incorporated a subdivided strategic approach to matching the needs of the consumer and the demands of the rapidly changing environment.

In so doing, the healthcare industry has borrowed a tactic from the playbook of other industries in the United States that have successfully incorporated a service-line (or product-line) strategy to get closer to their customers and be more in synch with their market.

Unfortunately, when the idea of service lines first surfaced in health care in the mid-1980s, many healthcare executives either misinterpreted how it should be implemented or dismissed it as merely a marketing tool. However, with increasing sophistication of data, expanding influence of the consumer, and rising competition from multiple sources, the service-line model has undergone a resurgence.

**8 ESSENTIALS OF A SERVICE-LINE INITIATIVE**

A successful service-line initiative includes the following fundamental components:

1. Defining the service lines (usually by data sources)
2. Establishing the core metrics for determining progress and success (e.g., market share, contribution margin)
3. Narrowing the organizational portfolio to two or three key service lines, at the outset of the initiative
4. Creating the optimal organizational structure for service-line management (e.g., matrix versus direct line responsibility)
5. Assessing the competitive market position for each service line
6. Developing substantive business plans for each line that correspond with the strategic plan and budget
7. Competing aggressively and measurably
8. Executing effectively on the strategies identified, and achieving the established goals

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The problem for many hospitals still remains in the execution, as some are still mired in rudimentary steps, such as defining the service lines. Yet with increasing emphasis on quality and pricing transparency and a greater retail orientation in general, the service-line construct will likely receive greater attention and more management engagement than ever before, and hospitals will need to quickly accelerate beyond such basic considerations.

The revised IPPS offers hospitals that have not yet implemented a sophisticated service-line approach an excellent opportunity to do so. Even though the general consensus is that under this reconfiguration, many hospitals will end up “budget neutral,” the implications are nonetheless significant and the door wide open for progressive organizations ready and poised to implement data-driven plans and market-oriented strategies. Those that do will have one more point of differentiation from their competition.

### Into the Weeds

If nothing else, the reconfiguration of DRGs should be viewed as a timely opportunity to dig in and thoroughly assess your organization’s entire pricing structure and strategy. In essence, it is an opportune time for you to dig into the details of how your organization is reimbursed and how that might change in the future—and to weed out the approaches that will no longer prove effective under the new payment system.

The DRG reconfiguration also can serve as a catalyst for analyzing and developing your approach to transparent pricing and, ultimately, clearing some more weeds. Market pricing—with its retail orientation and consumer-driven focus—is a topic of great interest in many circles and likely an emerging reality for both hospitals and physicians. Hence, the government’s move to redesign the fundamental algorithm for reimbursement should be considered in a larger context, and provide a springboard for a complete pricing assessment and a comprehensive financial evaluation for organizations determined to navigate the changing conditions that await the industry.

In short, progressive healthcare leaders recognize that shifting government reimbursement, transparent pricing, and strategically targeted revenue cycle

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management practices (strategic pricing) are inter-related, and will seize this opportunity to evaluate their organization’s overall pricing structure in light of recent market developments and external factors that will have long-term impact on their financial position. CMS’s rebasing initiative provides an excellent opportunity for hospitals to fully evaluate their cost structure and to document their pricing approach and algorithms. Thus, focusing on service lines, you should address the IPPS reimbursement changes in concert with an effort to establish strategic pricing, in a process that will involve reevaluating and reconfiguring your pricing based on competitive intensity versus market uniqueness.

### The Real Bottom Line? Embrace Change

We are on the verge of significant change in the nation’s healthcare sector, of which CMS’s DRG reconfiguration is just one small manifestation. Healthcare leaders who are attuned to today’s imminent change—whether it be a revised payment structure or a call for greater transparency—will be in a position to anticipate even greater changes ahead. We are moving toward the day when we may see the entire pricing and reimbursement framework altered dramatically, and to a time when the chargemaster, with all its complexity and free-market incongruity, will be phased out, to be replaced by a market-driven payment architecture that more closely aligns with other industries and most market sectors.

The ability to manage such seismic change will be the hallmark of great leaders who are community-centered, grounded in reason, tempered in experience, and progressive some would say almost to a fault. Such forward-thinking leaders will relish the opportunity to seize the opportunities that change presents and translate them into sustainable viability. ●

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