AMS Performance Based Incentive System®

Presentation to Maryland Health Services Cost Review Commission Physician Alignment and Engagement Work Group

March 11, 2014

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Opening Perspectives

- Maryland's unique all-payor system offers important strengths: e.g., Overall coordination of hospitals toward a common set of goals.
- Maryland recently implemented a new 5 year waiver including an aggressive cap.
- Effective hospital/physician collaboration is essential to success under the cap.
- Gainsharing is the direct payment by hospitals to physicians, based on performance. (Unlike "Shared Savings", it is based on hospital costs, not Medicare payments.) AMS has designed developed and implemented large scale, comprehensive gainsharing programs (all DRGs, all costs). The AMS PBIS® has received 3 approvals from Medicare, including BPCI Model 1.

Opening Perspectives (Continued)

- By directly linking physician incentives to efficiency and quality, the AMS PBIS® can provide the first major step in transforming provider culture.
- Based on experience, the critical date is 6 - 9 months following implementation of the program – the date on which the first incentive checks are issued. The impact of "performance" builds and expands from that point forward.
- The AMS PBIS® is inpatient only. But its architecture can be modified to recognize the inpatient impact of population based reimbursement, and to interface with other methodologies designed to address the non-acute environment.

Opening Perspectives

Incentives are based on individual performance. Physicians are not required to join a group to participate; not paid *per capita*. Methodology provides a direct linkage to measurable results.

- AMS PBIS® can be customized to address the unique needs of each institution:
  - Methodology incorporates adjustments to emphasize Improvement and/or Performance.
  - Internal steering committee conditions incentive payments based on specific quality and care redesign initiatives.
  - Methodology can be extended to consultants and ancillary physicians at the decision of the institution.
  - "Circuitbreakers" create a direct link between physician success and institutional success.

Presentation Objectives

- Background on AMS PBIS® Gainsharing Program
- Preliminary Results
- Methodology
- Implementation
- Sample Reports

AMS: Gainsharing Pedigree

- Principals were the architects of the New Jersey Prospective Reimbursement System for Acute Care Hospitals Based on Patient Case-Mix (i.e. All Payor DRG payment system).
- Developed AMS PBIS® for use in commercial and /or Medicare gainsharing programs.
- AMS PBIS® is the only broad based, comprehensive gainsharing methodology currently approved by CMS.
- CMMI Bundled Payments for Care Improvement Initiative(BPCI) - Model 1 is expansion of earlier Medicare Gainsharing Demonstrations.
- The AMS Performance Based Incentive System® (AMS PBIS®) has received 4 patents.

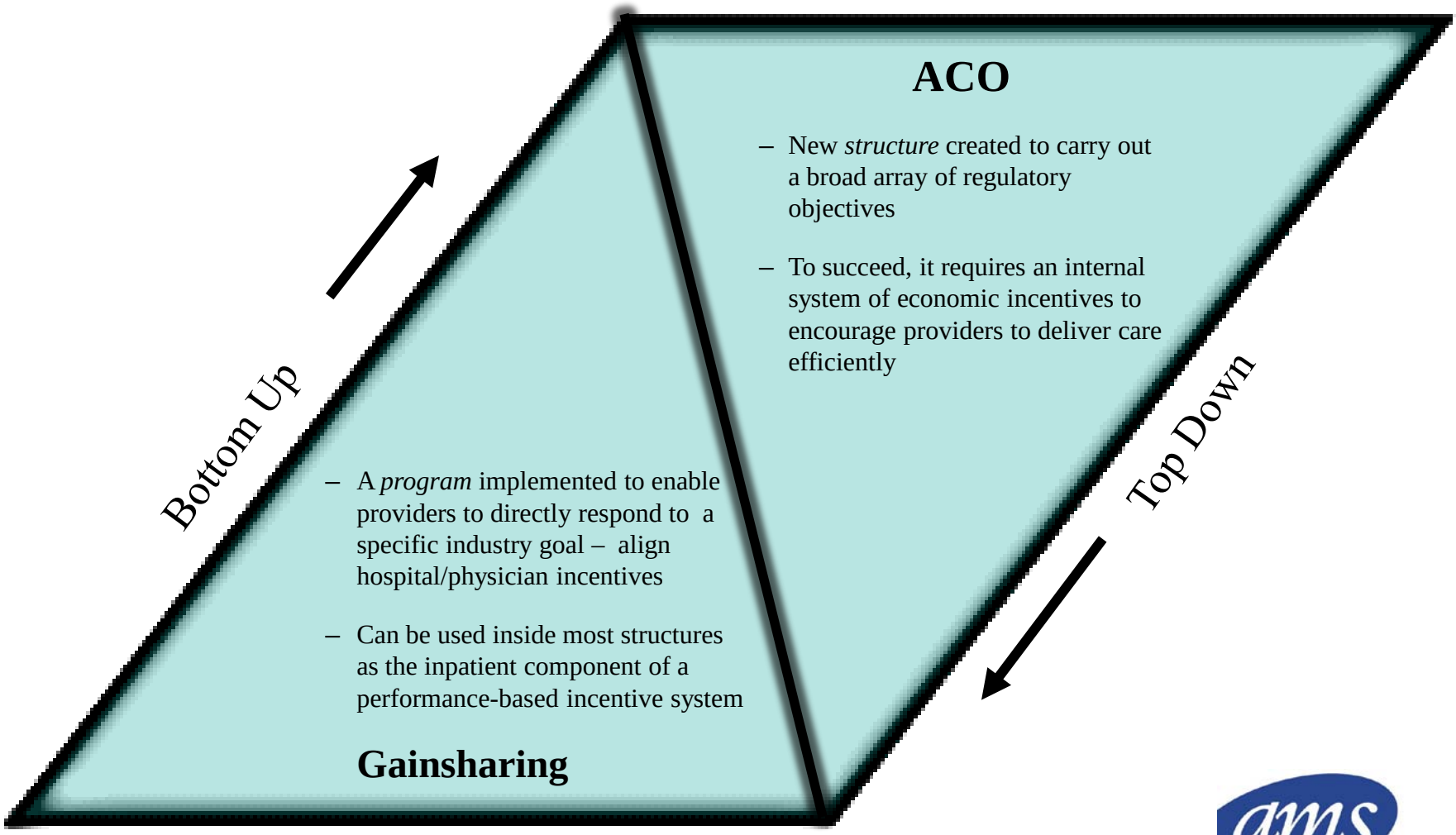
AMS Gainsharing Projects

Organization	Type	Start Date	End Date
NJ Physician - Hospital Collaboration Medicare Demonstration	Medicare	July 2009	March 2013
NJHA - Medicare Model 1	Medicare	April 2013	Ongoing
New Jersey Health Care Quality Institute/NJ Medicaid ACO Pilot Program	Medicaid	2013	Ongoing
Horizon Blue Cross/Blue Shield (NJ)	Commercial	2012	Ongoing
Continuum Health Partners Commercial Gainsharing Program	Commercial	2006	Ongoing
Beth Israel Medical Center Medicare Gainsharing Demonstration	Medicare	October 2008	September 2011
Greater NY Hospital Association Commercial Gainsharing Program	Commercial	2011	Ongoing

AMS CMS/CMMI Initiatives

- Model 1
  - NJHA - expansion includes 23 hospitals (25 sites)
  - GNYHA - approved, but hospitals opted to delay pending results on commercial program
  - Open Period - 4 NJ hospitals approved, but delayed implementation
- Models 2 and 4
  - Discussions ongoing with several hospitals to include AMS PBIS® as the inpatient gainsharing methoodology

A Stepping Stone



Why Implement Gainsharing?

- How can the hospital get the attention and active engagement needed from all physicians to make a difference?
- Do physicians understand how they are performing against the hospital's goals and specifically where/how they can contribute to achievement of the goals? Is the hospital delivering meaningful data to physicians?
- Is the hospital providing any incentive to physicians to make the effort to get involved with hospital efforts?

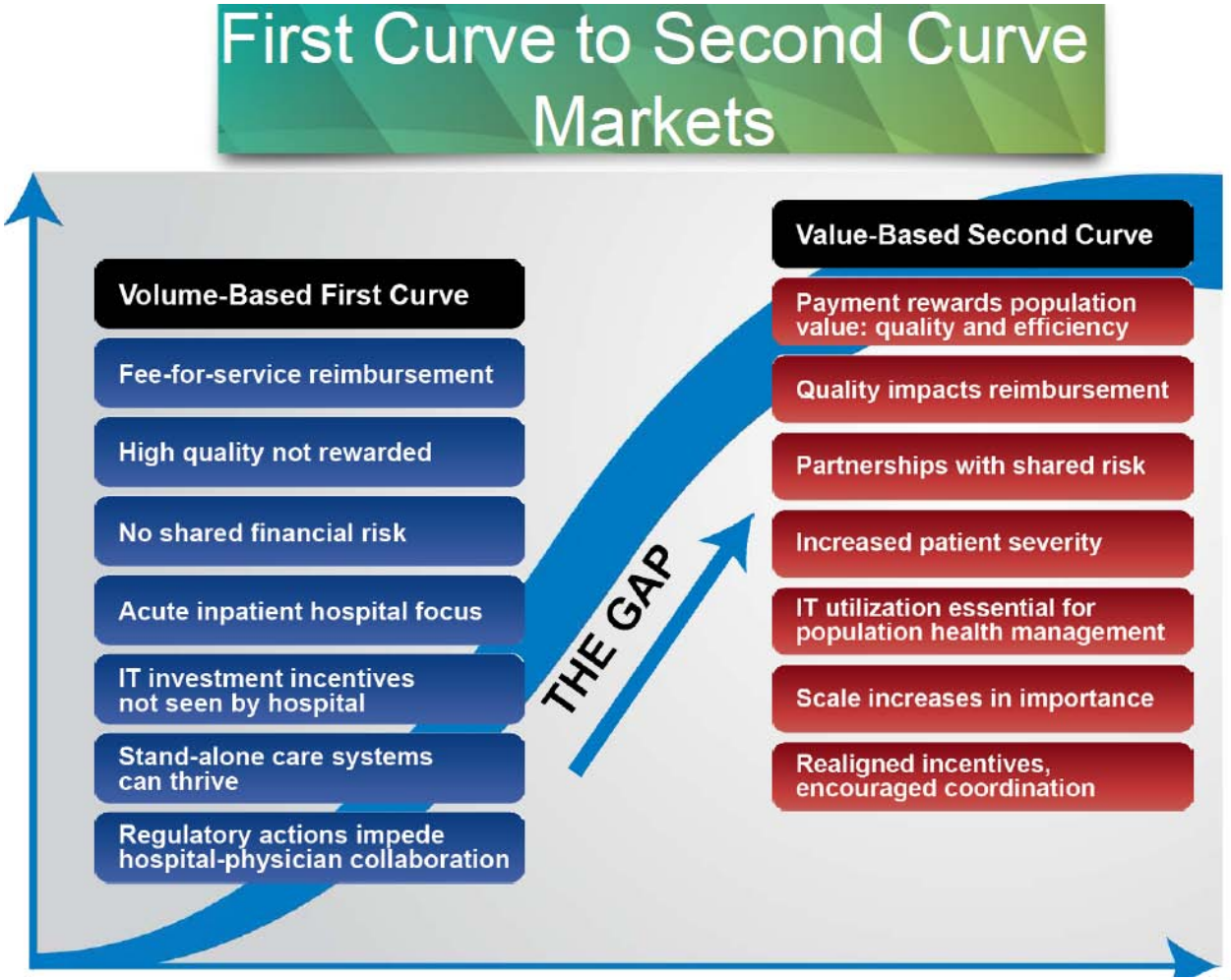
Why Implement Gainsharing? (Continued)

- **Short Term**: Program developed to help hospitals manage current and future reimbursement cuts.
- **Long Term**: Provides an opportunity to engage physicians to align with hospital goals to improve quality and decrease costs through earned incentive payments.

Why Implement Gainsharing? (Continued)

- Shorter inpatient stays, when appropriate
- Fewer marginal but costly diagnostic tests
- Reduction in pharmacy expense (generics, formulary, etc.)
- Efficient use of operating rooms and reduction in turnaround time
- Cost effective use of critical care and telemetry units
- Evidence-based selection and purchase of medical devices and hardware
- Avoiding duplicative services
- Reducing administrative overhead
- Improving discharge planning
- Reduce readmissions

System Journey from Volume to Value



Source: Coyle, C. The Hospital Trustee's Role in Population Health. MHEI Annual Conference, October 14, 2013.

Benefits to CMS and HSCRC/MHA: Gainsharing Starts with Hospital Care

Maryland Goals		Gainsharing Implications
Maryland would lead the nation in implementing a gainsharing program in conjunction with its GPR.		Gainsharing is an ACO/HEZ starting point.
		Gainsharing is a workable alternative for hospitals unable to develop full-fledged ACOs because of regional culture, capital requirements, etc.
Change the way we pay for and provide health care.	Involves Maryland physicians in the need to slow growth in inpatient spending.	Physicians are incented on value. Allocates incentive payments to physicians on the basis of performance .
		Establishes internal collaborative framework for addressing adversarial relationship between physicians and hospitals.
	Does not impact Maryland's unique way of setting hospital prices.	Holds the potential to generate significant near-term savings for providers, thereby building momentum for reform.
	No cost to Medicare/other payors.	Incentives paid by providers.
	Spending cap: 3.58% Medicare Savings Target: $330 m over 5 years Per capita spend can not exceed 1 percentage point of national average	Cost reductions are required to "bend the curve".
Make the current system safer.	Bring Maryland readmission rates to national average in 5 years.	Emphasizes Quality: Links quality metrics to incentive payment, including institution-specific objectives. Severity of Illness: Utilizes severity adjusted, physician-specific data to identify savings opportunities, determine incentive payments. Comprehensive: Includes all DRGs (except psych, deliveries and newborns); encompasses clinical and non-clinical savings opportunities.
	Reduce infections and other hospital acquired conditions by 30% in 5 years.	

AMS PBIS®
Preliminary Results

Initial Results - What We are Learning

- Initial savings offset initial physician payments
- Physicians have received payments and see what their potential earnings could be
- Additional physician participation after initial payments
- Hospital Steering Committee is critical to help focus on opportunities for improvement/identification of processes that need to be put in place
- Increased physician engagement
- Communication with physicians is key - one-on-one, departmental meetings
- Quality scores improve on targeted initiatives

NJ Medicare Demo - 12 hospitals
5 Payment Period Results (30 months)

1,300 physicians - 125,569 Medicare admissions

- $89,454,394 cumulative savings, $767 per admission or 7.99%
  - Payment Period 1 = 3.25%
  - Payment Period 2 = 5.82%
  - Payment Period 3 = 7.77%
  - Payment Period 4 = 12.04%
  - Payment Period 5 = 11.55%
- All hospitals had savings in the 4th payment period while in the 5th period all but 1 had savings
- Cumulative Savings Summary:
  - 7 hospitals over 10%
  - 4 hospitals between 3 - 10%
  - 1 hospital under 3%

NOTE: *Savings analysis is a comparison of actual cost to base year cost adjusted for inflation, case-mix and SOI (i.e. expected cost). The statements contained in this document are solely those of NJHA/AMS and do not necessarily reflect the views or policies of CMS.*

GNYHA Summary Results - Phase 1 (4 hospitals)

- Physician Participation
  - Over 50% of commercial admissions covered by the participating physicians
- Cost Reduction (Savings to Hospitals)

	Cost Reduction/Admission	Cost Reduction as a % of Cost
Payment Period 1	$419	4.59%
Payment Period 2	$387	4.18%

Sample Practice Changes that Contributed to Improve Efficiency and Quality of Care

- Increased detail/accuracy and timeliness of documentation
- Earlier consultation with Discharge Planner
- Round/writing discharge order prior to noon and increase discharges on weekends
- Increase understanding/interest in implant costs and implementation of demand matching
- Decrease time between request for consultation and occurrence of consultation
- Earlier transition from ICU to standard acute floor

AMS PBIS®
The Methodology

Securing Physician "Buy-In"

The Program

- Strictly voluntary
- No change in form or process of payment
- Incentive only/no risk or penalties
- Provides protection against loss of income
- Encompasses both clinical and non-clinical opportunities
- Evaluation based on overall performance
- Provides detailed data on individual physician utilization and quality metrics, adjusted for severity of illness
- Provides ongoing feedback to physicians

Securing Physician "Buy-In" (Continued)

- **Emphasizes Quality:** Links quality metrics to incentive payment, including institution-specific objectives.
- **Severity of Illness:** Utilizes severity adjusted, physician-specific data to identify savings opportunities, determine incentive payments.
- **Comprehensive:** Includes all IPPS payments/all DRGs (except psych, deliveries and newborns); encompasses clinical and non-clinical savings opportunities.

Securing Physician "Buy-In" (Continued)

- Measurement: To promote physician acceptance, performance is evaluated based on regionally derived Best Practice Norms
  - 25th percentile of lowest patient costs in region
  - Severity adjusted DRGs (APR DRGs) used for costing
  - Responsible Physician/Physician of Record is eligible for incentive
    - Medical cases = discharging (attending) physician
    - Surgical cases = surgeon of record
    - Methodology to add specialists, consultants and ancillary physicians are being developed and may be included at the discretion of the hospital

Economic Framework

- The Program allows hospitals to incent physicians financially for improved quality of care and improved efficiency
- Creates a collaborative environment where both hospital and physician incentives are aligned
- Rewards achieved level of physician performance
  - ***Improvement*** - performance compared to own performance over time - prior year to current year
  - ***Performance*** - performance compared to peers - Best Practice Norm
- Provides loss of income protection

DASHBOARD
General Hospital
Prior - January 2010 through June 2010 and Current - July 2010 through December 2010
Non PAR - NPI Accuracy not Verified

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Analytics

Responsible Physician	0000000001	**Specialty**	Surgery/Colo/Rectal Surgery	
Physician's First Name		**Physician's Last Name**		

QUICK STATISTICS	Cost		Average LOS		INCENTIVE	Performance		Improvement		Total	
	Prior	Current	Prior	Current		Prior	Current	Prior	Current	Prior	Current
Your Information	$604,092	$962,797	12.35	9.85	Maximum Incentive	$4,933	$10,347	$9,750	$20,584	$14,683	$30,931
Best Practice Norm (BPN)	$274,061	$581,886	6.00	6.06	Your Incentive	$575	$2,736	$0	$2,534	$575	$5,270
Variance	$330,031	$380,911	6.35	3.79	Unearned Incentive	$4,358	$7,611	$9,750	$18,050	$14,108	$25,661

Admissions by Complexity Level (SOI)										
Current	SOI 1:	12	SOI 2:	14	SOI 3:	15	SOI 4 :	7	Total:	48
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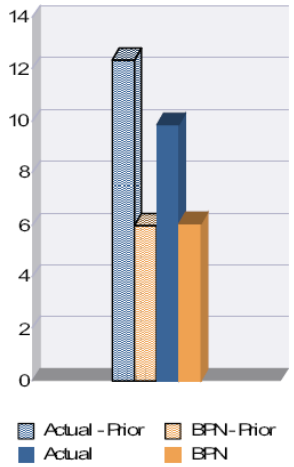
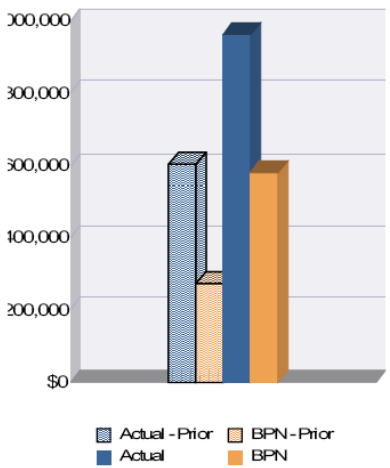
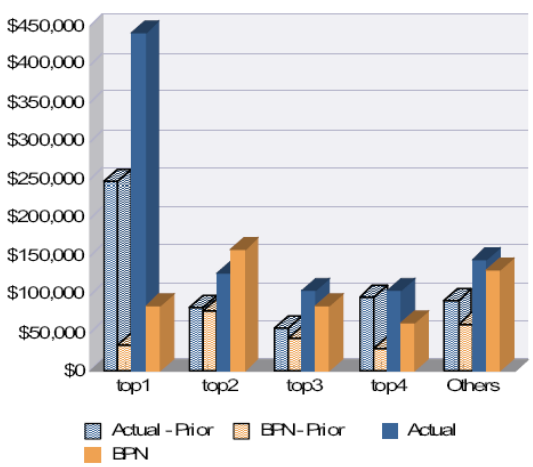
LOS Summary



Cost Summary



Top Cost Centers



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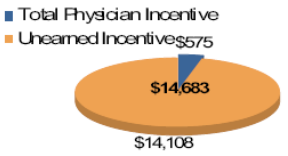

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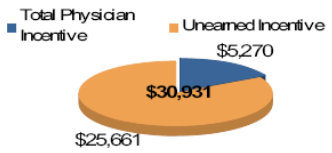

Cost Center Summary		Your Cost		BPN		Variance	
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Top3	Operating Room Cost	$56,178	$105,458	$43,884	$86,268	$12,294	$19,190
Top4	Med/Surg Supplies Sold Cost	$97,035	$104,980	$30,364	$63,034	$66,671	$41,946
Top5	Laboratory Cost	$22,462	$40,248	$12,964	$27,190	$9,498	$13,058
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Top10	Ambulatory Surgery Center Cost	$9,675	$10,063	$740	$1,499	$8,935	$8,564

Major Design Decisions

- To minimize operational burden
  - All necessary information extracted from routinely collected data (UB 04)
  - Start with inpatient stay
  - RCC cost-finding-industry standard
  - Select Responsible Physician (trade offs) / other physicians
  - No change in the current process or form of payment
  - Uniform, auditable, replicable and easily implemented

Patient Protection/Methodological

- Adjustment for Severity of Illness insures correct amount of resources (eliminates incentives for “cherry picking”, “quicker-sicker”, “stinting” and “steering”)
- Uniform methodology helps prevent “phantom savings”
- Limit on incentive payments to discourage new and untried practices
- Volume requirements help insure that program will be used to improve quality and operational performance; not to encourage changes in physician referral patterns
- Requires patient notice

Quality Measures

Standard Measures

- Measures calculated by AMS from submitted discharge data
  - Mortality
    - Admissions where a patient expired are identified using UB-04 billing data
  - Hospital Readmissions
    - Any admission to the same hospital occurring within 7 or 30 days after discharge
  - Hospital Inpatient Quality Reporting (Hospital Compare)

Additional Measures

- Assist hospitals with identification of additional *hospital-specific* quality measures
- Hospitals collect data and maintain documentation

Additional Measures for Hospital Consideration

Efficiency

- Delinquent medical records
- Timely operative report dictation
- Calling consultants in a timely manner
- First case start times in OR
- Denial rate (admission, concurrent days or end of stay)

Outcomes

- SCIP Measures
- VTE Measures
- Medication errors
- Returns to the OR
- Adverse events

Patient Experience

- HCAHPS - Physician Domain
- Validated patient complaints

Other

- Attendance at Grand Rounds
- Compliance with hospital policies
- Etc…

Institutional Safeguards

Facilitator

- Organizing the participants, administering the program (including application of the gainsharing methodology), and liaison with CMS:
  - Periodic data processing and an extensive reporting requirement to CMS and its various contractors
  - Direct engagement with the providers to insure effective implementation and enable participating hospitals and their physicians to capitalize on the opportunity
  - Insure adherence to waiver

Steering Committee

- Each participating hospital will form an internal steering committee to provide program governance. The committee will be composed of at least half physicians.
- Incentive payments may be conditioned on quality measures and performance measures implemented prospectively by the hospital's steering committee.
- The committee administers the program. Insures the fair administration of program requirements.

Steering Committee: Objectives

- Determines balance between Performance and Improvement
- Prioritizes institutional initiatives
- Sets conditions for incentive payment regarding quality and performance issues specific to the institution
- Determines whether or not, and how, to include consultants, ancillary and other physicians in the program
- Sets year 2 threshold regarding institutional savings and physician incentive payments

Program Integrity

- **Incentive Payments May Be Conditioned**
  - Quality measures and performance measures are implemented prospectively by steering committee
  - Savings
    - Year 2 - Institution must achieve overall savings

Integrating AMS PBIS® into a Global Model

Integrating AMS PBIS® into a Global Model

- Potentially Avoidable Admissions
  - Specific APR DRGs, severity levels and outpatient clinical categories
  - Identify broad clinical categories that should not be treated in a hospital setting
  - Payment to specific physicians could be conditioned based on admission rates related to specific APR DRG and/or severity levels
  - Incentives/penalties could be linked to the departments or specialties that play a role in the clinical categories identified by the Commission
  - Length of Stay (LOS) specific objectives can be established utilizing payer specific data (i.e. Medicare) or total LOS to align with the Waiver tests

Integrating AMS PBIS® into a Global Model (Cont'd)

- Attribution
  - Which available attribution strategy, or combination of strategies, will draw us closest to the goal of matching incentives with behavior? In addition to properly defining "effective responsibility", opportunities must be prioritized. Considerations include data availability, data integrity and cost/benefit.
- Internal Consistency
  - Population based reimbursement takes the Commission into new areas which, for historic reasons, may include existing incentives that could compromise the system's overall objectives.
  - Adding many new "moving parts" to the methodology creates opportunities for inconsistency: For example, direct and indirect policies and controls governing volume that relate to acute institutions, physicians, non-acute institutions and other non-institutional providers can work at cross-purposes with the overall goals of population based revenue.

Timing, Implementation and the New Waiver

- One of the benefits of implementing AMS PBIS® is that it can get the providers off to a quick start under the new waiver.
- Aligning incentives begins to turn from theory to reality when the first physician incentives are paid.
- Experience indicates that this can be accomplished within 1 year:
  - 3 months to receive, clean and process base year data;
  - 6 months of actual physician experience under the gainsharing program, and;
  - 3 months to process the results. (Successive cycles are 6 months.)

  These estimates do not include time for the Commission subcommittees, Commission approval, Medicare approval, hospital and physician recruitment. Some of these tasks can be done concurrently.
- **However, it is important to understand that because the waiver has already started, significant operational time may pass before effective alignment occurs.**

Implementation

Hospital First Step: Infrastructure

- Implementation team
- Program Coordinator
- Steering Committee
  - Part of hospital quality improvement program - 50% physician representation, administration, finance
  - Provides program oversight and a forum for sharing ideas, quality monitoring
  - Educate Steering Committee along with medical executive committee, medical staff
- Engage physician participation and enrollment in the program
- Identify key physician leader/liaison to ensure on-going physician support/engagement

AMS Approach

I. Application to CMS

- Review of CMS requirements
- Assist in preparation and submission

II. Identify Savings Opportunities/Cost Reductions

- Run most recent cost data and generate AMS PBIS® reports
- Simulate incentive payments based on standard method
- Review simulation results

AMS Approach (Continued)

III. Pre-Implementation Training and Education

- Develop education materials including Physician Handbook
- Establish and educate work groups
- Engage providers

IV. Implementation

- Standard data set submitted to AMS
- Calculate individual physician incentive payments
- Incentives determined periodically

Operational Support

- Support for Program Coordinators
  - Training on implementation
  - Development of resources
    - Physician Handbook and Operations Manual
  - Ongoing support
- Assistance with implementation
  - Attendance at hospital steering committee and other physician meetings to champion the program

AMS PBIS®
Sample Reports

Physician Incentive Reports

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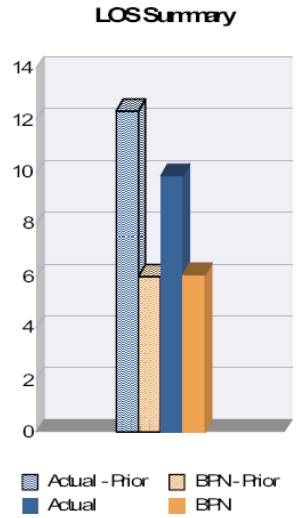

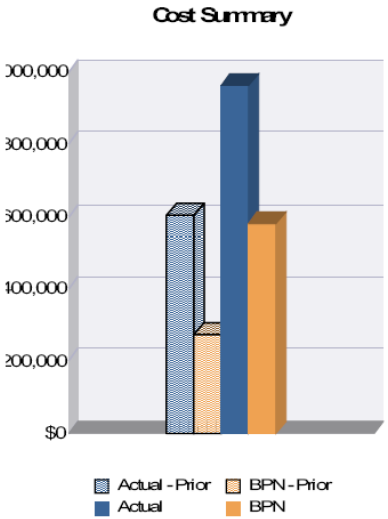

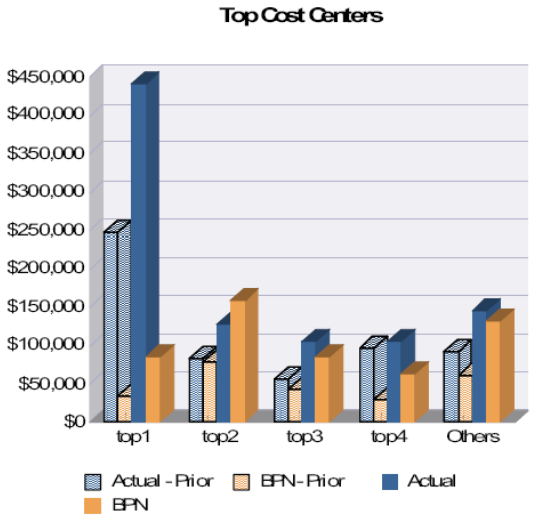

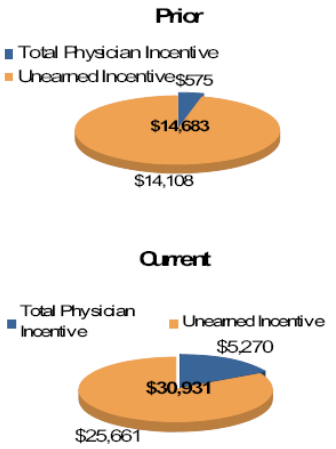

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Provider Number	0000001	**Provider Name**	General Hospital
Responsible Physician	000000001	**Specialty**	
Physician's First Name		**Physician's Last Name**	

Medical Improvement Incentive (LOI)	$454							
LOI Breakdown by Severity of Illness	1:	$454	2:	$0	3:	$0	4:	$0
Surgical Improvement Incentive	$2,079.99							
Performance Incentive	$2,735.73							
Total Physician Incentive	$5,269.95							
Total Unearned Incentive	$25,661.31							
Maximum Performance Incentive	$10,346.92							
Maximum Improvement Incentive	$20,584.34							
Total Eligible Cases	48 out of 49 cases							

Patient	APR / SOI	Case Type	Actual LOS	Actual Cost	BP LOS	BP Cost	LOS Opport	Savings Opport	Max Perf Inc	Actual Perf Inc
110014	2211	Surgical	5	$8,266	4.00	$7,624.91	1	$641	$136.89	$71.17
110014	2211	Surgical	4	$11,489	4.00	$7,624.91	0	$3,864	$136.89	$0.01
110014	2262	Surgical	2	$5,056	2.00	$4,057.99	0	$998	$72.85	$27.61
110014	2262	Surgical	2	$4,498	2.00	$4,057.99	0	$440	$72.85	$48.88
110014	2212	Surgical	5	$10,403	5.00	$9,611.98	0	$791	$172.57	$109.82
110014	2211	Surgical	5	$8,347	4.00	$7,624.91	1	$722	$136.89	$64.96
110014	2213	Surgical	13	$23,705	8.00	$14,762.54	5	$8,943	$265.04	$4.02
110014	2212	Surgical	7	$18,439	5.00	$9,611.98	2	$8,827	$172.57	$0.00
110014	2212	Surgical	14	$20,547	5.00	$9,611.98	9	$10,935	$172.57	$0.00
110014	2211	Surgical	5	$10,616	4.00	$7,624.91	1	$2,991	$136.89	$1.05
110014	2212	Surgical	11	$19,616	5.00	$9,611.98	6	$10,004	$172.57	$0.00
110014	2271	Surgical	1	$3,574	1.00	$4,297.86	0	$0	$77.16	$77.16
110014	2212	Surgical	7	$14,032	5.00	$9,611.98	2	$4,420	$172.57	$4.55
110014	2271	Surgical	6	$7,880	1.00	$4,297.86	5	$3,582	$77.16	$0.00
110014	2233	Surgical	10	$19,985	6.00	$10,732.12	4	$9,253	$192.68	$0.98
110014	2213	Surgical	14	$25,529	8.00	$14,762.54	6	$10,766	$265.04	$0.60

Identifying Savings Opportunities

Report 2

Inpatient Summary by Service Line

Statistics Based On Best Practice DRGs/Physicians; July 2010 through December 2010; Medicare Only Claims

Excludes Psychiatry Service Lines and APRDRGs (540,541,560,626,640) For Normal Deliveries and Newborns

000001 General Hospital

Service Line	Admissions (Eligible)	Average LOS	Average BP LOS	Average LOS Variance	Actual Total Cost	Best Practice Total Cost	Best Practice Variance	Savings Opport	Marginal Savings Opport [50%]
All Inlier Claims	**5,231**	**5.30**	**3.22**	**2.08**	**$58,297,654**	**$38,562,988**	**$19,734,665**	**$22,118,443**	**$11,059,222**
269 Open Heart Surgery	317	8.83	5.51	3.32	$11,413,750	$8,832,116	$2,581,635	$2,882,579	$1,441,290
050 Cardiology	936	4.25	2.71	1.54	$6,389,395	$3,932,074	$2,457,322	$2,740,598	$1,370,299
132 General Surgery	270	9.27	5.92	3.36	$5,285,075	$3,345,714	$1,939,361	$2,112,526	$1,056,263
055 Cardiovascular Surg	540	4.31	2.06	2.25	$7,477,203	$5,562,258	$1,914,945	$2,449,105	$1,224,552
274 Orthopedic Surgery	323	4.50	3.32	1.17	$4,834,417	$3,312,173	$1,522,244	$1,591,054	$795,527
125 Gastroenterology	504	4.97	2.93	2.05	$3,639,637	$2,147,576	$1,492,061	$1,674,252	$837,126
255 Neurology	375	4.76	2.76	2.00	$3,125,093	$1,694,647	$1,430,446	$1,512,100	$756,050
296 Pulmonary	449	5.72	3.89	1.84	$3,863,133	$2,508,550	$1,354,583	$1,560,413	$780,207
165 Infectious Disease	200	7.42	4.22	3.19	$2,199,640	$1,119,049	$1,080,591	$1,157,512	$578,756
250 Nephrology	271	5.88	3.32	2.56	$2,098,420	$1,230,524	$867,896	$945,647	$472,824
267 Oncology	144	6.24	3.74	2.50	$1,340,426	$843,118	$497,308	$623,186	$311,593
045 Cardiac Cath	154	4.21	2.01	2.21	$1,228,178	$788,883	$439,294	$506,914	$253,457
252 Neurological Surgery	52	5.29	2.69	2.60	$857,604	$439,602	$418,002	$422,900	$211,450
276 Orthopedics	144	4.73	2.72	2.01	$926,435	$544,644	$381,790	$397,681	$198,840
145 Hematology	111	4.60	2.75	1.86	$764,291	$451,633	$312,658	$351,150	$175,575
387 Urological Surgery	36	6.78	3.50	3.28	$561,070	$314,652	$246,418	$265,104	$132,552
129 General Medicine	68	4.01	2.13	1.89	$432,245	$225,420	$206,825	$230,065	$115,033
135 Gynecological Surg	76	2.26	2.13	0.13	$543,417	$372,541	$170,876	$180,823	$90,411
090 Endocrinology	126	4.04	2.79	1.25	$617,074	$475,657	$141,417	$203,464	$101,732
283 Otolaryngology	49	2.90	1.80	1.10	$243,991	$130,638	$113,352	$122,929	$61,465
330 Rheumatology	39	4.49	2.28	2.21	$226,381	$129,629	$96,752	$102,289	$51,144
070 Dermatology	24	4.88	3.25	1.63	$147,325	$96,585	$50,740	$56,087	$28,043
390 Urology	19	2.74	1.37	1.37	$64,538	$48,569	$15,968	$23,715	$11,857
085 ENT Surgery	3	2.67	1.33	1.33	$17,793	$11,954	$5,839	$6,349	$3,175
137 Gynecology	1	1.00	1.00	0.00	$1,123	$4,780	$-3,658	$0	$0

Report 4
Inpatient Summary by Service Line and APR-DRG
Top 10 Savings Opportunity APR-DRGs in each Service Line
Statistics Based On Best Practice DRGs/Physicians; July 2010 through December 2010; Medicare Only Claims
Excludes Psychiatry Service Lines and APRDRGs (540,541,560,626,640) For Normal Deliveries and Newborns

000001 General Hospital

APR-DRG: Severity	Admissions (Eligible)	Average LOS	Average BP LOS	Average LOS Variance	Actual Total Cost	Best Practice Total Cost	Best Practice Variance	Savings Opport	Marginal Savings Opport [50%]
Service Line : 129 General Medicine									
All Inlier claims	**68**	**4.01**	**2.13**	**1.89**	**$432,245**	**$225,420**	**$206,825**	**$230,065**	**$115,033**
813 Major Other Complications Of Treatment	9	4.44	2.50	1.94	$82,322	$34,888	$47,433	$50,472	$25,236
812 Moderate Poisoning Of Medicinal Agents	10	3.60	2.00	1.60	$58,179	$24,405	$33,774	$33,774	$16,887
815 Extreme Other Injury, Poisoning & Toxic Effect Diagnoses	1	20.00	4.00	16.00	$38,568	$7,533	$31,035	$31,034	$15,517
812 Major Poisoning Of Medicinal Agents	6	5.17	2.00	3.17	$54,395	$24,189	$30,207	$30,322	$15,161
813 Moderate Other Complications Of Treatment	12	3.75	2.00	1.75	$60,883	$37,698	$23,185	$27,306	$13,653
861 Major Signs, Symptoms & Other Factors Influencing Health Status	6	6.00	3.00	3.00	$39,028	$22,211	$16,816	$21,352	$10,676
930 Major Multiple Significant Trauma w/o O.R. Procedure	2	5.00	4.00	1.00	$24,191	$14,005	$10,186	$11,175	$5,587
816 Major Toxic Effects Of Non-Medicinal Substances	1	8.00	2.00	6.00	$11,341	$4,068	$7,273	$7,273	$3,636
811 Major Allergic Reactions	2	3.50	2.00	1.50	$12,049	$6,343	$5,705	$6,148	$3,074
Service Line : 132 General Surgery									
All Inlier claims	**270**	**9.27**	**5.92**	**3.36**	**$5,285,075**	**$3,345,714**	**$1,939,361**	**$2,112,526**	**$1,056,263**
005 Extreme Tracheostomy w Long Term Mechanical Ventilation w/o Extensive Pr	7	32.00	22.00	10.00	$571,582	$361,413	$210,168	$218,767	$109,384
221 Extreme Major Small & Large Bowel Procedures	6	23.00	11.00	12.00	$293,911	$140,361	$153,550	$156,392	$78,196
221 Moderate Major Small & Large Bowel Procedures	17	8.88	5.00	3.88	$314,127	$163,404	$150,723	$153,262	$76,631
221 Major Major Small & Large Bowel Procedures	16	11.94	8.00	3.94	$360,413	$236,201	$124,213	$128,612	$64,306
004 Extreme Tracheostomy w Long Term Mechanical Ventilation w Extensive Proc	6	27.17	27.00	0.17	$511,659	$433,926	$77,732	$126,551	$63,275
710 Extreme Infectious & Parasitic Diseases Including HIV w O.R. Procedure	6	22.00	11.00	11.00	$217,442	$141,009	$76,433	$81,325	$40,662
223 Extreme Other Small & Large Bowel Procedures	1	49.00	11.00	38.00	$83,010	$19,733	$63,277	$63,277	$31,639
220 Major Major Stomach, Esophageal & Duodenal Procedures	4	14.00	8.00	6.00	$125,218	$62,487	$62,731	$62,731	$31,366
220 Extreme Major Stomach, Esophageal & Duodenal Procedures	2	20.50	12.00	8.50	$100,045	$48,756	$51,289	$51,289	$25,645

Report 6
Inpatient Summary by Service Line by Physician ID
July 2010 through December 2010; Medicare Only Claims
Providers With Greatest Savings Opportunity
Selection Criteria Based On Physicians with Cost Above 140% or $100,000 of BP Cost for the Service Line
Service Lines with > 2.5% of Variance for Provider or over $100,000 in Variance
Excludes Psychiatry Service Lines and APRDRGs (540,541,560,626,640) For Normal Deliveries and Newborns
Non PAR - NPI Accuracy not Verified

000001 General Hospital

Physician ID	Admissions (Eligible)	Average LOS	Average BP LOS	Average LOS Variance	Actual Total Cost	Best Practice Total Cost	Best Practice Variance	Savings Opport	Marginal Savings Opport [50%]
			Service Line:	055 Cardiovascular Surg					
All Physicians	**540**	**4.31**	**2.06**	**2.25**	**$7,477,203**	**$5,562,258**	**$1,914,945**	**$2,449,105**	**$1,224,552**
166951	40	4.78	1.78	3.00	$640,866	$414,412	$226,453	$243,417	$121,709
139678	35	5.11	2.23	2.89	$562,983	$374,160	$188,823	$216,273	$108,136
131690	25	7.20	4.48	2.72	$476,754	$310,643	$166,111	$194,608	$97,304
183136	38	4.39	1.74	2.66	$536,939	$372,061	$164,878	$199,372	$99,686
174037	17	6.59	2.41	4.18	$322,864	$189,726	$133,138	$140,351	$70,176
113410	28	3.82	1.75	2.07	$407,043	$293,104	$113,939	$133,572	$66,786
107361	12	8.42	2.25	6.17	$235,926	$135,402	$100,524	$109,651	$54,825
138685	12	5.67	2.08	3.58	$186,384	$124,084	$62,299	$65,692	$32,846
125536	13	3.85	1.77	2.08	$185,105	$131,050	$54,056	$61,447	$30,723
			Service Line:	125 Gastroenterology					
All Physicians	**504**	**4.97**	**2.93**	**2.05**	**$3,639,637**	**$2,147,576**	**$1,492,061**	**$1,674,252**	**$837,126**
104340	27	4.70	2.89	1.81	$204,286	$106,161	$98,125	$108,880	$54,440
110484	14	8.00	3.43	4.57	$158,672	$69,528	$89,144	$91,064	$45,532
192207	11	7.18	3.27	3.91	$124,304	$51,571	$72,733	$73,958	$36,979
181118	11	7.09	3.32	3.77	$116,509	$52,968	$63,541	$63,770	$31,885
104325	10	5.60	3.60	2.00	$110,282	$50,407	$59,875	$63,383	$31,692
172006	13	5.92	3.27	2.65	$102,332	$60,249	$42,083	$44,047	$22,023
165935	17	6.06	3.56	2.50	$124,888	$88,278	$36,609	$48,247	$24,123
188178	13	5.23	3.38	1.85	$96,858	$63,845	$33,012	$38,265	$19,133
130681	14	5.36	3.43	1.93	$101,562	$69,509	$32,053	$39,082	$19,541
196258	19	3.95	2.16	1.79	$87,234	$61,101	$26,133	$29,653	$14,827
133646	10	4.30	2.90	1.40	$69,627	$43,747	$25,879	$31,542	$15,771
113422	10	4.20	2.90	1.30	$60,954	$40,248	$20,705	$25,188	$12,594
			Service Line:	132 General Surgery					
All Physicians	**270**	**9.27**	**5.92**	**3.36**	**$5,285,075**	**$3,345,714**	**$1,939,361**	**$2,112,526**	**$1,056,263**
156843	43	10.44	6.51	3.93	$927,511	$567,796	$359,715	$394,798	$197,399
100388	15	8.73	6.07	2.67	$269,415	$176,454	$92,961	$100,208	$50,104

Report 11
Inpatient Cost Center Detail (Average Costs) by Physician
All Providers in CY 2010
Statistics Based On All Physicians for Best Practice DRGs; July 2010 through December 2010; Medicare Only Claims
Service Lines with > 2.5% of Variance for Provider or over $100,000 in Variance
Excludes Psychiatry Service Lines and APRDRGs (540,541,560,626,640) For Normal Deliveries and Newborns
Non PAR - NPI Accuracy not Verified

0000001 General Hospital

125 Gastroenterology

244 Moderate Diverticulitis & Diverticulosis

Responsible Physician 130688

Type	Admits	Total	Avg LOS	ANS	A_P	ASC	BCU	BLD	CCA	CCU	DEL	DIA	DRU	EEG	EKG
Actual	1	$5,283	6.00	$0	$3,912	$0	$0	$0	$0	$0	$0	$0	$223	$0	$0
Best Practice	847	$3,539	3.00	$6	$1,734	$7	$0	$17	$0	$53	$0	$0	$319	$0	$32
Variance		$1,744	3.00	$-6	$2,179	$-7	$0	$-17	$0	$-53	$0	$0	$-95	$0	$-32

	EMR	ICU	LAB	MSS	NBN	NNI	OCC	ORR	PHT	RAD	RAI	RAT	RRR	RSP	Other
Actual	$363	$0	$174	$46	$0	$0	$0	$0	$99	$467	$0	$0	$0	$0	$0
Best Practice	$367	$75	$238	$51	$0	$0	$2	$37	$7	$568	$7	$0	$10	$11	$0
Variance	$-4	$-75	$-64	$-5	$0	$0	$-2	$-37	$92	$-102	$-7	$0	$-10	$-11	$0

Responsible Physician 156843

Type	Admits	Total	Avg LOS	ANS	A_P	ASC	BCU	BLD	CCA	CCU	DEL	DIA	DRU	EEG	EKG
Actual	1	$5,239	3.00	$0	$0	$0	$0	$216	$0	$0	$0	$0	$18	$0	$8
Best Practice	847	$3,539	3.00	$6	$1,734	$7	$0	$17	$0	$53	$0	$0	$319	$0	$32
Variance		$1,700	0.00	$-6	$-1,734	$-7	$0	$199	$0	$-53	$0	$0	$-300	$0	$-24

	EMR	ICU	LAB	MSS	NBN	NNI	OCC	ORR	PHT	RAD	RAI	RAT	RRR	RSP	Other
Actual	$0	$4,425	$122	$41	$0	$0	$0	$0	$0	$287	$0	$0	$123	$0	$0
Best Practice	$367	$75	$238	$51	$0	$0	$2	$37	$7	$568	$7	$0	$10	$11	$0
Variance	$-367	$4,350	$-116	$-10	$0	$0	$-2	$-37	$-7	$-282	$-7	$0	$113	$-11	$0

Responsible Physician 183120

Type	Admits	Total	Avg LOS	ANS	A_P	ASC	BCU	BLD	CCA	CCU	DEL	DIA	DRU	EEG	EKG
Actual	1	$5,158	4.00	$0	$2,609	$0	$0	$0	$0	$0	$0	$0	$665	$0	$0
Best Practice	847	$3,539	3.00	$6	$1,734	$7	$0	$17	$0	$53	$0	$0	$319	$0	$32
Variance		$1,619	1.00	$-6	$875	$-7	$0	$-17	$0	$-53	$0	$0	$346	$0	$-32

	EMR	ICU	LAB	MSS	NBN	NNI	OCC	ORR	PHT	RAD	RAI	RAT	RRR	RSP	Other
Actual	$363	$0	$246	$13	$0	$0	$0	$0	$0	$853	$0	$0	$0	$409	$0
Best Practice	$367	$75	$238	$51	$0	$0	$2	$37	$7	$568	$7	$0	$10	$11	$0
Variance	$-4	$-75	$8	$-37	$0	$0	$-2	$-37	$-7	$284	$-7	$0	$-10	$398	$0

Other Reports

- Savings Reports
  - Trends base year or prior year costs and compares to actual cost by hospital, physician and/or service line
- Monitor Changes in Key Areas
  - LOS
  - Case-Mix/SOI
  - Re-Admissions
  - Mortality

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