Healthcare Financial Management

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The day after the 2012 presidential election, President Barack Obama's victory was hailed as a vindication for the Affordable Care Act (ACA). Pundits predicted that the marathon healthcare overhaul would turn into a sprint and be rolled out aggressively. Speaker of the House John Boehner conceded in a Nov. 8 interview with Diane Sawyer of ABC News, "Obamacare is the law of the land."

Eric Zimmerman, a partner with the Washington, D.C., office of the law firm McDermott Will & Emery offers the following advice for any providers that have hesitated to act: "They can now take their heads out of the sand. [The ACA is] here to stay and it's time to get on board and take on strategies that can position hospitals for success in this brave new world" (Zigmond, J., and Daly, R., "Obama Win Seen as Victory for Healthcare Reform," Modern Healthcare, Nov. 7, 2012).

Healthcare reform's brave new world may be challenging for hospitals. About two thirds of respondents to a Modern Healthcare online survey conducted soon after the presidential election said the reform law would have a negative impact on the bottom line of their healthcare business; the remaining one-third said the law would have a positive impact ("Modern Healthcare Survey Finds Deep Anger over ACA," Modern Healthcare, Nov. 8, 2012).

What might explain the concern about the financial impact of the healthcare reform law? To answer that question, one should revisit the presidential campaign and the debate about Medicare reform, which centered largely around one number: $716 billion.

Impact on Medicare Spending

During the first presidential debate and the vice presidential debate, President Obama and Vice President Joe Biden described the $716 billion as ACA-created "savings" that would be generated when Medicare stops overpaying hospitals, physicians, and insurance companies. Thus, one big question is whether healthcare providers are

actually overpaid by Medicare. In its March 2011 Report to the Congress: Medicare Payment Policy, the nonpartisan Medicare Payment Advisory Commission (MedPAC) estimated that the average Medicare margin for all hospitals is minus 7 percent, and reported that almost two-thirds of hospitals lose money on Medicare.

The source of the $716 billion figure was a July 24, 2012, letter from Douglas Elmendorf, director of the nonpartisan Congressional Budget Office (CBO), to Speaker Boehner. This 22-page document provided a report from the CBO and Joint Committee on Taxation on the potential fiscal impact of the Repeal of Obamacare Act (which was approved by the House, but died in the Democratically controlled Senate). The report concluded, "[If the ACA were repealed], spending for Medicare would increase by an estimated $716 billion over that 2013-2022 period" (Elmendorf, D.W., letter to Speaker of the House John Boehner, July 24, 2012).

The CBO report broke down the $716 billion as the net result of three changes to spending:

* A $517 billion decrease to Medicare Part A (Hospital Insurance)

* A $247 billion decrease to Medicare Part B (Medical Insurance)

* A $48 billion increase to Medicare Part D (Prescription Drug Coverage)

Drilling Down to the Details

In his letter to Boehner, Elmendorf notes that most of the $716 billion net decrease comes from reductions in funding to various providers in the Medicare fee for-service sector, including $260 billion from hospitals, $66 billion from home health services, $39 billion from skilled nursing services, $17 billion from hospice services, and $33 billion from other services. It is estimated that hospital cuts of $10 billion to $15 billion in 2013 will ramp up to $30 billion to $35 billion in 2022. (ACA market basket update reductions and productivity adjustments for the period from FY11 through FY20 are shown in the exhibit below.) To put the hospital cuts in perspective, they amount to a 9

percent across-the-board reduction to Medicare payment, or a decrease of approximately $6.5 million per hospital per year, over the next 10 years.

How will these cuts be implemented? In simple terms, the inpatient prospective payment system (IPPS) used by the Centers for Medicare & Medicaid Services (CMS) to pay hospitals will increase at a slower rate as a result of ACA-driven offsets to the market basket update (which functions as the IPPS inflation adjuster) and productivity adjustments. These reductions will lower hospital margins, and CMS chief actuary Richard Foster has concluded that up to 20 percent of hospitals could become unprofitable as a result ("Medicare and the Mayo Clinic," The Wall Street Journal, Jan. 8, 2010).

Medicare Spending Growth Limits

In addition to the hospital payment cuts spelled out in the healthcare reform law, Medicare spending growth limits handed down by the Independent Payment Advisory Board (IPAB) also could have an adverse impact on providers.

Per the Obama administration's 2013 budget proposal, the IPAB will have the authority to limit Medicare spending growth to the growth of gross domestic product (GDP) plus 0.5 percent, rather than GDP plus 1 percent (Kaiser Health News, "Obama's Healthcare Policy Record," Sept. 10, 2012). This could be problematic for hospitals, as healthcare costs are projected to outpace GDP growth over the next 10 years by about 2 percent per year.

Action Steps for Hospitals

Struggling under the mandated payment cuts and possible IPAB-imposed spending growth limits, some hospitals could go out of business or operate under financial duress, reducing availability and quality of care for Medicare beneficiaries. That was the conclusion of the 2012 Medicare Trustees Report: "If the health sector could not transition to more efficient models of care delivery and achieve productivity increases commensurate with economy-wide productivity ... then the availability and quality of health care received by Medicare beneficiaries relative to that received by those with

private health insurance would fall overtime ..." (The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, April 23, 2012).

The following are just a few of the approaches that hospitals have taken to offset the challenge of payment reductions amid demands for improved access and quality.

Limit Medicare volume. What hospitals are being asked to do- maintain access, improve quality, and reduce costs with less funding- is a tall order at best. As one way to cope, some providers may opt to discontinue taking Medicare patients altogether or stop accepting new Medicare patients. This has happened in response to Medicaid payment rates in California. In a recent personal communication, Jennifer Pereur, the director of government programs at Hill Physicians Medical Group, described the challenge this way: "For years, providers have struggled with low reimbursement for Medi-Cal. It's a challenge to find physicians who will take rates that are half of what they receive for Medicare. Access is already an issue."

Some providers have chosen to stop accepting Medicare patients due to current payment pressures. For example, despite its widely recognized excellence in care coordination, operational efficiency, and use of healthcare IT, the Mayo system in total reportedly lost $840 million treating Medicare patients in 2009, a figure that includes a $120 million loss at its hospital and four clinics in Arizona. As a result, Mayo no longer accepts Medicare patients at its primary care clinic in Scottsdale, a suburb of Phoenix ("Medicare and the Mayo Clinic," The Wall Street Journal, Jan. 8, 2010).

Everett Clinic in Everett, Wash.- one of the most advanced physician practice groups in the nation, and one of 10 participants in CMS's Physician Group Practice Demonstration- has lost $10 million a year treating Medicare patients. In early 2012, the clinic stopped accepting Medicare fee-for-service patients and began to require its Medicare patients (with limited exceptions) to join Medicare Advantage plans (The Everett Clinic, "Medicare and Medicare Advantage," www.everettclinic.com/

community-report/legislative-advocacy/medicareand-medicare-advantage.ashx?p=4129, accessed Oct. 14, 2012).

Admittedly, these are just two examples, but they are telling in that both organizations are leading-edge, highly efficient institutions that have found it challenging to operate profitably with Medicare under current payment rates, even before most of the reductions mandated by the ACA take effect.

Reduce people expenses. Some providers, struggling with current payment rates and preparing for further downward pressures, have chosen to lay off employees. For example, in October 2012, UCSF Medical Center and its Benioff Children's Hospital announced combined reductions of 300 FTEs to lower the cost of care and prepare for the full implementation of the ACA and other challenges. UCSF COO Ken Jones says that numerous pressures and ACA mandates "are going to make every hospital look at every job and ask, 'Do we need this?" (Rauber, C, "UCSF to Join Hospitals in Cutting Jobs," San Francisco Business Times, Oct. 19, 2012).

Improve operational efficiency. It almost goes without saying that hospitals will need to run a tighter ship, going forward. Areas of potential focus- in all cases supported by data analytics- include optimizing staffing (for example, through productivity analyses), improving clinical operations, enhancing the supply chain (by standardizing physician preference items, for instance), carefully examining operating room and emergency department throughput, and revamping both the front and back ends of the revenue cycle.

Follow the government's road map for success. Under the American Recovery and Reinvestment Act, Medicare-eligible providers may receive meaningful use funds for certified electronic health records (EHRs) for two more years- 2013 and 2014. Hospitals should take advantage of this governmental subsidization of EHRs, the use of which should save money for hospitals in the long term.

Also, hospitals should be fully cognizant of the numerous healthcare delivery reforms outlined in the ACA- including programs focusing on value-based purchasing, accountable care organizations, hospital readmissions reductions, bundled payments,

and the payment adjustment for hospital-acquired conditions-all of which have economic carrots and/or sticks. In general, hospitals should get on the fee-for value train and give serious consideration to entering into accountable care arrangements, facilitated by Medicare or commercial payers.

Preparing for the Challenges Ahead

The ACA's $260 billion reductions in hospital funding, together with Medicare spending growth limits that could be handed down by the IPAB, constitute a significant, long-term challenge to hospital finances. Hospitals have several traditional and innovative options for responding to this challenge- but respond they must, for their financial well-being and for the sake of our society, which needs higher-quality health care delivered as efficiently as possible.

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