



# Medicare Performance Initiative

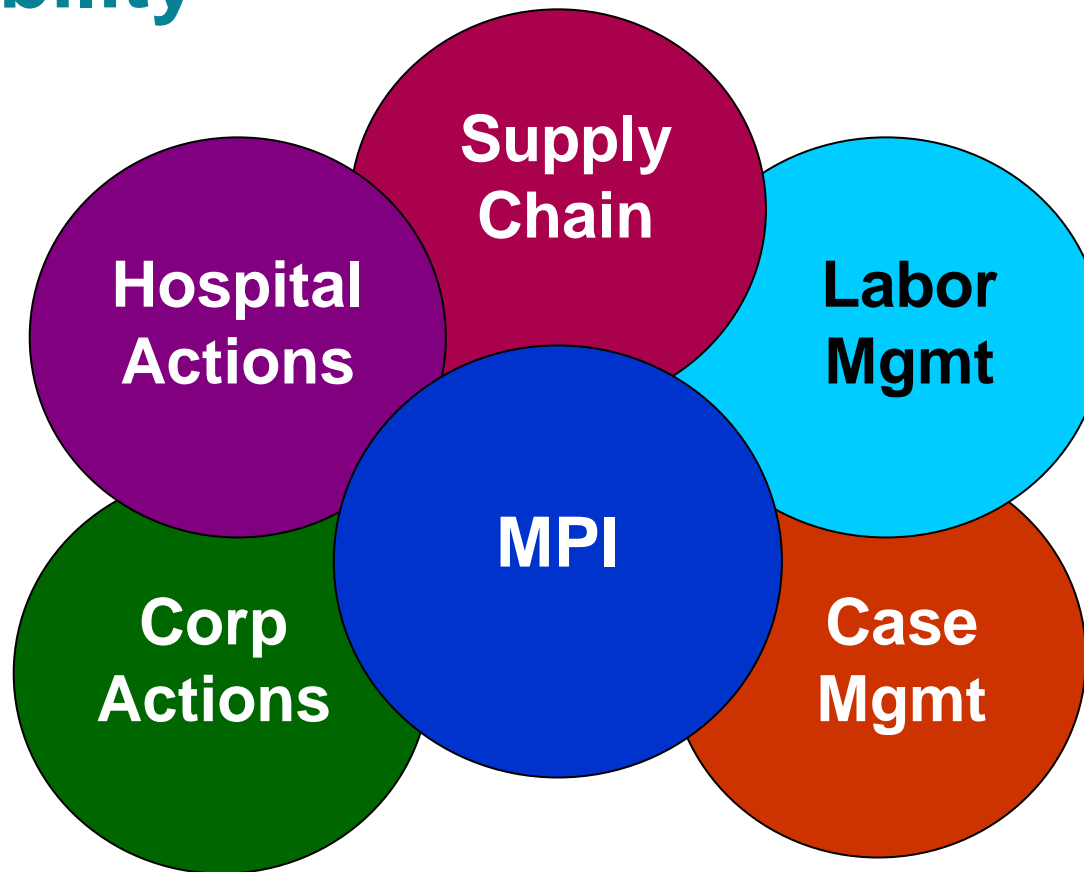
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Senior Vice President, Operations Finance

## Background

- Performance Management and Innovation (PMI) group
- Content experts with clinical, operational, and analytical backgrounds and skill sets
- Goal to increase capacity, improve patient outcomes, and reduce costs
- Assess and recommend improvements in operational processes and patient throughput
- Initiatives in areas of labor management, patient case management, supply chain management
- Medicare Performance Initiative (MPI)

# Summary of Initiatives to Improve Profitability



Driving greater efficiency in resource use and cost

# What MPI Is and Is Not

- MPI is a reduction of variable costs for those MS-DRGs where costs currently exceed Medicare payment
- MPI is an approach to identify a more effective application of resources in the treatment of patients
- MPI is NOT a reduction to our commitment to quality
- MPI is NOT a reduction in clinically appropriate and medically necessary services

# Why Focus on Just Medicare?

- Largest individual payer
- The number of Medicare beneficiaries continues to grow
  - Baby boomers are aging at rapid rate
  - Likely shifts from Medicare Advantage plans into Medicare
- Medicare will drive reform policy that will possibly include a “public plan option” with “Medicare like” payment rates
- Near term cuts to existing Medicare payments
- Cost reductions are made across-the board and will benefit other payers, creating a “halo effect”

# How We Will Approach MPI

- Using high level key indicators along with “deep dive” analytics of detailed costs and quality measures by physician
- Focus on five high volume Medicare MS-DRG opportunities where costs exceed payments
- With the goal to identify where variable costs can be reduced through:
  - Standardization of physician preference items
  - Achieving better unit pricing
  - Reduction of the variability of how different physicians treat the same disease
- PMI Content Expert and Regional CMOs team-up to facilitate the MPI project at each hospital
- Roll out 4 hospitals at a time

# How We Will Approach MPI

- Execute a three-phase approach at each hospital
  - Phase I Pre-Site Preparation
  - Phase II On-Site Engagement
  - Phase III Post-Site Tracking and Monitoring
- Create a Steering Committee and separate sub teams at each hospital to address each MS-DRG
- Identify physician champions
- Develop customized prescriptive work plans to reduce the variable costs using local, national, and acceptable best practices for standards of care
- Hardwire a repeatable process to address more MS-DRGs in the future
- Drive accountability and execution:
  - Monitor progress and track results
  - Hardwire monitoring into monthly operations reviews

# What's in it for the Physician?

- Inefficient physicians (cost/quality) are already being excluded from health plans in certain markets
- At the very least physicians are subject to plan benefit designs that create steerage to/from physicians through higher co-pays
- Implementation of the Recovery Audit Contractor (RAC) program
- Hospital and physician incentives will be more aligned under reform models, to pay for improved quality and lower cost...CMS initiated the Acute Care Episode (ACE) Demonstration Project or “global fees”
- The concept of the ACE demonstration is “...to improve collaboration between the physician and the hospital...for improvements in care efficiency”
- Improving profitability and quality enhances the hospital's ability to attract and retain the best employees and fund investments in capital equipment and facilities

# Cast of Characters

- Lead Actors
  - Regional CMO
  - Hospital A-Team
  - PMI Content Expert
  - Physician Champion
- Supporting Roles
  - Clinical Department
  - Finance
  - Case Managers
  - Materials Management
- 4 Teams of one RCMO and one PMI Content Expert will serve as project leaders at each hospital

# Approach to Variable Cost Analytics

- Filter and analyze data by MS-DRG, by physician
  - ALOS
  - Per case variable cost vs. payment
  - Resources consumed (cost and frequency counts)
  - Identify physicians with practice patterns of greater resource utilization than their peers (ALOS, physician preference items, order volumes of procedures or tests)
  - Review of quality indicators such as complications, mortality rates, and readmission rates
- Use this data to focus on opportunities for improvement:
  - Standardization of physician preference items
  - Achieving better unit pricing
  - Reduction of the variability of how different physicians treat the same disease

# XYZ Hospital

## 5 Top Medicare MS-DRG Opportunities

MS-DRG		Total Cases	Total FY 2008 (\$000)	
#	Product Line		EBIT Loss*	Variable Costs
470	Orthopedics	450	(\$1,059)	\$4,470
460	Spinal	183	(\$700)	\$3,376
291	Cardiovascular	164	(\$343)	\$862
247	Cath/EP	319	(\$362)	\$3,022
871	Infectious Disease	217	(\$356)	\$1,423
<b>TOTAL</b>		<b>1,333</b>	<b>(\$2,820)</b>	<b>\$13,153</b>

\* EBIT based on fully loaded hospital costs, but before corporate overhead.

# XYZ Hospital – MS-DRG 871 by Physician

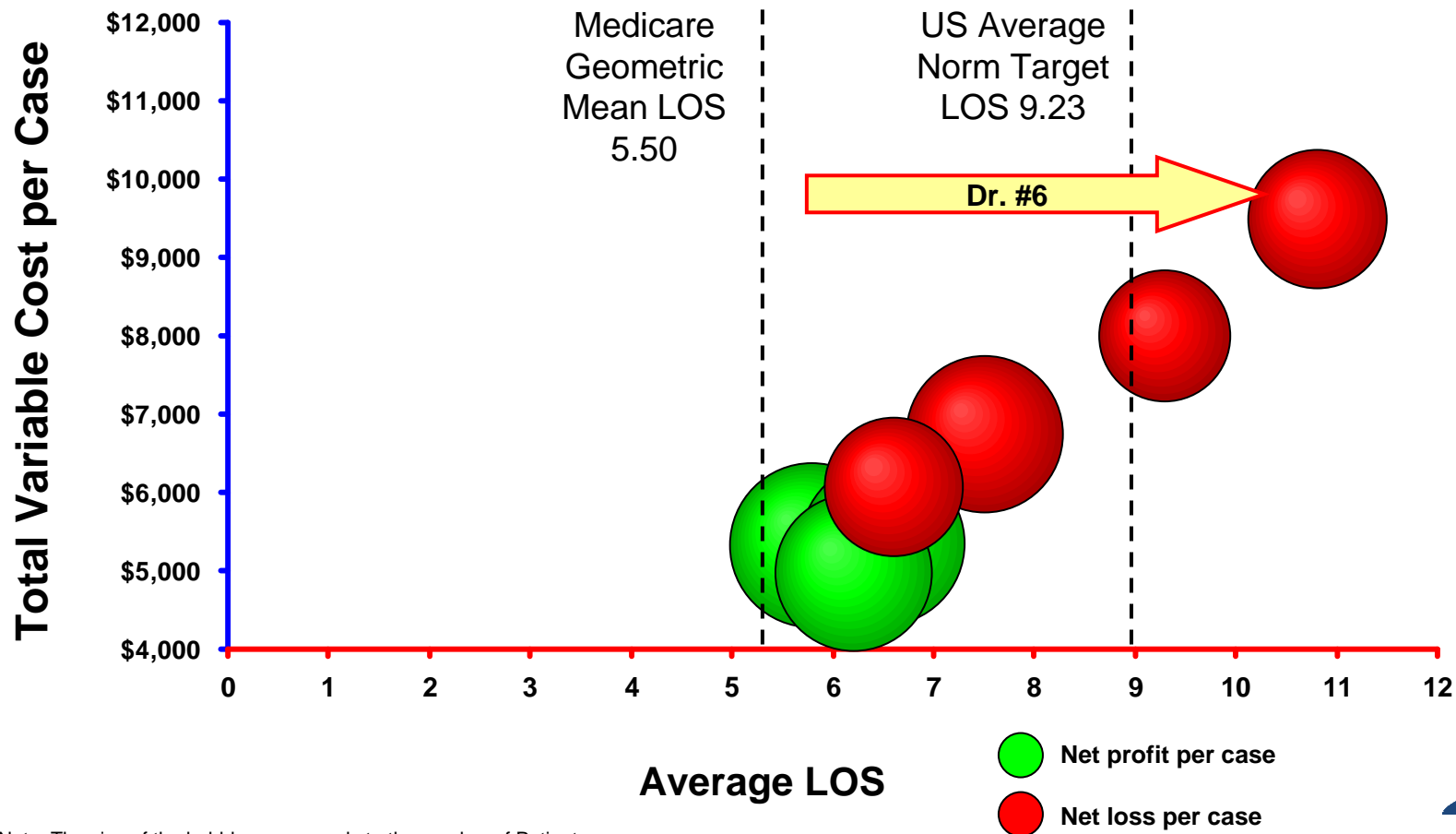
Septicemia or Severe Sepsis w/o MV 96+ Hours w/ MCC

Physician	Total Cases	EBIT Per Case	Per Case Variable Cost Drivers				
			ALOS	Total Variable Cost	Pharmacy Variable Cost	Imaging	
						# of Tests	Variable Cost
#1	12	\$785	5.8	\$5,326	\$1,119	10	\$380
#2	12	\$164	6.5	\$5,344	\$731	11	\$457
#3	11	(\$2,339)	7.5	\$6,734	\$1,352	13	\$778
#4	11	\$483	6.2	\$4,974	\$746	9	\$411
#5	9	(\$900)	6.6	\$6,103	\$1,117	10	\$415
#6	8	(\$6,333)	10.8	\$9,483	\$2,485	16	\$716
#7	8	(\$4,449)	9.3	\$7,381	\$1,094	15	\$805

# XYZ Hospital – MS-DRG 871

## Average LOS and Variable Cost per Case by Physician

Average Variable Cost per Case = \$6,558



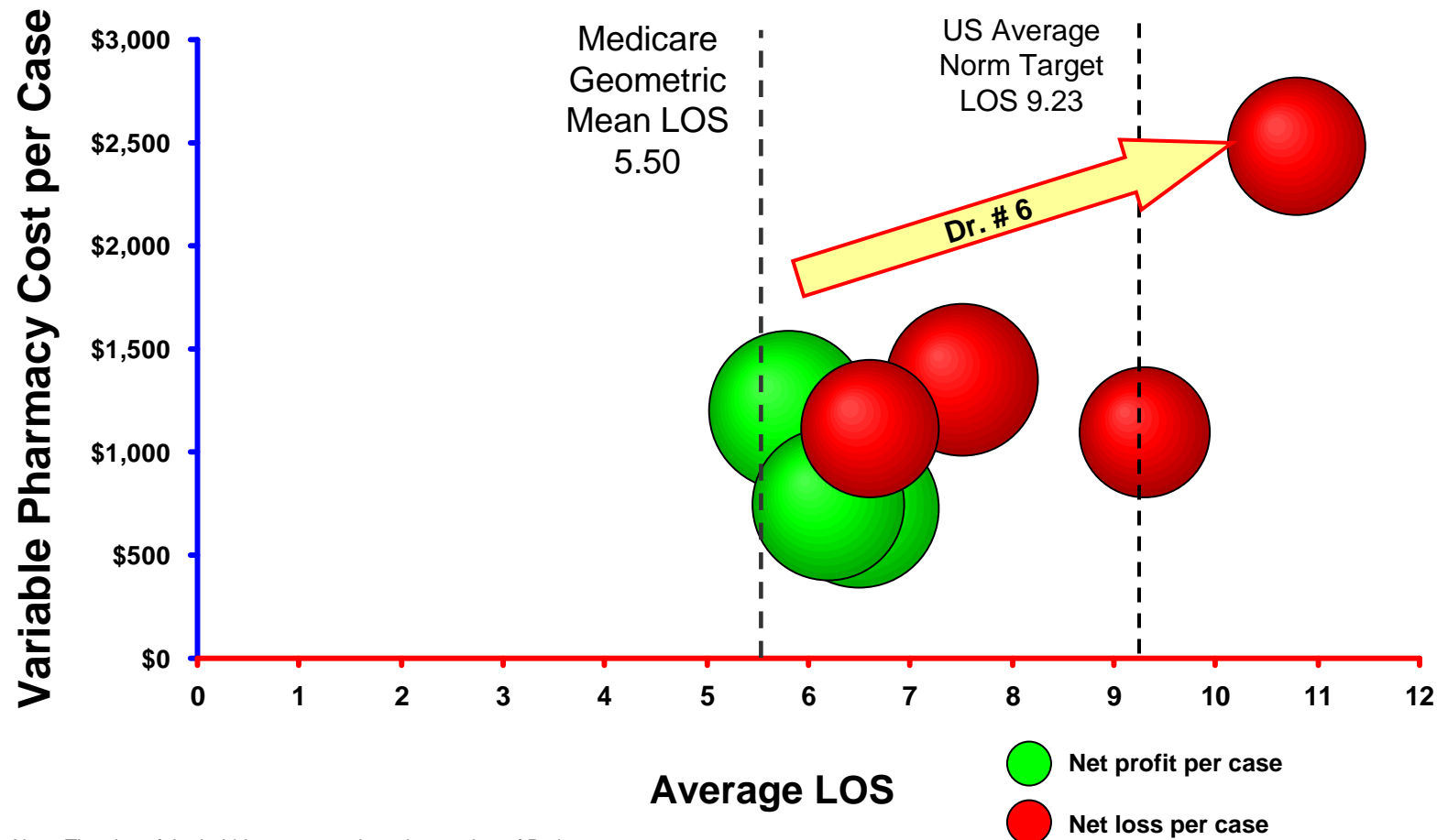
Note: The size of the bubble corresponds to the number of Patients.

Source: Data Access through Showcase Queries and DS 210 for US Average Norm LOS

# XYZ Hospital – MS-DRG 871

## Average LOS and Variable Pharmacy Cost per Case by Physician

Average Variable Pharmacy Cost per Case = \$1,276

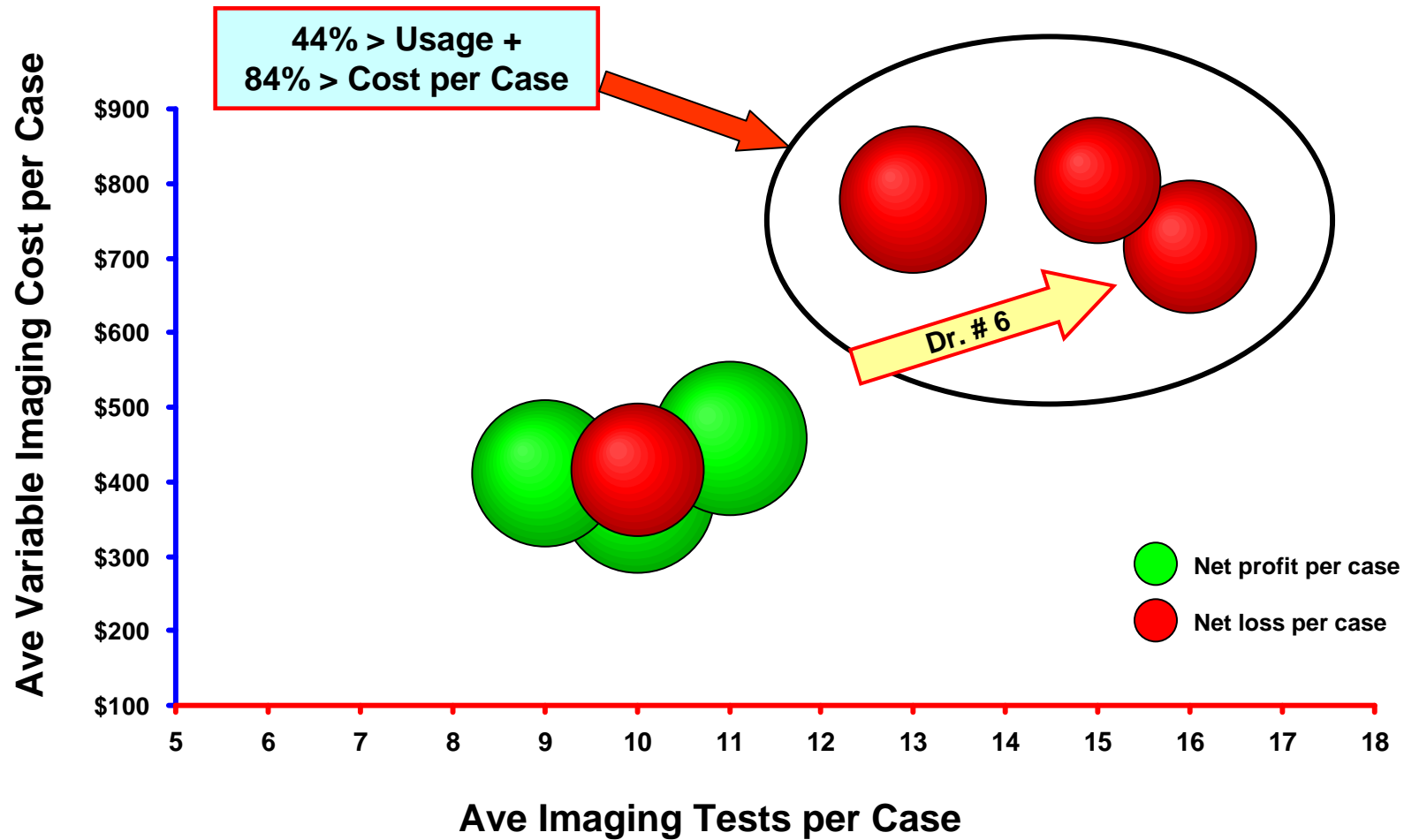


Note: The size of the bubble corresponds to the number of Patients.

Source: Data Access through Showcase Queries and DS 210 for US Average Norm LOS

# XYZ Hospital – MS-DRG 871

## Average Imaging Tests & Variable Imaging Cost per Case by Physician



Note: The size of the bubble corresponds to the number of Patients.

Source: Data Access through Showcase Queries and DS 210 for US Average Norm LOS

# XYZ Hospital – MS-DRG 871 by Physician

Septicemia or Severe Sepsis w/o MV 96+ Hours w/ MCC

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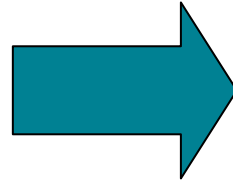
# MPI Roll-out Timeline

- Anticipate 6-weeks to complete Phases I and II at each hospital
  - Weeks 1-2 (Phase I)
    - Preparation of data set, tool kit, draft work plans; strategy sessions with Regional CMOs and Regional Operations; initial engagement of Hospital A-Teams; selection of hospital project champion and formation of hospital Steering Committee
  - Week 3 (Phase II commences)
    - On-site rollout; engagement of hospital steering committee and DRG sub-teams; develop physician engagement strategy; identify physician champions; finalize DRG-specific work plans; commence work plan execution
  - Week 4-5
    - Ongoing work plan execution, team meetings; data analysis and opportunity quantification; physician meetings
  - Week 6
    - Establish agreement on baseline metrics, targeted improvements, remaining work plan steps and timelines; identify next wave of MS-DRGs to be addressed by A-Team as part of repeatable, hardwired process
- Completion of rollout to all 50 Tenet hospitals projected by Q1 2011.

# Key Takeaways

## Apply an Approach

- Data-driven, with quality in the discussion
- Deliberate, collaborative and consistent
- Physician champions
- Focused on Medicare
- Repeatable & hardwired
- Monitored and tracked



## Results Expected

- Positively influence physician practice patterns
- Reduced cost of care in our hospitals
- Immediate financial improvement
- Improved competitive positioning for health reform