Delta Region Community Health Systems Development (DRCHSD) Program

RCM/PPM Webinar Series

National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

DRCHSD Program Supported by FORHP and DRA

U.S. Department of Health & Human Services

HRSA

Federal Office of Rural Health Policy

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ruralcenter.org

National Rural Health Resource Center

Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/DEI

ruralcenter.org

National Rural Health Resource Center

Pre-Polling Questions

1. I am ___ in my understanding of how to compare my organization's Key Performance Indicators (KPIs), provider productivity benchmarking, and Current Procedural Terminology (CPT) code distribution to industry benchmarks.

2. I am ___ in my understanding of best practices to enhance back-end revenue cycle performance.

3. I am ___ in my understanding of changes and best practices related to Rural Health Clinic (RHC) operations and reimbursement.

DRCHSD Revenue Cycle Management Series

- Session 1- February 2, 2023:

Front and Back-End Revenue Cycle Management Best Practices

- Session 2- February 9, 2023

Middle Revenue Cycle Best Practices and Social Determinants of Health

- Session 3- February 16, 2023

Physician Practice Management Best Practices

Physician Practice Management Best Practices

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Physician Practice Management Best Practices

February 16, 2023

Meet the Presenters

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Learning Objectives

Physician Practice Management:

1. Review Key Performance Indicator's (KPI's), Provider Benchmarking, and E&M Distribution Performance.
2. Revenue cycle areas of opportunity.
   - Provider Productivity, Scheduling, Patient Check-in, Patient Collections, Charge Capture, Coding, Billing, Denials, and Aging Accounts Receivable

Rural Health Clinics

1. Gain an understanding of industry best practices to optimize the operations and reimbursement of Rural Health Clinics

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Physician Practice Management

1. Key Performance Indicators
2. Provider Benchmarking
3. Provider E&M Distributions
4. Revenue Cycle Processes
5. Rural Health Clinics

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Delta Best Practice Key Performance Indicators

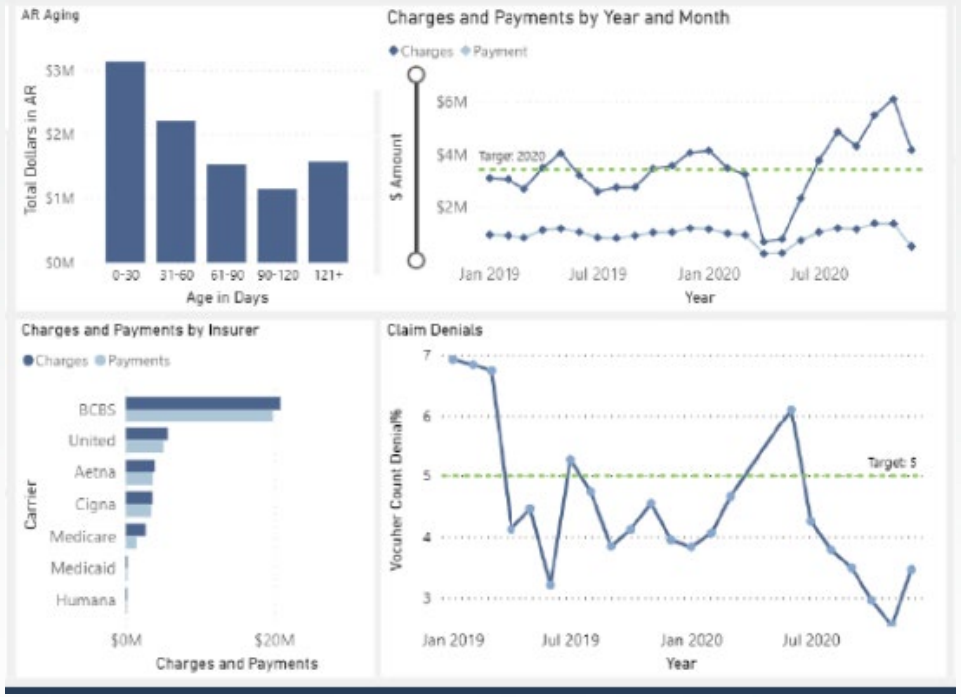
1

Key Performance Indicators

- Denial Rate
- Percentage of AR > 90 Days
- Clinic Charge Lag
- Point of Service Collections as a % of Total Patient Payments
- Collections per Total RVU
- Visits by Provider
- wRVUs by Provider
- Surgeries / Procedures by Provider
- Number of New Patients
- Wellness Visits
- No-show Rates
- Point of Service Collections (Actual vs. Expected
- Registration Accuracy
- Charge Lag
- Open Encounters
- Patient Satisfaction Survey Results
- Patient Portal Utilization

Practice Management Dashboard

- What capabilities does our EHR have?
- Where is data living within our system? Hospital vs. Clinic?
- What metrics are critical for clinic success?
- Who is responsible for what reports/metrics



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Provider Encounter Benchmarking

2

Encounter Benchmark
FORVIS Community Hospital

Total Encounters

#	Provider Name	Specialty [3]	FTE Status [3]	Historical Level [4]	Historical Percentile Ranking [5]	*Market Data* [1] [2] 10th Percentile	25th Percentile	Median	75th Percentile	90th Percentile
1	Bock, Emmaleigh	Pediatrics - General	1.00	3,500	78 P	1,928	1,473	2,491	3,306	4,193
2	Fossier, Bradley	Family Medicine	1.00	3,162	69 P	1,432	1,865	2,623	3,326	4,090
3	Hancock, Laurie	NP - Pediatric/Child Health	1.00	2,800	87 P	1,185	310	1,191	2,227	2,959
4	Tilley, Brandon	Family Medicine	1.00	4,000	88 P	1,432	1,865	2,623	3,326	4,090

Footnotes:
(1) Based on MGMA Physician Compensation and Production Survey, 2021 Report Based on 2020 Data. Data is an equally weighted blend of National and Southern Region Data.
(2) Market data is adjusted by Provider's FTE status to adjust for part time production.
(3) Based on representation from Hospital. FTE status assumes a 1.0 FTE works approximately 2,080 hours annually (40 hours per week 52 weeks per year).
(4) Historical data utilizes (DATE RANGE) provider data. Data provided by Hospital.
(5) FORVIS approximated the historical percentile ranking based on calculations utilizing market data and actual historical data.

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Provider Productivity Benchmarking

2

Work RVU Benchmark
FORVIS Community Hospital

WORK RVUs

#	Provider Name	Specialty [3]	FTE Status [3]	Historical Level [4]	Historical Percentile Ranking [5]	Market Data [1] [2] 10th Percentile	25th Percentile	Median	75th Percentile	90th Percentile
1	Morrison, Clay	Pediatrics - General	1.00	5,220	51 P	2,731	3,990	5,161	6,413	7,867
2	Smith, Steve	Family Medicine	0.86	3,429	20 P	2,716	3,757	4,769	5,933	7,172
4	Clouse, Valorie	NP - Pediatric/Child Health	0.86	5,350	104% of 90th	759	1,538	2,724	3,570	5,152
8	Cleveland, Carson	Family Medicine	0.86	7,825	109% of 90th	2,716	3,757	4,769	5,933	7,172

Footnotes:

(1) Based on an equally weighted blend of the following surveys: (i) MGMA Physician Compensation and Production Survey, 2022 Report Based on 2021 Data. Data is an equally weighted blend of National and Regional Data.

(2) Market data is adjusted by Provider's FTE status to adjust for part time production.

(3) Based on representation from Hospital. FTE status assumes a 1.0 FTE works approximately 2,080 hours annually (40 hours per week 52 weeks per year).

(4) Historical data utilizes (DATE RANGE) CPT data and CMS CY 2022 Physician Fee Schedule to calculate annual wRVUs. CPT data provided by client.

(5) FORVIS approximated the historical percentile ranking based on calculations utilizing market data and actual historical data.

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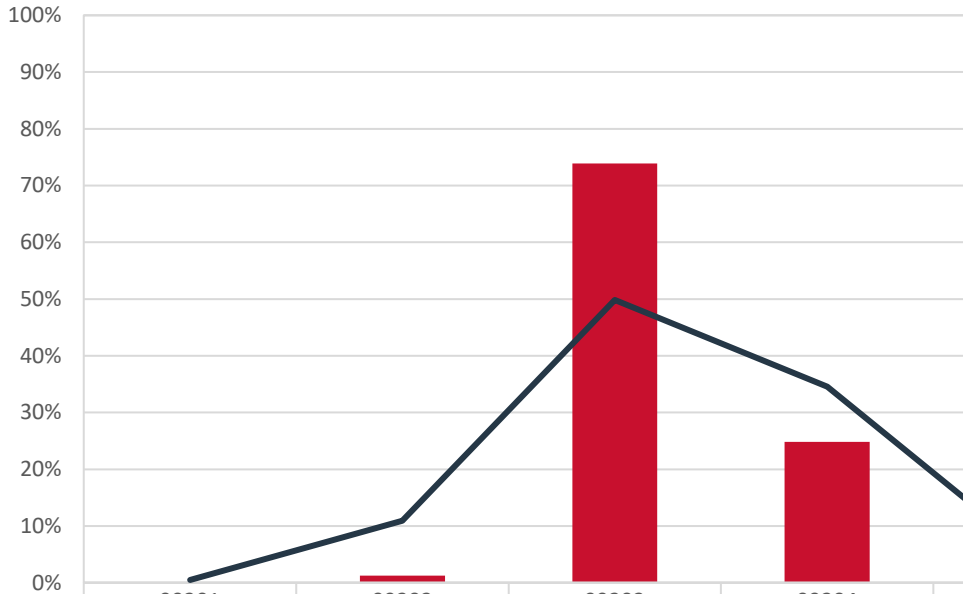
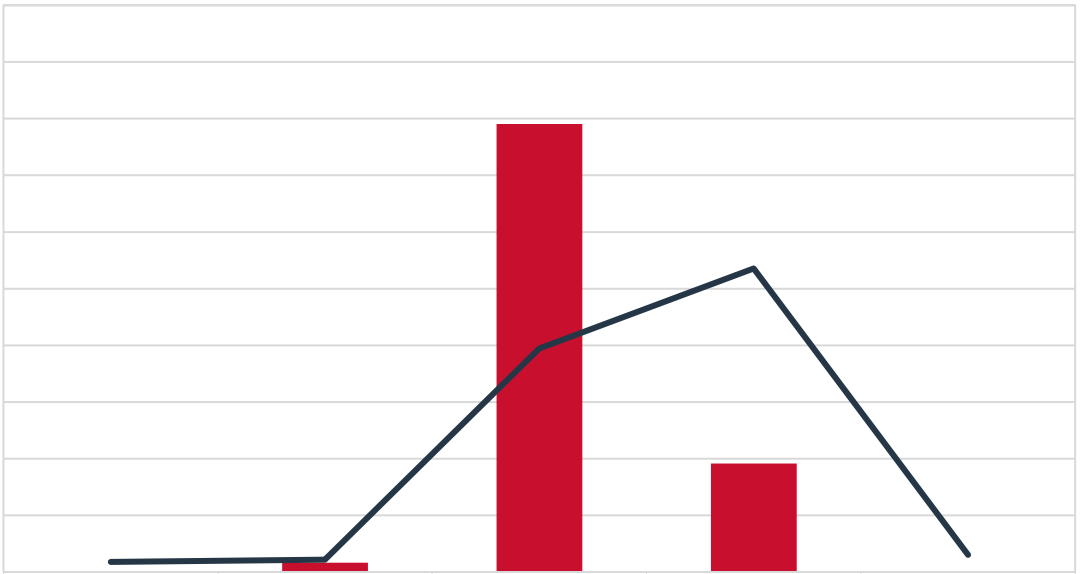
Family Medicine (MD) E/M Distribution Levels

NEW PATIENT ENCOUNTERS [2] [3]



	99201	99202	99203	99204
%	0%	1%	74%	25%
CMS	0%	11%	50%	35%
Units	-	2	119	40

ESTABLISHED PATIENT ENCOUNTERS [2] [3]



	99211	99212	99213	99214	99215
%	0%	2%	79%	19%	0%
CMS	2%	2%	39%	54%	3%
Units	-	33	1,603	388	3

Footnotes:

1.) Medicare specialty identified for Provider.

2.) Based on CPT data provided by client. Calculations utilize CPT data for September 1, 2021 to August 31, 2022 and publicly available Medicare E&M Utilization data.

3.) The illustrations compares Provider's distribution of encounters to CMS's distribution of similar codes. The first illustrations represent the distribution for New Patient encounters while the second illustration represents Established Patient encounters.

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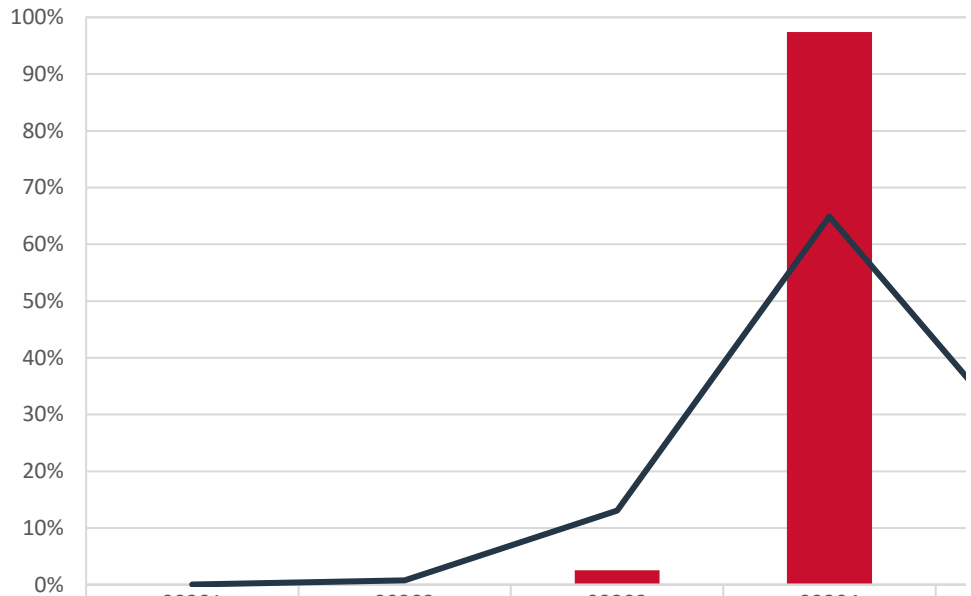
Endocrinology (MD) E/M Distribution Levels

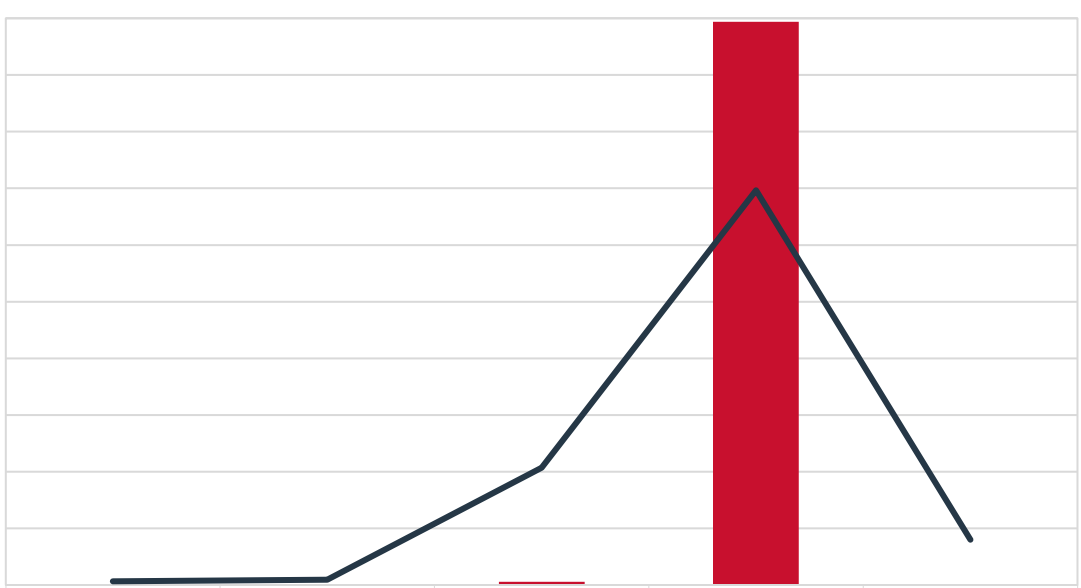
3

NEW PATIENT ENCOUNTERS [2] [3]



	99201	99202	99203	99204
%	0%	0%	3%	97%
CMS	0%	1%	13%	65%
Units	-	-	3	113

ESTABLISHED PATIENT ENCOUNTERS [2] [3]



	99211	99212	99213	99214	99215
%	0%	0%	1%	99%	0%
CMS	1%	1%	21%	70%	8%
Units	-	-	1	169	-

Footnotes:

1.) Medicare specialty identified for Provider.

2.) Based on CPT data provided by client. Calculations utilize CPT data for September 1, 2021 to August 31, 2022 and publicly available Medicare E&M Utilization data.

3.) The illustrations compares Provider's distribution of encounters to CMS's distribution of similar codes. The first illustrations represent the distribution for New Patient encounters while the second illustration represents Established Patient encounters.

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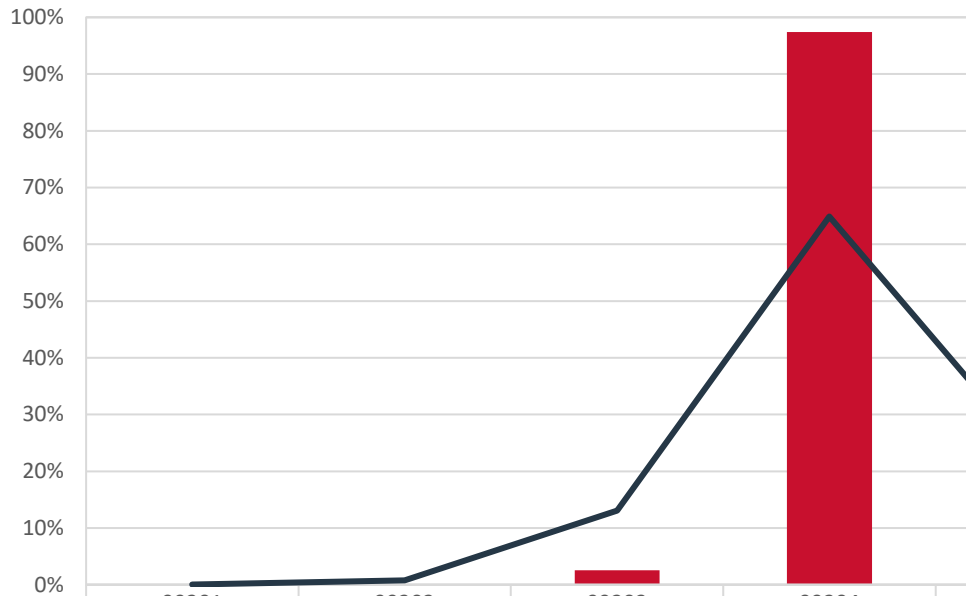
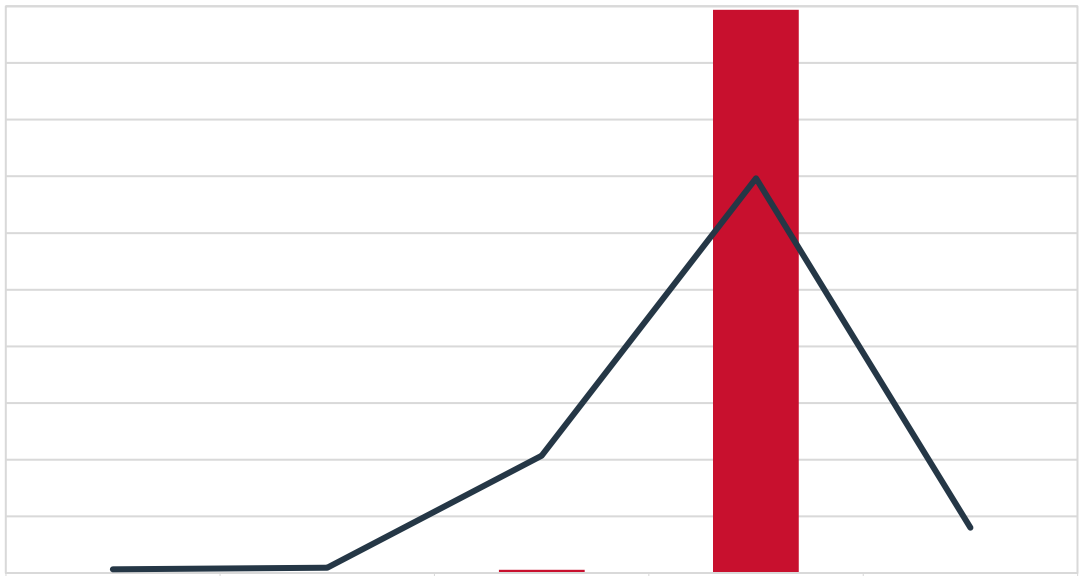
Pediatric (MD) E/M Distribution Levels

NEW PATIENT ENCOUNTERS [2] [3]



	99201	99202	99203	99204
%	0%	0%	3%	97%
CMS	0%	1%	13%	65%
Units	-	-	3	113

ESTABLISHED PATIENT ENCOUNTERS [2] [3]



	99211	99212	99213	99214	99215
%	0%	0%	1%	99%	0%
CMS	1%	1%	21%	70%	8%
Units	-	-	1	169	-

Footnotes:

1.) Medicare specialty identified for Provider.

2.) Based on CPT data provided by client. Calculations utilize CPT data for September 1, 2021 to August 31, 2022 and publicly available Medicare E&M Utilization data.

3.) The illustrations compares Provider's distribution of encounters to CMS's distribution of similar codes. The first illustrations represent the distribution for New Patient encounters while the second illustration represents Established Patient encounters.

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Revenue Cycle Processes

Overview

The entire process of front desk, billing, and collection functions in a clinic should be streamlined for the revenue cycle process to be effective as possible. Functions should be performed by all involved physicians, non-physician providers, managers, and staff. High performing clinic revenue cycle processes reduce variation in functions and improve efficiency in revenue generation.

Areas to Review

Provider Productivity

- What capabilities does our EHR have?
- Are we utilizing additional software/programs to support providers?
- Do our providers have contract incentives for volumes/production?
- It is important to maintain updated E&M Distributions by provider to understand coding trends and performance compared to like providers/specialists across your organizations and practice regions. Other things to consider for providers falling below expected volume/production levels:
  - Provider scheduling and appointment slot utilization
  - New patient screening process
  - Rescheduling
  - Protocols for chronic care patients
  - Utilization of provider extenders
  - Clinic staffing and support
  - Accurate documentation and coding of patient encounters

Revenue Cycle Processes 2

Areas to Review

Scheduling:

- Appointment Types / Timing
  - It is important to have a good understanding of common appointment types and approximate lengths of each (by provider). Using this information will allow for a schedule to be customized, efficient, and meet the needs of the clinic.
- Clinical Workflow
  - What is best for the patient?
  - What can we do to meet the needs of both patients and staff?
  - How do we make exceptions / changes when needed?
- Provider Preference
  - How long does is take the provider to see each patient type?
  - Does the provider prefer to stack specific types of patients?
  - What coding and documentation factors need to be considered?
- Scheduling Process
  - Are we scheduling appointments in advance?
  - What information are we collection during our scheduling call?
  - What options do patients have to schedule/request appointments?

FORVIS Community Hospital Clinic

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00:00 AM	Existing PT	Existing PT	Existing PT	Existing PT	Procedure
8:20:00 AM	Existing PT	Existing PT	Existing PT	Existing PT	
8:40:00 AM	Existing PT	Existing PT	Existing PT	Existing PT	Existing PT
9:00:00 AM	Existing PT	Existing PT	Existing PT	Existing PT	Procedure
9:20:00 AM	Existing PT	Existing PT	Existing PT	Existing PT	
9:40:00 AM	Walk-in / Existing Pt	Existing PT	Walk-in / Existing Pt	Existing PT	Existing PT
10:00:00 AM	Walk-in / Existing Pt	Existing PT	Walk-in / Existing Pt	Existing PT	Procedure
10:20:00 AM	New PT	Existing PT	New PT	Existing PT	
10:40:00 AM		Existing PT		Existing PT	Existing PT
11:00:00 AM	New PT	Existing PT	New PT	Existing PT	Procedure
11:20:00 AM		New PT		New PT	
11:40:00 AM	Existing PT		Existing PT		Existing PT
12:00:00 PM					
12:20:00 PM					
12:40:00 PM					
1:00:00 PM	Existing PT	Walk-in / Existing Pt	Existing PT	Walk-in / Existing Pt	Procedure
1:20:00 PM	Existing PT	Walk-in / Existing Pt	Existing PT	Walk-in / Existing Pt	
1:40:00 PM	Existing PT	New PT	Existing PT	New PT	Walk-in / Existing Pt
2:00:00 PM	Existing PT		Existing PT		Walk-in / Existing Pt
2:20:00 PM	New PT	Existing PT	New PT	Existing PT	Walk-in / Existing Pt
2:40:00 PM		Existing PT		Existing PT	Walk-in / Existing Pt
3:00:00 PM	Walk-in / Existing Pt	Existing PT	Walk-in / Existing Pt	Existing PT	Walk-in / Existing Pt
3:20:00 PM	Walk-in / Existing Pt	Existing PT	Walk-in / Existing Pt	Existing PT	Walk-in / Existing Pt
3:40:00 PM	Procedure	Existing PT	Procedure	Existing PT	Walk-in / Existing Pt
4:00:00 PM		Existing PT		Existing PT	Walk-in / Existing Pt
4:20:00 PM	Procedure	Walk-in / Existing Pt	Procedure	Walk-in / Existing Pt	Walk-in / Existing Pt
4:40:00 PM		Walk-in / Existing Pt		Walk-in / Existing Pt	Walk-in / Existing Pt
5:00:00 PM	Walk-in / Existing Pt	Walk-in / Existing Pt	Walk-in / Existing Pt	Walk-in / Existing Pt	Walk-in / Existing Pt

Revenue Cycle Processes 3

Areas to Review

Patient Check-in

- What information has been collected prior to patient arrival?
- Has insurance been verified?
- How much extra time is our staff spending on other items:
  - Value Added, Non-Value Added (essential), Non-Value Added (non-essential)
- It is important to have uniform and efficient check-in processes across clinic and hospital locations. The goal is to provide patients with a uniform and seamless process regardless of where they are receiving care within our system.
- Registration activity benchmarking

Patient Collections (Point of Service and Outstanding Balances)

- Are we tracking different types of collections and when they were received? Are we categorizing each appropriately?
- What is our process for Point of Service (POS) collections?
- Do we have standard scripting/prompts for staff to use?
- It is critical to understand your EHR/Revenue Software capabilities to tailor your process to meet your organizations needs. Staff should be trained accordingly to ensure they have access to all needed systems and information.

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Revenue Cycle Processes 4

Areas to Review

Charge Capture/Coding

- Do we have a good understanding of coding and documentation trends, limitations, and needs for each provider?

- Provider Responsibility vs. Nurse Responsibility vs. Other Staff/Vendor Responsibility
  - Code Selection (CPT and ICD)
  - Documentation
  - Template Utilization
  - Encounter Review
  - Encounter Update/Correction Process

- It is important to conduct provider coding and documentation audits to understand coding trends, provider concerns, and any gaps in knowledge that may exists. This can be done internally (if resources are available) or externally, and at a frequency that works best for your organization.

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Revenue Cycle Processes 5

Areas to Review

Billing

- In-house vs. Third Party
- Where are we billing from within the clinic? Does that differ from the Hospital?
- What is the process for finalizing an encounter prior to billing?
  - Coding and Documentation Review
  - Notification for Corrections
  - Updating Encounters
  - Final Review for Billing

Denials

- Who is actively managing denials and where is this information located?
- Like coding and documentation audits, denial tracking can help understand provider gaps and needs. The ability to track, trend, and provide detailed denial information to providers can help tailor training or resource allocation accordingly.

Accounts Receivable (AR)

- Do we have detailed AR information for our clinic? Are we able to see the information by aging group (0-30, 31-60, 61-90, 91+ days)
- Collectible vs. Bad Debt

Optimizing RHC Reimbursement and Operations

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All Inclusive Rate Strategy
New RHCs (Provider-Based or Freestanding)

Beginning	Ending	Rate
1/1/2021	12/31/2021	$100
1/1/2022	12/31/2022	$113
1/1/2023	12/31/2023	$126
1/1/2024	12/31/2024	$139
1/1/2025	12/31/2025	$152
1/1/2026	12/31/2026	$165
1/1/2027	12/31/2027	$178
1/1/2028	12/31/2028	$190
1/1/2029	12/31/2029	$190 + MEI

Areas to Review

Key Decision Points

- Medicare/Medicaid payor mix
- Current reimbursement for Medicare/Medicaid patients
  - If majority of services are Level 4 or Level 5 the transition may not be beneficial today
- Current services rendered in clinic location
  - 51% primary care threshold
- Location eligibility

All Inclusive Rate Strategy
RHCs with Grandfathered Rates

	2020	2021	2022	2023	2024	2025	2026	2027	2028
Grandfathered RHC Upper Limit	$250.00	$254.50	$259.08	$263.74	$268.48	$273.31	$278.22	$283.22	$288.31
Clinic specific cost per visit	$250.00	$260.00	$230.00	$265.00	$290.00	$270.00	$265.00	$285.00	$291.00

Green = A Year where clinic receives full cost per visit; Red = A year where the clinic is subject to their clinic-specific upper limit

Source: NARHC Washington Update Presentation (December 2020)

All Inclusive Rate Strategy
RHCs with Grandfathered Rates, continued

Areas to Review

Because the AIR is no longer uncapped, organization must closely monitor their cost per visit compared to the statutory limits.

- MEI is estimated to be between 2% and 3% per year
  - Too much added cost results in unreimbursed expenses
  - Too little cost added results in not maximizing AIR reimbursement

The RHC rate should follow the RHC provider number.

- Changes in address require a new 855A to be filed
  - Grandfathered rate may be lost if not processed correctly
  - RHC status may be lost if new location does not meet RHC location requirements

RHC Reimbursement Maximization Strategies

Areas to Review

No show reduction

- Improved patient access functions to reduce no shows experienced by clinic

Medicaid conversion

- Beneficial if RHC encounters a high percentage of uninsured patients
  - Can these patients be enrolled in Medicaid?
  - Financial and patient care benefits

Annual Wellness Visit (AWV) maximization

- Reimbursed at 100%
- Are patients aware of the offering?
- Need to “stick to the script”

Washington Updates
2023 Omnibus Package

Areas to Review

Two additional provider types approved as RHC providers effective January 1, 2024.

- Marriage and Family Therapists (MFTs)
- Mental Health Counselors

Intensive Outpatient (IOP) services treatment category created effective January 1, 2024.

- Patients who require more complex mental health care than able to be accomplished during a typical office visit but not sever enough for inpatient services
- Additional details expected in Medicare Physician Fee Schedule proposed rule

Medicare telehealth flexibilities extended through December 31, 2024.

- Previously set to expire on the 152nd day after the end of the PHE

Washington Updates
RHC Burden Reduction Act

Areas to Review

Introduced to Senate on February 1st by Senators John Barrasso (WY), Tina Smith (MN), Marsha Blackburn (TN), and Michael Bennet (CO).

Includes 5 provisions to modernize the RHC program:

- Modernizes physician supervision requirements by aligning to state scope of NP/PA practice
- Removes requirement to directly provide certain lab services on-site and change to provide “prompt access”
- Allows RHCs to either employ or contract with NPs and Pas
- Addresses location eligibility issues that arose following the last census performed by the Census Bureau
- Increases the amount of behavioral health services that can be provided in the RHC when located in a mental health HPSA

Post-Polling Questions

1. I am ____ in my understanding of how to compare my organization's Key Performance Indicators (KPIs), provider productivity benchmarking, and Current Procedural Terminology (CPT) code distribution to industry benchmarks.

2. I am ____ in my understanding of best practices to enhance back-end revenue cycle performance.

3. I am ____ in my understanding of changes and best practices related to Rural Health Clinic (RHC) operations and reimbursement.

4. I am ____ that I will apply the knowledge gained from this educational training to measure my organization's internal performance related to Revenue Cycle Management and Physician Practice Management (RCM/PPM).

Questions?

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Thank you!

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Assurance / Tax / Advisory