

TEN WAYS TO IMPROVE MEDICARE PROFITABILITY

HFMA California Chapter Fall Conference

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Presented by:

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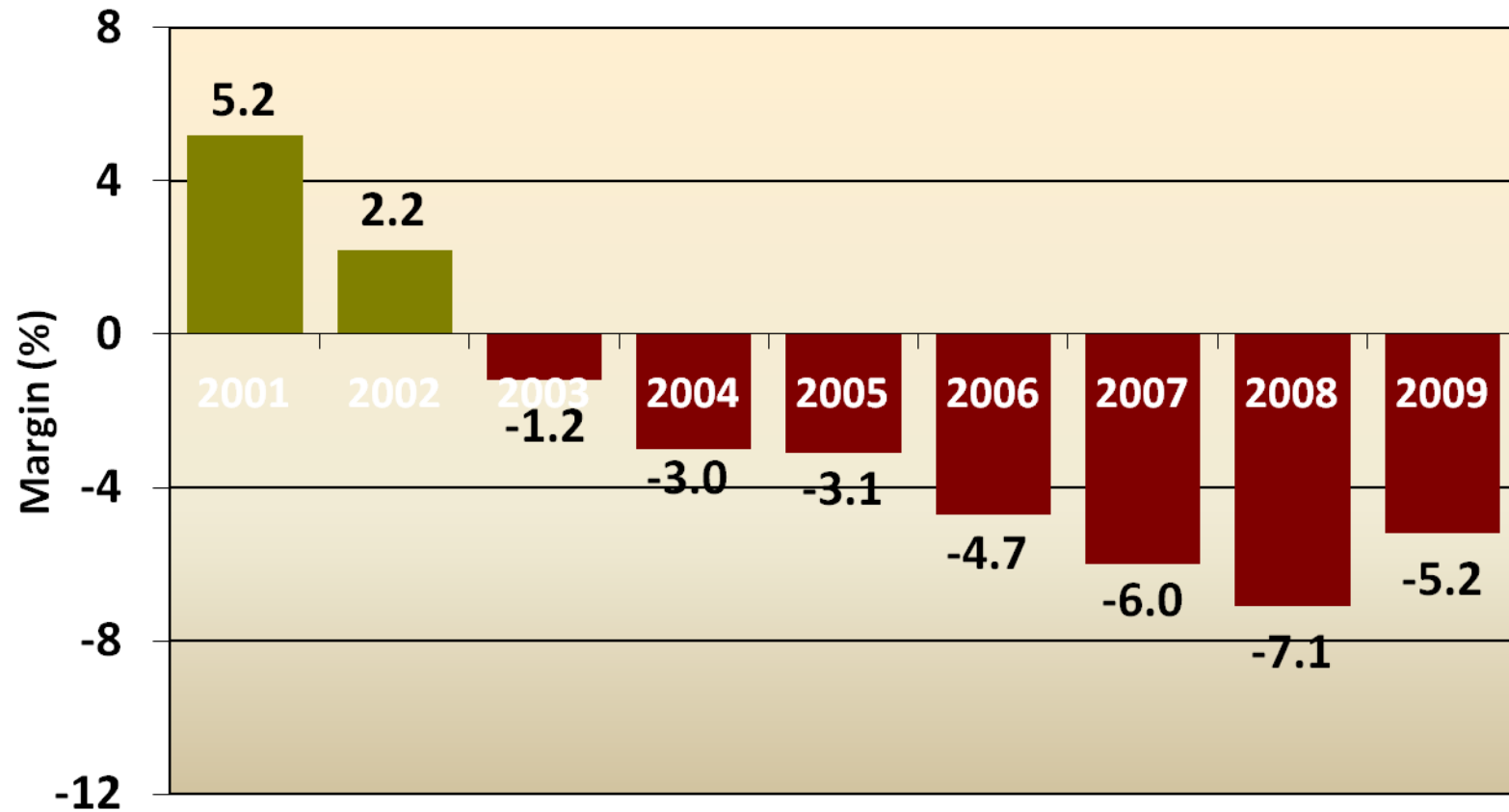
Cleverley + Associates

Today's Objectives

- 1) Why focus on Medicare profitability?
- 2) Current Medicare Payment Information
- 3) High and Low Medicare Profit Hospital Differences
- 4) Ten Areas to Improve Medicare Profit

Discouraging trend

Overall Medicare Margins 2001-2009



Source: Medpac, "Medicare Payment Policy," March 2011

Implications for the future

RECOMMENDATION 3

The Congress should increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2012 by 1 percent. The Congress should also require the Secretary of Health and Human Services to make adjustments to inpatient payment rates in future years to fully recover all overpayments due to documentation and coding improvements.

Key points:

- Access, quality not impacted so payment ok
- Margin issues can be solved with cost containment

Source: Medpac, "Medicare Payment Policy," March 2011

RATIONALE 3

In considering its update recommendation, the Commission has struck a balance between a number of competing factors. On the one hand, average total Medicare margins are negative (–5 percent in 2009 and projected to reach –7 percent in 2011). On the other hand, our update framework indicators (access to care, including supply and service volume; quality of care; and access to capital) are positive. Furthermore, the negative Medicare margins are due at least in part to the lack of private financial pressure for cost containment, and the set of hospitals identified as efficient have a median Medicare margin of about 3 percent. On the basis of these circumstances, the Commission contemplated an update of 2.5 percent.

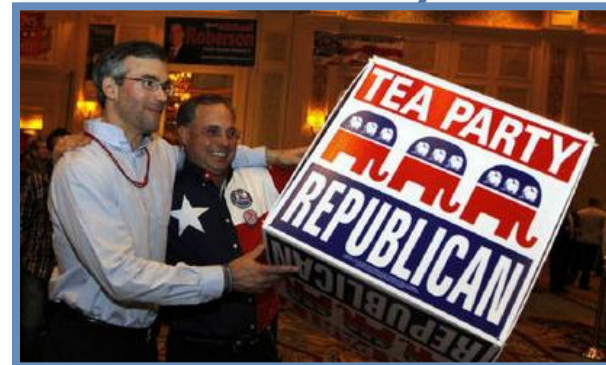
Implications for the future – Health reform

March 23, 2010



Patient Protection and Affordable Care Act (PPACA)

November 2, 2010



Tea Party Victories

January 19, 2011



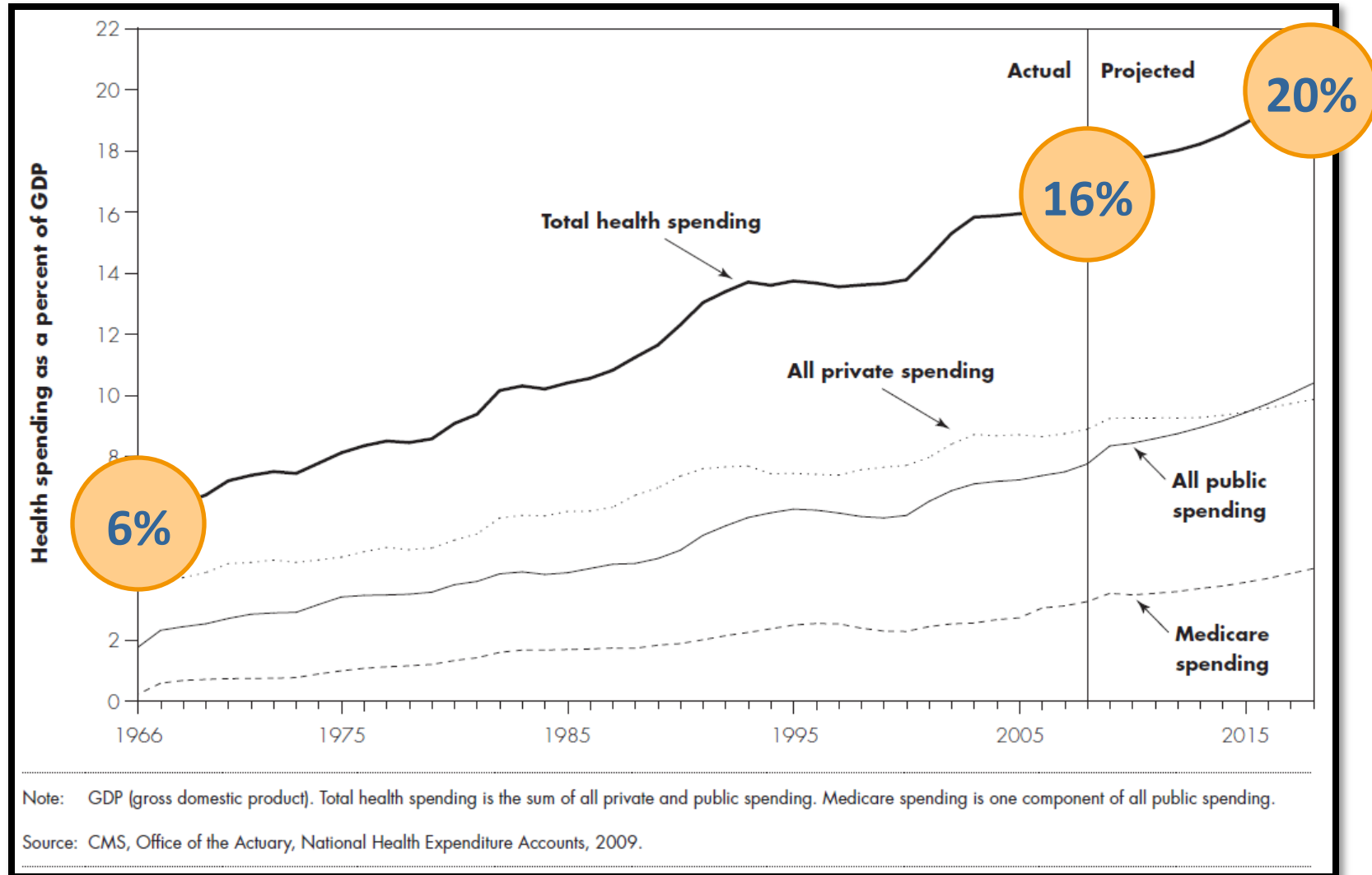
House repeals legislation (Senate rejects 2/2/11)

Today

- >50% likely voters favor repeal (*Rasmussen*)
- State efforts for repeal through courts or elections

Implications for the future

What we know:



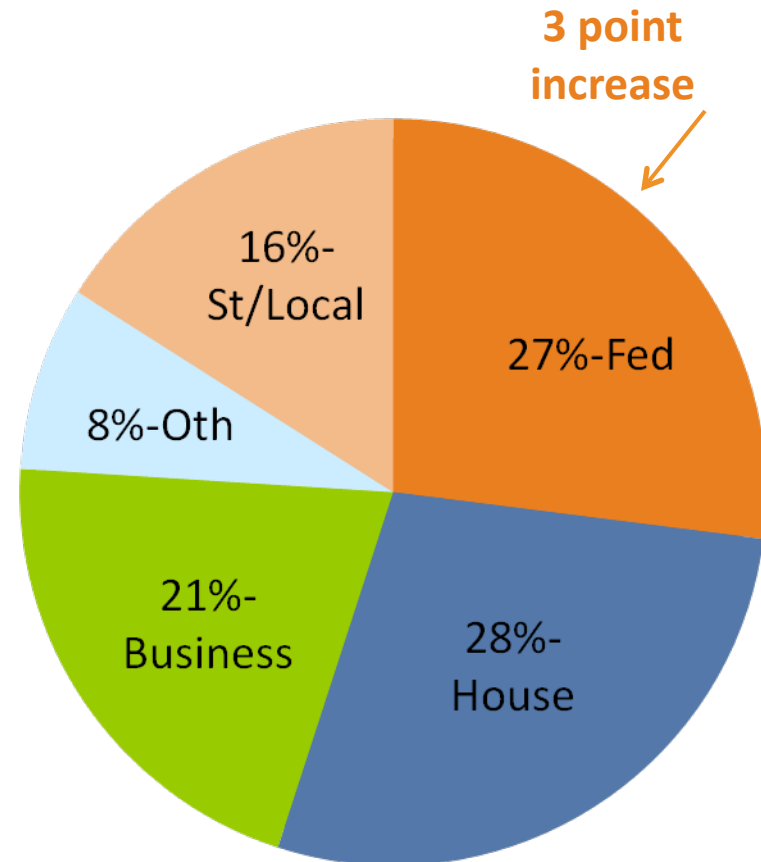
Implications for the future

What we know:

National Health Expenditures in 2009		
National Health Expenditures	↑ 4%	17.6% of GDP
Medicare	↑ 8%	20% of NHE
Medicaid	↑ 9%	15% of NHE
Private Health Insurance	↑ 1%	32% of NHE
Out of Pocket	↑ <1%	12% of NHE

•Source: CMS

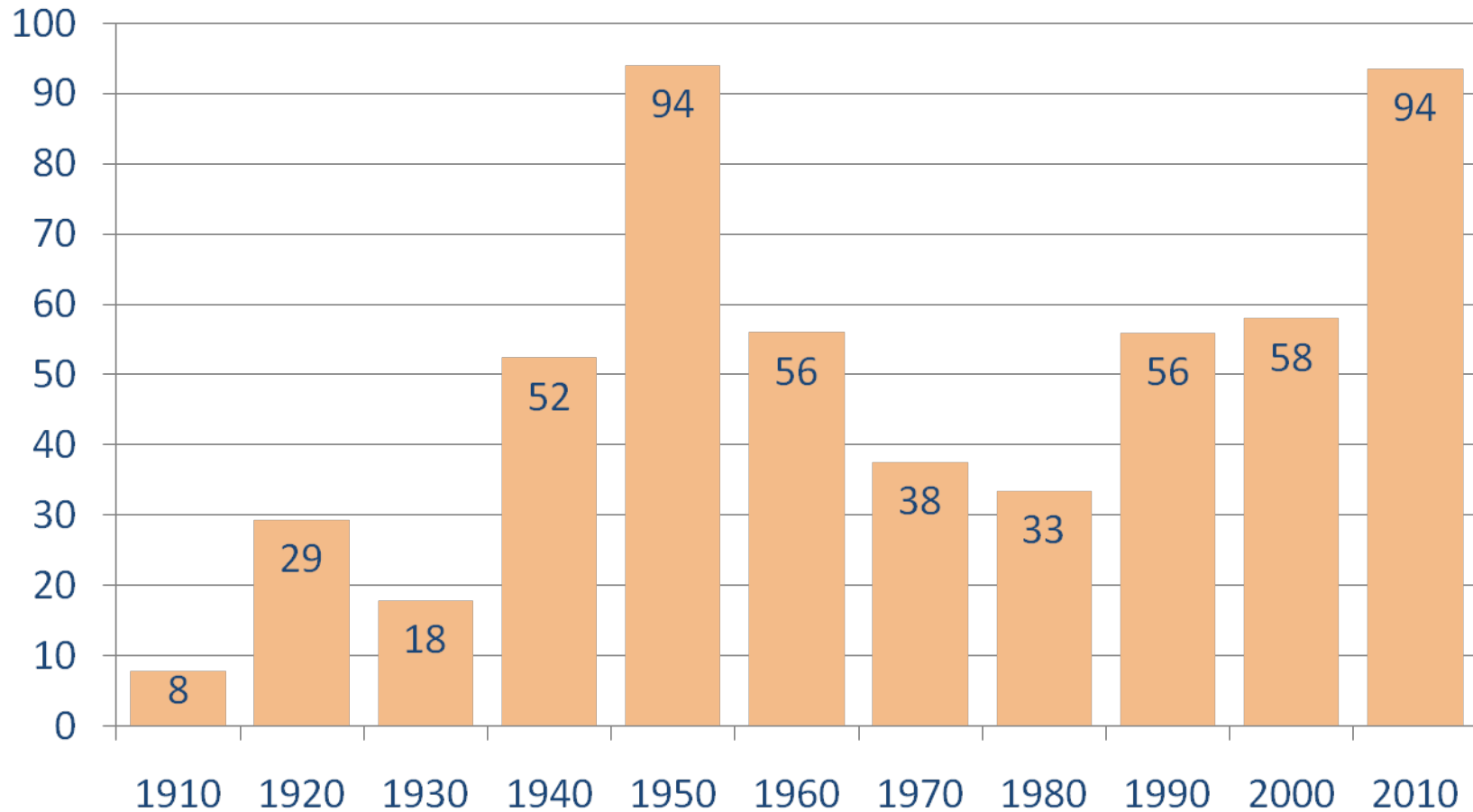
Who's paying NHE?



Implications for the future

What we know:

Gross Public Debt as a Percentage of GDP



Implications for the future

A little math:

Rising Health Expenditures +
Increasing Government Responsibility for Healthcare +
Rapidly Escalating Federal Debt Levels =

Limited Growth for Federal Health Programs



Medicare Payment Information

Medicare Inpatient Payment



Payment Basics

Payment by diagnosis-related group (DRG)

751 DRGs related to 25 major diagnostic categories

MS-DRGs split into 3 possible groups:

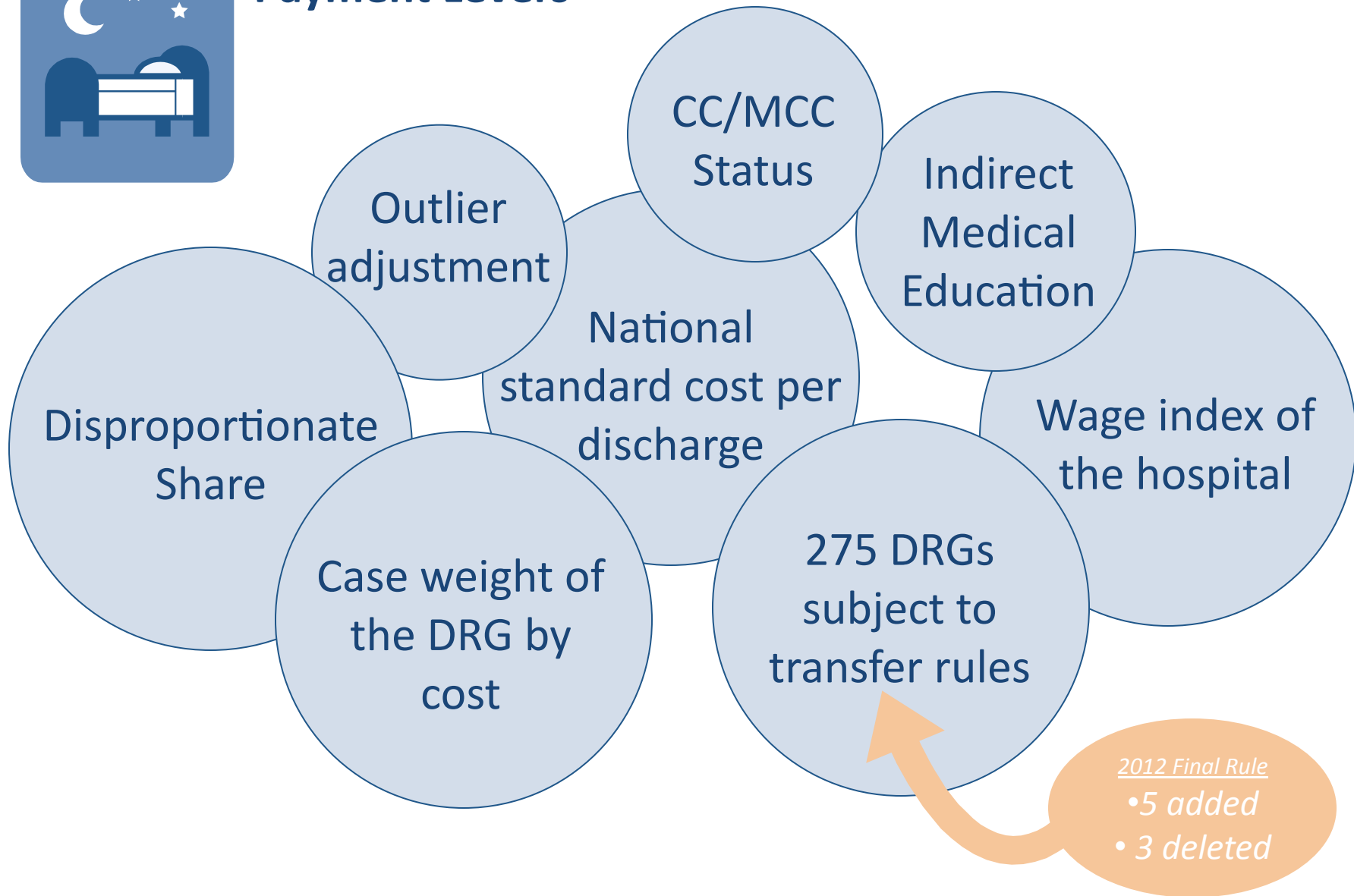
- 1. MCCs
- 2. CCs
- 3. No CCs

2012 Final Rule
5 New MS DRGs/1 Deleted

Medicare Inpatient Payment



Payment Levers



Medicare Inpatient Payment



Payment Changes

- Updated Standardized Amounts
 - Market basket increase (adjusted for productivity) and documentation and coding adjustment of -2% results in the following net increases to standardized rates:
 - Federal Operating Rate:
 - Increased 0.9%
 - FY2012 = \$5,209.74
 - FY2011 = \$5,164.11
 - Federal Capital Rate:
 - Increased 0.3%
 - FY2012 = \$421.42
 - FY2011 = \$420.01

Medicare Inpatient Payment



Payment Changes – Top 10 MS-DRG Changes

MS-DRG	MS-DRG Title	2012 Weights	Total Change in RW	Percent Change in RW
215	OTHER HEART ASSIST SYSTEM IMPLANT	13.7629	1.154	9%
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	2.6984	0.831	44%
453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	10.9193	0.654	6%
007	LUNG TRANSPLANT	9.8710	0.536	6%
456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	9.8152	0.527	6%
576	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	3.4936	-0.431	-11%
769	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.5259	-0.537	-26%
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	12.1033	-0.562	-4%
014	ALLOGENEIC BONE MARROW TRANSPLANT	10.2792	-1.316	-11%
001	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	24.2794	-2.065	-8%

Source: 2012 IPPS Final Rule

Medicare Outpatient Payment



Payment Basics

Payment by ambulatory payment classification (APC)

823 APC Groups

- Medical
- Surgical – reducible
- Significant procedures
- Ancillary
- Partial hospitalization
- Pass-through drugs, bio, radiopharm
- Non-pass-through drugs, bio, radiopharm

- Each CPT / HCPCS code is assigned to one APC group
- Each CPT / HCPCS code has an indicator that tells how that procedure will be reimbursed by Medicare

Medicare Outpatient Payment



Payment Changes

- Increase to Conversion Factor = \$69.420 (2011=\$68.876)
- HOP QDRP Measures 2011 – 2014
 - 23 collected (up from 15 in 2011) in 2012 to determine 2013 payment
- Outlier Threshold = \$2,100 (2011=\$2,025)
- 823 APCs
- Key Areas of Change
 - CT abdomen + pelvis = combined services APCs
 - Supervision requirements for outpatient therapeutic services

Medicare Outpatient Payment



Payment Changes – Top 10 APC RW Changes

APC	Group Title	SI	2011 Relative Weight	RW Difference	% Change
0082	Coronary or Non-Coronary Atherectomy	T	104.8857	12.1605	13.11%
0315	Level II Implantation of Neurostimulator Generator	S	284.8462	11.1548	4.08%
0086	Level III Electrophysiologic Procedures	T	133.7624	11.1156	9.06%
0083	Level I Endovascular Revascularization of the Lower Extremity	T	65.1118	10.2280	18.64%
0169	Lithotripsy	T	51.4038	9.4241	22.45%
0442	Dosimetric Drug Administration	S	22.9208	-9.5902	-29.50%
0108	Insertion/Replacement/Repair of AICD Leads, Generator, and Pacing Electrodes	T	379.7887	-9.7463	-2.50%
0107	Insertion of Cardioverter-Defibrillator	T	329.3230	-10.4849	-3.09%
0375	Ancillary Outpatient Services When Patient Expires	S	79.4058	-13.1098	-14.17%
0259	Level VII ENT Procedures	T	395.1320	-55.8305	-12.38%

Source: 2012 OPSS Proposed Rule



High- and Low-Medicare Profit Hospital Differences



Inpatient market factors

	DRG Profit - High	DRG Profit - Low	LA Metro	SD Metro	CA Median	US Median
Expected Profit on DRGs %	19.8	-37.4	9.5	-2.1	-0.4	-3.1
Expected Profit on APCs %	-11.9	-27.7	-17.3	-20.2	-19.0	-16.4
Inpatient Revenue %	53.3	34.9	72.6	71.9	68.6	51.1
Surgical Cases %	20.1	18.2	21.9	30.0	25.1	24.0
Medicaid Days %	21.0	7.4	23.2	16.7	20.9	16.4
Medicare Days %	49.7	61.1	38.4	40.3	41.2	50.8
Disproportionate Share %	14.5	3.4	20.1	15.5	13.7	10.3



Medicare Payment per Case (CMI & WI adjusted)

	<i>DRG Profit – High</i>	<i>DRG Profit – Low</i>	<i>US</i>
DRG	\$5,311	\$4,827	\$4,651
Outlier	151	156	196
DSH	855	131	558
Indirect medical education	282	21	145
Capital	384	237	436
Coinsurance/Deductible	582	708	552
Other	157	40	99
<i>Total</i>	<i>\$7,722</i>	<i>\$6,120</i>	<i>\$6,637</i>



Medicare Cost per Case (CMI & WI adjusted)

	<i>DRG Profit – High</i>	<i>DRG Profit – Low</i>	<i>US</i>
Routine care	1,922	3,743	2,092
ICU/CCU	998	1,102	1,170
<i>Total nursing</i>	<i>2,919</i>	<i>4,845</i>	<i>3,261</i>
Medical/surgical supplies	727	1,090	982
Laboratory	444	477	437
Operating room	473	626	622
Radiology/MRI	261	287	275
Pharmacy	658	766	688
Emergency room	153	130	168
Cardiology/Blood	244	253	197
PT/OT/Inhalation therapy	294	390	333
Other	148	100	127
<i>Total ancillary</i>	<i>3,401</i>	<i>4,118</i>	<i>3,829</i>
<i>Total costs</i>	<i>\$6,320</i>	<i>\$8,964</i>	<i>\$7,091</i>

Source: MedPar Files



Outpatient market factors

	APC Profit - High	APC Profit - Low	LA Metro	SD Metro	CA Median	US Median
Expected Profit on DRGs %	4.9	-10.8	9.5	-2.1	-0.4	-3.1
Expected Profit on APCs %	9.1	-49.1	-17.3	-20.2	-19.0	-16.4
Inpatient Revenue %	49.8	49.4	72.6	71.9	68.6	51.1
Surgical Cases %	24.5	23.3	21.9	30.0	25.1	24.0
Medicaid Days %	16.0	16.5	23.2	16.7	20.9	16.4
Medicare Days %	51.4	48.6	38.4	40.3	41.2	50.8
Disproportionate Share %	10.5	10.7	20.1	15.5	13.7	10.3



Payment Components by Group

	<i>APC Profit High</i>	<i>APC Profit Low</i>	<i>US</i>
Avg payment per claim	\$625	\$502	\$556
Avg payment per relative wt	\$63.31	\$67.10	\$65.96
Avg relative wt per claim	9.82	7.48	8.54
<i>Avg profit per claim</i>	<i>\$82</i>	<i>(\$264)</i>	<i>(\$109)</i>



Cost Components by Group

	<i>APC Profit High</i>	<i>APC Profit Low</i>	<i>US</i>
Avg cost per claim	\$600	\$778	\$692
Avg cost per relative wt	\$63	\$105	\$85



Review Current Medicare Profit

Case Hospital Discussion

Medicare Inpatient Profit (000)

	Case	Competitor
Payment		
<i>Other than outliers</i>	37,298,919	58,188,231
<i>Outliers</i>	2,680,841	2,778,556
<i>Indirect medical education</i>	1,412,403	2,603,375
<i>Disproportionate Share</i>	5,423,263	4,387,393
Sub-Total	46,815,426	67,957,555
<i>Capital payments</i>	3,381,199	5,324,770
<i>Direct Graduate Medical Education</i>	886,578	1,111,880
Total Payments (excluding direct medical education)	50,511,186	73,522,663
Costs		
Total Costs	61,302,856	84,823,320
Profit	-10,791,670	-11,300,657
<i>Medicare margin %</i>	<i>-21.4%</i>	<i>-15.4%</i>

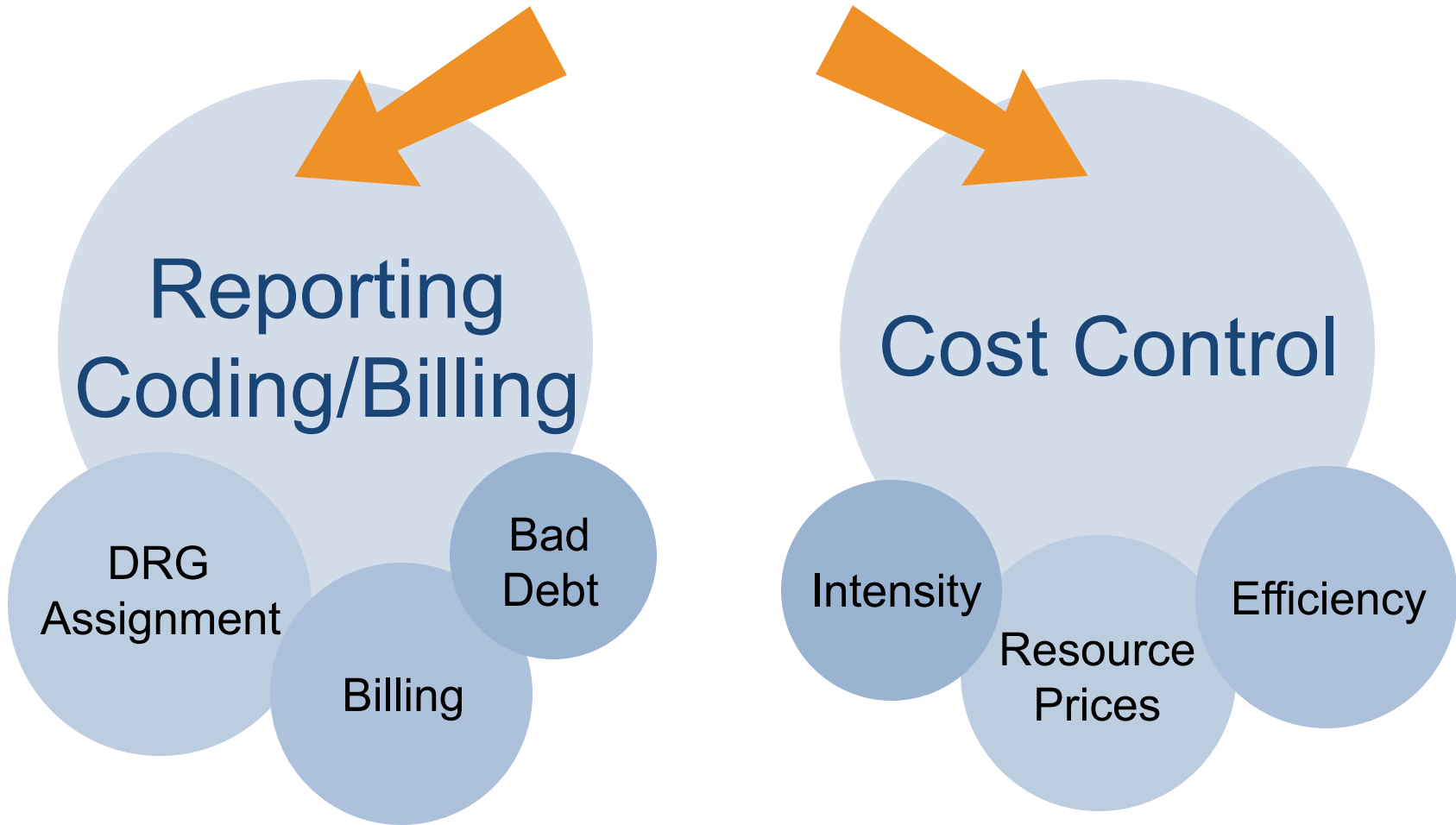
Medicare Outpatient Profit (000)

	Case	Competitor
Payment		
Total Payments (including outlier)	21,396,846	46,763,668
Costs		
Total costs	25,653,774	52,808,398
Profit	-4,256,928	-6,044,730
<i>Medicare margin %</i>	<i>-19.9%</i>	<i>-12.9%</i>



Ten Areas to Enhance Medicare Profitability

Improving Medicare profit





1. Payment Issues: Medicare Bad Debt, DSH

1 Payment Issues

Notes on bad debt and DSH:

- Medicare bad debt levels have been increasing across the US. Determine if your levels reflect “typical” increases. Levels can be compared historically and to peers.
- Medicare disproportionate share payments (DSH) are targeted for reduction in PPACA, but will still be an important revenue source for qualifying hospitals. Comparison of Medicaid to DSH levels in your market can serve as an important benchmark. Medicaid eligible patient assessment is key.

1 Medicare Bad Debt

Bad Debt Averages — 2010

	US (4,306 Hospitals)	CA (341 Hospitals)
# with no IP bad debt	272	41
% with no IP bad debt	6%	12%
# with no OP bad debt	521	48
% with no OP bad debt	12%	14%
Median IP bad debt	14.0%	18.9%
Median OP bad debt	8.7%	23.8%

1 Medicare Bad Debt

Inpatient & Outpatient Medicare Bad Debt Percentages

	2009		2010	
	Inpatient Bad Debt%	Outpatient Bad Debt%	Inpatient Bad Debt%	Outpatient Bad Debt%
Case Hospital	7.2%	12.4%	20.0%	26.1%
Competitor	9.5%	12.5%	40.5%	33.5%

Bad Debt % = Reimbursable Bad Debt/Deductibles and Coinsurance

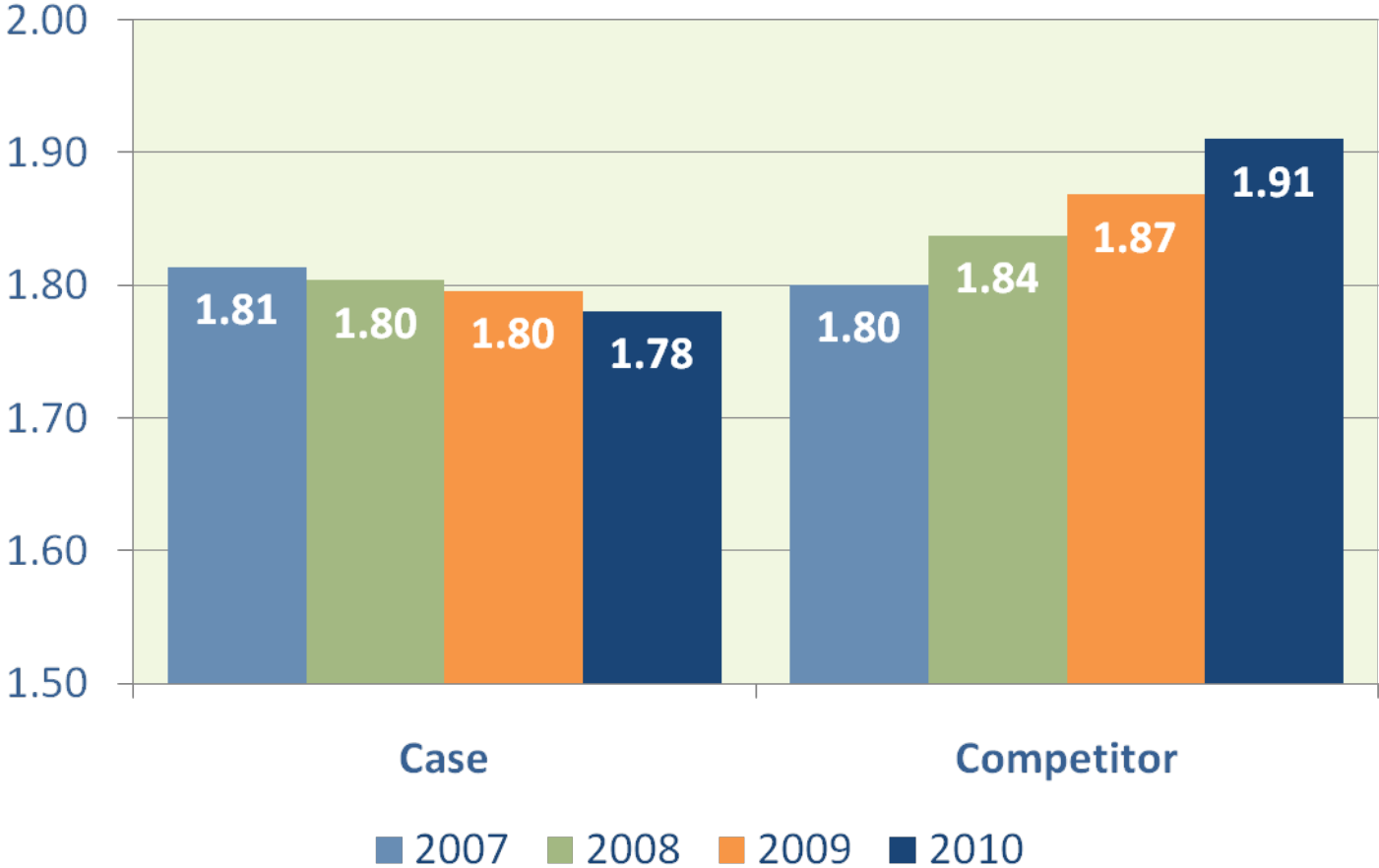
Medicare bad debt level is significantly higher in 2010. At 2010 levels, a 1% increase in inpatient bad debt percentage would generate approximately **\$29,038** in Medicare reimbursement. Similarly, a 1% increase in outpatient bad debt percentage would generate approximately **\$30,828** in Medicare reimbursement.



2. Review DRG Coding

2 DRG Coding

MEDICARE CMI – 2007-2010



2 DRG Coding

	DRG Profit - High	DRG Profit - Low	LA Metro	SD Metro	CA Median	US Median
Change in Medicare CMI %	1.7	1.1	3.1	1.6	3.1	2.7
Medicare CMI	1.3599	1.0976	1.5313	1.6179	1.5326	1.4324
CC/MCC Capture Rate	0.48	0.40	0.52	0.49	0.51	0.48
MSDRGs:(DRG 177+DRG 178) / (DRG 177+DRG 178+DRG 179)	0.91	0.83	0.93	0.91	0.91	0.90
MSDRGs:(DRG 193+DRG 194) / (DRG 193+DRG 194+DRG 195)	0.79	0.69	0.81	0.79	0.80	0.79
MSDRGs:(DRG 640) / (DRG 640+DRG 641)	0.35	0.22	0.37	0.38	0.38	0.35

2 DRG Coding

MEDICARE CMI TOP OPPORTUNITIES

MSDRG Family	Definition	Medicare Reimbursement Shift at Competitor CMI
163/164/165	Major chest procedures	90,974
207/208	Respiratory system diagnosis w ventilator support	113,538
233/234	Coronary bypass w cardiac cath	85,984
246/247	Perc cardiovasc proc w drug-eluting stent	114,280
329/330/331	Major small & large bowel procedures	142,390
480/481/482	Hip & femur procedures except major joint	83,111

2 DRG Coding

Notes on MS-DRG Coding Distribution:

- Top two MCC and CC diagnosis codes for the 246/247 family are listed below.
- Case Hospital had 0.31 MCC diagnosis codes per patient claim, versus 0.44 for Competitor. Multiple MCC (or CC) diagnosis codes can be listed on each patient claim. Competitor's heavier use of diagnosis codes appears to be yielding higher MS-DRG assignment and reimbursement.

KEY DIAGNOSIS CODES IN MS-DRG 246/247

(Medicare Data – 2010)

Diagnosis Code	Definition	% on Case Hosp Claims	% on Compet Claims	MCC or CC?
41071	Subendocardial Infarction, Initial Episode Of Care	11.3%	17.4%	MCC
41402	Coronary Atherosclerosis Of Autologous Vein Bypass Graft	13.7%	19.1%	CC



3. Review Transfer Payment Validity

3 Transfer Validation

- Review all DRGs where transfer-payment existed
- Confirm that post acute care was provided
- Rebill for claims in which post acute care not provided
- Must rebill claims within one year of discharge date
- 10% to 15% of transfer claims may need to be rebilled

3 Transfer Validation

Transfer Case Example

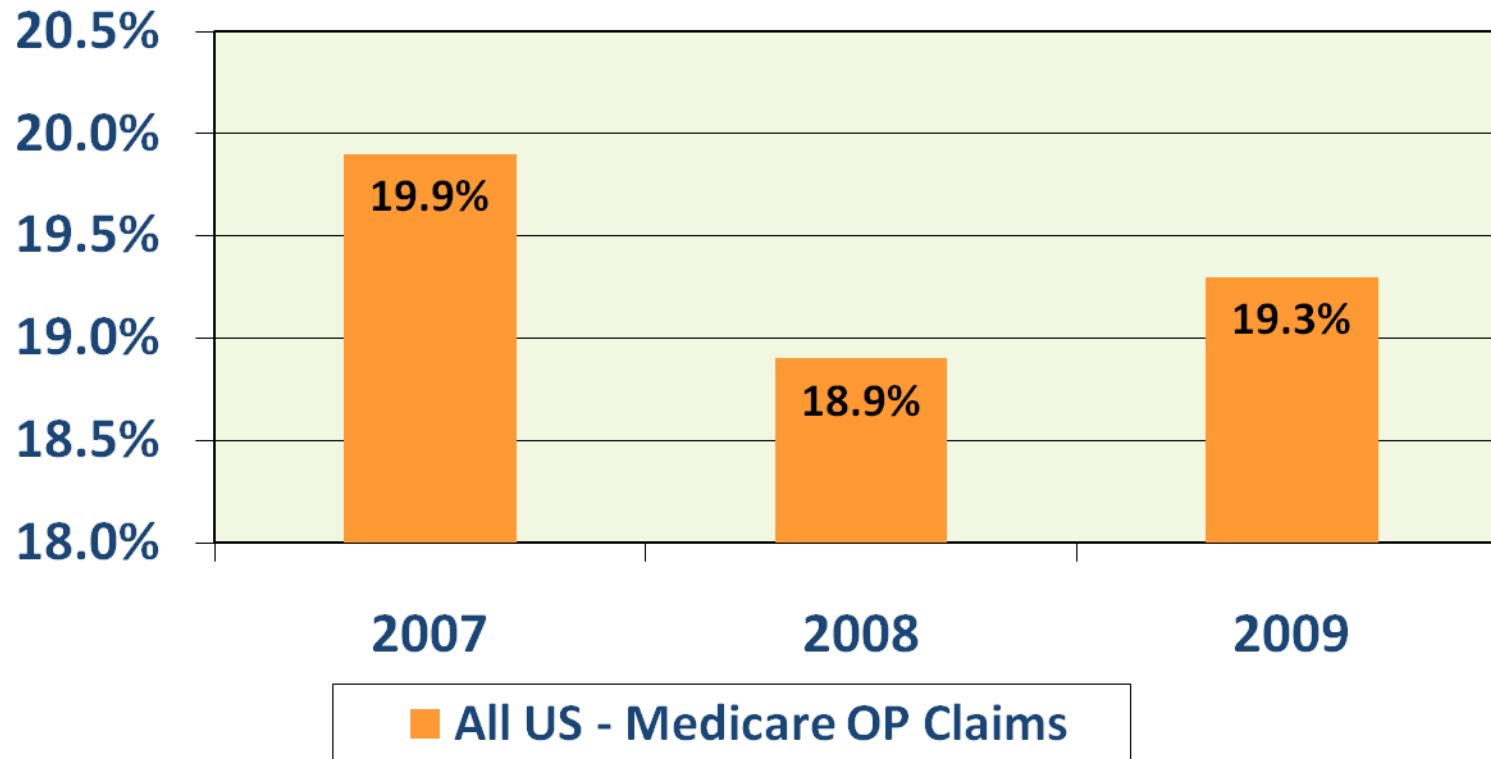
- **MSDRG # 870**
- **02/20/2010 to 02/26/2010**
- **SNF Discharge Status**
- **\$20,780 Total payments**
- **\$18,444 Additional payment**



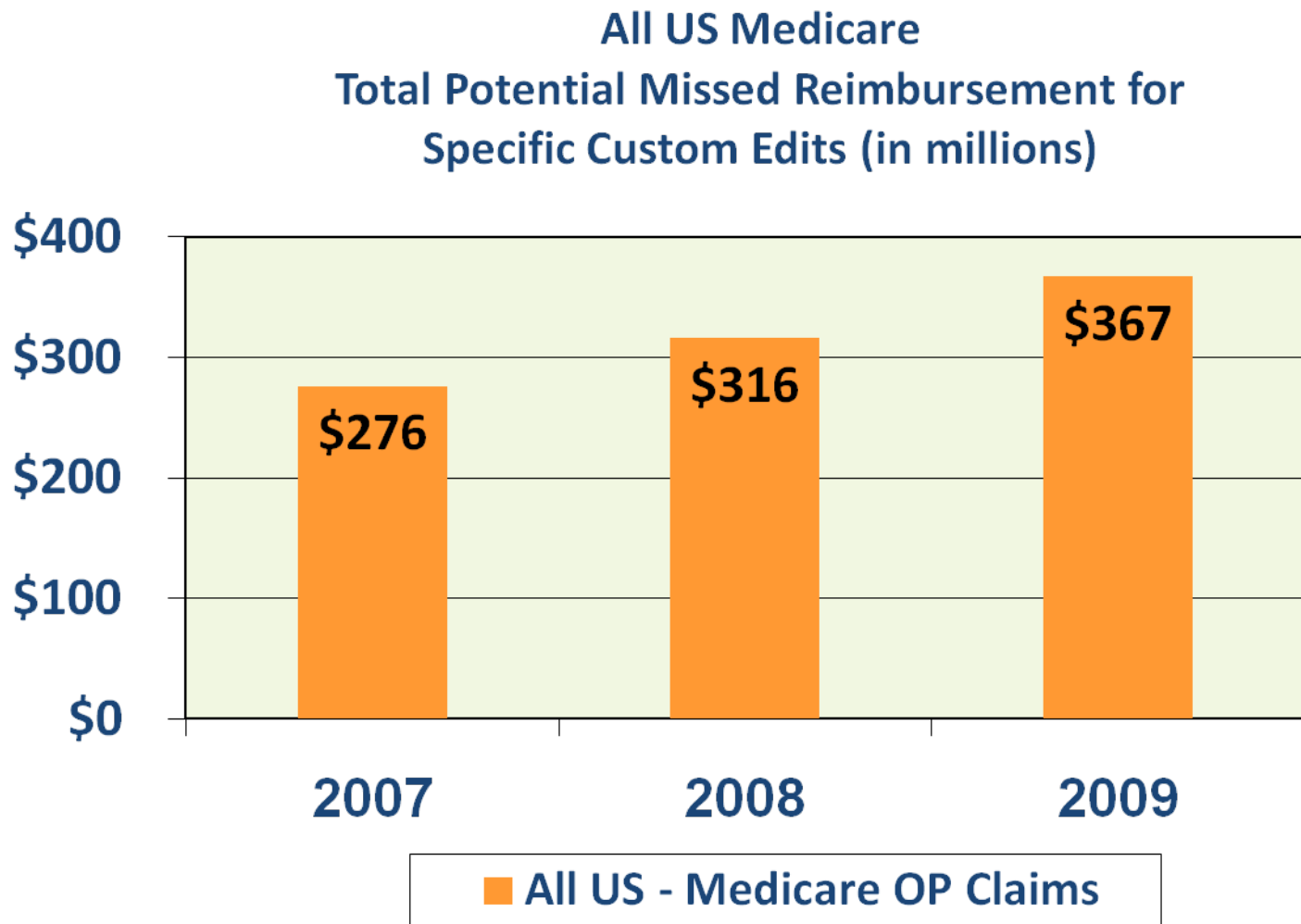
4. Monitor Billing Procedures

4 Billing Procedures

All US Average Error Rate -
Medicare Outpatient Claims for
Specific Custom Edits



4 Billing Procedures

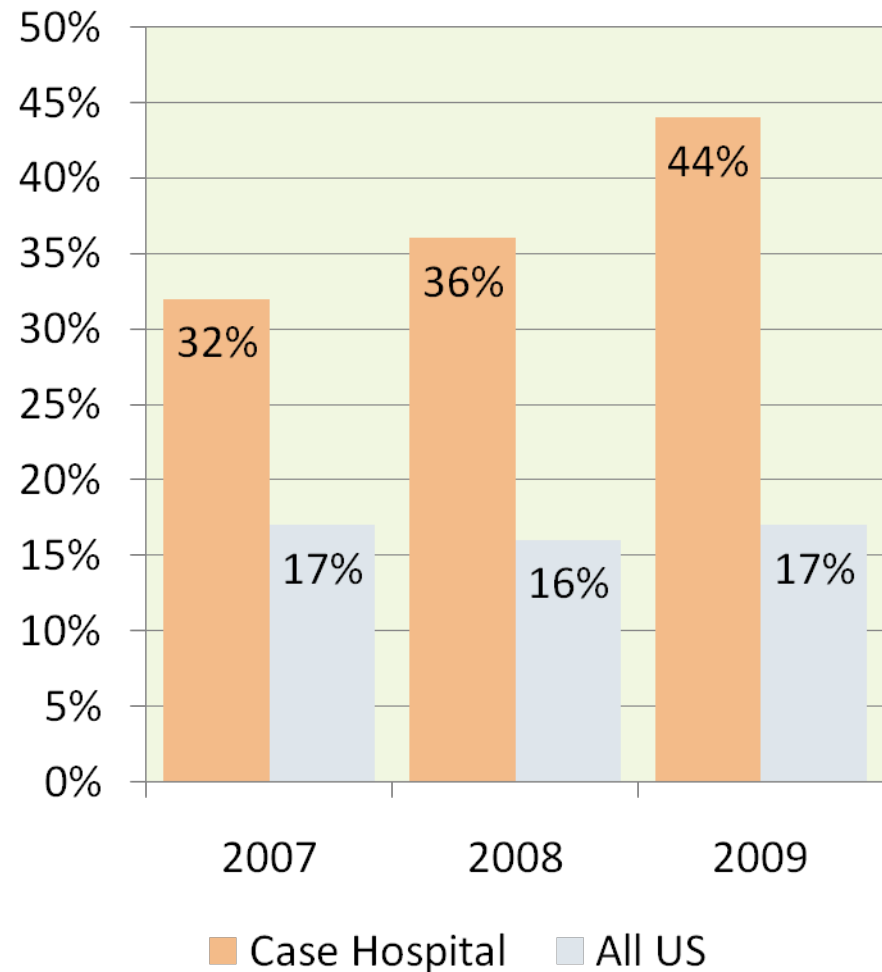


4 Billing Procedures

Example: Drug Administration

- A pharmaceutical item requiring injection or infusion is present without the administration procedure.
- Results include chemotherapy and non-chemotherapy administration.
- This indicator excludes surgery, cardiology, and gastrointestinal service claims.

% OP Claims Missing Drug Admin



4 Billing Procedures

	APC Profit - High	APC Profit - Low	LA Metro	SD Metro	CA Median	US Median
Injectable Drug without Administration %	15.3	17.2	22.2	17.9	18.9	16.1

4 Billing Procedures

Non-Chemo Drug Administration

Top 10 Most Frequent Codes Triggering Error (All US)

HCPCS	Code Description	Percent of Total Occurrences
J2405	Ondansetron hcl inj 1 mg	14.4%
J1642	Inj heparin sodium per 10 u	8.0%
J2250	Inj midazolam hydrochloride	7.2%
J3010	Fentanyl citrate injeciton, .1	6.6%
J2270	Morphine sulfate injection	5.9%
J1885	Ketorolac tromethamine inj	5.6%
J1644	Inj heparin sodium per 1000u	4.6%
J1170	Hydromorphone injection	4.5%
J1650	Inj enoxaparin sodium	4.4%
J1745	Infliximab inj 10 mg	4.2%



5. Emergency Room & Clinic Coding Frequency

5 ER/Clinic Coding Frequency

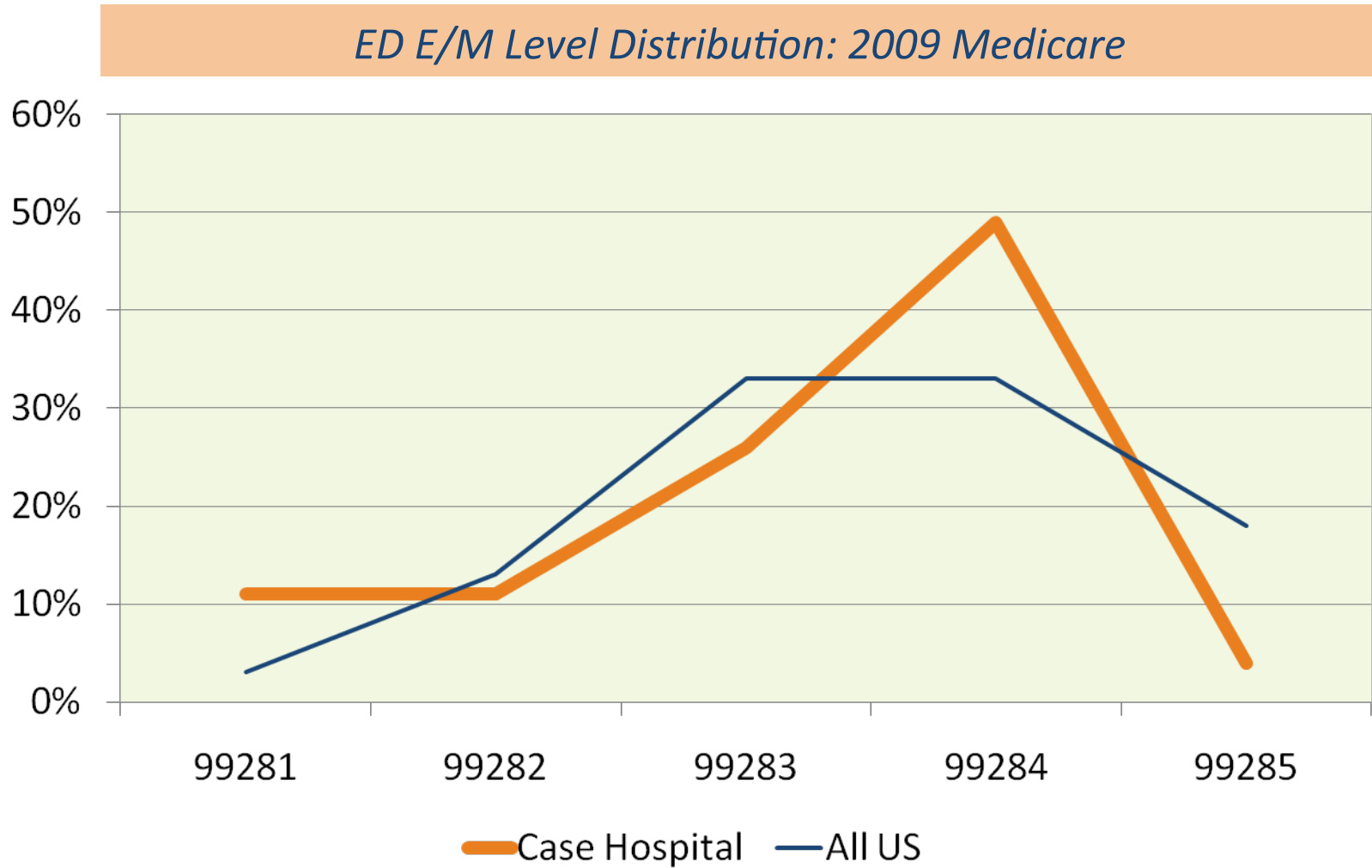
➤ E/M Levels

- Emergency Department
- Clinic

➤ CMS states in the 2010 OPPS Final Rule...

“In the absence of national guidelines, we will continue to regularly reevaluate *patterns* of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services.”

5 ER/Clinic Coding Frequency





6. Comparison with Fee Schedule

6 Fee Schedule

Medicare Fee-Schedule Items

- Status Indicator A services
 - ✓ Lab
 - ✓ Ambulance
 - ✓ Physical therapy
 - ✓ Occupational therapy
 - ✓ Speech therapy

- Payment is lower of price or fee schedule
- Critical for commercial contracts, as well

6 Fee Schedule

Medicare Fee-Schedule Issues

<i>Item Description</i>	<i>HCPCS</i>	<i>Medicare Outpatient Volume</i>	<i>Fee Schedule</i>	<i>CDM Price</i>	<i>Lost Payment</i>
LIPID PANEL	80061	2,776	\$18.72	\$4.03	\$40,791
COMPREHENSIVE METABOLIC PROFIL	80053	2,321	14.77	5.03	22,601
THYROID STIMULATING HORMONE	84443	831	23.47	5.03	15,322
<i>Total All Fee Schedule Items</i>					<i>\$138,486</i>



7. Assess Facility-Level Costliness

7 Facility-level cost

Why one facility metric of comparison?

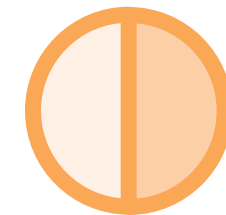
1) Evaluates complete hospital cost position



2) Permits trending over time



3) Allows for comparative benchmarking



Traditional facility-level hospital cost metrics:

- 1) Cost per adjusted patient day (*with or without CMI adjustment*)
- 2) Cost per adjusted discharge (*with or without CMI adjustment*)

7 Facility-level cost

Issues with traditional 'adjusted' metrics

	Total Costs (000)	Patient Days	Gross OP Rev (000)	Gross IP Rev (000)	Adj Pt Days	Cost/ Adj Pt Day
Data prior to rate increase	60,000	12,000	70,000	60,000	26,000	<u>2,308</u>
10% OP rate increase	60,000	12,000	77,000	60,000	27,400	<u>2,190</u>

Adjusted Patient Days Formula:

IP Patient Days X [1+(Gross OP Rev/Gross IP Rev)]

7 Facility-level cost

The ultimate goal in understanding and addressing cost issues

CREATE LOW COST PATIENT ENCOUNTERS



Inpatient Costs
Cost per Discharge



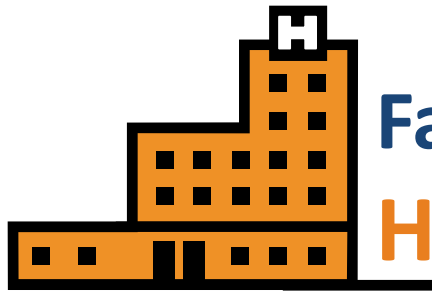
Outpatient Costs
Cost per Visit

Patient Encounter Cost:

$$\text{Cost} = (Q1 \times C1) + (Q2 \times C2) + \dots + (Qn \times Cn)$$

Where Q = quantity of units and C = cost per unit

7 Facility-level cost



Facility-level cost measure:

Hospital Cost Index[®]

Inpatient Cost Index

Formula:

*Your Medicare Cost
per Discharge (CMI/WI adj)
US Median Medicare Cost
per Discharge (CMI/WI adj)*

Outpatient Cost Index

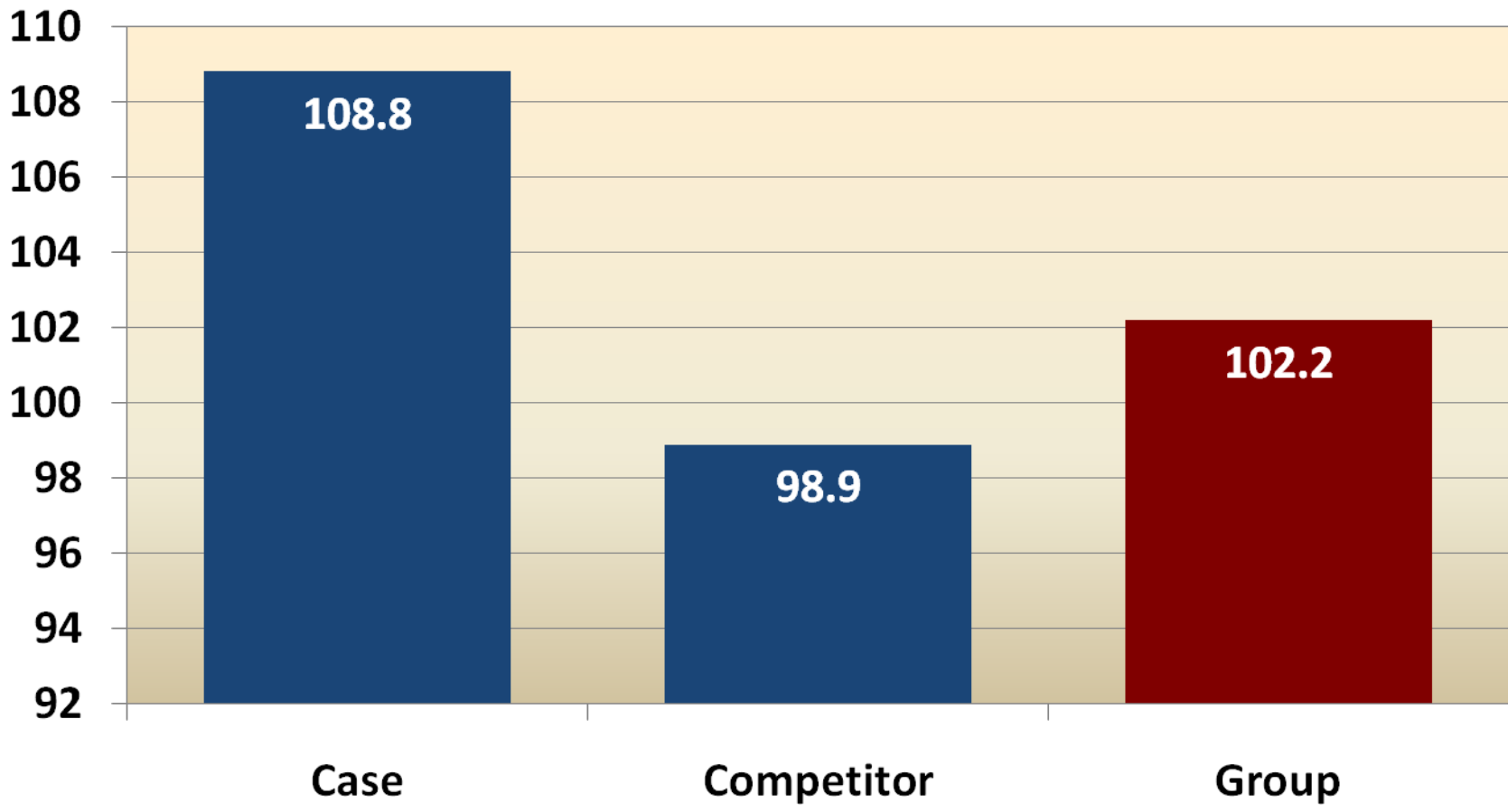
Formula:

*Your Medicare Cost
per Visit (RW/WI adj)
US Median Medicare Cost
per Visit (RW/WI adj)*

A high index score indicates a higher relative cost position.

7 Facility-level cost

Hospital Cost Index®



7 Facility-level cost

	Medicare Cost Per Discharge (CMI/WI adj)	Medicare Cost Per Visit (RW/WI adj)
Case	\$7,762	\$72
Competitor	\$6,759	\$69
Group	\$6,415	\$71

7 Facility-level cost

	DRG Profit - High	DRG Profit - Low	APC Profit - High	APC Profit - Low	LA	SD	CA	US
Hospital Cost Index®	91.3	117.3	85.8	120.5	95.0	95.5	95.5	100.8
Average Cost per Medicare Discharge (CMI = 1.0)	5,781	8,689	6,249	7,446	6,332	6,618	6,459	6,803
Average Cost per Visit (RW = 1.0)	77	87	63	103	73	74	72	80

7 Facility-level cost



Potential Savings	
Case Hospital HCI	108.8
<i>Group Avg</i>	102.2
<i>Present cost</i>	\$317,000,000
<i>times (6.6 / 102.2)</i>	<u>x 6.6%</u>
<i>Potential savings</i>	\$20,922,000



8. Macro Issues of Price & Intensity

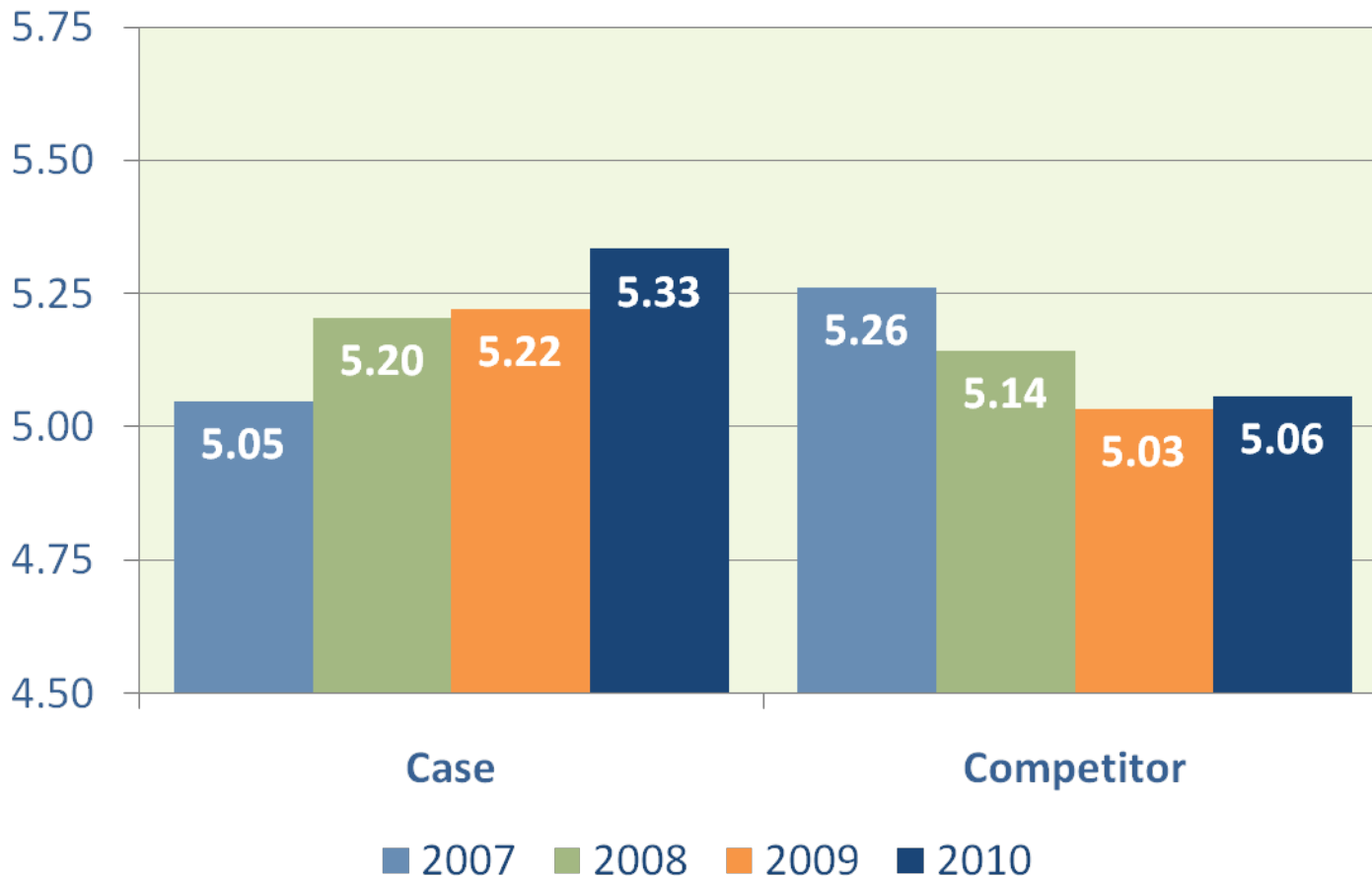
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Macro Price & Intensity Issues



Example: How does length of stay compare?

MEDICARE LOS – 2007-2010



8

Macro Price & Intensity Issues

	DRG Profit - High	DRG Profit - Low	LA	SD	CA	US
Medicare LOS (CMI = 1.0)	3.3	3.3	3.2	2.7	3.1	3.2
Surgical Cases %	20.1	18.2	21.9	30.0	25.1	24.0

8

Macro Price & Intensity Issues



Example: How does length of stay compare?

Notes on LOS Opportunity:

- Submitted “all payer” claims data also shows LOS opportunity for nearly every MSDRG
- Physician variation does exist (top ten physician day savings, at right), however, a more practical approach may be a general hospital-wide emphasis on LOS as this issue impacts a variety of case categories

TOP DAY SAVINGS – PHYSICIAN LEVEL

(All Payer Submitted Data – Calendar Year 2009)

Physician Code	Number of Patient Claims	Average LOS	Sum of LOS Savings
504XXX	189	13.15	472.73
111XXX	702	5.75	275.38
311XXX	584	6.74	201.56
391XXX	654	5.57	156.40
137XXX	134	6.63	143.90
611XXX	161	9.86	135.55
901XXX	521	13.32	95.76
611XXX	217	7.80	90.48
392XXX	150	5.53	90.28
501XXX	5	37.00	86.44

8 Macro Price & Intensity Issues

 How do labor costs/productivity compare?

1. Routine care department costs are at the Custom Group 66th percentile
2. Direct cost per patient day is higher than comparison peers and Custom Group

	Case Hospital	Competitor	Custom Group
Routine Direct Cost per Patient Day WI	413	363	343

3. Productive hours per patient day are higher than California median

	Mgmt hrs/day	Techs hrs/day	RNs hrs/day	Licensed Voc Nurses hrs/day	Aides & Orderlies hrs/day	Clerical hrs/day	Total Productive hrs/day
Case Hospital	2.04	0.46	0.68	6.56	3.68	1.97	15.40
Group Median	0.20	0.01	5.89	0.63	2.31	0.59	9.62



9. Identify Specific DRG-Savings Opportunities

9 Specific DRGs

TOP DEPARTMENTAL SAVINGS OPPORTUNITIES

Department	Direct Cost	Cost per Unit	Output Unit	Percentile within Group	Savings at Peer Group Median
Central Services and Supply	22,084,462	153.74	Adj. Pt Days	74	1,565,391

TOP SUPPLY SAVINGS DRGs

(Medicare Data – 2009)

MSDRG	Description	Case 1 Supply Cost	US Supply Cost	Case 1 Discharges	Total Savings
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	5,783	4,612	286	334,831
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	32,342	20,246	11	133,058
246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	8,716	6,257	42	103,271

9 Specific DRGs

Notes on MSDRG 247 (and 246):

- Submitted “all payer” claims data also shows supply and pharmacy cost opportunity
- There is virtually zero variation in stent item code use by physicians, however, there is significant variation in the number of stents per patient (seen at right).
- Some cases exceed four stents (could be 246 categorized)
- Cost per stent is significantly higher compared to US averages

NUMBER OF STENTS – PHYSICIAN LEVEL

(All Payer Submitted Data – Calendar Year 2009)

Physician Code	Number of Patient Claims	Max Number of Stents	Average Number of Stents
Highest two averages:			
XXXX1	2	4	2.5
XXXX2	5	5	2.4
Volume greater than 20 claims:			
XXXX3	78	5	1.7
XXXX4	33	4	1.6
XXXX5	22	3	1.5
XXXX6	64	3	1.5
XXXX7	50	4	1.4
XXXX8	24	4	1.4
XXXX9	44	3	1.4
XXX10	59	4	1.3
Lowest two averages:			
XXX11	1	1	1.0
XXX12	1	1	1.0

9 Specific DRGs

	DRG Profit - High	DRG Profit - Low	LA	SD	CA	US
Avg Medical Supply Cost per Medicare Discharge (CMI = 1.0)	548	715	798	849	827	777
MSDRG 247 Supply Cost	4,207	5,135	4,410	4,079	4,587	4,486



10. Identify Specific APC-Savings Opportunities

10 Specific APCs

APC 0614 Level 3 Type A Emergency Visits

Description	Case	Competitor	Group
Number of Visits	1,452	1,410	25,328
Avg Relative Wt per Visit	4.69	2.98	3.56
Avg Charge per Visit	917.64	920.27	1,071.36
Avg Payment per Visit	281.44	202.81	211.03
Avg Cost per Visit	522.87	229.68	245.50
Avg Profit per Visit	-241.42	-26.87	-27.22
Avg Charge per Relative Wt	195.75	308.45	294.50
Avg Payment per Relative Wt	60.04	67.98	59.18
Avg Cost per Relative Wt	111.54	76.98	68.34
Total Profit	-350,547	-37,890	-35,319

Key points:

1) Reduction of costs to the Group Average would result in savings of **\$294,187**.

10 Specific APCs

APC Cost Detail, cont.

		Case		Competitor		Group		
APC Procedures – Cost per Unit & Utilization Rate		Weight	Cost/Visit	Cost/Visit		Cost/Visit		
99283	Emergency dept visit	2.1150	295.78	100	155.10	100	119.02	100
93005	Electrocardiogram, tracing	0.3789	42.40	43	52.43	4	46.87	13
71020	Chest x-ray	0.7093	47.35	32	54.03	10	50.06	10
90774	Ther/proph/diag inj, iv p	0.7942	57.98	18	70.11	1	35.29	11
90760	Hydration iv infusion, in	1.8090	129.60	16	89.31	1	89.74	3
90775	Tx/pro/dx inj new drug add-on	0.7942	86.53	13			39.14	7
90801	Psy dx interview	1.7066	94.74	12	76.82	1	172.81	0
90761	Hydrate iv infusion, add-	0.3945	55.38	9	72.94	1	84.30	3
94640	Airway inhalation treatment	0.3527	70.31	8	41.48	2	29.99	2
Fee Procedures – Cost per Unit & Utilization Rate								
36415	Drawing blood	0.0504	1.61	9	2.06	22	2.75	19
85025	Automated hemogram	0.1788	16.24	55	13.18	18	15.35	29
84484	Assay of troponin, quant	0.2202	43.39	30	19.28	1	19.95	8
Bundled Procedures – Cost per Unit & Utilization Rate								
NULLC	No CPT® Code		38.66	24	13.81	9	13.15	71

10 Specific APCs

	APC Profit - High	APC Profit - Low	LA	SD	CA	US
Avg Relative Weight per Outpatient Visit	7.8	6.8	8.2	8.5	7.7	7.4

Summary

- + Medicare payments will not keep pace with cost increases
- + Hospitals that make money on Medicare control both cost and payment
- + Benchmarking data can help to identify payment and cost opportunities



Questions?

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