



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

Introduction

Established in 1965, Medicare is a social insurance program that provides health and financial security for individuals ages 65 and older and for younger people with permanent disabilities. It serves as the nation's largest health insurance program, covering a population of 47 million people for a broad range of services.¹

Total gross Medicare spending in 2010 was an estimated \$528 billion,² comprising 12 percent of the federal budget,³ one-fifth of total national health expenditures,⁴ and 3.5 percent of gross domestic product.⁵ For various reasons, Medicare spending is increasing steadily—in absolute as well as relative terms—so all of these figures are expected to grow in the future. Because of its magnitude, Medicare is often a significant part of discussions about how to moderate the growth of both federal spending and healthcare spending.

According to the Centers for Medicare & Medicaid Services (CMS), in 2009, more than seven million Medicare beneficiaries experienced more than 12.4 million inpatient hospitalizations.⁶ Hospital payments account for the greatest share of Medicare spending, and Medicare is the largest payer for hospital services, financing nearly four in ten hospital stays.⁷ Consequently, Medicare accounts for 35 to 55 percent of revenue for most hospitals.⁸

Hospital Margins

In 2009, the average U.S. hospital generated an operating margin (loss) of -0.1 percent.⁹ Margins on Medicare were worse, estimated at -5 percent for the average hospital in 2009 and projected to reach -7 percent in 2011.¹⁰ According to the American Hospital Association (AHA), 61 percent of hospitals lose money on Medicare.¹¹

Market Basket Updates: Reductions and Productivity Adjustments

On an annual basis, CMS updates its payments and cost limits, issuing market basket updates to reflect input price inflation facing providers in the provision of medical services. Table 1 provides historical and forward-looking information on the market basket update for the Inpatient Prospective Payment System (IPPS).

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Table 1: Market Basket Update History and Projections¹²

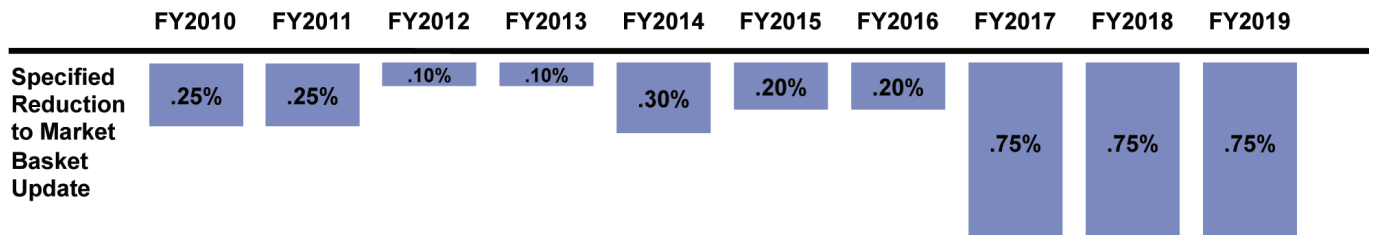
Historical IPPS market basket update:	IPPS market basket update projections:
<ul style="list-style-type: none"> • 2000 = 2.9% • 2001 = 3.4% • 2002 = 3.3% • 2003 = 3.5% • 2004 = 3.4% • 2005 = 3.3% • 2006 = 3.7% • 2007 = 3.4% • 2008 = 3.3% • 2009 = 3.6% • 2010 = 2.1% • 2011 = 2.6% • 2012 = 3.0% (unadjusted) 	<ul style="list-style-type: none"> • 2013 = 2.78% • 2014 = 2.80% • 2015 = 2.98% • 2016 = 3.30% • 2017 = 3.20% • 2018 = 3.10% • 2019 = 3.10%

The reductions to the market basket update and the productivity adjustments total \$112.6 billion in Medicare savings (reduced reimbursements to hospitals) for FY2010-FY2019.¹⁷ While one may describe these as “favorable” changes from a CMS budgetary-control perspective, they will obviously place greater financial pressure on hospitals.

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The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. 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,” mandated negative adjustments to CMS’s IPPS market basket update, specifying annual percentage reductions for FY2010 through FY2019.

Table 2: Specified Reductions to Medicare Market Basket Updates, FY2010-FY2019¹³

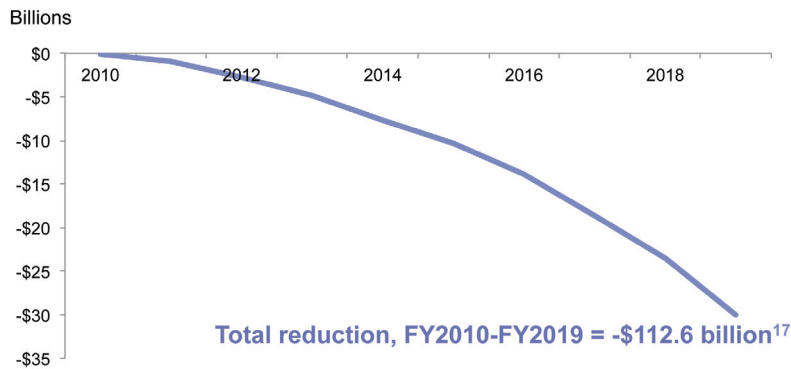


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In addition, section 3401 mandated to-be-determined productivity adjustments for FY2012 through FY2020 and beyond. In general, the productivity adjustments are to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity.^{14, 15} The FY2012 productivity adjustment is -1.0 percent.¹⁶

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Table 3: Projected Hospital Inpatient Prospective Payment System Market Basket Revisions and Productivity Adjustments, FY2010-FY2019



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Documentation and Coding Improvements (DCI) Adjustments

DCI was a result of the two-year phase-in starting in 2008 of moving from DRGs (diagnosis-related groups) to MS-DRGs (Medicare severity diagnosis-related groups) to better capture severity-of-illness differences between patients. These changes also refined reimbursements, allowing more dollars for “sicker” patients with supporting documentation. While documentation and coding improvements accurately improve measurement of patient severity, they can also increase reported case mix under MS-DRGs even if patients’ levels of illness and resource needs do not differ from previous years.

Recoupments

CMS and the Medicare Payment Advisory Commission (MedPAC) estimated that DCI increased payments from CMS to hospitals by 5.8 percent in 2008 and 2009. As the AHA has related, in FY2011, CMS applied half of this adjustment or 2.9 percent as a one-time recoupment that will be restored in FY2012 via a +2.9 percent adjustment. CMS also applied a new 2.9 percent cut in FY2012 to recoup the remaining half of the 5.8 percent. For FY2012, the +2.9 percent adjustment to remove the FY2011 recoupment cancels out the 2.9 percent FY2012 DCI recoupment. (The FY2012 recoupment is also a one-time or temporary cut that will be restored in FY2013.)¹⁸

Prospective Documentation and Coding Cut

CMS has decided to make a prospective documentation and coding cut to permanently remove increased payments from the system. Per

Table 4: Summary of Reductions to Medicare Reimbursement, FY2011-FY2020

	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
Reductions to Market Basket Update	-0.25%	-0.10%	-0.10%	-0.30%	-0.20%	-0.20%	-0.75%	-0.75%	-0.75%	
Productivity Adjustments		-1.00%	TBD	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%							
Documentation and Coding Improvements Prospective Cuts		-2.00%	TBD							

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CMS, a total prospective cut of 5.4 percent is needed. Through FY2011, CMS had applied cuts totaling 1.5 percent, thus a cut of 3.9 percent remains necessary. CMS has decided to apply slightly over 50 percent of this cut—2.0 percent—in FY2012, with the remaining 1.9 percent possibly applied in FY2013 and/or subsequent years.¹⁹

Calculation of the FY2012 IPPS Market Basket Update Per the Final Rule

CMS issued the final rule for the FY2012 IPPS on Aug. 1, 2011. At 1,509 pages in length, it was considerably longer and more “generous” to hospitals than the proposed rule issued on May 5, 2011.

Per CMS, the IPPS market basket update is 3.0 percent. After the ACA-mandated reduction (-0.1 percent) and productivity adjustment of -1.0 percent, the IPPS market basket update is 1.9 percent. Factoring in a final documentation and coding improvement prospective cut of -2.0 percent and a 1.1 percent increase in response to litigation against the Department of Health and Human Services (to restore rural floor budget neutrality adjustments for FY2007 and FY2008) yields a net payment increase of 1.0 percent for FY2012.²⁰

While the net change for the IPPS from FY2011 to FY2012 is positive, hospitals will still face financial pressures. The intent of the market basket update is to offset increases in hospital input prices, so in theory, its effect should be margin-neutral. However, as has been noted, there are adjustments to the market basket update, and if the sum of them is negative, added pressure is placed on hospitals to maintain margins. For FY2012, the adjustments total -2.0 percent.

Example of FY2012 Medicare Economics for a Hospital

Whether a hospital is currently profitable with the Medicare portion of its business (and statistics indicate that there are relatively few such organizations), breaking even or losing money, because of the complexity and increased impact of these reductions to Medicare reimbursement in the future (e.g., the ACA-specified reduction to the market basket update jumps to 0.75 percent in FY2017-FY2019, in contrast with 0.1 percent in FY2012 and FY2013), it is important to understand, monitor and take steps to mitigate the adverse effects of the reductions.

What would be the added financial pressure placed on a 300-bed hospital with \$250 million in revenue in FY2011 as a result of the final IPPS rule for FY2012? Assume that the effects of hospital input price inflation offset the unadjusted market basket update, that the hospital experiences no volume growth in FY2012 (for the sake of simplicity), and that Medicare accounts for 40 percent of the hospital's total revenue (i.e., \$100 million). Since, as previously mentioned, the adjustments to the market basket update for FY2012 total -2.0 percent, this hospital will need to reduce costs by \$2 million in FY2012 in order to maintain Medicare margins at the level they were in FY2011.

The Budget Control Act of 2011: The Spectre of Additional Cuts to Medicare

Passed by the House of Representatives on Aug. 1, 2011 by a vote of 269-161 and by the Senate the following day by a vote of 74-26, the Budget Control Act of 2011 was signed into law by President Barack Obama on Aug. 2, 2011 as Public Law 112-25. The 74-page law has generally been referred to as the "debt deal."

The debt deal creates and tasks a 12-member Joint Committee of Congress (the so-called "Super Committee") to produce proposed legislation by Nov. 23, 2011 that would reduce the deficit by at least \$1.5 trillion over 10 years. Each chamber of Congress would consider the proposal of the Joint Committee on an up-or-down basis without any amendments by Dec. 23, 2011. The debt deal sets up a new sequestration process to cut spending across-the-board and ensure that any debt limit increase is met with greater spending cuts if the Joint Committee fails to agree upon and produce a proposal with at least \$1.2 trillion in spending cuts. If this happens, then the President may request up to \$1.2 trillion for a debt limit increase. Assuming the President is able to increase the debt limit by \$1.2 trillion (contingent

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upon congressional approval), across-the-board spending cuts would result that would equal the difference between \$1.2 trillion and the deficit reduction (if any) enacted as a result of the Joint Committee and subsequent approval by both chambers of Congress.²¹

The across-the-board spending cuts would apply to FY2013-FY2021, and to both mandatory and discretionary programs. The final agreement specifies that total reductions would be split equally between two categories of expense: 1) defense discretionary; and 2) non-defense discretionary plus covered entitlements.²² The across-the-board cuts would apply to Medicare, though the cut to Medicare is capped at 2 percent, which would reportedly save \$126 billion and be limited to cuts to provider payments.²³ Social Security, veterans' benefits, civilian and military retirement, and all low-income subsidies including Medicaid and "welfare" programs (e.g., food stamps) would be exempt, as would net interest payments.

How large a cut could the Joint Committee conceivably propose for Medicare? As a preliminary analytical exercise, if one assumes that Medicare will bear its proportional share of the cuts, \$150 to \$200 billion in cuts to Medicare could be expected over the 10 years. If one further assumes that the cuts will be accomplished by reduced reimbursements to providers, with no reduction to benefits (currently a more politically popular approach), and that the IPPS would bear its proportional share of the cuts, the IPPS would be cut by \$50 to \$65 billion over the 10 years. The IPPS cuts would translate into a cut of \$1.5 to \$1.9 million per hospital per year, which would be equivalent to a 2.3 to 2.9 percent average annual reduction to the IPPS.

What would be the combined, cumulative impact of the debt deal-driven cuts and the aforementioned ACA-mandated reductions to the IPPS market basket update? For the 10-year period of FY2012 to FY2021, payments to hospitals under the IPPS will be sliced by \$162 to \$177 billion, and this would translate into a cut of approximately \$5 million for the average IPPS-participating hospital (with 210 beds) per year, relative to pre-health reform conditions.

As for possible non-IPPS cuts, Washington, D.C.-based law firm Patton Boggs commented, "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

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to the newly established health insurance exchanges, adding additional pressure to states already in fiscal crisis.”²⁴

Furthermore, credit agency Standard & Poor’s (S&P) is placing pressure on the federal government to follow through on near-term budget cuts and put together a credible long-term deficit reduction plan. On Aug. 5, 2011, S&P lowered the United States’ AAA rating for the first time since granting it in 1917. The rating was dropped a notch to AA-plus. In its statement about the downgrade, S&P said that it is issuing a negative outlook, which means that there is a chance it will lower the rating again within the next two years. S&P said such a downgrade, to AA, would occur 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.²⁵

Risk-Based Reimbursement

Philosophically aligned with the broad pay-for-performance movement, the ACA’s healthcare delivery reforms pertaining to value-based purchasing, hospital readmissions and healthcare-acquired conditions tie financial carrots and sticks to quality performance. By 2016, 6 percent of a hospital’s IPPS reimbursement will be at risk, placing greater pressure on hospitals to excel from a quality standpoint in spite of steadily declining funding from Medicare.

No Relief from Commercial Payers

Lest one think that hospitals will be able to simply shift costs to commercial payers to offset downward pressures on Medicare reimbursement, commercial payers, themselves facing financial challenges, will increasingly prove unable and unwilling to offset pressure on government reimbursement rates, placing greater pressure on hospitals to contain costs.²⁶

Where to Now?

The combination of ACA-mandated reductions, likely cuts to Medicare as a result of the debt deal, the rise of risk-based reimbursement, and pressure from commercial payers portend a formidable, decade-long “perfect storm” for hospital finances. What should hospitals do to mitigate these significant threats to revenue? While it goes without saying that hospitals should continue to strive for continued administrative efficiency gains, the sheer magnitude of the financial challenge posed by these increasingly potent forces dictates that hospitals should focus attention on improving the efficiency and effectiveness of their core activity—the process and delivery of care.

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Strategies to Offset the Reductions in Medicare Reimbursement

The following strategies are well-established, proven best practices to help hospitals reduce costs and create efficiencies. Each of the strategies can be implemented within six months.

Partner with Clinical Leadership

Clearly, given the need for improved, more cost-effective care delivery, the hospital's chief financial officer (CFO) should start by meeting with the chief medical officer and others on the clinical leadership team to forge or reinforce a financial-clinical partnership. At the meeting, the CFO should: 1) provide an assessment of the current financial condition of the hospital; 2) explain the impending increased financial pressures and their likely impact on the organization; and 3) solicit the support and assistance of the clinical leadership team.

Perform Detailed Margin Analysis

The finance department should identify low-margin MS-DRGs for which reimbursement is significantly lower than actual cost. Cost-saving strategies should be targeted at these MS-DRGs.

In addition, the finance department should analyze MS-DRG/service line margins down to the physician and patient level to determine the areas of profitability and loss, looking at direct cost contribution margin. Attention should be given to the five MS-DRGs/service lines with the highest volumes, the highest profitability, and the greatest losses, respectively, with an in-depth review to ascertain the reasons for profit or loss. A few months after this initial analysis is completed, the hospital should establish a process of ongoing margin analysis and review by a team of service line managers and physicians as well as the hospital's senior management team.

Engage with Service Line Managers and Physicians

Finance should initiate the creation of a Clinical Performance Improvement Action Team (CPIAT), composed of service line managers and physicians. At the outset, using data analytics provided by finance, the CPIAT should focus on and address the following issues:

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- » Supply utilization
- » Length of stay
- » Drug costs
- » Readmissions within 30 days of discharge
- » Ancillary testing usage

In addition, the reasons for Medicare and Medicaid clinical denials should be reviewed and analyzed, with appropriate steps taken to address the causes of the denials. A clinical documentation improvement program for special care areas and the surgical floors should be established. Also, the necessity of accurate and complete coding needs to be emphasized to physicians, since the process is driven by physician input.

Physician scorecards (statistically valid, case mix-adjusted) should be established to measure quality and cost at the physician level against the hospital's targets for supply utilization, length of stay, drug costs, and other resources utilized, based on the work of the CPIAT. In addition, the scorecards should be used to benchmark physician performance against peers and national norms for quality and efficiency. Low-cost, high-quality physicians should be identified and used as role models for best practices.

Financial-clinical grand rounds should be initiated to review various cases of costs, care and outcomes and to incorporate lessons learned into the organization's standards of care.

Revamp Care Coordination

Care coordination policies should be evaluated and improved. Avoidable readmissions can be reduced by improving the discharge planning process. Specific practical recommendations include:

- » Including on check lists and auditing that these items are always verified at discharge: medications and how to take them, follow-up appointments, who is the primary caregiver at home, diet and exercise parameters, need for home healthcare visits, and notifications (when to call one's doctor)
- » Understanding how attending physicians are utilizing consultants and the potential impact on costs and bed days
- » Ensuring that every discharge summary is sent to the primary care physician

To enhance care coordination, prevent duplicative tests and reduce costs, the hospital should establish or connect with a local or regional health information exchange.

Ensure Efficient Operating Room (OR) Utilization

Optimizing OR utilization can be accomplished through improved scheduling (that aligns surgeons and surgeries), method changes, standardization of processes, and operational reporting. These actions can decrease scheduling gaps and delays, reduce costs, and enhance care delivery.

Analytics can be used to identify variances in operating time and OR room turnover time by procedure and operating physician, facilitating process improvement conversations with OR staff and physicians. In addition, the root causes of surgery start time delays and post-anesthesia care unit (PACU) admission delays can be determined, helping identify top performers and enabling best-practice sharing.

Improve Emergency Room (ER) Operations

Much has been written in recent years about the space and staffing challenges faced by ERs. Data analysis and review of ER supply and drug utilization, ancillary testing and inappropriate usage can help improve ER operations and reduce costs.

Conclusions

Medicare accounts for a large portion of revenue for the vast majority of U.S. hospitals. In general, hospital operating margins are basically at breakeven, and margins on Medicare are worse. The ACA-driven reductions and the DCI adjustments to the IPPS are multifaceted, complex and material, and they will constitute a significant threat to hospital finances for many years. Then add to the mix likely further cuts to Medicare as a result of the debt deal, the trend toward more risk-based reimbursement, and pressure from commercial payers—the result is a seemingly overwhelming challenge for hospitals.

By targeting the largest and core activity of the hospital—the process and delivery of care—the previously mentioned strategies constitute areas of promising opportunity for the hospital to achieve financial gains of sufficient size to offset the reductions in Medicare reimbursement. In addition, as such initiatives improve the general care delivery model, they will also benefit the hospital's non-Medicare business, resulting in revenue and efficiency advancements for the whole organization.

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Next Steps

By laying out and sizing the serious financial challenges facing hospitals, this white paper constitutes a call to action, to be informed and to pursue one or more of the aforementioned strategies to offset the reductions in Medicare funding. For more information, please visit www.medeanalytics.com/medicarezero. To learn about MedeAnalytics' Clinical Performance Manager solution, which has been designed to support every one of the recommended strategies, please visit www.medeanalytics.com/cpm.

About MedeAnalytics

Founded in 1994, MedeAnalytics delivers performance management solutions across the healthcare system—including hospitals, physician practices and payers—to ensure accountability and improve financial, operational and clinical outcomes. For more information, visit www.medeanalytics.com.

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