Handout #3
Evaluation of the Financial Impact of Shifting Elective PCI From Hospitals to ASCs

1. Does information need to be collected directly from every Maryland program or should select programs that are seen as representative of other hospitals and possible scenarios sufficient?

    - If the latter, what are the relevant criteria and circumstances to consider?

    - Does information need to be kept anonymous and is that feasible, while still being able to verify information and/or request clarification?

2. What are some of the secondary effects of allowing/shifting elective PCI to ASCs?

    - To what extent would there be any reduction in space/investment in equipment by hospitals with the move of PCI to an ASC? Is it important to capture and consider this information?

    - Will other cardiac procedures also shift to the ASC setting, such as diagnostic cardiac catheterizations or other procedures?

    - Are anticipated secondary effects positive in terms of reducing costs and increasing efficiency or not? Can and should those be estimated or quantified as part of a study?

    - Is payor mix likely to change for hospitals? Will those changes likely be positive or negative for hospitals and the health care system?

3. What specific financial information should be requested from hospitals? What information is missing or should be removed from the following proposed lists?

    - Overhead attributed to diagnostic cardiac catheterization and PCI services

        - For cardiac surgery programs, should something broader than PCI services be used to evaluate the financial impact on hospitals? Will that likely result in a more accurate picture instead of trying to artificially separate PCI/cardiac catheterizations?

    - Estimated change in overhead under various assumptions about changes in elective PCI volume

    - Fixed Costs and Depreciation of CCL equipment

        - How much efficiency is gained in terms of equipment with having a higher volume of cardiac catheterizations/PCI?

- Labor Costs (salaries/benefits)
    - Salaried and contract/temporary staff
- Cost per Case at Various Volume Levels
    - Do we need to try and isolate PCI service costs and assign a percentage based on use of equipment/time of staff directly tied to PCI services versus other services that overlap with respect to capital and labor costs?
- Revenue per Case at Various Volume Levels (as determined by potential shifts projected if elective PCI is in allowed in ASCs)
- Overall changes in costs and revenue for elective PCI services
    - Should changes in cost and revenue captured be broader because other cardiac procedures are likely to be impacted too?