Where the Money Is

As margins decline, hospitals should look to their heart programs for financial opportunities.

BY LARRY SOBAL, MBA, MHA, CMPE

Although it is early, 2018 is shaping up to be a very interesting year in health care, and cardiovascular programs are right in the mix. The uncertainty of health reform, political appointments, and the direction of Centers for Medicare & Medicaid Services (CMS) all contribute to a continually changing health care landscape and a heightened level of intrigue about what will happen.

As I travel to heart programs around the United States, I see that most have many opportunities for improvement. Near the top of every program's strategic priority list is financial improvement, either through growth or cost reduction. Yet, at the same time, I find many programs are regularly avoiding capitalizing on their largest financial opportunities—for some, millions of dollars are routinely being left on the table.

For the purposes of this article, the phrases *cardiovascular (CV) practice* and *heart program* are interchangeable, as the issues discussed apply to both heart programs (or CV service lines) as well as individual cardiology and/or cardiothoracic surgery practices, which may be independent or embedded into a CV service line through some form of contractual alignment or employment.

Despite a transformation from what was once an inpatient-dominated service line, heart programs are still strongly rooted in hospitals. Some facts about the current state of the hospital industry are as follows[1]:

- Changing economic, regulatory, and consumer demands have accelerated large-scale reform in health care delivery across the country.
- There are 5,564 registered hospitals in the United States. Of these, 4,862 (approximately 85%) are considered community hospitals. There are 2,845 nonprofit community hospitals and 1,034 for-profit community hospitals. Additionally, 983 are owned by state or local (county, hospital district) government entities.
- Patients with heart disease are not the only patient type moving from inpatient to outpatient settings. The number of inpatient hospital facilities decreased from 6,522 in December 1990 to 6,142 in December 2014. The number of total inpatient hospital beds has decreased from 32.8 beds per 1,000 people in 1990 to 17.3 beds per 1,000 people in 2014 (a 47% decrease), according to CMS.[2]
- For 2016, the average operating margin for a nonprofit hospital was 2.7%, according to the latest data available from Moody's Investors Service.[3]

Even with expanded insurance coverage under the Affordable Care Act, hospital leaders are acutely aware that the government payment programs do not cover costs. For Medicare, hospitals received 88 cents for every dollar spent caring for beneficiaries in 2015 and 90 cents for Medicaid patients, according to the American Hospital Association. Combined underpayments from the government programs were $57.8 billion in 2015. This includes a shortfall of $41.6 billion for Medicare and $16.2 billion for Medicaid, the association reported.[4]

Figure 1 shows the degree to which hospital margins are being impacted by Medicare.[5] There has never been a better time to be performing at your best financially. Where are those opportunities in heart programs? The following sections list some of the most common areas.

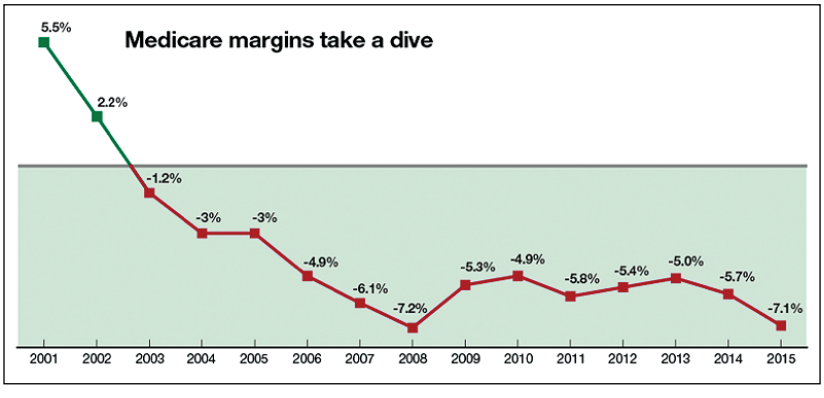

Figure 1. The impact Medicare is having on hospital margins. Reprinted from Medicare Payment Advisory Commission, Medicare Payment Policy, March 2017.

VOLUME GROWTH

Although some CV-related volumes are declining, there are still plenty of opportunities for appropriate volume growth if you are willing to take the steps to go after them.

Optimizing your ambulatory clinic can result in a tremendous increase in office visits in 2018. The top performing MedAxiom cardiology practice members routinely see 25+ patients per physician per day, have same-day access for urgent patients, and get new nonurgent patients into the office the same week. Imagine taking your ambulatory clinic to that level of performance. The financial benefits related to access and clinic optimization occur in multiple ways:

- A 20% to 30% increase in office visits increases new patient access and works down the backlog of the hundreds/thousands of follow-up patients who are waiting to be scheduled.
- Patients seen in the office, especially new patients, generate (appropriately) a lot of downstream services including diagnostic testing, labs, procedures, etc.
- A poorly functioning clinic has many abstract costs, such as higher employee turnover, harder recruiting, emotional distress, etc. This dysfunction is eating dollars.

What about improving access? Aside from heroic "shoe-horning" in patients, or just plain begging, can you consistently get new patients into your weekly schedule? Are your return visits backlogged so that annual visits become 14-month appointments? Has your daily clinic volume declined since you adopted your electronic medical record? Now is the time to reengineer your scheduling policies, practices, and clinic workflows, and set some minimum patient volume standards. And, if you have not investigated the multiple benefits of using scribes, you may be missing a huge improvement of your access as well as physician, staff, and patient satisfaction.

Two commonly underserved populations are those with peripheral artery disease (PAD) and atrial fibrillation (AF). Consistent feedback to heart programs is that the referral base is not fully aware of your capabilities for PAD or AF and is not well educated on how to best assess and refer those patients when seen during an office visit. When is the last time your cardiologists visited your key referral groups and provided some useful PAD and AF advice? Do you make it easy to get those patients into your practice for a consult versus other options in your community? Do you have specialty clinics focused on acute PAD and AF patients? Population demographics point to AF and PAD being high growth areas—is 2018 the year you are going to capture them and become the heart center of choice for these patients?

REVENUE GROWTH

Many heart programs are not being fully paid (or paid at all) for the work they are already doing. Ten years ago, most cardiology groups were independent, still using paper medical records, with certified professional coders, and the process of documenting, coding, billing, and collecting was much simpler (and much more effective).

Today, a heart program would be unique if it knew its charge lag time, total days in accounts receivable, net collection ratio, or denial rate. Not knowing, and not having a finger on the pulse of your revenue cycle processes, is like burning money. Some of the problems are:

- Documentation and code selection for office visits do not accurately reflect the level of service provided.
- Revenue cycle functions are not capturing all possible reimbursement from cath and electrophysiology lab procedures, both on the professional and technical side.
- Programs are still routinely doing work without adequate preauthorization and receiving a denial/not getting paid.
- Billing functions are still collecting inpatient charges on pieces of paper that physicians (hopefully, but not consistently) turn in.
- Certain activities are not billed because the process to capture and code the charges has fallen through the cracks.

Want to add a million dollars of new revenue in 2018 without asking any providers to see more patients? Do a revenue cycle audit. The concept of improved documentation resulting in higher reimbursement never seems to make it to the top of anyone's strategic priority list, but it should; many programs have found millions of dollars in uncaptured revenue.

Another large revenue opportunity, chronic care management (CCM), is not new but CMS implemented some changes for 2017[6] that make this opportunity much more attractive and feasible. Since 2015, CMS has been providing monthly reimbursement for CCM of patients not conducted during a face-to-face patient visit to help better treat patients with multiple chronic conditions. CMS ultimately aims to reduce preventable readmissions, emergency department visits, nursing home intakes, and other utilization costs that often do not have a positive effect on the patient's long-term health.

The original attraction of CCM was that CMS would pay practices about $42 per month per patient for providing 20 minutes or more of (nonphysician) care coordination. This is work you are likely already doing. The 2017 Physician Fee Schedule Final Rule implement-

ed payment policies designed to make it easier and more financially attractive for physician practices to furnish CCM services to Medicare beneficiaries. These policies include easier enrollment of patients in your CCM program, no longer requiring a face-to-face visit for existing patients, elimination of separate consent forms, additional reimbursements for time increments beyond 20 minutes, and expanding reimbursement to $68 upon creation of a patient's care plan and additional reimbursements for CCM patients of moderate or high complexity.

The net result of a well-orchestrated CCM is that physicians receive new revenue and patients with multiple chronic conditions receive better coordination of their care. Because cardiology practices have tens of thousands of Medicare beneficiaries with two or more chronic conditions in their panel, this is a multimillion dollar opportunity.

A third opportunity for revenue growth is related to the recently announced Bundled Payments for Care Improvement (BPCI) Advanced program. On January 9, 2018, CMS announced its long-awaited relaunch of the original BPCI program with some new improvements.[7] This is good news for heart programs; there has been a shortage of alternative payment models (APMs) for specialists who qualify as an approved APM under the Medicare Access and CHIP Reauthorization Act (MACRA)/Quality Payment Program (QPP), and this new program changes that. You can choose from 32 clinical care episodes, including percutaneous coronary intervention (PCI) provided in both the inpatient and outpatient setting. Recent data from one heart program showed a potential $1,000 to $3,000 opportunity per congestive heart failure (CHF) episode. It is important to note that the application to participate is due by March 12, 2018. The Model Performance Period for BPCI Advanced starts on October 1, 2018 and runs through December 31, 2023.

Of course, there are many reward opportunities available through QPP, accountable care organizations (ACOs), and a variety of other alternative payment models that offer upside risk.

COST REDUCTION

There is no doubt that adding new volumes and new revenues will improve your heart program operating margin and capture some of those dollars being left on the table. But reducing costs, especially unnecessary costs, flows right to your bottom line. This is particularly true when you are being paid a fixed reimbursement for certain procedures, such as Medicare PCI.

One common example is heart programs that have not adopted a formalized same-day discharge (SDD) program for PCI procedures, at the financial detriment of themselves and their Medicare patients. The bottom line is that when hospitals admit low-risk PCI patients—who should be candidates for SDD—overnight, there is no part of the reimbursement that covers the inpatient portion of that stay.

One published study demonstrated that combining PCI SDD and procedures performed using a transradial (TR) approach can result in as much as $3,500 less costs, much of that due to a shorter length of stay. Shifting current practice from transfemoral intervention non-SDD to TR SDD by 30% could potentially save a hospital performing 1,000 PCIs $1 million each year.[8]

CATH LAB OPTIMIZATION

Once a virtually guaranteed high-profit center for hospitals, many cath labs are seeing their margins decline despite growing patient panel sizes. Clearly, some labs seem caught in a time warp, doing many things the same way they did 10 or more years ago regarding processes, patient flow, etc. Introducing transcatheter therapies for aortic valve replacement, patent foramen ovale, chronic total occlusion, left atrial appendage, and other new procedures and technologies only exacerbates the inefficiency.

For many cath labs, it is not unusual for most of their improvement energy to be focused on supply cost reduction. But, at some point, labs need to move on to the more arduous task of reengineering workflows and processes and optimally filling the daily cath lab schedule.

If your cath lab is no longer meeting its financial expectations, is requesting new employees, has gaps and inconsistencies in patient readiness for procedures, has conflicting patient information, and struggles with on-time start delays, it may need to create a modern "cath lab care pathway." The pathway is defined by best practices that lead with quality while reducing costs and enhancing revenue. The financial benefits related to cath lab optimization are:

- Increased patient access and throughput through redesigned scheduling templates/capacity model.
- Redesigned staff roles and responsibilities.
- Level loading volumes throughout the week and case scheduling that reduces overtime.
- Reengineering processes void of waste and reduced departmental expenses.

CHF CENTER OF EXCELLENCE

The ironic thing about CHF is that it has been an area of focus for some time due to CHF readmission penalties. Under the Hospital Readmissions Reduction Program, CMS was withholding up to 3% of regular

reimbursements for more than 2,500 hospitals in 2017 because they had a higher than expected number of readmissions within 30 days of discharge for six conditions, one of the most common of which is heart failure.[9]

But it is not just the readmission penalties that you want to eliminate. By creating a systemic CHF center of excellence, the financial benefits related to CHF improvement occur in several ways:

- Variable cost avoidance/reduction for Medicare CHF inpatients, including reduced length of stay and attaining better financial performance on CHF-related diagnosis-related group payments.
- Non-Medicare readmission reductions, usually 20% to 40%, that often capture incentives built into ACOs or commercial payer contracts.
- Volume-related revenue growth through referral channel management.

It is also not just the Medicare population that you need to focus on—many of your commercial contracts are designed so that better coordination and management of CHF also reaps positive financial impact.

ADVANCED PRACTICE PROVIDER OPTIMIZATION

There is great variation in how heart programs utilize advanced practice providers (APPs). It is not uncommon to find a heart-related APP program as a negative entry on a heart program's finance ledger. This scenario is unfortunate and unnecessary. The financial benefits related to APP optimization include:

- Programs utilizing APPs at the top of their license, where the majority of their work is reimbursable through expanded use of APPs in clinic and improved efficiency of APPs in the hospital.
- Programs properly billing under the APP national provider identifier number.
- Using APPs (instead of physicians) for work that can appropriately be performed by an APP, such as early discharge facilitation, assurance of core measure fulfillment, and appropriate documentation to capture acuity.

By definition, APPs should be a valued and highly utilized team of providers and the majority of their work should be reimbursable services. When this team works to the top of their license in an aligned team-based environment, where their capacity is maximized, there should be a minimum of 200% return on investment on the APP costs. This means that an individual APP has the capacity to contribute in revenue twice their cost on the expense side. There are examples of high-touch, high-resource chronic disease management programs, such as CHF, in which the patient volumes are lower such that this may not be the case. However, these types of programs come with a significant cost avoidance strategy that should allow them to still be a positive financial contribution to the organization.

CONCLUSION

Once renowned as a hospital's primary source of financial contribution and stability, heart programs are facing many pressures, including a more economically challenging future thanks to political uncertainty, increases in uninsured care, growing competition as patients move from inpatient to outpatient settings, and reimbursement model movement away from lucrative fee-for-service structures. And, they are experiencing these pressures more strongly than practically any other service line.

For 2018, it will benefit organizations to look "under the hood" and give their heart programs tune-ups, or complete overhauls, so that they stop leaving money on the table unnecessarily, capture the full financial potential of their programs, and position themselves for sustainable financial success. ■

1. Murphy B. 50 Things to Know About the Hospital Industry—2017. Becker's Hospital Review. https://www.beckershospitalreview.com/hospital-management-administration/50-things-to-know-about-the-hospital-industry-2017.html. Accessed November 26, 2017.
2. Centers for Medicare & Medicaid Services. 2015 CMS Statistics. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf. Accessed November 26, 2017.
3. Breen T. Hospital profit margins declined from 2015 to 2016, Moody's finds. https://www.advisory.com/daily-briefing/2017/05/18/moodys-report. Accessed November 26, 2017.
4. American Hospital Association Underpayment by Medicare and Medicaid fact sheet, December 2016. http://www.aha.org/content/16/medicaremedicaidunderpmt.pdf. Accessed November 26, 2017.
5. Report to the Congress Medicare Payment Policy, March 2017. http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf. Accessed November 26, 2017.
6. Chronic Care Management Services Changes for 2017. Medicare Learning Network. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement-ServicesChanges2017.pdf. Accessed November 27, 2017.
7. CMS announces new payment model to improve quality, coordination, and cost-effectiveness for both inpatient and outpatient care. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-01-09.html. Accessed January 9, 2018.
8. Amin AP, Patterson M, House JA, et al. Costs associated with access site and same-day discharge among Medicare beneficiaries undergoing percutaneous coronary intervention. an evaluation of the current percutaneous coronary intervention care pathways in the United States. JACC Cardiovasc Interv. 2017;10:342-351.
9. Castellucci M. Results of CMS' readmissions program has hospitals, experts questioning its purpose. http://www.modernhealthcare.com/article/20170812/NEWS/170819965. Accessed November 29, 2017.

Larry Sobal, MBA, MHA, CMPE
Executive Vice President, MedAxiom
Neptune Beach, Florida
lsobal@medaxiom.com
Disclosures: None.