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Cost Efficiencies in Healthcare

May 20, 2010

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Healthcare Outlook

- **Not-for-profit healthcare outlook remains negative despite the gains in equity and credit markets**
- **Hospitals will face one of the toughest environments in decades**
- **The challenge will be curbing expenses in an already stressed arena**
- **Medicare cuts are likely in the long term**
- **Hospitals may have a backlog of capital projects**

http://www.modernhealthcare.com Healthcare Business News
Moody's Outlook Negative for Not-for-Profits, by Melanie Evans

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Digging into the Challenges

- **Resource Allocation**
- **Reimbursement Impact**
- **Cost Management**
  - Length of Stay
  - Commodity
  - Pharmacy Costs
  - PPI (Physician Preference Items)

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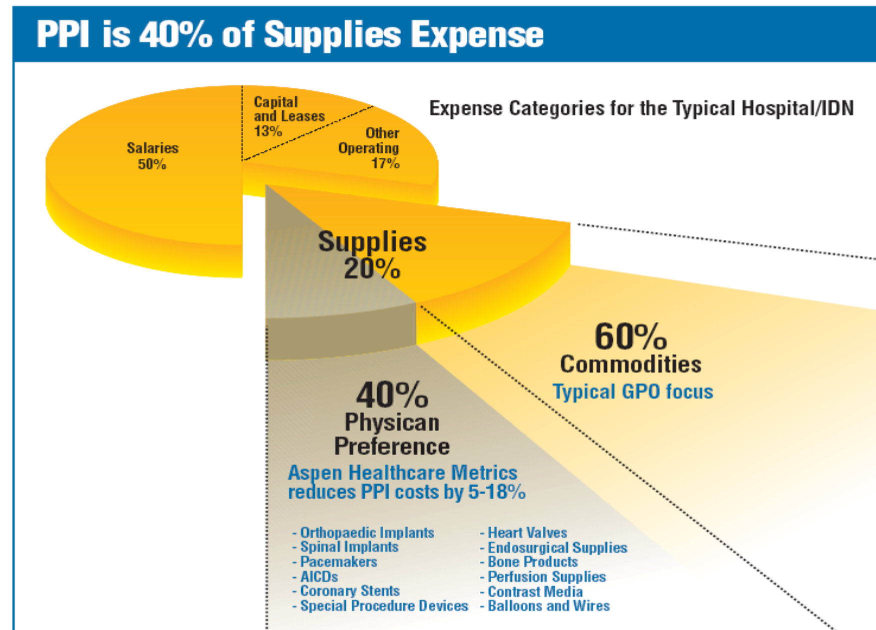
Labor & Supplies are Primary Expenditures

- **Supply Categories**
  - Pharmaceuticals
  - Med/Surgical supplies
  - Medical Devices/Implants
  - Imaging supplies
  - Laboratory supplies
  - Food & Nutrition
  - Other supplies



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Challenges to Building a World Class Supply Chain Operation

- **Simplifying the complex purchasing process (multiple order points and multiple-stand-alone-purchasing systems within the IDN prevent an enterprise view)**
- **Assuring correct price on P.O.'s and invoices**
- **Recognizing e-procurement as means to reduce purchasing transaction costs**
- **Changing system and behaviors to optimize standardization opportunities**
  - Gaining support of physicians/clinicians in the product standardization change process

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What is a GPO?

- **A group purchasing organization (GPO) is an entity that helps health care providers realize savings and efficiencies by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors and other vendors**
- **Funding:**
  - Administrative fees paid by the vendors
  - Fees paid by the buying member
  - Combination of both of these methods.

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Group Purchasing – Historical Perspective

- **First GPO was Hospital Bureau of New York**
- **40 in early 1970's**
- **Explosive Growth - > 600 by 1999**
  - For Profits vs.. Not For Profits
  - Impact of Medicare Prospective Payment System and DRG's
  - Impact of Managed care Organizations (HMO's)
- **Over 900 today, but 7 control 85% of Market**
  - 96% participation of all hospitals
  - 72% of all purchases are through GPO contracts

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Group Purchasing – Why do GPO's exist?

- **Aggregate purchasing power of member hospitals**
- **Guarantee a larger volume to suppliers**
- **Measure success based on contract compliance: 10-15% savings**
- **Improve hospital resource allocation**
- **Enable hospitals to save up to $33 billion each year through lower product prices.**
- **Provide valuable cost-avoidance savings to hospitals and other providers by helping them standardize and streamline their purchasing optimizing resource allocation**

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GPO Team

3M, BD, Lilly's
Olympus, Steris
Smith & Nephew

Cardinal
McKesson
PSS
Owens-Minor

Priority Healthcare
Amerisource
McKesson
Cardinal

Healthcare Facility

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Group Purchasing – Challenges for the Future

- **Integrated Delivery Networks**
- **Safe Harbor – Aligning Incentives**
- **Monopolistic/Anti-Competitive Accusations**
  - Emerging Technology Companies
  - Historically Under-Utilized Businesses
  - Inappropriate Supplier Practices, e.g. Bundling
- **Expanding the Value Proposition**
  - Revenue Cycle
  - Technology Solutions
  - Clinical Consulting

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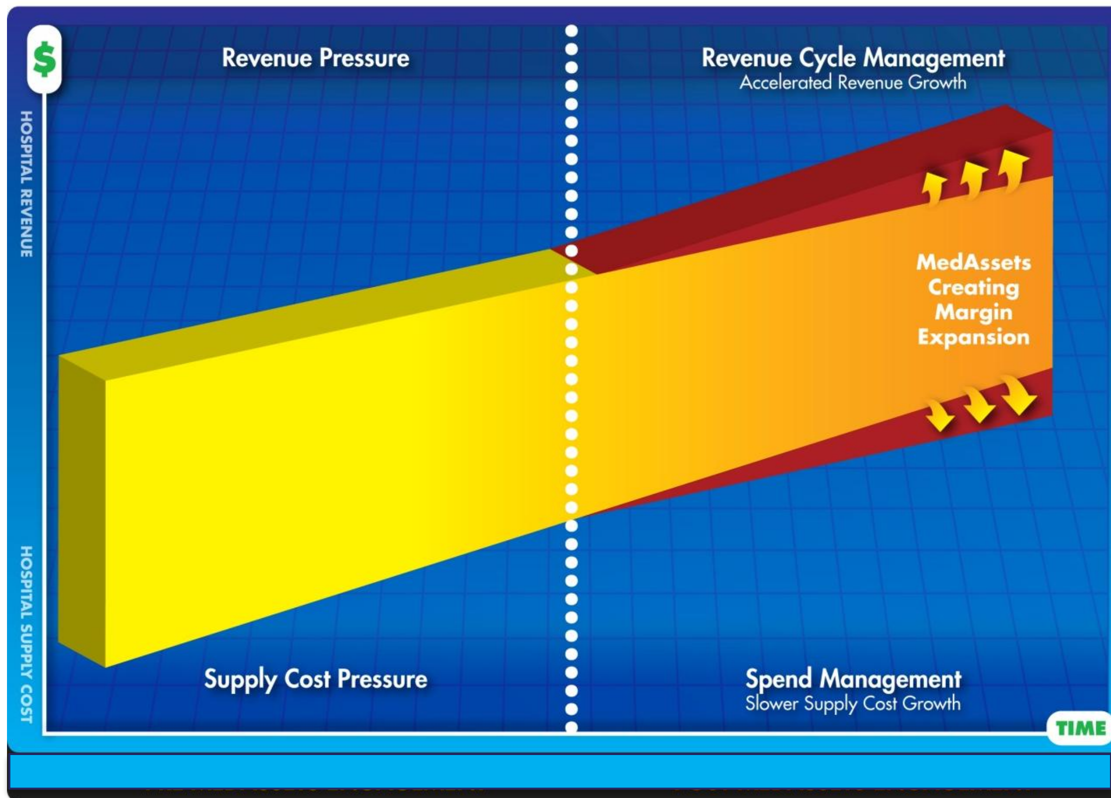
Changing the Value Proposition

Improve customer operating margins by 1.5% to 5.0%



Strategic Sales and Account Management	Enterprise Implementation	Flexible ASP-based Technology	Enterprise Financial Performance Targets

- **Hospitals facing declining revenue growth / increasing supply cost growth**
- **Solutions successfully mitigates this trend**
- **Behavior change measured through financial targets**
- **Low-cost implementation**
- **Sustainable, measurable results**

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Contracting Philosophy Sample

- **Support customer's needs for capital preservation**
- **Customer Driven Contracting Process –Advisory Councils**
- **Competitive, Rigorous, Contracting process in compliance with the Healthcare Industry Group Purchasing Industry Initiative (HGPII)**
- **Support customer's needs (emerging technology, patient/staff safety, diversity solutions, and "green" products)**

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Customer Guidance

30 Advisory Councils Steer Direction

- Bi-Annual Meetings, Monthly Teleconferences, Virtual Interaction through Web Portal
- Contract Committees: Set general program direction, prioritize bid calendar, assist with RFP development and proposal review
- Executive Committees: Assist with strategic planning
- Revenue Cycle Committees: Assist in product development and enhancement strategies

Contract Advisory Committees	Supply Chain Committees	Revenue Cycle Committees
Alternate Care	IDN Advisory	Charge Integrity: CDM Management
Captial Equipment	Supply Chain Analytics	Pricing and Compliance
Clinical Pharmacy	Medical Affairs	Claims and Denials Management
Construction	Value Analysis	Contract Management and Patient Bill Estimation
Executive Services		Decision Support
Food & Nutrition	**C-Suite/Executive Committees**	Revenue Capture
Imaging/Radiology	Chief Executive Officer	Revenue Recovery and Receivables Management
Laboratory	Chief Information Officer/IT Leadership	
Long Term Care	Chief Operating Officer/Chief Financial Officer	
Materials Management	Revenue Cycle Executive Advisory Committee	
Pediatrics		
Pharmacy		
Supplier Diversity		
Surgery Center		
Surgical Services		

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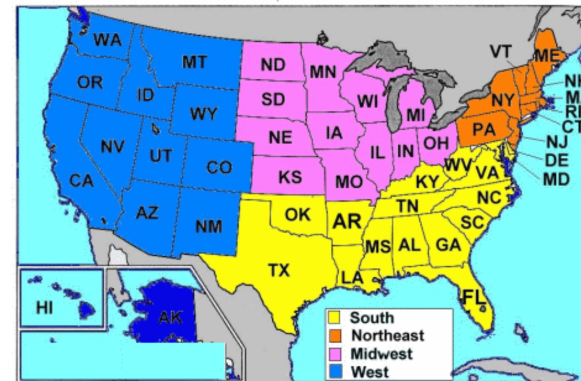
Regional Strategies-Success Breeds Success

- **Consolidated Service Centers**
- **Regional Supply Chain Management Partnership**



Member selection success factors:

- Geographic regional focus
- Similar Goals
- Compliance

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Linking Supply Chain to Revenue Cycle

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Mission Critical Issues

- **As Providers move forward, it has become clear that Supply Chain and Revenue Cycle Management are intrinsically linked as has been the case in other industries**

What hospital CFO hasn't, at least once, thought of an industrial assembly line with envy? Imagine knowing exactly what implants were used for every total hip or knee replacement performed—and what these high-tech devices cost. Think about the potential revenue that could be gained from managed care carve-outs and other charge-based reimbursements if you knew exactly how much each patient cost the hospital. Consider the value of being able to make strategic and financial decisions about key service lines based on
real cost data—not estimates.

HFM May 2004. "Linking Supply Costs and Revenue: The Time Has Come"

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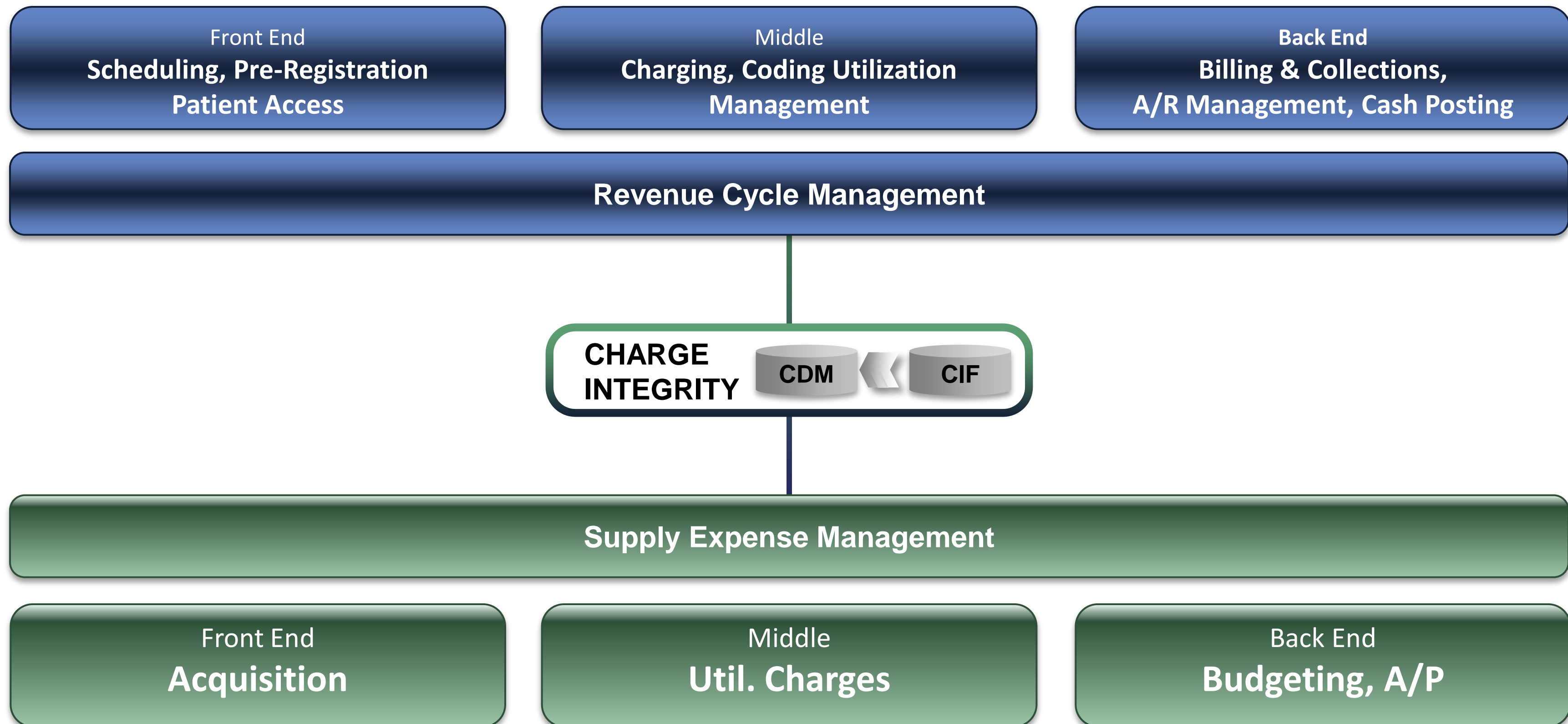
Delivering Linkage Between Supply Chain and Revenue Cycle



Gain *financial visibility* into the hospital by linking the Supply Chain with the Revenue Cycle

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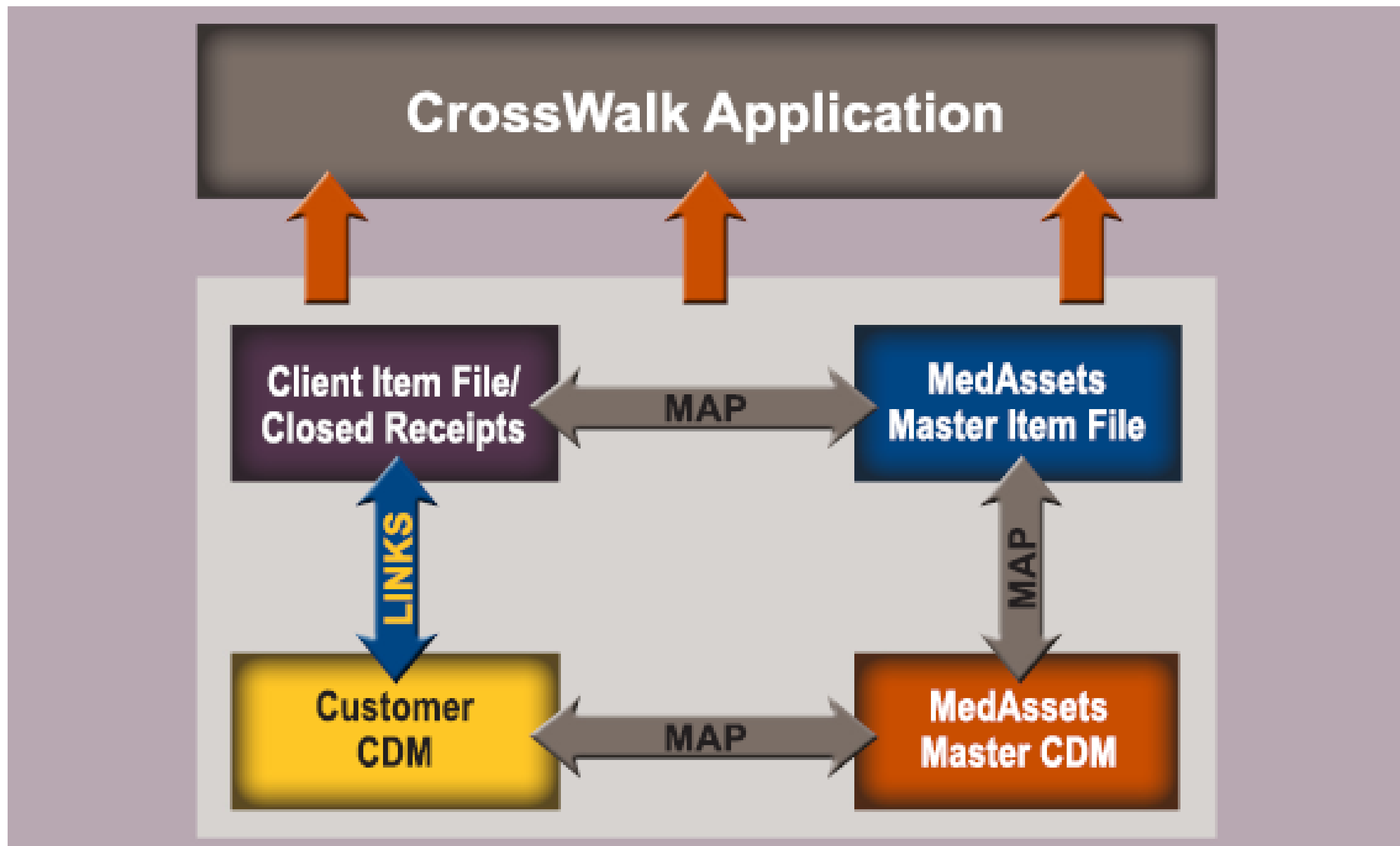
Understanding the Linkage



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What Business Need Does Linkage Serve?

Hospital CDM File

All hospital patient chargeable supply items, including their charges, are stored in this file

Between Two Disparate Databases

Hospital Purchasing/ Materials Management

All hospital supply items, including their costs, are stored in this system

What causes the problem is no communication between the Hospital ChargeMaster (CDM) and the Hospitals Purchasing Systems, the charge of an item is not necessarily tied to its cost

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Benefits of Linkage

- **Accurate supply item pricing and revenue capture**
  - Ensure all chargeable supplies are accounted for in the CDM and priced above cost
  - Ensure all supply items are appropriately charged consistent with your mark-up strategy (Defensible Pricing)
  - Provides pricing benchmarks for similar facilities nationwide
  - On-going review of your mark-up strategy for defensibility and revenue targets
- **Improved reimbursement through accurate identification of carve outs**
- **Direct link with the Chargemaster tool – CDM Master**
- **Hundreds of man hours of analysis performed in just a few minutes**
- **Clean, accurate data and management reports indicating areas for financial or compliance improvement**

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A Strategy for Medicare Break-even

What are the Three “ah-has” of Current Reform

1. **“Almost” Universal Health Coverage** *(coverage of 31-38 million more Americans)*

2. **Reimbursement pressure creates payment changes** *(Medicare reductions, bundled payments, Value Based Purchasing, Episodic care)*

3. **These pressures will force providers to reduce cost and manage utilization** *specialization of clinical services, outsource of non-clinical services, physician –hospital collaboration)*

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Three Ways to Thrive Under A Leaner Reimbursement Environment

1. **Address Supply Chain**
2. **Work Toward Breakeven on Medicare**
3. **Employ Your Physicians**

HealthLeaders Magazine, December 4, 2009

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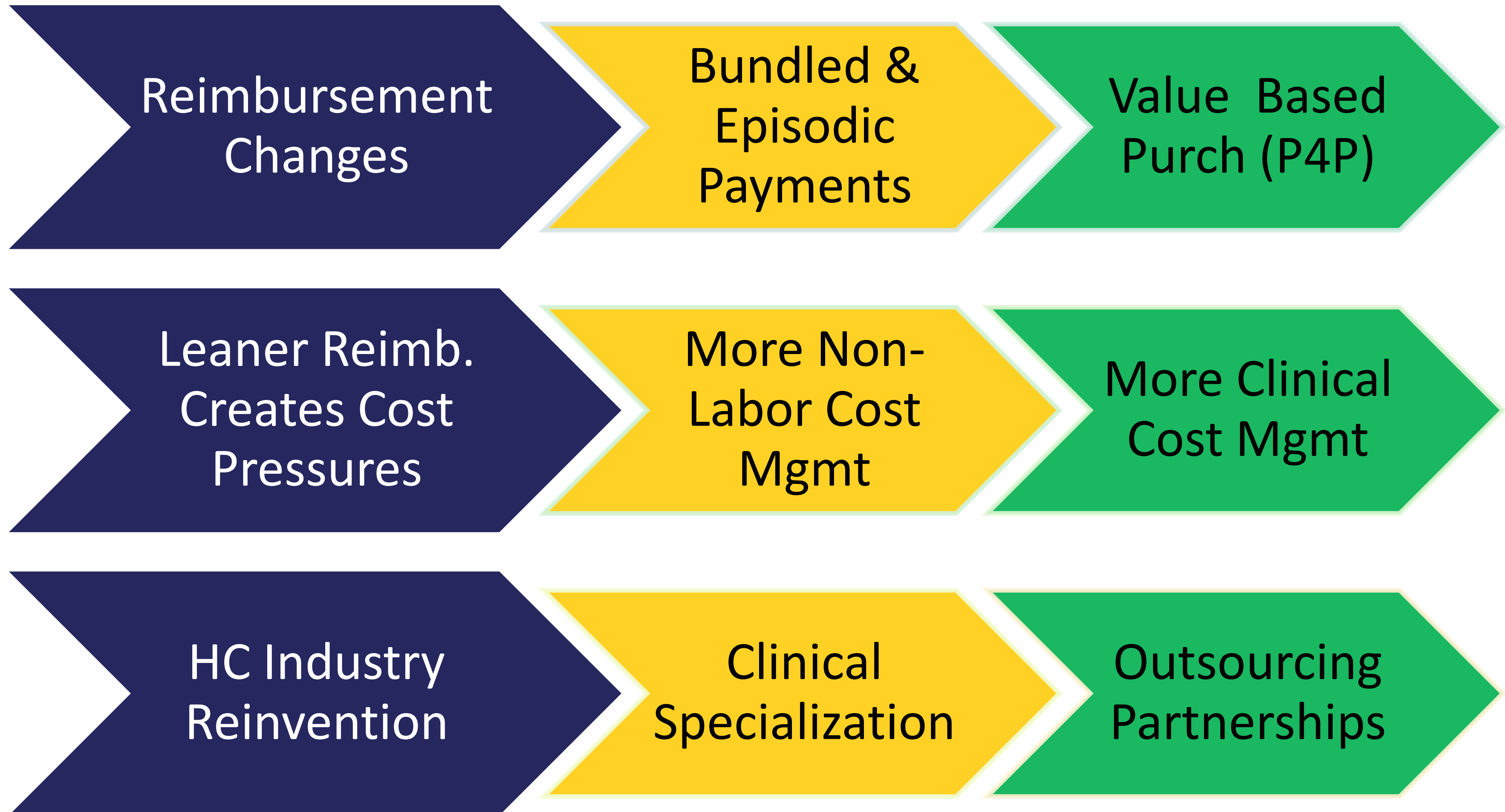
How Will Reform Reshape Our Business



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What's Broken & What are We Trying to Fix

Hospitals will Never Be Paid as Well as They are Today	• Losing 10%+ on Medicare Cases, losing 14% on Medicaid* • Days of "Cost Shifting" MC losses may be over
Fee for Volume versus Fee for Value	• Rewards Volume, not prevention/quality improvement, • Value Based Purchasing: Reimbursement tied to Quality Performance (30-day Readmits, Avoidable Admissions, HACs/HAIs, RAC audits.).
Care Delivered in Silos	• Physicians, hospitals, other providers not aligned due to incentives • Coordination lacking inside/outside walls of hospital • EMR Adoption/MU will help, but requires new processes, & routines
Chronic Disease Patient Volume Increasing	• Rapid increase in multiple chronic diseases (CHF, COPD, Diabetes) • 5% patients = 55% of admissions, care at Medicare rates

**Source:Modern HC 6-29-09, pg 16 MEDPAC . FierceHealthFinance, 12-15-09*

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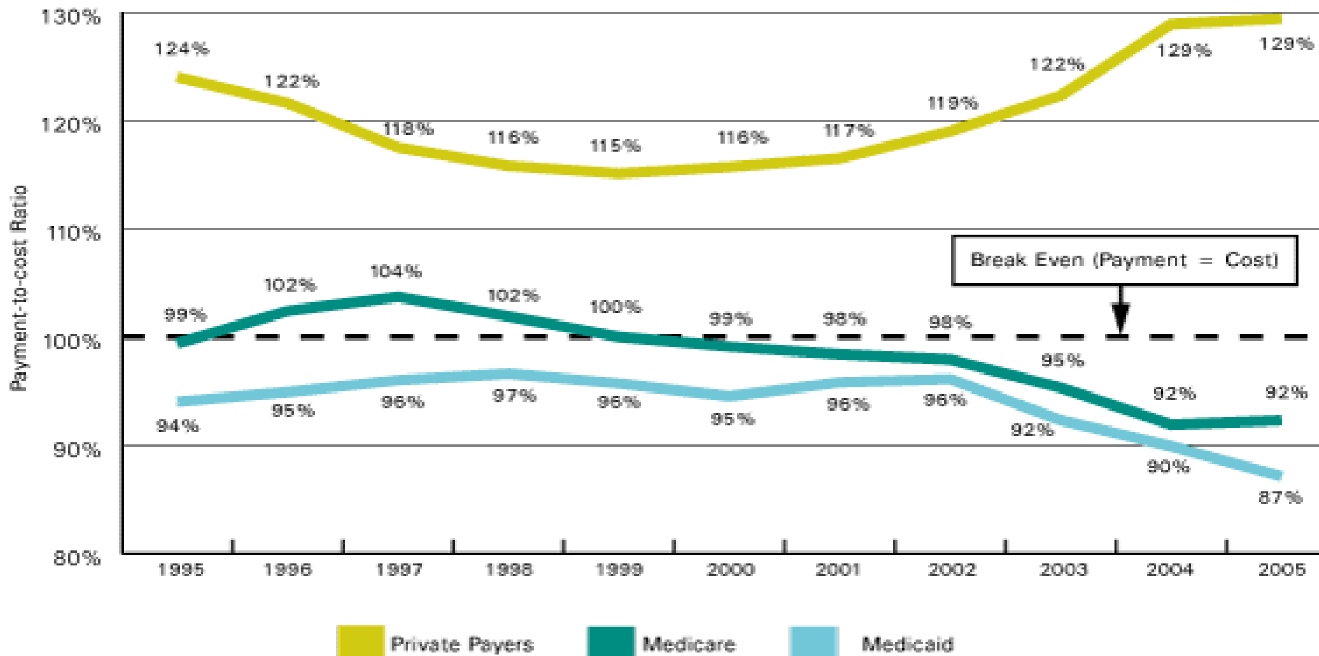
As revenue rises from non-Medicare payers, the financial pressure the hospital is under declines, costs increase, and Medicare margins fall….. Rather than reflecting inadequate Medicare payments, these losses may reflect inadequate cost control.

MEDPAC Medicare Payment Advisory Commission
March 2010



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St Elsewhere Hospital -
Medicare Profitability - By Service Line

Service Line	MCR MCA Volume	IP Revenue	Total Cost	Margin	Percent Margin
Cardiology	4516	$101,244,753	$111,995,994	-$10,751,241	-11%
Cardiac Surgery	229	$22,026,430	$24,524,270	-$2,497,840	-11%
Vascular Surgery & PVI	553	$24,590,739	$27,268,505	-$2,677,766	-11%
Medical	6700	$135,751,727	$149,298,379	-$13,546,652	-10%
Behavioral Health	523	$7,810,408	$9,346,300	-$1,535,892	-20%
Surgical	1510	$64,945,224	$67,756,005	-$2,810,781	-4%
Women & Children	151	$2,334,740	$3,075,316	-$740,576	-32%
Oncology	322	$8,639,660	$9,343,225	-$703,565	-8%
Orthopedics	1188	$27,645,993	$33,795,529	-$6,149,536	-22%
Neurosciences	997	$22,605,909	$25,609,915	-$3,004,006	-13%
Other	733	$92,001,853	$95,057,258	-$3,055,405	-3%
Total	**17424**	**$509,597,437**	**$557,070,697**	**-$47,473,260**	**-9%**

Medicare volumes from 2008 Medicare data files
Volumes for Medicare Advantage estimated from CMS Website – Medicare Advantage/ Enrollment Data
Medicare reimbursement per MSDRG from the 2008 Medicare Data
Medicare Cost date based on Aspen's detail cost and reimbursement data

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Proposed Reimbursement Changes Under Senate Reform Bill

Senate Bill (HR 3590)
Passed
~ $871 B
31 million
• Taxes on "Cadillac" plans • Savings from delivery system • Fees on industry participants

MedPAC with Rate-Setting Authority	• Includes a MedPAC-like body with rate-setting authority; excludes hospitals through 2019
Value-Based Purchasing	• Reduces payment to facilities with lower than average quality, providing bonus payments to high-quality facilities; budget neutral
Readmissions Policy	• Reduces reimbursement for all MS-DRGs based on higher than average readmission rates
Innovative Payment System Pilots	• Establishes pilots for bundled payments and accountable care organizations
Imaging Services	• Increases advanced imaging practice expense utilization

Medicare Alternative Models

- **Elective** (Total Joint Replacement) Bundled MC Part A and Part B
- **Chronic** (CHF, Pulmonary, etc) Episodic Payment to Manage
- **Emergent** (Major Bowel) Fee for Service

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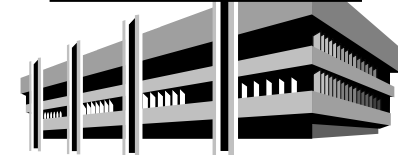
Economics of Bundled Payments

Traditional Medicare Payments	
Hospital	$11,080.00
Orthopedic surgeon**	$1,456.00
Surgeon assistant Anesthesiologist Consulting physicians (cardiologist, internist, pulmonologist, urologist, etc)	$964.00
Total traditional Medicare payment	**$13,500.00**
Bundled payment (participating hospital's bid)	**$12,700.00**
Savings	**$800.00**
Savings to Medicare	$400.00
Savings to Medicare beneficiary	$400.00



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Episode-Based Performance Measurement And Payment: Making It A Reality

Moving toward episode-based approaches for payment and performance measurement involves testing of design elements.

Prometheus creates Evidence-informed Case Rates® (ECR's)

All claims (IP, OP and Pharmacy) are aggregated to separate typical costs from potentially avoidable costs for defined episodes of care

Patient-specific risk factors adjust the model

Costs and risk factors lead to a patient-specific ECR budget that is used to drive reimbursement for Providers

Prometheus, Prometheus Payment, ECRs, are registered trademarks of Prometheus Payment Inc.

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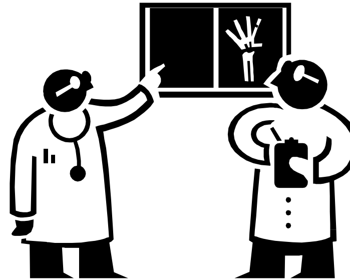
Theory of Evidence-Based Care

PROBLEM

For any given diagnosis, a doctor can consider a number of ways to treat a patient. How does a doctor know which treatment to use?



SOLUTION

Committees of doctors and others track treatments and their outcomes by medical specialty, developing treatment protocols based on the data.

RESULT

A doctor may choose to use or ignore the protocol..

New Yorker Magazine 11/09

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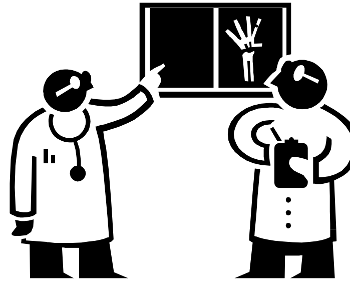
Changing the Game in the "New World"

PROBLEM
How does a doctor know which treatment to use?



SOLUTION
Treatment protocols based on the data.

NEW RESULT
More compliance to protocol, lower cost, better quality, better reimbursement

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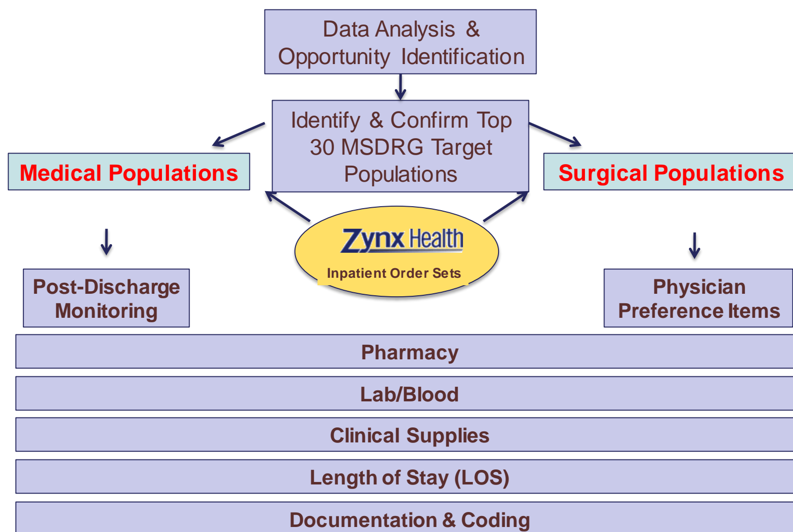
Advantages This Approach Seeks to Obtain

- **Financial Modeling**
- **Involved physician leadership**
- **Improved Medicare Performance**

Tool Box for Medicare Break Even



Long Term Success:

- Improved margins
- Effective management of resources
- High-quality care monitoring
- Best practices in patient care
- Effective patient throughput

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Measuring the Success of the GPO

Ineffective in capturing supply chain performance

- **Supply Expense as a Percentage of Net Revenue** – Revenue (contracts, net reimbursements, etc) is beyond control of supply chain, as are regional differences in reimbursement.
- **Supply Expense as a Percentage of Total Expense** – Other costs (labor, benefits, malpractice, etc) are beyond control of supply chain – and vary considerable nationwide
- **Supply Expense per Adjusted Patient Day** – is misleading -assumes that LOS is standard across country and penalizes hospitals with a short LOS
- **CMI** – Using the Case Mix Index (CMI) to “level the playing field” compounds the problem.

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Thank You

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