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Spring 2011 IDN Summit and Expo
Peer-to-Peer Learning Exchange Research Report

Profitable Diagnosis Related Groups (DRGs):
Achieving (and Keeping) Positive Margins in the Medicare Population

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Achieving (and Keeping) Positive Margins in the Medicare Population

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Introduction

The Accountable Care Act of 2010 (ACA) will create or pilot-test new systems of payment and new provider organizations. The reform law also contains at least \$113 billion in Medicare hospital reimbursement cuts. Another law, the HITECH Act of 2009, established rules designed to foster “meaningful use” of health information technology. And by 2013, a new coding system will take effect, designed to achieve far greater specificity of diagnoses to help improve quality and billing accuracy.

All of these changes have created what the Healthcare Financial Management Association calls a new “reform environment.” In this environment, higher quality and lower cost care will define and separate the survivors among providers. In particular, the challenge is whether hospitals can achieve and maintain positive margins in serving Medicare populations.

The key reforms include:

Hospital Inpatient Value-based Purchasing: Under this new payment scheme, a portion of virtually every hospital’s Medicare reimbursement is at risk, beginning with 1% in fiscal year 2013 and scaling up to 2% in fiscal year 2017. U.S. hospitals will have from \$500,000 to \$850,000 at risk annually under this program.

Hospital-acquired conditions: Already, hospitals are not reimbursed for certain preventable conditions acquired in the hospital. But beginning in 2015, CMS will rank hospitals on their risk-adjusted rates for certain HACs. Hospitals in the top quartile will be subject to a 1% payment penalty under Medicare. That means that 25% of all hospitals will lose 1% of their baseline MS-DRG payments.

Readmissions: Beginning in 2013, CMS will rank hospitals according to performance on a 30-day readmission rate for heart attack, heart failure and pneumonia. Hospitals with excess readmissions will be subject to a 1% reduction in Medicare reimbursement. In 2015, the scope of diagnoses and conditions will expand to include chronic obstructive pulmonary disease, coronary artery bypass graft surgery, percutaneous coronary intervention and other vascular conditions. Also in 2015, the penalty for excess readmission will have increased to 3% of Medicare reimbursement.

Meaningful use: As part of the American Recovery and Reinvestment Act and further defined by the Office of the National Coordinator for Health Information Technology, beginning in 2011 and continuing until 2014, hospitals will be eligible for incentive payments in return for demonstrating meaningful use of certified electronic health record technology, such as electronic prescribing. However, beginning in 2015, hospitals that fail to meet meaningful use criteria will be penalized. That penalty starts at 1% and increases to 5% by 2018.

These changes won’t occur in a vacuum; they come as hospitals are already losing money on patient care, particularly under Medicare. In 2009, U.S. hospitals lost \$5.1 billion from patient care operations, according to a report in *hfm Magazine*. The March 2010 report of the Medicare Payment Advisory Commission estimated that Medicare margins would be minus 5.9% for calendar 2010.

For more, see the online version at http://idnsummit.com/event/peer_exchange for charts from Aspen Healthcare Metrics, detailing losses by service line and MS-DRG. Even cardiology, a source of profit from private payers, shows a 13% loss from Medicare. In the past, healthcare providers have made up for Medicare shortfalls through better margins from private payers. That is about to change, as future reimbursement for all payers is going to be closer to the Medicare rates than to private rates.

The organizations that survive will use data and best practices to analyze their spending variations, improve care processes, eliminate waste, reduce costs, and validate documentation and coding for appropriate reimbursement. They will also engage their physicians and nursing staffs in a relentless effort to root out unnecessary spending, and improve processes to reduce patient harm and improve adherence to evidence-based practices.

Silver linings in reform

There are opportunities in some of the reform initiatives. For example, information exchanges are required under meaningful use rules, whereby providers will be expected to exchange care data that will allow for comparative effectiveness research on what drives high-quality, lower-cost outcomes.

The law also creates truly integrated care networks that can coordinate care of a given patient throughout a community involving primary care physicians, specialists, outpatient/inpatient procedures, home health care and in-home patient monitoring, all of which will be critical in serving Medicare populations.

The areas of opportunity include:

ACOs: Under the reform law, physician groups, hospitals, hospital-physician partnerships and joint ventures can all become accountable care organizations (ACOs) and participate in the new Medicare Shared Savings Program that begins Jan. 1, 2012, if they meet certain requirements. They must have a formal legal structure to distribute shared savings, and they must have enough primary care professionals for a minimum of 5,000 beneficiaries. They must also agree to participate in the federal program for a minimum of three years and must have processes in place to promote evidence-based medicine and report data on quality and costs, according to the CMS. Beginning in 2012, they will be eligible to receive a percentage of any savings if their actual expenditures are a certain percentage below a specified benchmark.

Bundled payments: Beginning in 2013, the Department of Health and Human Services must establish a national, voluntary, five-year pilot program on bundling payments to providers around 10 clinical conditions. If successful, the pilots may be expanded after 2015. Bundled payments present payers and policy makers an attractive solution to fragmentation. Bundled payments are designed to drive shared accountability across the continuum, making hospitals, physicians, and post-acute care providers collectively responsible for the cost and quality of entire episodes of care.

While payers and policy makers theoretically have free range to define care bundles, two types of bundles are most common for acute care services. First, inpatient bundling combines hospital technical revenue and physician professional revenue into a single payment for a hospital admission. Episodic bundling expands the bundle definition, adding payment for post-acute care and readmissions within a given timeframe to the inpatient bundle.

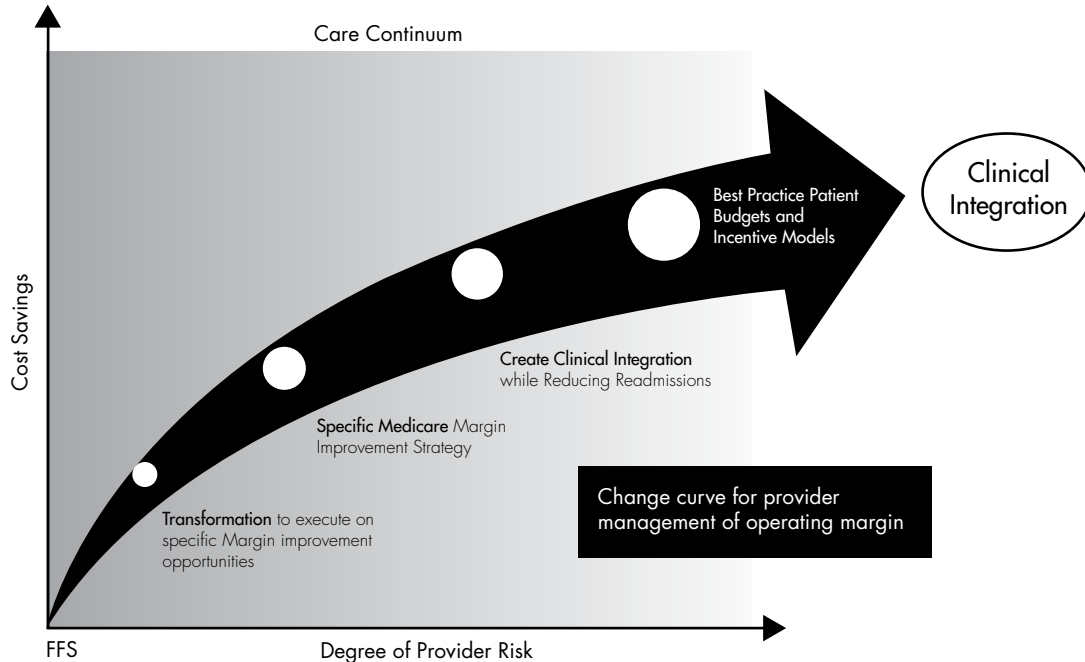
ICD-10-CM: Another opportunity is the new coding system. The shift from ICD-9-CM to ICD-10-CM will take the industry from 17,000 codes to almost 90,000 codes. The broadness of ICD-9 has often forced physicians and coders to select a billing code that comes closest to the condition being treated but does not provide an accurate diagnosis. This can result in treatment delays while clinicians search for more detailed information, limiting the effectiveness of clinical decision-support tools providing the best prompts and appropriate alerts, as well as reducing accuracy that limits the value of analytics designed to improve care. The new codes can accommodate a host of new diagnoses and procedures, taking advantage of decades of advances in medical knowledge. That should be a significant enabler of higher quality care, including better outcomes comparison and evidenced-based procedures. It should also greatly enhance efforts to more accurately account for the cost of care.

As just one example, the diagnosis coding language of ICD-10-CM should do a better job with elderly Medicare beneficiaries with chronic illnesses who often develop pressure ulcers. ICD-9-CM cannot capture the severity and location of these pressure ulcers as well as ICD-10-CM, which can identify the severity and location of the pressure ulcers under a single code, ensuring appropriate and timely treatment, and thereby reduced length of stay.

Ultimately what these changes mean is a re-invention of how clinical care is provided. The following chart shows the progression of clinical integration from the current fragmented, every-provider-for-himself approach toward true episodic care readiness.

The higher up the curve, the greater the amount of total variation that has to be properly managed and the greater the clinical integration providers need to effectively and efficiently manage patients over time and across settings. And the more the industry moves away from fee for service, the more providers have to focus on margin instead of top-line revenue.

Reinvention is Critical...



Understanding the true costs of care

A hospital's clinical specialty areas may be centers of excellence, but they may also be centers of declining margins. With the tidal wave of baby boomers entering Medicare, demand for services such as cardiology and orthopedics will grow, so it also makes sense to perform a margin analysis on the key MS-DRGs in these service lines.

Hospitals have many data sources to draw on to analyze episodes of care. They include electronic medical records, cost accounting systems, billing and finance systems, labor costs, lengths of stay and 30-day readmission rates by MS-DRG/physician. Collective data expose inconsistent, redundant, or wasteful utilization of services and supplies that undermine quality of care and drive up cost. The data can also reveal clinical factors that may be contributing to high readmission rates.

The areas of concern cut across the hospital enterprise and include:

- Operations, such as patient throughput, length of stay, services utilization review and productivity;
- Clinical, such as quality indicators, documentation and coding and payment rates;
- Supply, including price benchmarking, contracting and supply utilization review;
- Culture, including organizational readiness for change, physician buy-in to change and cooperation among departments.

The care episode data should be trended over time and compared with national benchmarks. Doing so provides a scorecard for the organization and a baseline for measuring improvement initiatives.

There are a number of products in the marketplace that help hospitals examine spending patterns at the micro level—such as physician vs. physician—by unit, by department and by service line. In particular, this data is necessary in order to persuade physicians to use lower-cost products and adopt evidence-based clinical protocols.

Physicians are the only stakeholders who can admit patients and provide direct care. Their practices directly impact utilization of supplies, equipment, ancillary services departments and staff. So it is critical to engage physicians and use the results of the data analysis to educate them on the impact of their care decisions on hospital quality and cost metrics.

There are also some less-automated means of gathering data on cost and quality. One involves simply observing care processes as they unfold, documenting what is happening, why it is happening, who is doing what in the process and then comparing the cases involved with others. Lean and Six Sigma processes can be employed to identify, analyze and act to reduce waste in the system.

Conclusion

Obviously, the reform environment has many hurdles and potential pitfalls. There is a world of new complexity to navigate. But in another way, the challenge is relatively straightforward. Hospitals, physicians and others have to work together on every episode of care. Hospitals must take the lead in gathering accurate, actionable data and analyzing it against national benchmarks and best practices. Physicians must be able to see the data on their utilization and outcomes, and buy into meaningful changes designed to reduce costs and improve margins per episode of care, while also reducing preventable readmissions and medical errors.

Through incentivized clinical integration, budgeting per episode of patient care and commitment to quality, providers should be able to not only survive healthcare reform but even thrive, no matter what twists and turns healthcare reform may take.

Questions for discussion

1. Is your organization ready for bundled payment per episode of care?
2. Has your organization begun a process of evaluating Medicare margins by service line or MS-DRG?
3. What gaps are there in your data to being able to fully assess costs and margins in this way?
4. What role can the supply chain take in supporting the switch to episodic care?
5. What is the best way to bring physicians and other clinicians into improvement efforts?