Techniques in Gastrointestinal Endoscopy (2011) 13, 254-259

ELSEVIER

Techniques in
GASTROINTESTINAL
ENDOSCOPY

www.techgiendoscopy.com

Improving ambulatory endoscopy center performance

John M. Poisson

Physicians Endoscopy, LLC, Doylestown, Pennsylvania.

KEYWORDS:
Health care reform;
Quality of care;
Revenue per procedure;
Cost per procedure;
Clinical integration;
Accountable care organization;
Room utilization

The key to improving ambulatory endoscopy center (AEC) performance revolves around implementing certain key activities while at the same time consistently measuring and reporting specific mission-critical metrics throughout the organization. Although many of these key activities could be described as "business fundamentals," the impact of health care reform will be driven home within the AEC environment as reimbursement transforms from the purely fee-for-service model to other alternate reimbursement arrangements. Although other contributions to this issue focus on potential future reimbursement models in more detail, a focus on quality and cost-effectiveness is a common theme in most potential new reimbursement mechanisms. In the historical AEC environment, procedural volume has always been King; his Queen is room utilization. These factors are undoubtedly the two key drivers of performance within the center today and will remain so in the future. However, all kingdoms need their knights of the round table and this article focuses on those elements that assist in driving financial, operational, and clinical performance. These same elements will prove critical in tomorrow's AEC reimbursement environment that transforms as the result of various health care reform initiatives.

Drivers of financial performance

Revenue per procedure

Given that governmental reimbursement rates for Medicare and Medicaid are nonnegotiable in the ambulatory endoscopy center (AEC) setting, the key to increasing overall average revenue per procedure lies within optimizing commercial third-party reimbursement rates. Thus, working under the assumption that the AEC will treat all patients regardless of their insurance class (meaning no "cherry picking" of payer plans), in today's market the fee-for-service reimbursement model remains dominant and thus both initial and ongoing payer contracting activities are critical. For the de novo center just getting off the ground, a disciplined payer-contracting philosophy is required. It is all too easy to accept substandard initial reimbursement rates in an effort to accelerate cash flow in the early months of center operations. This is a fatal flaw that has plagued many AECs nationwide—because not only is the initial reimbursement rate poor, but also the same established base rate serves as the foundation for future rate increases.

For example, the benefit of a slightly higher commercial rate—in this case just $25 per procedure (Table 1)—can be dramatic over time. Assuming a 3% annual increase, in just 5 short years the benefit of this initial difference in the initial negotiated reimbursement rate amounts to several hundred thousand dollars in increased revenue for a payer plan with 2500 annual procedures performed at the AEC. In a de novo start-up, the board of managers needs the fortitude and patience and a solid working capital fund to allow the personnel charged with payer-contracting efforts the time to complete satisfactory negotiated rates.

Payer contracting is not a one-time initial effort. It is a consistent mission-critical element that requires constant attention. Many AECs do not implement a disciplined and structured approach to renegotiations. In the 2008, 2009, and 2010 fiscal years, CMS rates were reduced for all common gastrointestinal (GI) procedures performed within the AEC setting. The year 2011 represents the 4th and final

Competing interests: Minority owner, Physicians Endoscopy, LLC (Doylestown, PA); Endoscopy Center of Western New York, LLC (Williamsville, NY); Long Island Center for Digestive Health, LLC (Garden City, NY); Advanced Endoscopy Center, LLC (Bronx, NY); East Side Endoscopy, LLC (New York, NY); and Carnegie Hill Endoscopy, LLC (New York, NY); and member, Economic Advisory Panel, Ethicon Endosurgery (Cincinnati, OH).

Address reprint requests to John M. Poisson, Physicians Endoscopy, LLC, 1456 Ferry Road, Suite 305, Doylestown, PA 18901. E-mail: jpoisson@endocenters.com

1096-2883/11/$-see front matter © 2011 Published by Elsevier Inc.
doi:10.1016/j.tgie.2011.08.002

Table 1 Initial base rate comparison

Year	Rate ($)	Rate ($)	Difference ($)	$ per 2500 procedures
1	450	475	25.00	62,500
2	464	489	25.75	64,375
3	477	504	26.52	66,306
4	492	519	27.32	68,295
5	506	535	28.14	70,344
Average	478	504	26.55	66,364
Incremental revenue over 5 years				331,821

year of the Center for Medicare and Medicaid Services (CMS) rate reductions (at least as publically stated by CMS at this time). That said, a well-managed AEC with a typical Medicare mix of 25% to 30% should have experienced an actual increase in the average collections per procedure during all 4 of these CMS rate-reduction years. A disciplined approach to commercial payer renegotiations results in commercial rate increases that more than offset the CMS cuts because commercial payers represent 70% to 75% of the typical payer mix in most AECs.

The power of compounding is clearly evident in contract renegotiations. Table 2 shows a comparison of 2 different annual reimbursement increases across the same commercial payer with 2500 annual procedures. The average incremental 1.5% increase in reimbursement rates provides nearly $200,000 in increased revenue over 5 years.

There are many keys to successful payer-contracting efforts—and the primary theme is having "data" at hand. Ensuring information is available to document why your AEC deserves higher reimbursement will greatly assist in negotiation efforts. Understanding your costs per case and annual patients serviced within each provider plan as well as being able to firmly demonstrate clinical quality metrics will provide some of the necessary elements to justify higher reimbursement. In addition, having a general understanding of area reimbursement at other AECs is helpful—however, be extremely careful to remain compliant within all regulatory standards, especially antitrust issues, when addressing this delicate subject. These same data, especially on the cost-per-case expense side of the equation, will greatly assist the AEC in future Accountable Care Organization (ACO) negotiations whereby cost-effectiveness will be a key element.

Capturing secondary reimbursement

In the typical AEC environment the vast majority of patients are serviced for either upper endoscopy or colonoscopy issues, and occasionally a patient has both upper and lower procedures performed on the same day. CMS and most commercial payers will reimburse the second procedure in this circumstance at a 50% reimbursement level if properly documented. These "flip" patients generally take more time in the procedure room and two scopes are used during the treatment; thus the incremental reimbursement makes logical sense.

However, a commonly overlooked opportunity in the AEC is the proper billing for secondary maneuvers. In this case, for example, a patient has a colonoscopy with a polypectomy in a portion of the colon and subsequently a biopsy in a completely different area of the colon. If properly documented, this secondary maneuver is also eligible for a 50% reimbursement level by CMS and most commercial payers. It is not uncommon for 10% to 12% of all patients to receive secondary maneuvers within a typical AEC setting. Thus, for an AEC servicing 7500 annual patients with an average reimbursement of $475 per procedure, an incremental 750 secondary maneuvers could deliver more than $175,000 in supplemental reimbursement if properly documented and medically necessary.

Staffing levels

All AECs desire to drive down their costs per procedure—the challenge is developing and implementing a strategic plan to address this effort. In reviewing a typical expense budget for an AEC, the greatest efficiencies and potential cost reductions fall clearly in line with the facility's largest cost item—staffing.

It is important to "right size" the staffing for expected patient volumes on a daily basis. Although most AECs carefully ensure sufficient staff are always available to maintain proper patient service metrics, many AECs find it difficult to reduce staffing levels on a low-census day. This requires a flexible staffing culture among the staffing team—which is likely a mixture of full-time, part-time, and

Table 2 Impact of negotiated rate increases

Year	2.5% annual increase ($)	4% annual increase ($)	Difference ($)	$ per 2500 procedures
1	475	475	—	—
2	487	494	7.13	17,813
3	499	514	14.71	36,783
4	512	534	22.79	56,968
5	524	556	31.37	78,429
Average	499	515	15.20	37,999
Incremental revenue over 5 years				189,993