Medicare Zero™:
An analysis of reductions to Medicare’s Hospital IPPS and ways to improve Medicare margins to breakeven or better

A MEDEANALYTICS WEBINAR

Wednesday, August 31, 2011 | 1:15 p.m. CT, 11:15 a.m. PT
Our Presenter

Ken Perez, Senior Vice President of Marketing

Ken directs MedeAnalytics’ healthcare policy team and serves as the company’s senior vice president of marketing. He leads the strategic direction and orchestration of all of MedeAnalytics' marketing functions, including product marketing, product management and marketing communications.
Overview

- The history of Medicare and its significance to hospitals
- Reductions to the Inpatient Prospective Payment System
- Strategies to offset the reductions in Medicare reimbursement
The History of Medicare and Its Significance to Hospitals
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
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
The Significance of Medicare

- 47 million Medicare beneficiaries\(^1\)
- Total gross Medicare spending in FY2010 of $528 billion\(^2\)
  - 12% of the federal budget\(^3\)
  - 20% of total national health expenditures\(^4\)
  - 3.5% of gross domestic product\(^5\)

**Sources:**
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:
Hospital Margins
(2009 data)

- 0.1% average operating margin for all hospitals\(^1\)
- 5% average total Medicare margins for all hospitals, projected to reach -7% in 2011\(^2\)
- 61% of hospitals lose money on Medicare\(^3\)

---

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.
Hospital Payment Shortfall Relative to Costs for Medicare, Medicaid, and Other Government, 1997–2009

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2009, for community hospitals.

(1) Costs reflect a cap of 1.0 on the cost-to-charge ratio.
Reductions to the Inpatient Prospective Payment System
Health Reform

- 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 Payments 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 final FY2012 productivity adjustment is -1.0%.\(^3\)

Sources:
1. Section 3401 of HR 3590, the ACA.
### IPPS Market Basket Update History and Projections

#### Historical IPPS market basket update:
- 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% (unadjusted)

#### IPPS market basket update projections:
- 2013 = 2.78%
- 2014 = 2.80%
- 2015 = 2.98%
- 2016 = 3.30%
- 2017 = 3.20%
- 2018 = 3.10%
- 2019 = 3.10%

Increasing Pressure on Medicare Margins

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

Total reduction, FY2010-FY2019 = -$112.6 billion

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.

- To recoup the 5.8% overpayment, CMS applied a one-time DCI recoupment of -2.9% in FY2011 and has a -2.9% one-time DCI recoupment in FY2012 that will be restored in FY2013. But the removal of the FY2011 recoupment (+2.9%) in FY2012 effectively cancels out the FY2012 adjustment (-2.9%).

- CMS also proposes to make a prospective DCI cut to permanently remove increased payments from the system. Per CMS, a total prospective cut of -5.4% is needed. To date, CMS has applied cuts totaling -1.5%, thus a cut of -3.9% remains necessary. CMS has applied a -2.0% DCI prospective cut in FY2012, with the remainder to be applied in FY2013 and/or subsequent years.

## Summary of Adjustments to Medicare Reimbursement

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reductions</strong></td>
<td>-.25%</td>
<td>-.10%</td>
<td>-.10%</td>
<td>-.30%</td>
<td>-.20%</td>
<td>-.20%</td>
<td>-.75%</td>
<td>-.75%</td>
<td>-.75%</td>
<td>-.75%</td>
</tr>
<tr>
<td><strong>Market Basket</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Update</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Productivity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adjustments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>and Coding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improvements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recoupments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Removals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>of Prior-Year DCI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recoupments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DCI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prospective Cuts</strong></td>
<td>-.20%</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**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.


Adjusted Market Basket Update for FY2012

- Unadjusted IPPS market basket update for FY2012: 3.00%
- Reduction per the ACA: <0.10%
- Productivity adjustment per the ACA: <1.00%
- DCI prospective cut: <2.00%
- Response to litigation: 1.10%
- Net payment change: 1.00%
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
- Cuts discretionary spending over 10 years by $917 billion and raises the debt ceiling by $900 billion
  - Medicare is excluded from these cuts.
The Budget Control Act of 2011

- Creates and tasks a 12-member Joint Committee of Congress 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 Joint 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% (an estimated $126 billion) and would be limited to cuts to provider payments.
The Potential Cut to Medicare

- "Cutting" Medicare: The difference between reduced benefits and reduced payments to providers

- A reasonable starting point: A “proportional” model:
  - The cut to Medicare is in line with Medicare’s proportional share of the federal budget
  - The cut to the IPPS is in line with the IPPS’s proportional share of the Medicare budget

- Per this model, **Medicare would be cut by $150 to $200 billion** over the 10 years, and **the IPPS would be cut by $50 to $65 billion**.

- The IPPS cuts would translate into a cut of **$1.5 to $1.9 million per hospital per year** (equivalent to a 2.3% to 2.9% average annual reduction).
The Cumulative Impact

- The past two years: A “sea change” for Medicare reimbursement of hospitals

- ACA-mandated reductions to the IPPS plus potential cuts to the IPPS as a result of the Budget Control Act of 2011 for FY2012 to FY2021 could total $162 billion to $177 billion.

- This translates into a cut of $5 million for the average IPPS-participating hospital (with 210 beds) per year, relative to pre-health reform conditions.
Non-IPPS Cuts

“All deficit reduction proposals to date should be considered on the table, particularly those that have been scored and would produce significant savings, including cuts to graduate medical education programs, home health providers, labs, rural hospitals, Medigap and Medicaid reform measures, just to name a few. Healthcare reform and new programs created by the Affordable Care Act are also vulnerable, including delivery system pilots and demos and support to the newly established health insurance exchanges, adding additional pressure to states already in fiscal crisis.”

Continued Pressure from

- 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.

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

Hospital Medicare Payment at Risk, Year by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Value-Based Purchasing</th>
<th>30-Day Readmissions</th>
<th>Hospital-Acquired Conditions</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2010</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Oct 2011</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2012</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2013</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2014</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2015</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2016</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2017</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2018</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2019</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Oct 2020</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
</tbody>
</table>

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.”

Strategies to Offset the Reductions in Medicare Reimbursement
Strategies to Offset the Reductions in Medicare Reimbursement

1. Partner with clinical leadership
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. Partner with Clinical Leadership

- 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
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/](http://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
Variability at the Physician Level

Average Length of Stay Comparison – Total Knee Replacement

<table>
<thead>
<tr>
<th>Physician</th>
<th>Hospital ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phys. A</td>
<td>3.2</td>
</tr>
<tr>
<td>Phys. B</td>
<td>3.7</td>
</tr>
<tr>
<td>Phys. C</td>
<td>4.8</td>
</tr>
<tr>
<td>Phys. D</td>
<td>4.5</td>
</tr>
<tr>
<td>Phys. E</td>
<td>3.3</td>
</tr>
<tr>
<td>Phys. F</td>
<td>5.4</td>
</tr>
<tr>
<td>Phys. G</td>
<td>3.1</td>
</tr>
<tr>
<td>Phys. H</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Each 1 day LOS variance

$950 direct cost/day

X

100 patients

= $95,000

Expected Bed Day Savings
Physician-Centric Peer Group Analysis

My Average Length of Stay

Peer Physicians

5.4
4.2

My Cost/Severity Index

Direct Cost Per Case

Case Mix

My Top 5 Procedures by Revenue

My 30-Day Readmission Rate

Readmission Rate

Peer Physicians

1.7%

Dr. Smithson
Orthopedics
St. Joseph Medical Center
October 2009

© 2011 MedeAnalytics, Inc. All rights reserved.
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

© 2011 MedeAnalytics, Inc. All rights reserved.
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
Lower Costs through Improved Care Coordination

Discharge Planning

Readmission Rate

# of Consulting MDs

Length of Stay
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
OR Throughput Analysis

- Delay Incidence Rate by Surgeon (%)
- OR Cycle Time Dashboard
- Anesthesiologist Performance Comparison Dashboard
6. Improve Emergency Room Operations

- Well-documented space and staffing challenges faced by ERs

- Data analysis and review of ER:
  - Supply and drug utilization
  - Ancillary testing
  - Inappropriate usage
## Best Practices Case Study:  
St. Joseph Medical Center, Towson, MD

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

**Overall net savings of $11.8 million in the first year of implementation**
Strategies to Offset the Reductions in Medicare Reimbursement

1. Partner with clinical leadership
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
Summary

- Medicare reimbursement is a major factor in hospitals’ finances, and Medicare margins are already poor.

- Statutory reductions to Medicare reimbursement portend a “perfect storm” for hospital finances.

- The largest and core activity of the hospital—the process and delivery of care—constitutes an area of promising opportunity to achieve financial gains sufficient to offset the reductions in Medicare reimbursement.

- There are six proven, actionable strategies to improve the efficiency and effectiveness of clinical operations.
Medicare Zero™:
A Comprehensive Analysis of the Impact of Health Reform and the Debt Deal on Medicare Funding of Hospitals and Strategies for Financial Survival

By Ken Perez, Senior Vice President of Marketing
Clinical Performance Manager

www.medeanalytics.com/cpm

Strategic insight into the drivers of cost and quality across the enterprise and at the individual physician level

Features

- Service line trend analysis
- Individual physician scorecards
- Resource utilization/cost analysis
- Clinical quality metrics reporting
- Customer satisfaction scores
- Core measures analysis
- Physician cost and quality benchmarking
- Patient demographic analysis
- Cost/margin analysis
Questions

Ken Perez
ken.perez@medeanalytics.com
(510) 379-3243