DRG in Europe, esp. Germany

System overview and consequences for coding---

DRG-konferansen 5. – 6. mars 2007

Oslo

Dr. Michael Wilke

RAMBØLL management

Agenda

1. **Rambøll Management**
2. The German HealthCare System
3. DRG in Europe & The German Solution
4. Consequences for coding quality

We are part of the Ramboll Group

- 5,000 employees consulting in:
  - Engineering (energy, infastructure, building, logistics, environment)
  - International development
  - IT
  - Management
- 70 Offices worldwide
- Projects in over 100 countries

RAMBØLL management

Knowledge taking people further---

Rambøll Management

- Founded 1971 in Aarhus, Denmark
- In Germany since 2000
- App. 450 employees in Europe
- 700 projects per Year
- Focus on public sector
  - EU
  - Ministries
  - Communities
  - Insurance
  - hospitals

Our services in healthcare

- Hospital:
  - Strategy development
  - Coding audits
  - Change Management
    - Lean healthcare
    - Optimizing medication safety and efficiency
    - Clinical pathway
  - HR – development
  - Trainings
- Ministries
  - Policy field analysis
  - Studies
  - Surveys

Dr. med. Michael Wilke

- Head of Competence Center Health Management
- Physician in Surgery, Anesthesia, intensive care, emergency medicine
- Since 1997 involved in DRG - projects
- Head of DRG Competence Center in Munich Schwabing hospital
- Member of Casemix advisory comittee in the German Ministry of Health
- Member of „Patient Classifications International“ (PCS/I) scientific comittee
- Over 140 publications and lectures for DRG - topics

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German health system

Germany has a compulsory health insurance system for app. 88% of the population (12% privately insured)

- Currently app. 250 insurance companies in the compulsory system
  - Coverage of all healthcare service expenditures
  - Financing via percentage of wages (50% employer, 50% employee), avg. fee is ca. 14,2%
- Accidents at work covered by special accident insurance
- App. 150 private companies
- Investments are covered by the states, but due to bad financial situation, many states suffer severe investment jam.

German health system

The most important difference to the Nordics

- Strictly different financing mechanisms and budget proportions between the different sectors:
  - Outpatient
  - Inpatient
  - Rehabilitation
  - Prevention

Healthcare expenditures 2005

- In 2005 there was a total of € 250 Bill. of healthcare expenditures
- App. € 144 Bill. Were covered by the compulsory system (see details right)
- Private companies covered app. 9% of the expenditures

Services	Expenditure in Bill. €	%
Doctors fees	21,6	15,04
Dental care	7,52	5,24
Dental prosthetics	2,45	1,7
Medication (from pharmacy and others)	23,65	16,47
Orthopedic aides and others	8,18	5,7
Hospital services	49,01	34,12
Sickness funding	5,86	4,08
Transportation	2,8	1,95
Prevention and Rehabilitation	2,38	1,66
Homecare	1,93	1,34
Administrative costs	8,05	5,61
Other	10,18	7,09
Total expenditures (compulsory only)	**143,61**	**100**

The hospital sector

- Hospitals are in ownership of:
- States or communities (app. 40%)
- Social and religious welfare organizations (app. 30%)
- Private companies (app. 30%)

Funding:

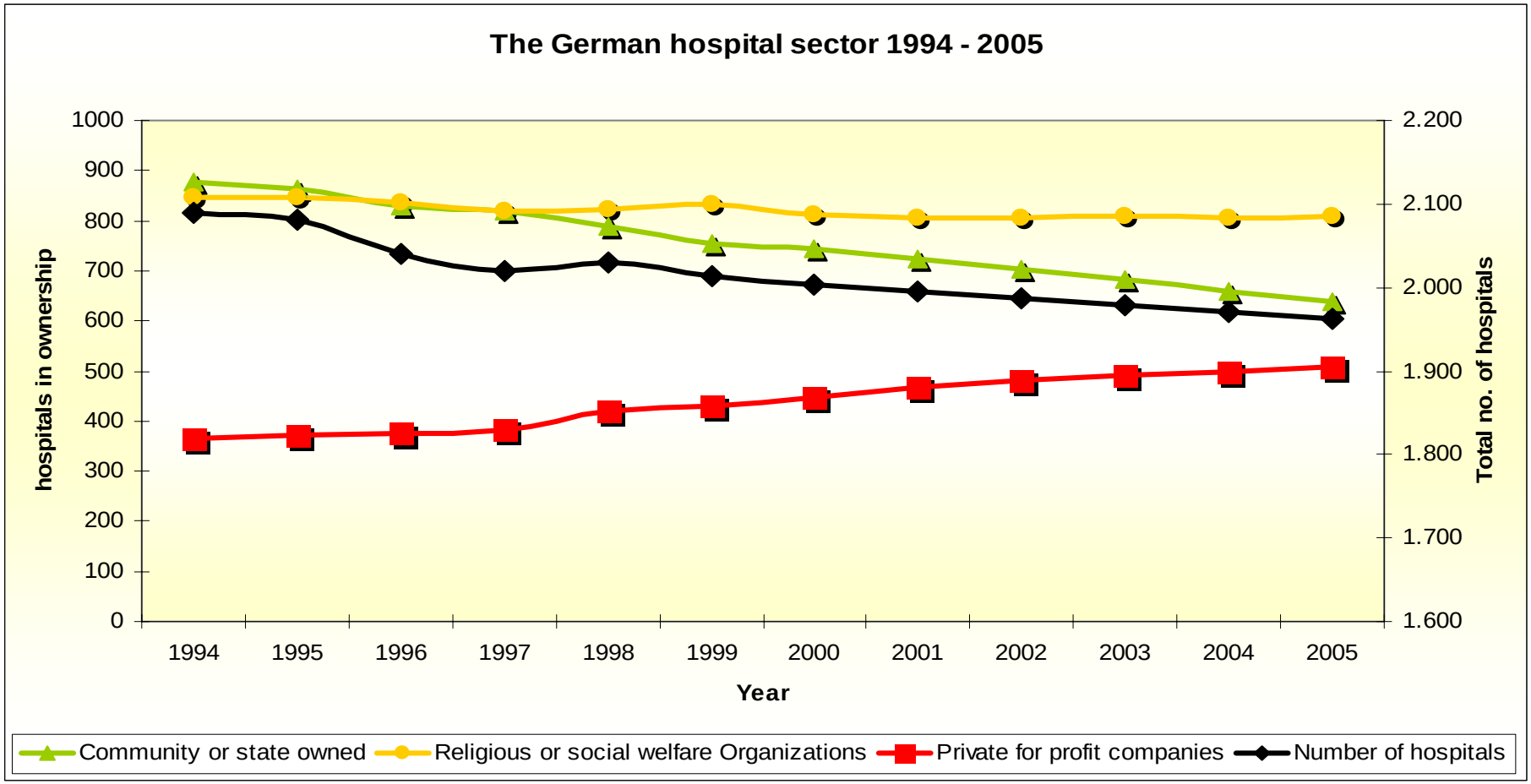
- Buildings and technical equipment → regional state (except private hospitals)
- Medical treatment → insurance (public, private, other)
- All companies contract to the same conditions with each hospital!!

Hospital financing

The hospital system is heavily regulated by federal and state laws

- Since 1993 continuous budget cap
  - Budget can only grow accordant to cash inflow on insurer‘s side
  - Insurers income dependent on wage – level
- Since 2000 step-by-step introduction of prospective payment system via DRGs (Diagnoses related groups) → shifting cost risks in treatment from insurance to hospital!
- As introduction is adjusted to relative sloth of public sector, private companies can easily make profits

Hospital sector in constant shift to private ownership and reduction of total number



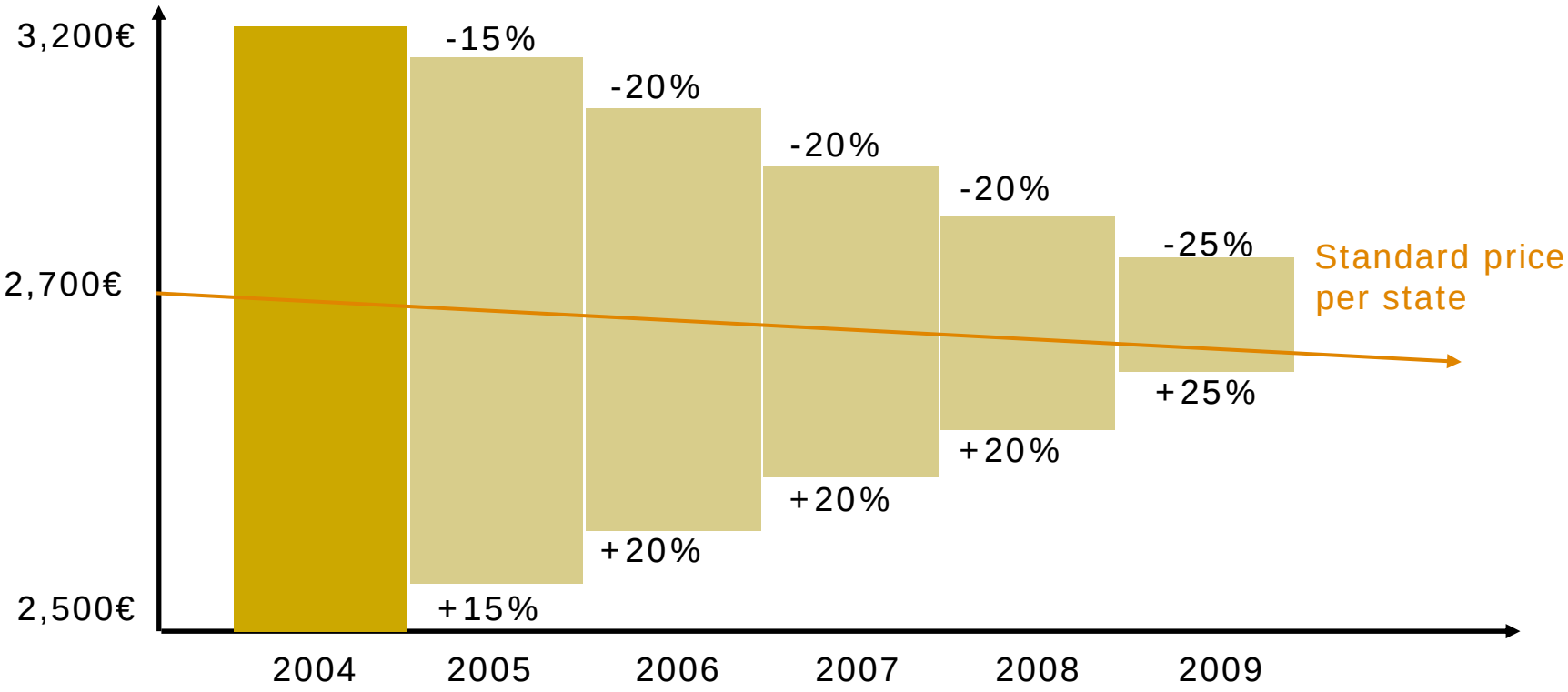
DRG introduction in Germany

Step-by-step adjustment of hospital income from historical budget to activity based payment → *convergence*

- Expensive hospitals loose budget, cheaper ones get more
- Adjustment happens on state level
- DRG – System does not yet explain all cost differences → if special risks are not paid, the hospitals treating those have a significant market disadvantage (e.g. complicated hospital infections)
- The ***goal*** in Germany is ***100% activity-based payment!***

‚Convergence' – price adjustment

Base price for standard patient (cost weight 1.0)



Risk adjustment

To prevent taking budget away from the ‚wrong' hospitals, the following measures were taken

- Continuous improvement of accuracy (and complexity) of the DRG – payment system
- DRGs for individual negotiation (long-term care for spine injuries, etc.)
- Co-payments (mainly expensive drugs and prosthesis)
- Extra budgets for special tasks (e.g. burn unit, infectious disease isolation unit)

Nevertheless budgets shifts occur mainly from big (university or tertiary) hospitals to smaller ones (with less differentiated treatment)!

Co-payments

Mainly expensive drugs

- Antifungals
- Chemotherapy
- Intensive care
- Blood and blood products

Special opportunity: ‚NUB – payments' for NEW diagnostic and therapeutic methods (not older than 3 years, only from year to year, hospitals have to file for individually)

Outlook 2007 – 2009: Health system financing

Coming changes (health reform effective 04/2007):

- Building up a national healthcare fund
  - Insurance companies get money out of it correspondent to the morbidity of their members
  - Government gives money for unemployed, children, etc.
  - If one company does not collect enough money from the fund, co-payments from the members
- Private companies have to include more members without formal health check before
- Selective contracting will be possible
- Most important: Better possibilities of transsectoral collaboration and building up e.g. population based service structures

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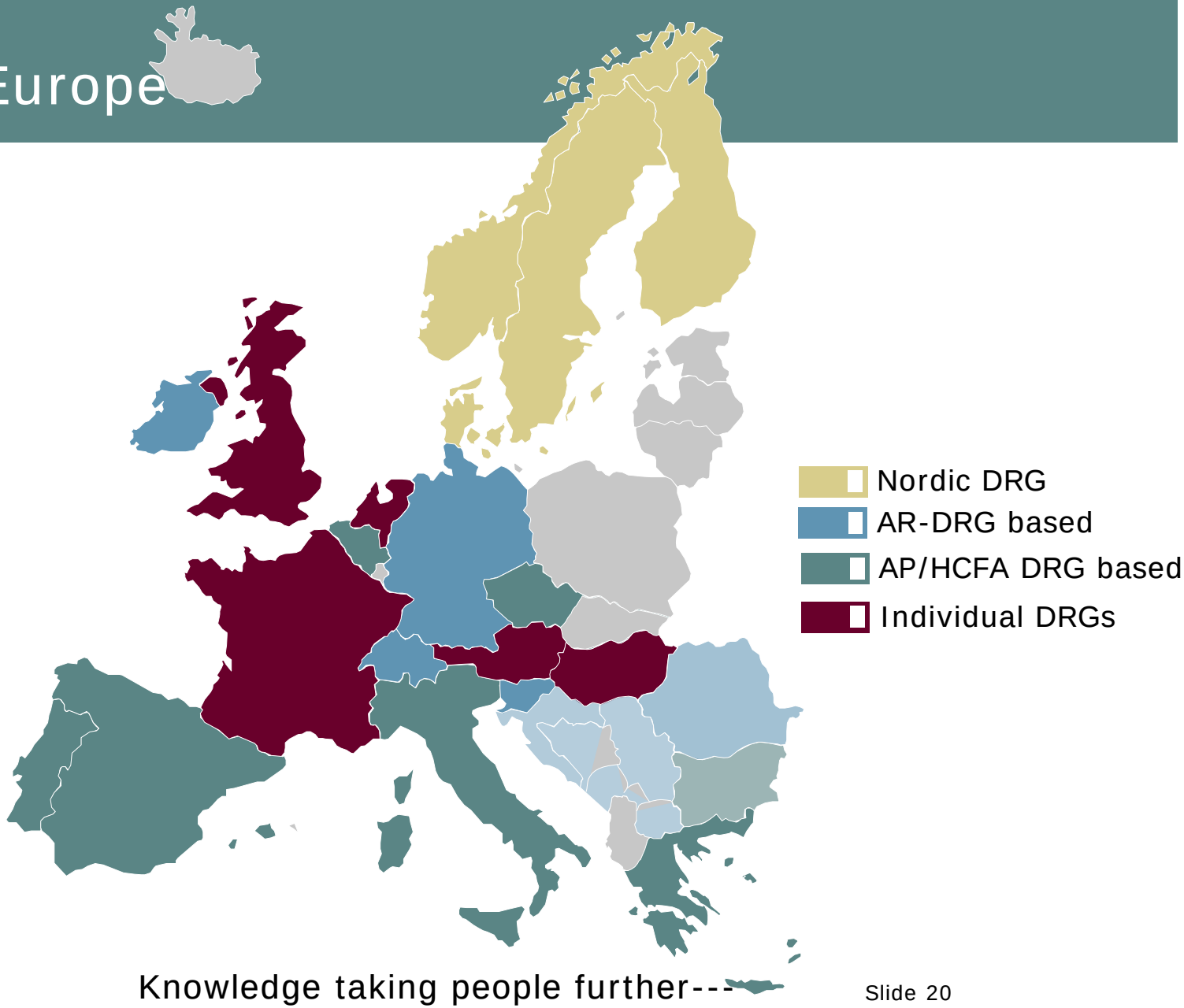
DRG in Europe



Why DRG?

DRGs are the most common instrument for activity based hospital financing systems in industrial nations worldwide

However, there are the Paradigms of DRG – reimbursement:

- Principally excellent idea, because reimbursement is directly bound to diseases and their related cost
- Moreover it is patient-related
- But: The bigger proportion of the hospital budget to be financed via DRG the more complex they have to be

Additional challenge in Germany: >300 payors

The German Solution

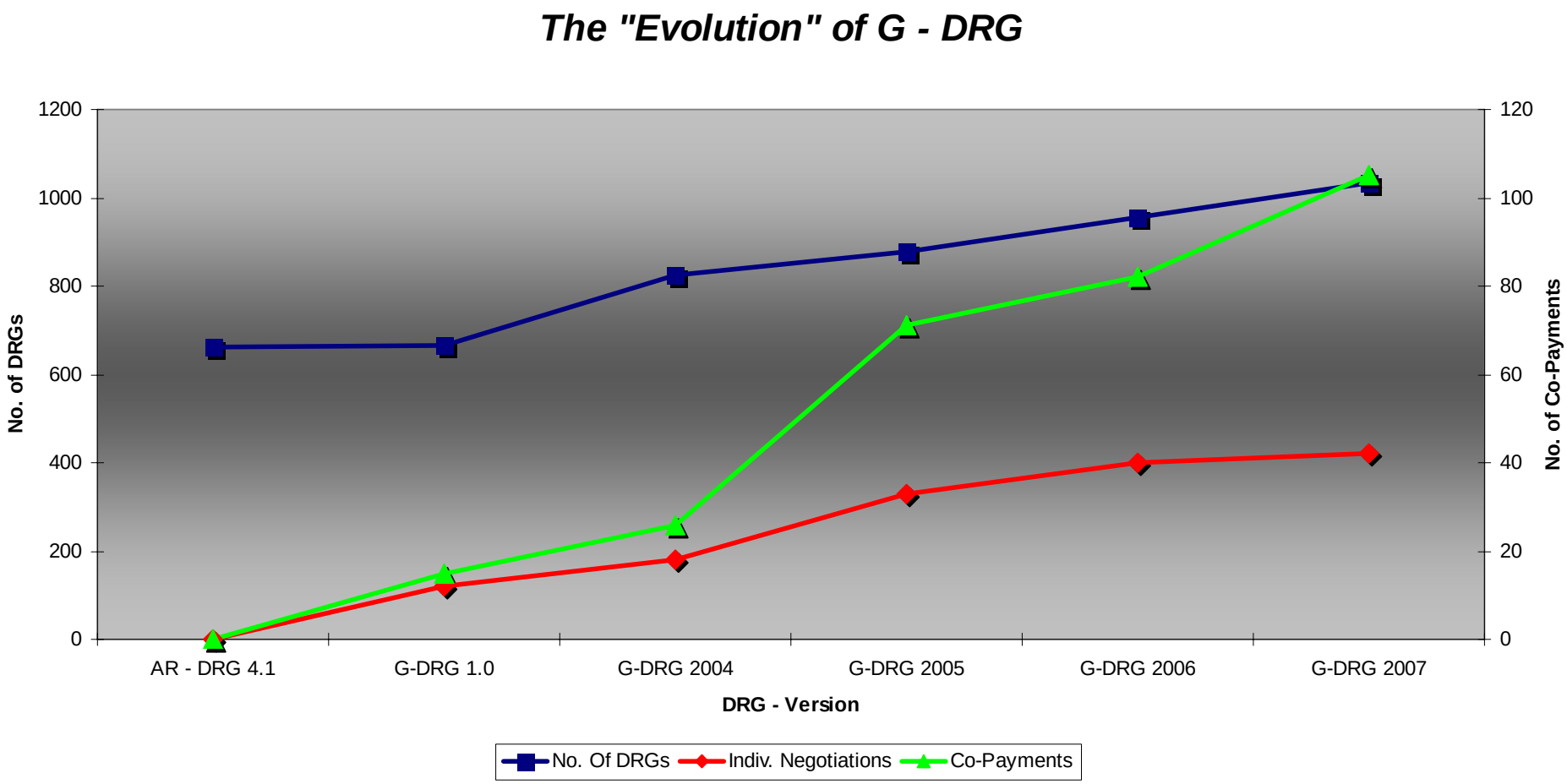
In Germany the Australian Refined DRG System (AR-DRG) was taken as starting point and then adapted, key features:

- Strong relation to clinical entities
- Excellent respection of co-morbidities via CCL/PCCL system
- Logical, hierarchical nomenclature instead of mere *numbers*

Additional features:

- Hours of mechanical ventilation trigger expensive DRGs
- Age and birthweight as further discriminators
- Length of stay is taken into account for short- and long stay outliers

The German solution II



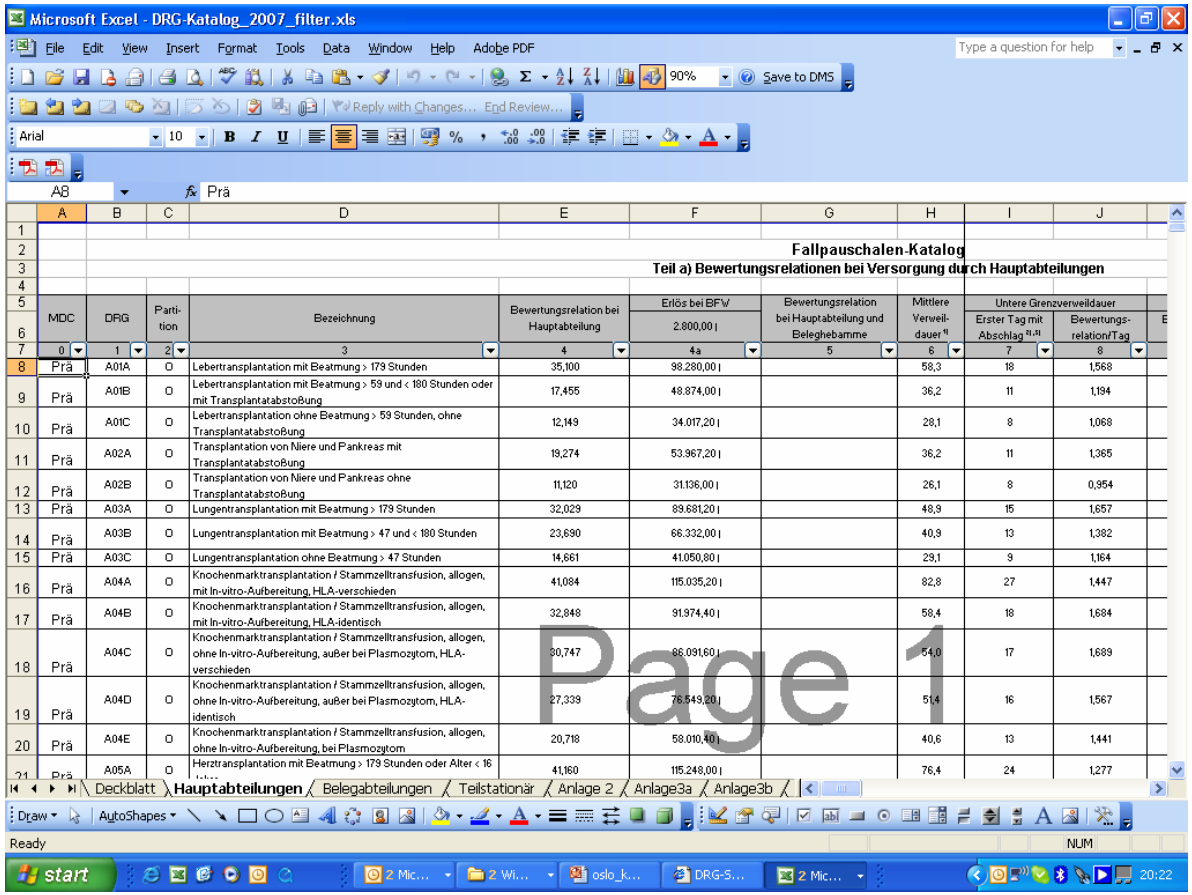
The German Solution III

G-DRG Version 2007 in brief:

- 1035 DRGs with nationwide cost weights
- 47 DRGs for individual negotiation or same-day
- 105 co-payments
- App. 100 NUB-payments

The German Solution IV

Some examples:



Microsoft Excel - DRG-Katalog_2007_filter.xls

Fallpauschalen-Katalog

Teil a) Bewertungsrelationen bei Versorgung durch Hauptabteilungen

MDC	DRG	Partition	Bezeichnung	Bewertungsrelation bei Hauptabteilung	Erlös bei BFW 2.800,00	Bewertungsrelation bei Hauptabteilung und Beleghebamme	Mittlere Verweildauer	Untere Grenzverweildauer: Erster Tag mit Abschlag	Untere Grenzverweildauer: Bewertungsrelation/Tag
0	1	2	3	4	4a	5	6	7	8
Prä	A01A	O	Lebertransplantation mit Beatmung > 179 Stunden	35,100	98.280,00		58,3	18	1,568
Prä	A01B	O	Lebertransplantation mit Beatmung > 59 und < 180 Stunden oder mit Transplantatabstoßung	17,455	48.874,00		36,2	11	1,194
Prä	A01C	O	Lebertransplantation ohne Beatmung > 59 Stunden, ohne Transplantatabstoßung	12,149	34.017,20		28,1	8	1,068
Prä	A02A	O	Transplantation von Niere und Pankreas mit Transplantatabstoßung	19,274	53.967,20		36,2	11	1,365
Prä	A02B	O	Transplantation von Niere und Pankreas ohne Transplantatabstoßung	11,120	31.136,00		26,1	8	0,954
Prä	A03A	O	Lungentransplantation mit Beatmung > 179 Stunden	32,029	89.681,20		48,9	15	1,657
Prä	A03B	O	Lungentransplantation mit Beatmung > 47 und < 180 Stunden	23,690	66.332,00		40,9	13	1,382
Prä	A03C	O	Lungentransplantation ohne Beatmung > 47 Stunden	14,661	41.050,80		29,1	9	1,164
Prä	A04A	O	Knochenmarktransplantation / Stammzelltransfusion, allogen, mit In-vitro-Aufbereitung, HLA-verschieden	41,084	115.035,20		82,8	27	1,447
Prä	A04B	O	Knochenmarktransplantation / Stammzelltransfusion, allogen, mit In-vitro-Aufbereitung, HLA-identisch	32,848	91.974,40		58,4	18	1,684
Prä	A04C	O	Knochenmarktransplantation / Stammzelltransfusion, allogen, ohne In-vitro-Aufbereitung, außer bei Plasmozytom, HLA-verschieden	30,747	86.091,60		54,0	17	1,689
Prä	A04D	O	Knochenmarktransplantation / Stammzelltransfusion, allogen, ohne In-vitro-Aufbereitung, außer bei Plasmozytom, HLA-identisch	27,339	76.549,20		51,4	16	1,567
Prä	A04E	O	Knochenmarktransplantation / Stammzelltransfusion, allogen, ohne In-vitro-Aufbereitung, bei Plasmozytom	20,718	58.010,40		40,6	13	1,441
Prä	A05A	O	Herztransplantation mit Beatmung > 179 Stunden oder Alter < 16	41,160	115.248,00		76,4	24	1,277

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Coding Quality in the G – DRG system

The basis for G-DRG coding:

- ICD10 – GM (German Modification) → currently ca. 16.000 codes
- OPS – 301 (Operation and Procedures acc. §301) ca. 35.000 codes
- German Coding standards (Deutsche Kodierrichtlinien – DKR), app. 200 pages

Coding Quality in the G – DRG system

The most important coding standards:

- Principle diagnosis is defined as „diagnosis that is the reason for hospital admission (to be defined on discharge)“
- *Relevant* secondary diagnoses are those diagnoses that cause „additional resource utlization in diagnostics, treatment or nursing“
- *Relevant* procedures have the same definition as secondary diagnoses

Coding Quality in the G – DRG system

Insurers can check DRG-bills via the Medical Service of the sickness funds (MDK):

- Either in case of doubts if the hospital treatment is adequate or maybe outpatient treatment could have been done instead
- Or in case of doubts wether the Coding is o.k. or not
- In Germany app. 805.000 patients are reviewed and the hospitals pay back app. € 650.000.000.- (1,4% of budget) for coding errors and outpatients treated as inpatients

Thus correct coding is a major financial issue!

Coding Quality in the G – DRG system

How is coding done in practice?

- Either by doctors
- Or by coders (constant shift over the last five years)
- Most hospitals have at least one „medical controller“ who checks the DRGs before sending to the insurance company
- Regular internal audits are rare, most of the auditing is externally caused

Coding Quality in the G – DRG system

The major challenges:

- Excellent clinical documentation → it‘s the basis for coding
- Standardized coding process with IT support, access to the clinical documentation for the coders and final check before sending out
- Congruence between documentation ←→ discharge report ←→ coding (single most reason for succesful claims!)
- Regular internal audits (more in the afternoon)

Thank you very much for your attention!

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