

A Look Ahead...

Further Implementation of Healthcare Reform in 2015: Cardiac Cath Program Implications

By Ross Swanson

It has become quite apparent that the impact of national healthcare reform is going to be broadly felt across hospital departments, and the confines of the cardiac catheterization laboratory (CCL) are no exception. Corazon has been working with our clients to ensure that their CCLs focus on items that directly correlate with patient procedure types and overarching clinical practice as related to the specifications of healthcare reform.

Looking ahead, our team believes the following three areas will be more fully realized in 2015, profoundly impacting the cath lab environment:

- 1) Service expansion or consolidation across health systems or affiliated networks;
- 2) The change in patient mix associated with the two-midnight rule; and
- 3) Expanding the eligible patient pool that accompanies service expansion (including increased detection of peripheral vascular disease and increased modalities within electrophysiology).

Service Expansion or Consolidation

State regulations are rapidly changing, mostly with fewer limits to certain services such as percutaneous coronary intervention (PCI). Restrictive PCI regulations have seen tremendous implosion since the 2011 PCI guidelines promoted elective PCI with cardiac surgery off-site to a Class IIb (may be considered) from a Class III (likely harmful) recommendation. The need for cardiovascular patient populations to have less restricted entry to necessary care will continue to drive the loosening of such regulations. The need to expand services has never been more evident. Attempts to expand access to care will increase, becoming even more necessary with the increasing numbers of insured people.

No doubt, 2015 will require cath lab leaders to be forward thinking in order to ensure their labs are prepared now, before further changes associated with healthcare reform are enacted. For example, CCL clinical staff must be technically proficient in current and future procedures, and able to leverage operational efficiencies to allow for an influx of cases (i.e., additional patients and increased procedure types), which may also include more complex scheduling practices.

Diagnostic-only CCLs wishing to expand their level of service to include therapeutic procedures such as PCI will need to build or ensure stronger working relationships with their individual facility decision-support or business development offices. In the coming year, it will be paramount that CCL leaders (including physicians) are able to access patient-level market data to understand patient capture and also missed opportunity. The hospital's business offices will also be required to know the local state regulations to determine what the CCL service options are, along with whether the cath lab meets the exact requirements and what any associated timelines will be for new service development. Finally, the completion of application submissions to both state departments of health and national benchmarking organizations such as the American College of Cardiology's National Cardiovascular Data Registry (ACC-NCDR) can be grueling and subject to errors, and therefore, ongoing

collaboration between CCL leadership and the internal decision-support or business development office is a must.

Besides expanding services, consolidation of services may be likely as the entire healthcare industry cares for more complex patients with fewer resources. Given that some CCLs will face expansion into new service opportunities, consolidation might be the best opportunity for labs with marginal volumes and great support networks. The initial implementation of healthcare reform measures has created quite a paradigm shift for cardiovascular departments. The era of simply expanding services in the CCL to equate to a greater contribution margin is long gone.

Labs with marginal volumes and sometimes stretched resources may need to consider measures for reduction in services, especially if the lab is part of a larger health system or integrated care network that has other facilities acting as the "hub" for more complex cardiovascular care. Ceasing operations or redistributing services are never easy decisions, but nonetheless these are decisions that might be necessary to ensure that the greatest number of patients derive benefit.

Clinical quality must also factor into decision-making. Quality scrutiny seemingly intensifies every year, and this trend will continue into 2015. Value-based care measures already require that the care provided is meaningful and beneficial. Our team believes that access to real-time quality reports, as well as participation in national benchmarking databases such as the ACC-NCDR, should be implemented. Indeed, procedural volume is not the only parameter of a successful CCL. Patient access to care and whether or not the local population's needs are being met are vital as well.

Change in Patient Mix with the Two-Midnight Rule

Many thoughts exist regarding the controversial two-midnight rule. In fact, debate even surrounds the definition of the rule (see below); however, regardless of predictions related to the specific ruling, the Centers for Medicare & Medicaid Services (CMS) and the commercial payors will continue to review patient status more closely in 2015. The creation of measures such as the two-midnight rule is a direct response to healthcare reform initiatives to reduce hospital admissions and place more focus on preventative measures.

The two-midnight rule was finalized in Medicare's 2014 Inpatient Rule (released in 2013), though compliance cannot be reviewed until April 2015. Even though it may change slightly, some form of the rule will be in place to direct more patients to outpatient status. The current definition states that if the admitting physician reasonably expects that a patient will need a hospital stay spanning at least two midnights, then the hospital is eligible for Part A reimbursement. But if a patient stays in a hospital less than two nights, then the hospital will have to list the encounter as observation, and bill Medicare for the lower Part B payment, which also imposes higher cost-sharing on patients. Perhaps the greatest impact will be felt in the CCL with both diagnostic cath and elective PCI patients, due to their already decreasing lengths of stay.

PCI Volume	Current Year	2-Midnight Effect
Inpatient Volume: LOS of >= 2.0 days	125	125
Inpatient Volume: LOS of < 2.0 days	75	0
Outpatient Volume	100	175
Total PCI Volume	300	300
PCI IP vs. OP %	Current Year	2-Midnight Effect
Inpatient %	67%	42%
Outpatient %	33%	58%
Total %	100%	100%
Revenue	Current Year	2-Midnight Effect
Total Inpatient	\$2,734,010	\$1,708,756
Total Outpatient	\$810,440	\$1,418,270
Total Medicare Reimbursement	\$3,544,450	\$3,127,026
Reimbursement Difference	-\$417,424	

Table 1. Due to the large impact of the two-midnight rule, Corazon has developed an online calculator as a resource to help CCLs prepare for revenue reductions in the year ahead based on this change (at <http://www.corazoninc.com/resources/toolbox/2-midnight-rule-calculator/>). For example, consider a CCL that performs 300 PCIs with a 66% inpatient and 33% outpatient ratio, which is fairly standard in today's market. Under the imposed two-midnight rule, these same patients will experience ratios that are reversed to 40%IP and 60% OP, which could represent a revenue loss of greater than \$400,000 for one lab. The loss in revenue alone will further erode profits, which will increase the risk of capital restrictions such as equipment and facility upgrades. These losses, coupled with increased overall patient volumes, will place greater strains on the CCL department.

The two-midnight rule will impact CCLs on two major fronts. First, preparing an increasing number of patients for immediate discharge to home or any sub-acute facility will likely place an increased liability on already-stretched CCL staffs. In the past, highly functional cath lab staff had the ability to rely solely on their procedure-based technical expertise. Now, CCL staff members will need to focus greater energy on items such as delivering optimal patient discharge education. This will include organizing an increasing number of follow-up appointments so that the patients remain connected to the "wellness" aspect of their ongoing care. We believe that the time spent for caring patients in the immediate recovery phase by CCL staff may increase two-fold in many facilities, as these patients will no longer be directed to inpatient-based units for care.

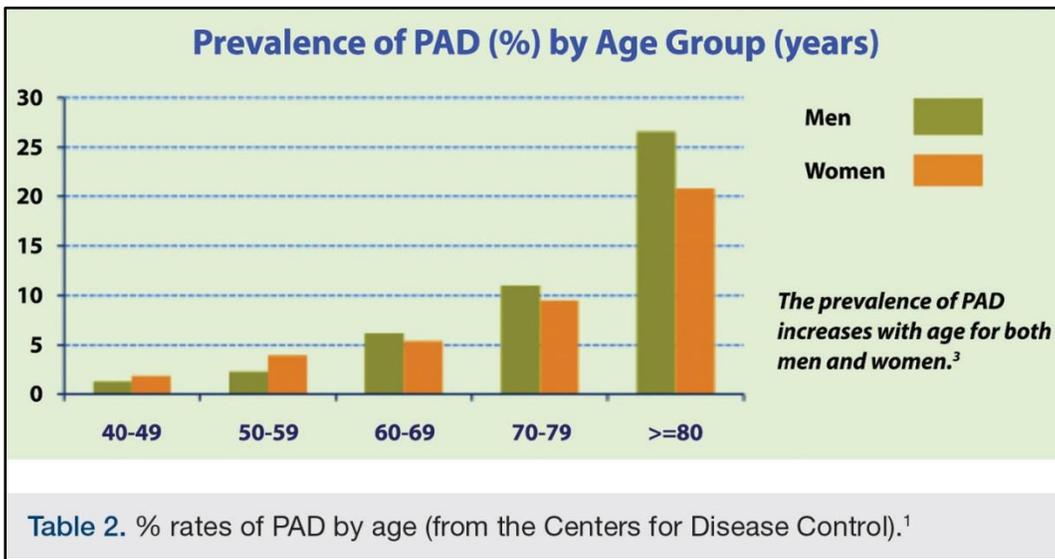
The second major impact of the two-midnight rule relates directly to finances. Currently, outpatient PCIs are paid approximately \$2,000 less than inpatient PCIs. Therefore, CCL team members need to consider the number of inpatient procedures currently performed with a length of stay (LOS) from 1.1-1.9 days, which can be common for diagnostic cath and PCI patients. After enforcement of the two-midnight rule, these short LOS patients must ALL be classified as outpatients. The financial impact of this change in patient status will be profound (Table 1).

Expanding the Eligible Patient Pool with Service Expansion

The final item with the greatest impact for CCLs in 2015 will involve some long overdue service expansions. We believe that 2015 should be the year to launch new campaigns to reach the peripheral vascular (PV) disease population and patients with common arrhythmias (such as atrial fibrillation) that would benefit from electrophysiology (EP) services.

Any campaigns to reach these target populations will be further aided by the increase in patient insurance coverage. Greater patient coverage will bring a resultant increase in peripheral and EP disease detection measures. More CCLs will need to ensure that the skills to treat both PV and EP conditions are present, especially if those populations are not being well cared for in the local market.

The increased coverage needs will be magnified, because the incidence of people with PV disease and/or arrhythmia has only increased with the overall aging of the population. Table 2 demonstrates the prevalence of patients by age with PV disease.¹ Physician coverage (or even perceived turf battles) may be the underlying issue regarding access to PV or EP types of treatment. Cardiac programs will need to creatively overcome the physician shortage needs associated with these complex treatments. Options may include leveraging local networks or system facilities (as described in the above service consolidation discussion), so that patients are directed to the most appropriate level of care.



Redirecting PV or EP patients for interventional treatment does not necessarily mean that patient is lost to the local facility for any type of follow-up care. Now, and moving into the future, all cardiac care options should be promoted as one program, irrespective of the facility where care is rendered. This approach will allow the patient to view all care components (and facilities) as one branded program, especially since lower acuity follow-up care should be provided anywhere within a system or network.

Throughout the next few years, all cath labs will need to consider what role they provide in the care of PV and/or EP patients. These patient types can include some hefty capital resources, which might be difficult for many facilities to support, especially in underserved regions. For example, capital needs for PV and EP patients will include larger flat-panel detectors within the imaging equipment to accommodate views across larger vascular beds and perhaps even bi-plane needs for more comprehensive EP studies. These items carry some of the highest dollar investments across all CCL equipment needs.

The distribution of advanced technology does not end in the procedure room, especially as telemedicine approaches have rapidly evolved from simple triage assistance technology to implantable devices that not only monitor the patient's current state (vital signs, serum chemistry, etc.), but these same devices also have the ability to notify the provider without the patient intervening. The field of cardiac EP is arguably the most proactive in all of medicine, with the deployment of remote monitoring for patients with implanted devices. CCLs will need to respond to these cutting-edge demands by having the necessary and often expensive supplies available (including the implants and remote monitoring equipment). Also, the mere fact that the patients will be more seamlessly connected than ever before may create an increased burden on staff, with potential for information overload, as alluded to in the first section, and any service expansion that may include increased PV and EP services provides even greater challenges to CCL scheduling, staffing, and equipment needs. Fortunately, the increased needs and volumes of patients will likely be balanced through additional scrutiny of procedure appropriateness such as the already employed Appropriate Use Criteria (AUC). Not all patients will be deemed appropriate for some form of interventional care; however, CCLs must become proactive. CCL leaders and staff must partner more effectively with physician providers, especially when working in areas of innovation such as PV or EP. Stay focused, as these programs are market differentiators that may ensure the survival of your CCL program.

In many ways, the foundation for cardiac cath lab success in 2015 has already been laid with the initial implementation of healthcare measures from the last two years. CCLs will need to prepare for the upcoming year by evaluating critical service offerings, complying with inpatient/outpatient status, and even service expansion into peripheral services such as PV or EP. Preparing your CCL for success in the year ahead does not require a crystal ball. Facilities that proactively plan and prepare for the changes ahead will rise to the top!

Reference:
 1. Peripheral arterial disease in the legs. A factsheet from Centers for Disease Control's National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention. Available at http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/docs/fs_pad.pdf.



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