MEDEANALYTICS® 1

Our Presenter

Ken Perez, Senior Vice President of Marketing and Director of Healthcare Policy

Ken leads the strategic direction and orchestration of all of MedeAnalytics' marketing functions, including product marketing, marketing communications and healthcare policy research and analysis. He is a frequent commentator on healthcare policy issues in publications and at industry events. Ken has over 20 years of experience in business, serving in senior marketing, business development and finance roles for healthcare IT and technology companies.

MEDEANALYTICS® 2

Overview

- Societal, legislative and market context
- The history of Medicare and its significance to hospitals
- Planned and potential cuts to Medicare reimbursement
- Recommendations for hospitals

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Societal, Legislative and Market Context

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Economic Drivers

- U.S. federal debt = $15 trillion, equal to 100% of U.S. annual GDP
- Others in the high-debt club: Japan (229%), Greece (152%), Jamaica (137%), Lebanon (134%), Italy (120%), Ireland (114%) and Iceland (103%)[1]
- Annual national health expenditures = ~$2.7 trillion or ~18% of GDP
- Sequestration mandates cuts in total federal spending, including a 2% cut to Medicare for nine years starting in 2013

1. International Monetary Fund, cited by AFP, "US borrowing tops 100% of GDP: Treasury," Aug. 3, 2011.

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Impact on U.S. Competitiveness

Warren Buffett: *"Healthcare is a tapeworm in America, one that cuts our competitiveness far more than taxes do."*

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GM

Impact on U.S. Competitiveness

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GM

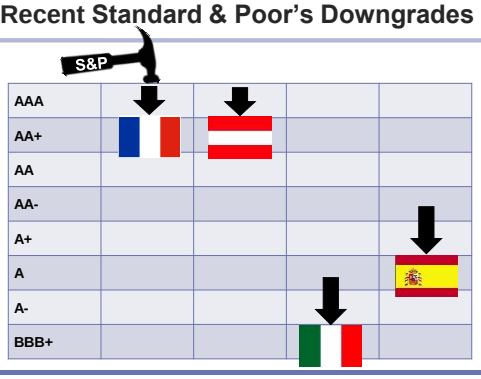
HSR

Continued Pressure from STANDARD &POOR'S

- Aug. 5, 2011: S&P lowered the United States' AAA rating for the first time since granting it in 1917, dropping it one notch to AA+.
- S&P issued a "negative outlook," communicating that there is a chance it will lower the rating again within the next two years, ***if the agency sees smaller reductions in spending than Congress and the administration have agreed to make***, higher interest rates or new fiscal pressures during this period.

Source: Martin Crutsinger, "S&P downgrades US credit rating from AAA," www.ap.org, Aug. 5, 2011.

Recent Standard & Poor's Downgrades



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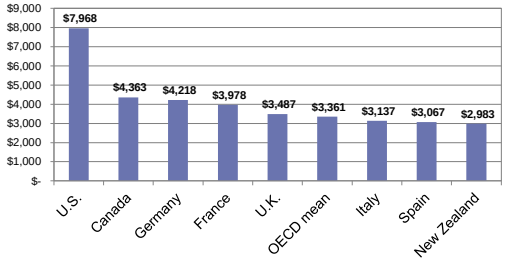
Per Capita Healthcare Spending in 2009

(adjusted for cost-of-living differences)



Source: *OECD Health Data 2011*, www.oecd.org, Nov. 2011.

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The History of Medicare and Its Significance to Hospitals

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A Brief History of Medicare

- July 30, 1965: The Social Security Act (H.R. 6675) was signed into law as Public Law 89-97.
- Title XVIII of the law created Medicare, while Title XIX created Medicaid.
- Medicare extended health coverage to almost all Americans aged 65 or older. About 19 million beneficiaries enrolled in Medicare in the first year of the program.
- Medicare was the responsibility of the Social Security Administration (SSA), an agency of the Department of Health, Education and Welfare (HEW).
- 1972: The Social Security Amendments expanded Medicare to provide coverage to two additional high-risk groups: disabled persons receiving cash benefits for 24 months under the Social Security program and persons suffering from end-stage renal disease.

Source: www.hhs.gov

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A Brief History of Medicare (continued)

- 1977: the Health Care Financing Administration (HCFA) was created under HEW to effectively coordinate Medicare and Medicaid.
- 1980: HEW was divided into the Department of Education and the Department of Health and Human Services (HHS).
- June 14, 2001: HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).
- December 8, 2003: President George W. Bush signed the Medicare Prescription Drug Improvement and Modernization Act (MMA) into law. This landmark legislation provided seniors and people living with disabilities a prescription drug benefit, more healthcare choices and better benefits.

Source: www.hhs.gov

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The Significance of Medicare

- 48 million Medicare beneficiaries[1]
- Total gross Medicare spending in FY2011 of $555 billion[2]
  - 14% of the federal budget[3]
  - 20% of total national health expenditures[4]
  - 4% of gross domestic product[5]

Sources:
1. Kaiser Family Foundation, "Total Number of Medicare Beneficiaries, 2011, " www.statehealthfacts.org.
2. Kaiser Family Foundation, "Medicare Spending and Financing," Sept. 2011, based on CBO, Aug. 2011 data.
3. Office of Management and Budget, FY2011 Budget, Table S-1, Feb. 2010, p. 150.
4. CMS, "NHE Fact Sheet," www.cms.gov, accessed April 27, 2012.
5. Office of Management and Budget, FY2011 Budget, Table S-1, Feb. 2010, p. 150.

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The Significance of Medicare for Hospitals

- In 2009, more than 7 million Medicare beneficiaries experienced more than 12.4 million inpatient hospitalizations.[1]
- Medicare finances nearly 4 in 10 hospital stays.[2]
- Medicare is the leading payer for most hospitals, accounting for 35 to 55 percent of revenue.[3]

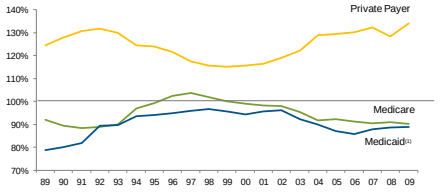
Sources:
1. U.S. DHHS, "Administration Implements New Health Reform Provision to Improve Care Quality, Lower Costs," April 29, 2011.
2. Lisa Potetz, et al., Medicare Spending and Financing: A Primer, Feb. 2011, p. 1, citing data from AHRQ's HCUP.
3. Mark Taylor, "New Medicare Cuts Will Force Hospitals to Plug Major Revenue Leak," *H&HN*, Sept. 2010.

Hospital Margins

- Percent of hospitals with negative operating margins: 28.3%
- -5% average total Medicare margins for all hospitals, projected to reach -7% in 2011[2]
- 61% of hospitals lose money on Medicare[3]

1. Avalere Health analysis of 2010 AHA survey data, *Trendwatch Chartbook 2012*, p. A-31.
2. MedPAC, "Report to the Congress: Medicare Payment Policy," March 2011, pgs. 37, 60.
3. AHA , "Fragile State of Hospital Finances," 2009 AHA survey data.

Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1989–2009

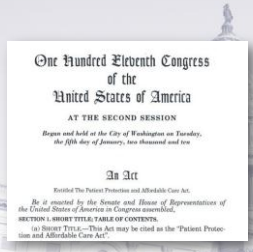


Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2009, for community hospitals.
(1) Includes Medicaid Disproportionate Share payments.

Planned and Potential Cuts to Medicare Reimbursement

Health Reform

Health Reform


One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday, the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

- H.R. 3590, the Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010 as Public Law 111-148.
- H.R. 4872, the Health Care and Education Affordability Reconciliation Act (HCEARA) was signed into law on March 30, 2010 as Public Law 111-152.

Reductions to Medicare Market Basket Updates

- Section 3401 of the ACA: Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates that Do Not Already Incorporate Such Improvements
- Reductions to CMS' Inpatient Prospective Payment System (IPPS) market basket update:
  - Specified percentages for FY2010 through FY2019
  - To-be-determined productivity adjustments for FY2012 through FY2020 and beyond
    - Equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity.[1, 2]
    - The proposed FY2013 productivity adjustment is -0.8%.[3]

Sources:
1. Section 3401 of HR 3590, the ACA.
2. Larry Goldberg, "CMS Issues Final FY 2011 Medicare IPPS Update with Market Basket Increase of 2.35 Percent and A Negative Coding Adjustment of 2.9 Percent," *Washington Bulletin*, Aug. 2, 2010.
3. CMS, FY2013 IPPS proposed rule, April 24, 2012, pg. 1075.

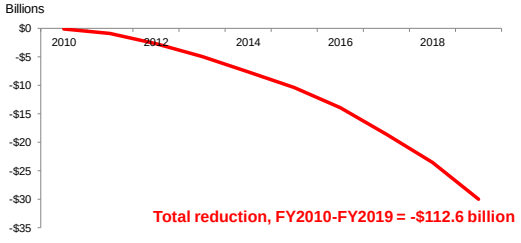
IPPS Market Basket Update History and Projections

Historical IPPS market basket update:	IPPS market basket update projections:
• 2000 = 2.9% • 2001 = 3.4% • 2002 = 3.3% • 2003 = 3.5% • 2004 = 3.4% • 2005 = 3.3% • 2006 = 3.7% • 2007 = 3.4% • 2008 = 3.3% • 2009 = 3.6% • 2010 = 2.1% • 2011 = 2.6% • 2012 = 3.0%	• 2013 = 3.00% (proposed, unadjusted) • 2014 = 2.80% • 2015 = 2.98% • 2016 = 3.30% • 2017 = 3.20% • 2018 = 3.10% • 2019 = 3.10%

Sources: CMS, "Actual regulation market basket updates," http://www.cms.gov/MedicareProgramRatesStats/downloads/mktbskt-actual.pdf, accessed June 18, 2011; IHS Global Insight, Actual Update Factors," released by CMS Office of the Actuary, 2011; CMS, FY2012 IPPS final rule, pg. 101; CMS, FY2013 IPPS proposed rule, pg. 1081.

Increasing Pressure on Medicare Margins

Projected Hospital Inpatient Prospective Payment System Market Basket Revisions and Productivity Adjustments, FY2010-FY2019



Sources: CMS, Office of the Actuary, National Health Statistics Group, "National Health Expenditure Projections 2009-2019," Sept. 2010, and CMS, Office of the Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010.

Documentation and Coding Improvements (DCI) Adjustments

- DCI was a result of the two-year phase-in starting in 2008 of moving from DRGs to MS-DRGs to better capture severity-of-illness differences among patients.
- These changes also refined reimbursements, allowing more dollars for "sicker" patients with supporting documentation.
- CMS and the Medicare Payment Advisory Commission estimated that DCI resulted in overpayments of 5.8% in 2008 and 2009 and needed a permanent adjustment to stop the flow of future overpayments.
- In simple terms, CMS has applied: one-time recoupments to correct for past overpayments, removals or reversals of recoupments in subsequent years, prospective cuts, and adjustments to correct other errors (e.g., overstated patient severity) based on retrospective analysis.

Sources: CMS, FY2012 IPPS final rule, Aug. 1, 2011 pg. 101.; CMS, FY2013 IPPS proposed rule, April 24, 2012, pgs. 54-56.

Summary of Adjustments to the IPPS

	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
Reductions to Market Basket Update	-.25%	-.10%	-.10%	-.30%	-.20%	-.20%	-.75%	-.75%	-.75%	
Productivity Adjustments		-1.00%	-0.80%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Documentation and Coding Improvements Recoupments	-2.90%	-2.90%								
Removals of Prior-Year DCI Recoupments		+2.90%	+2.90%							
DCI Prospective Cuts		-2.00%	-1.90%							
DCI Correction for FY2010 Patient Severity Overpayment			-0.80%							

Sources:

1. CMS, "Fact Sheet: Details for: Proposed Policy and Payment Changes for Inpatient Stays in Acute Care Hospital Inpatient and Long-Term Care Hospitals," April 19, 2011.
2. Section 3401 of HR 3590, the ACA, and Larry Goldberg, "CMS Issues Final FY 2011 Medicare IPPS Update with Market Basket Increase of 2.35 Percent and A Negative Coding Adjustment of 2.9 Percent," *Washington Bulletin*, Aug. 2, 2010.
3. CMS, FY2012 IPPS final rule, Aug. 1, 2011, pg. 101.
4. CMS, FY2013 IPPS proposed rule, April 24, 2012, pgs. 55, 1075.

Adjusted Market Basket Update for FY2013

Unadjusted market basket update for FY2013	3.00%
Reduction per the ACA	<0.10%>
Productivity adjustment per the ACA	<0.80%>
Net DCI adjustment	0.20%
Net payment change	2.30%

The Budget Control Act

The Budget Control Act of 2011

- Passed by the House on Aug. 1, 2011, 269-161
- Passed by the Senate on Aug. 2, 2011, 74-26
- Signed into law by President Barack Obama on Aug. 2, 2011 as Public Law 112-25
- Cut discretionary spending over 10 years by $917 billion and raised the debt ceiling by $900 billion
  - Medicare was excluded from these cuts.

The Budget Control Act of 2011

- Created and tasked a 12-member Joint Committee of Congress ("Super Committee") to produce proposed legislation by Nov. 23, 2011 that would reduce the deficit by at least $1.5 trillion over 10 years, with consideration by both chambers of Congress by Dec. 23, 2011.
- Sequestration process/"trigger" if the Super Committee is unable to agree upon a proposal with at least $1.2 trillion in spending cuts:
  - The President may request a debt limit increase of up to $1.2 trillion.
  - After congressional approval, across-the-board cuts equal to the debt limit increase would apply to both mandatory and discretionary programs, with total reductions split equally between defense discretionary and non-defense discretionary plus covered entitlements.
  - **The cut to Medicare is capped at 2% and would be limited to cuts to provider payments.**

The Potential Cut to Medicare

- A 2% cut to Medicare would equal **$142 billion**
- Such a cut would be applied to FY2013-2021 (nine years)
- If the Hospital IPPS and OPPS bear their proportional shares of the total cut to Medicare, one-third of the $142 billion or **$47 billion** would be cut from hospital reimbursements
- That would translate into about **$1.5 million** for the average hospital for each year during FY2013-2021

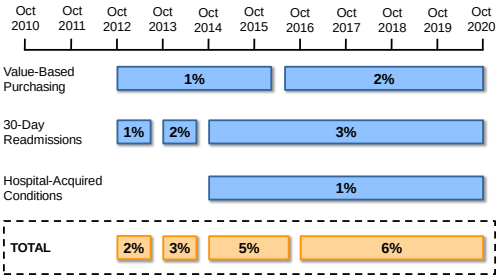
The Cumulative Impact

- The past three years: A "sea change" for Medicare reimbursement of hospitals
- ACA-mandated reductions to the IPPS plus potential cuts as a result of the Budget Control Act FY2013 to FY2021 could total **$156 billion** (or more).
- This translates into a cut of about **$5 million for the average hospital per year**, relative to pre-health reform and pre-Budget Control Act conditions.

The Rise of Risk-Based Reimbursement and the Fall of Cost Shifting

What Won't Change: The Era of Risk-Based Reimbursement Is Here

Hospital Medicare Payment at Risk, Year by Year



Source: Sg2 Analysis, 2011.

"Focusing on quality isn't a new concept for hospitals. For decades, changes in the industry have focused on improving quality care while decreasing costs. However, organizations will begin to feel increasing financial pressure to perform well."

- PricewaterhouseCoopers' Health Research Institute, *Health Reform: Prospering in a post-reform world*, May 2010

No Relief from Commercial Payers

"The cross-subsidization model will face increasing strain, as commercial payers will increasingly prove unable to afford to offset pressure on government reimbursement rates."

- Morgan Stanley, "Reimbursement Pressure to Spur M&A and Cost Control," *Healthcare Facilities*, July 8, 2011.

The Sustainable Growth Rate and the "Doc Fix"

A Bigger Risk for Hospitals

Anders Gilberg, SVP at the Medical Group Management Association, commenting on the specter of the trigger plan's 2 percent cut to Medicare:

"That's a concern, but sort of ***pales in comparison to the SGR****."*

Source: Jessica Sigmond and Rich Daly, "Preparing a game plan: Healthcare groups' message to deficit panel: Spare us," *Modern Healthcare*, Aug. 22, 2011.

A Brief History of the SGR

- Section 4503 of the Balanced Budget Act of 1997 replaced the Medicare Volume Performance Standard with a sustainable growth rate provision, designed to restrain the growth of Medicare spending on physician services.
- The SGR requires Medicare each year to set a total budget for spending for the following year. If actual spending exceeds that budget, the conversion factor for subsequent years is reduced so that cumulative actual spending will not exceed cumulative budgeted (targeted) spending, with April 1,1996 as the starting point.

Kicking the Can Down the Road

- Congress has overridden the SGR each year from 2003 through 2012 with temporary "doc fixes."
- The physician fee schedule is slated to be cut by **30.9%** starting on Jan. 1, 2013.
- A permanent doc fix would cost **$300-400 billion** and would presumably require offsetting spending cuts.
- Hospitals are the biggest target for such cuts, a "robbing Peter to pay Paul" approach.

Recommendations for Hospitals

Not an Option

Scenario Planning with Detailed Financial and Operational Models

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October 2010: Decision to take the bull by the horns

Choices:

- Delay, hope for the best. Rely on reactionary "crisis management" - Neanderthal budget cutting
- Begin now, identify large, sensible initiatives that yield sustained change in the margin and cost structure for VUMC
- Begin now - deliver margin improvement of $35 million in FY11 – double in FY12 – control our future!

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Impact on VUMC Health Care (FY13-FY16)

- ***Likely*** losses tied to the Budget Control Act
  - Cuts to Medicare: $132M
  - Cuts to Medicaid: $160M
- ***Potential*** losses related to repeal of the ACA
  – $150 - 200M
- ***Probable*** losses with changes to global payment in a traditional tertiary-care fee-for-service model
  - $50 -100M

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Focus on Improving the Process and Delivery of Care

Strategies

1. Form a financial-clinical partnership
2. Perform detailed margin analysis
3. Engage with service line managers and physicians
4. Revamp care coordination
5. Ensure efficient operating room (OR) utilization
6. Improve emergency room (ER) operations

1. Form a Financial-Clinical Partnership

- Recognizing the need for improved, more cost-effective care delivery, the hospital's CFO should initiate a meeting with the CMO and others on the clinical leadership team to forge or reinforce a financial-clinical partnership.
- Key agenda items:
  - Candid assessment of the current financial condition of the hospital
  - Explanation and discussion of the impending increased financial pressures and their likely impact
  - Solicitation of the support and assistance of the clinical leadership team

hfma
healthcare financial management association

The Business of Caring

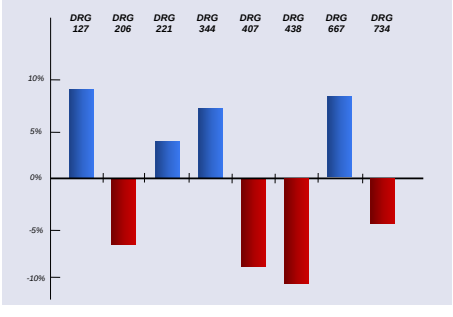
The Business of Caring highlights how nursing and other clinical leaders can collaborate with finance leaders to control costs and improve quality. Insights and how-to strategies for coping with the business side of health care are highlighted. Topics covered include budgeting, staffing, and cost control. This free, electronic publication is copublished on a quarterly basis by HFMA and the American Organization of Nurse Executives (AONE).

www.hfma.org/boc/

2. Perform Detailed Margin Analysis

- Identify loss-making MS-DRGs for which reimbursement is significantly lower than actual cost
- Analyze MS-DRG/service line margins down to the physician and patient level, with attention on the five MS-DRGs/service lines with the highest volume, the highest profitability, and the greatest losses
- Perform ongoing margin analysis, with review by service line managers, physicians and the hospital's senior management team

Medicare Margins by DRG



3. Engage with Service Line Managers and Physicians

- Clinical Performance Improvement Action Team
  - Initial foci: supply utilization, length of stay, drug costs, readmissions within 30 days of discharge, and ancillary testing usage
- Review and analysis of the reasons for Medicare (and Medicaid) clinical denials
- Clinical documentation improvement program
- Physician scorecards
- Financial-clinical grand rounds

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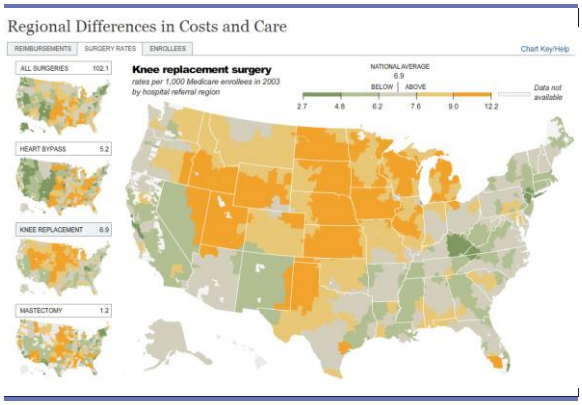

Sources: *Dartmouth Atlas of Healthcare, New York Times*

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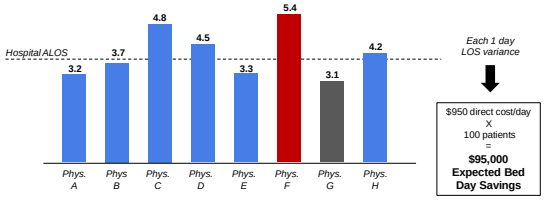
Variability at the Physician Level

Average Length of Stay Comparison – Total Knee Replacement



Each 1 day LOS variance

$950 direct cost/day
X
100 patients
=
$95,000 Expected Bed Day Savings

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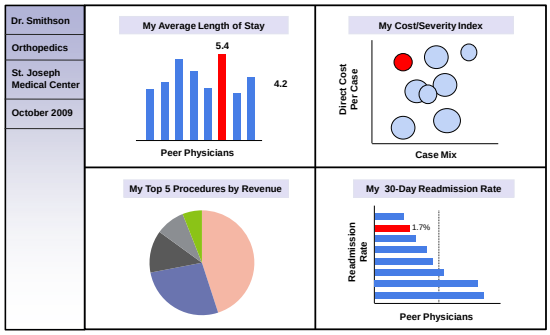
Physician-Centric Peer Group Analysis



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Common Challenges in Measuring Physician Costs and Quality

- ❑ Reliance on IT and Decision Support for performance data
- ❑ Severity/risk adjustment ("My patients are sicker…")
- ❑ Accuracy of cost information and allocation methodology
- ❑ Retrospective (monthly, quarterly, annual) performance reports
- ❑ Attributing physician ownership of patient encounters
- ❑ Hundreds of required and endorsed quality metrics (where to focus?)
- ❑ Sensitivity to balance between cost metrics and clinical quality
- ❑ Physician relations and change management process
- ❑ _____

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4. Revamp Care Coordination

- Evaluate and improve care coordination policies
- Reduce costly avoidable readmissions by improving the discharge process
- Establish or connect with a local or regional health information exchange

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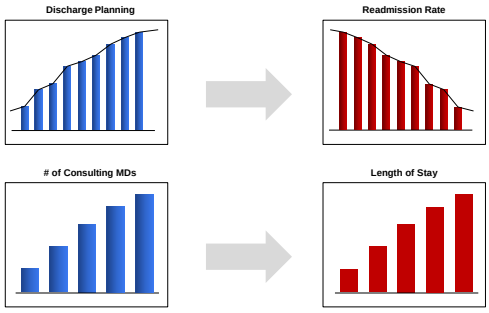
Lower Costs through Improved Care Coordination



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5. Ensure Efficient Operating Room Utilization

- Improved scheduling (aligning surgeons and surgeries), standardization of processes and operational reporting can decrease gaps and delays, reduce costs, and enhance care delivery
- Analytics can identify:
  - Variances In operating time and OR room turnover time by procedure and operating physician
  - Root causes of surgery start time delays and PACU admission delays

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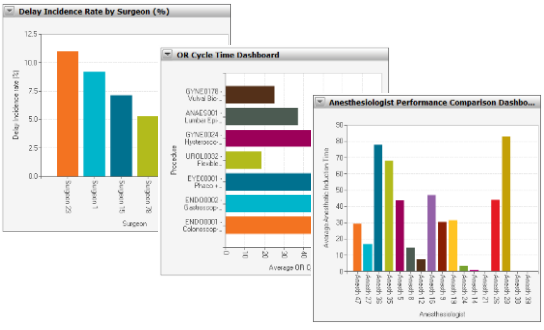
OR Throughput Analysis



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6. Improve Emergency Room Operations

- Space and staffing challenges faced by ERs are well documented.
- Data analysis and review of ER:
  - Supply and drug utilization
  - Ancillary testing
  - Inappropriate usage

Case Study: St. Joseph Medical Center

Best Practice	Result
Actively partner and engage with your physicians to increase revenue and reduce costs	Improved contribution margin per case by 8.3%, from $4,666 in 2008 to $5,051 in 2009
Optimize and reduce supply costs	
Evaluate care coordination policies and processes	Reduced average length of stay by 0.4 day, resulting in a savings of $2.6 million
Evaluate current service line profitability and market need	Turned negative operating margin into 2.4% operating surplus in one year
Overall net savings of **$11.8 million** in the first year of implementation	

Conclusions

- A decade-long “perfect storm”
- Multiple icebergs
- Vigilance, scenario planning and focus on improving care delivery

For More Information

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