NATIONAL RURAL HEALTH RESOURCE CENTER

Delta Region Community Health Systems Development (DRCHSD)

2022 Financial Webinar Series

National Rural Health Resource Center

Stroudwater Associates (Center

Delta Region Community Health Systems Development (DRCHSD) Program

Delta Regional Authority

U.S. Department of Health & Human Services

HRSA

Federal Office of Rural Health Policy

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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

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

NATIONAL RURAL HEALTH RESOURCE CENTER

Pre-Polling Questions

I am ____ in my understanding of the shared attributes of high performing clinics.

I am ____ in my understanding of how to identify potential performance improvement opportunities.

I am ____ in my understanding of tools and performance metrics that can be used to better manage physician practices.

Todays Speaker

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RHC Strategic, Financial & Operational Best Practices

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Agenda

- Context
- Characteristics of “Better Performers”
- Best Practices
- Key Takeaways

Context

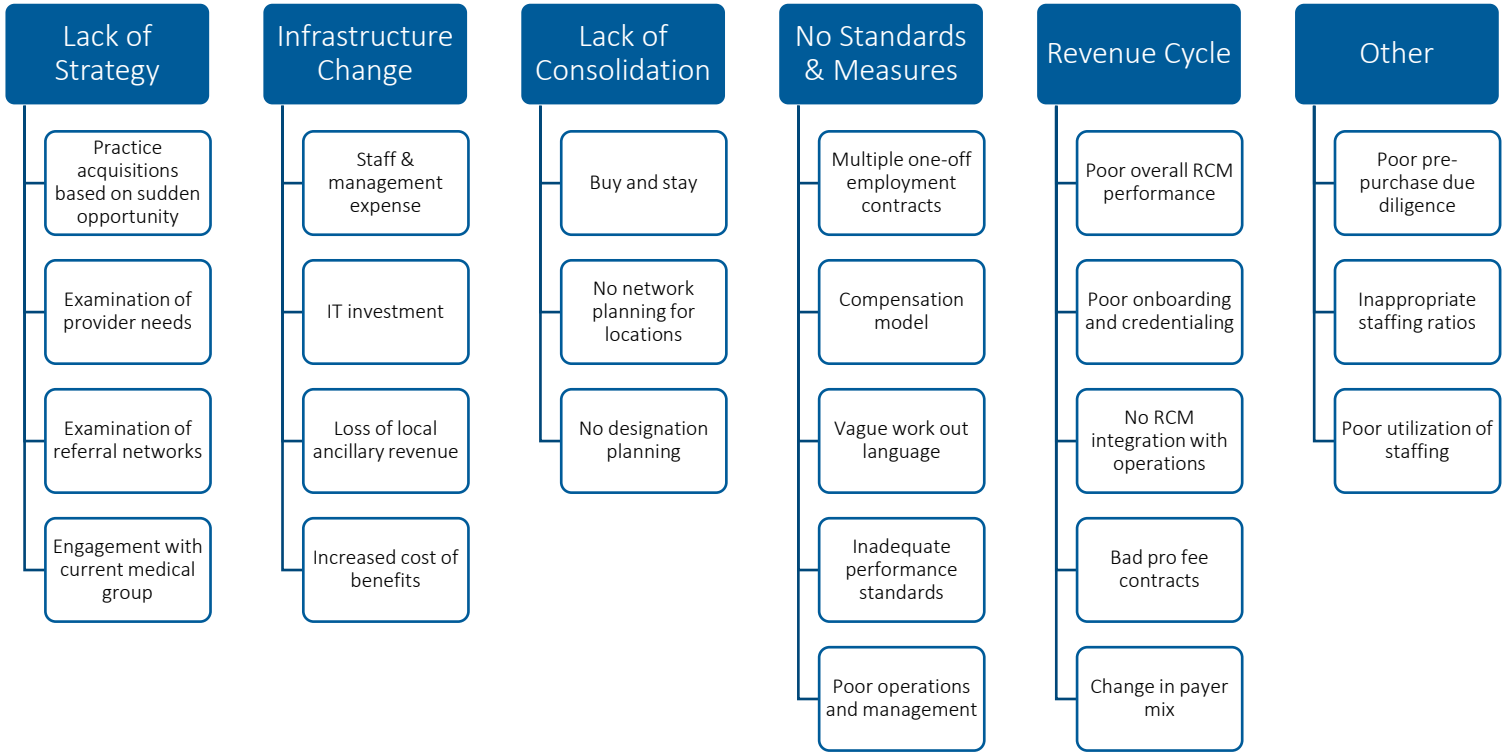
New RHC Reimbursement Methodology

- On December 27, 2020, the President signed into law, the "Consolidated Appropriations Act, 2021 (CAA)", and subsequently the HR 1868 on April 14, 2021, which changed the reimbursement methodology for RHCs starting on April 1, 2021
  - Starting on April 1, 2021, all new RHCs established after December 31, 2019, regardless of whether they are independent, owned and operated by a hospital with fewer than 50 beds, or owned and operated by a hospital with greater than 50 beds, shall be reimbursed based on reasonable cost with an upper payment limit ("UPL") set at the following rates:
    - a) In 2021, after March 31, at $100 per visit;
    - b) In 2022, at $113 per visit;
    - c) In 2023, at $126 per visit;
    - d) In 2024, at $139 per visit;
    - e) In 2025, at $152 per visit;
    - f) In 2026, at $165 per visit;
    - g) In 2027, at $178 per visit;
    - h) In 2028, at $190 per visit;
  - In subsequent years, the rate will increase based on the Medicare Economic Index ("MEI") for primary care services
- RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2020, will use their 2020 rate to establish a clinic-specific grandfathered UPL that will then be increased each year based on the MEI
- Since the final legislation varied greatly from the RHC Modernization Act and due to the impact on PB-RHCs, efforts are underway to change certain provisions
  - The removal of the un-capped cost-based reimbursement rate for RHCs owned and operated by hospitals with fewer than 50 beds will jeopardize the financial solvency of many hospitals

https://www.cms.gov/files/document/mm12185.pdf

Hospital-Owned Practices

- Hospitals and health systems are increasingly concerned with practice losses and large subsidies paid to cover losses
- Many hospitals and health systems "host" practices rather than manage them. Generally, common performance drivers and pitfalls include:



Increasingly, the dynamic of "hosting" is changing

The best performing hospitals work with provider practices collaboratively to improve performance

Stark Law & Commercial Reasonableness

- "The particular arrangement furnishes a legitimate business purpose of the parties to the arrangement and is sensible, considering characteristics of the parties, including their size, type, scope, and specialty. **An arrangement may be commercially reasonable even if it does not result in profit for one or more parties.**" (Title 42, Chapter IV, Subchapter B, Part 411, Subpart J, §411.351)
  - However, "in some circumstances, an entity's compensation of a physician at an ongoing loss may present program integrity concerns"[1]
- Does the arrangement make sense even if there were no referrals between the parties? Factors to consider:

Community Need

Community Benefit

Desire to Lower Overall Cost of Care

Desire to Improve Quality and Population Health

Market Conditions Not Conducive to Independent Provider Practice

1. https://www.federalregister.gov/documents/2020/12/02/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations

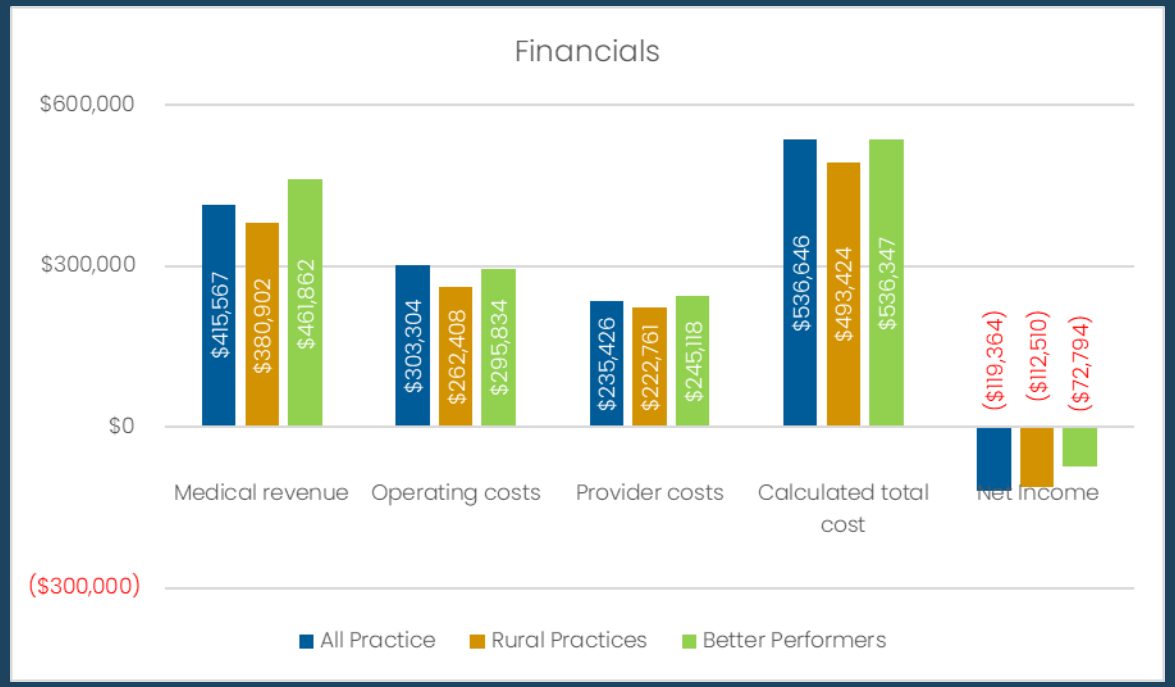
Characteristics of “Better Performers”

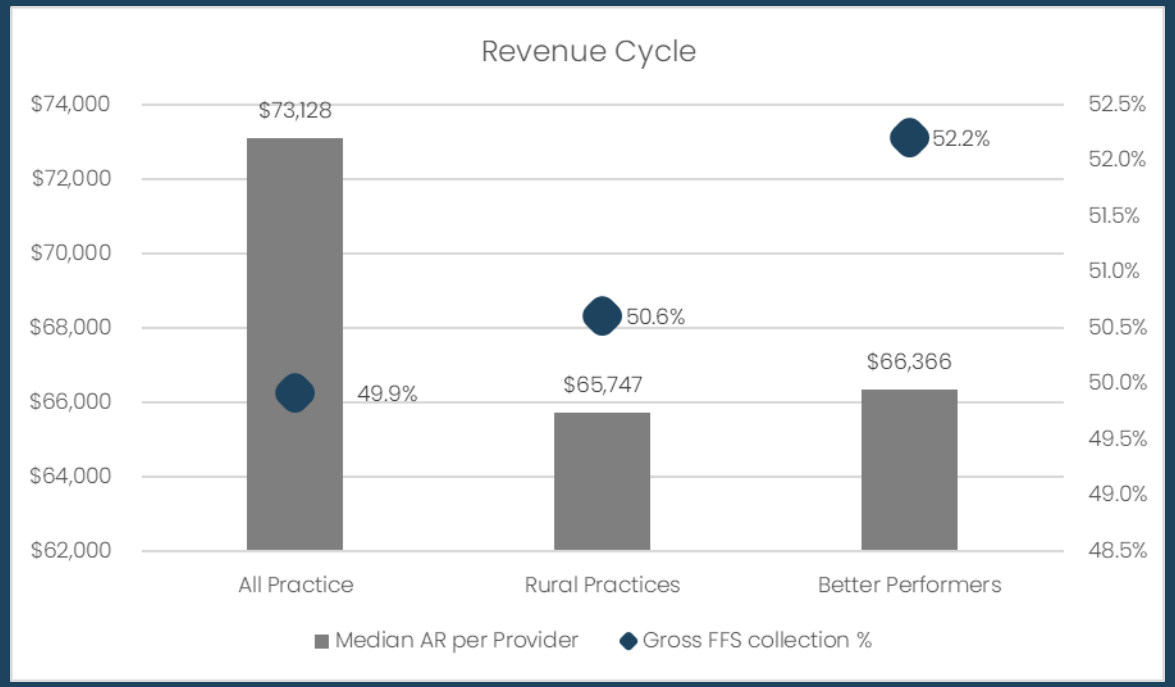
Key Attributes

Organization and Strategy	•Leadership team sets clear strategic direction and embodies core values and reinforces culture •Employ formal strategic planning process that is stakeholder-focused and grounded in performance improvement •Culture is one of commitment, open communication, trust, and high levels of accountability and job satisfaction
Operations	•Employ data-driven decision making and emphasize performance improvement at the clinic level •Focus on revenue cycle management, with better and faster collections and lower total Accounts Receivables ("AR") •More clinical support staff, improving provider efficiency
Productivity	•Higher provider and staff output •Provider compensation tied to productivity and, as a result, increased compensation relative to peers •Staff is incentivized for practice performance
Value	•Community and patients are the most critical stakeholders •Quality of care, patient satisfaction and reputation is emphasized and reported
Profitability	•Superior overall financial performance •Lower operating costs per unit of output and greater revenue after operating costs

How does Rural compare to All Practice and Better Performers?

- MGMA 2020 Cost and Revenue Report (2019 Data)
- Primary Care (Single Specialty) Per Provider Metrics
- All Practice: All national practices submitting data to MGMA
- Rural: Nonmetropolitan Area - Population of 49,999 or Fewer
- Better Performers: A practice can be a Better Performer by achieving success in four main areas. They must fit into the top percentiles nationally in one or all of the four evaluation areas that serve as the levers of best outcomes: Operations, Profitability, Productivity, Value





How does Rural compare to All Practice and Best Performers? (continued)

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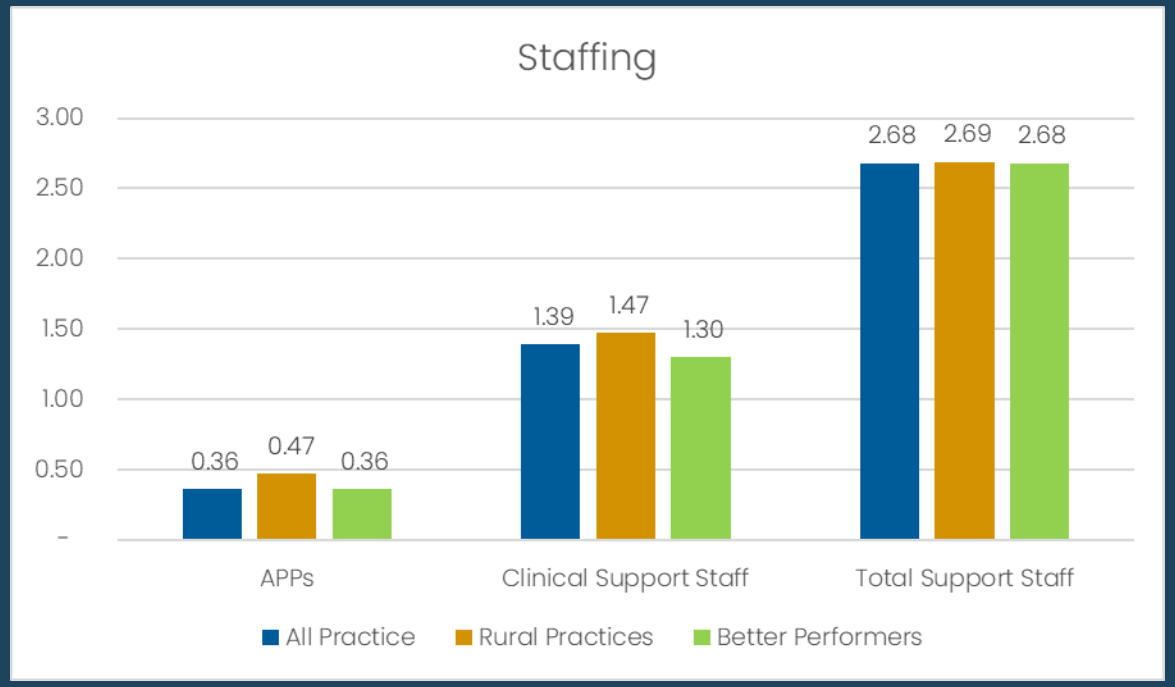
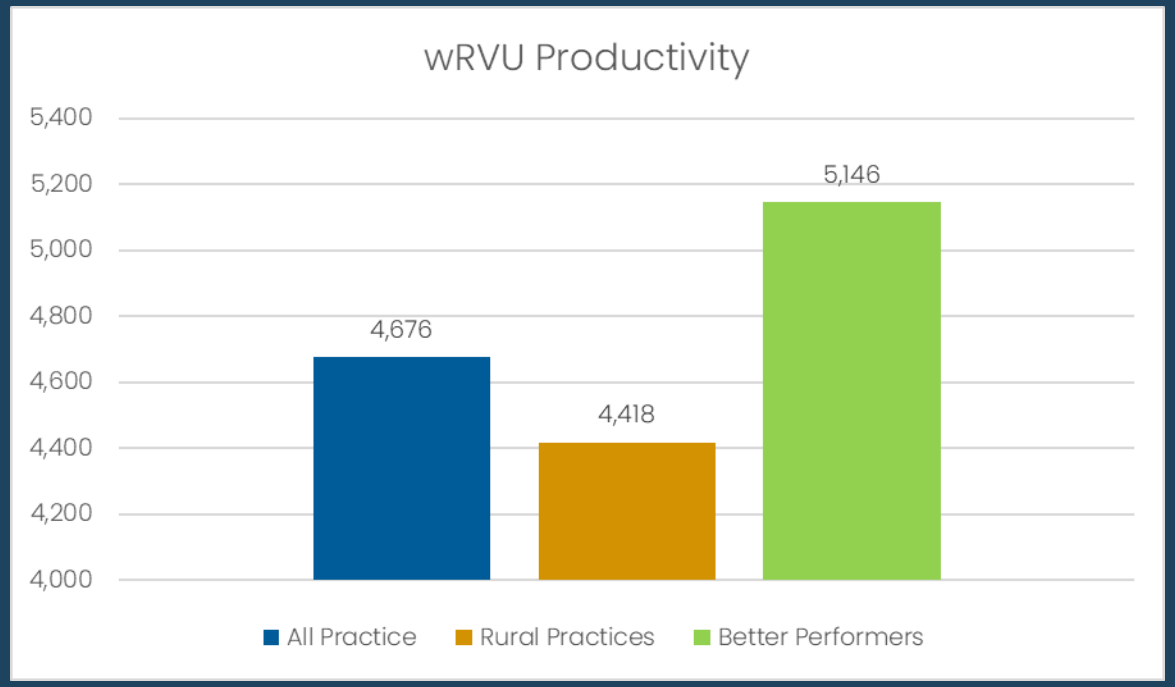
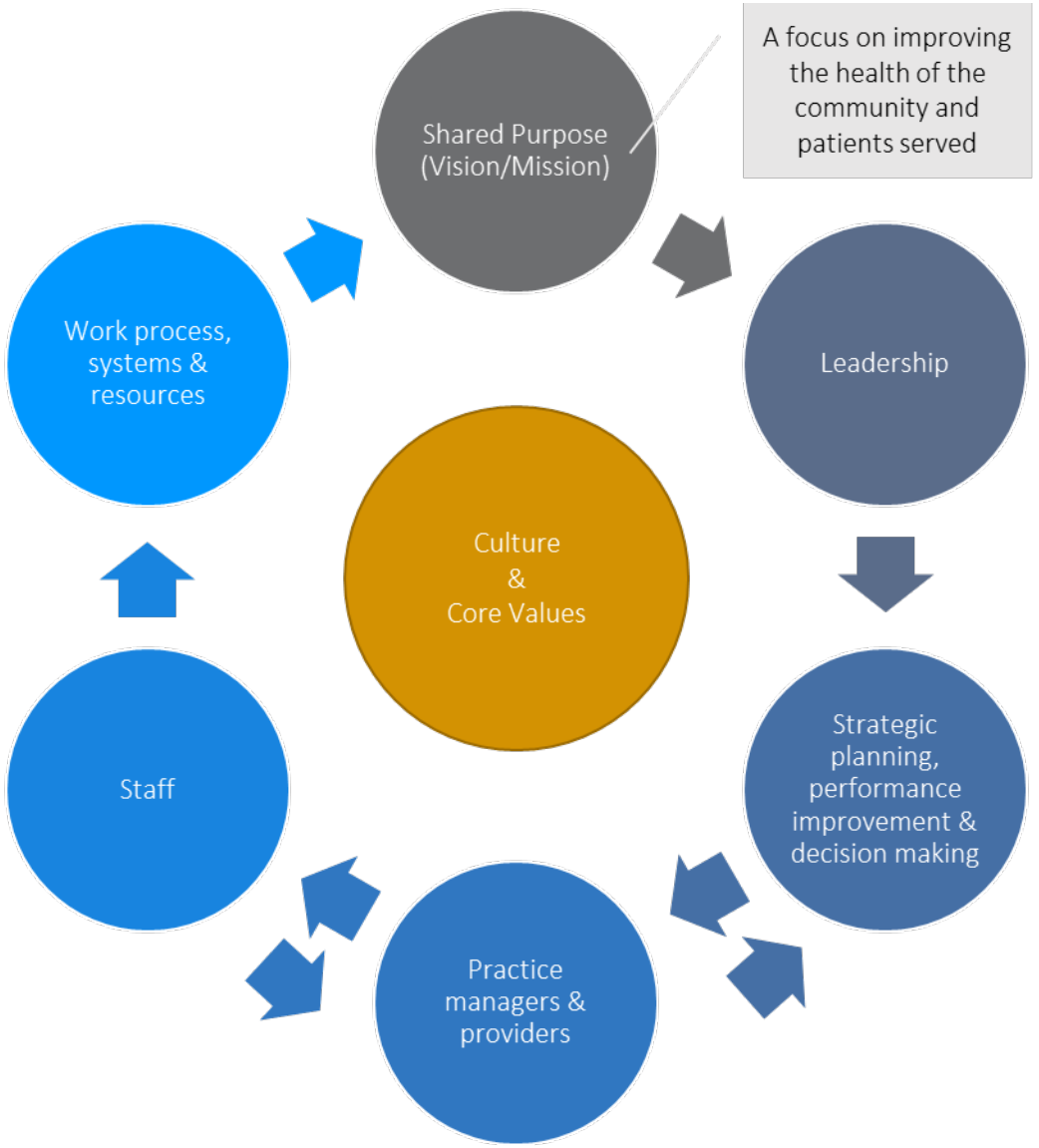




Best Practices

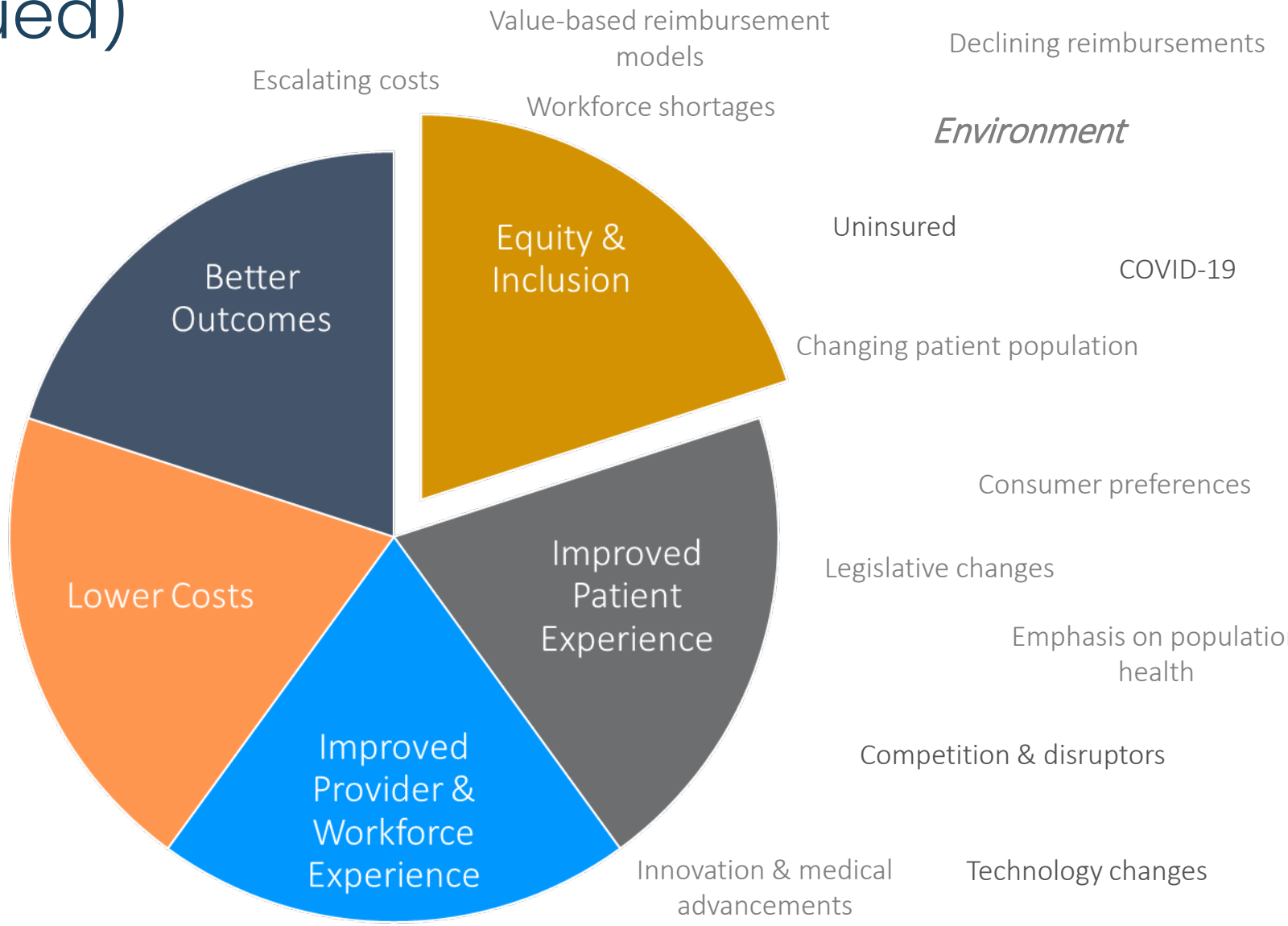
Organization and Strategy: Leadership & Strategic Direction

- Administration and physician leadership's most important role is to provide a clear and compelling strategic direction for an organization, and reinforce the core values and culture of the organization
  - A compelling strategic direction creates value for the organization's critical stakeholders (e.g., communities, patients), establishes a vision which describes the optimal future state and establishes a mission which defines what an organization does, whom it serves and how it creates value
  - Better performers exercise a formal Strategic Planning effort that involves stakeholders across the organization to develop a plan to bring about an organization's vision and mission
    - A well defined and executed Strategic Plan results in favorable financial performance
- Practice managers and practicing providers must share in the organization's vision, mission and values, reinforce the organization's culture, and are critical to shaping and achieving the organization's strategic plan
  - Bi-directional communication and collaboration amongst leadership, practice managers, providers and staff is essential
- Organizational cohesion and alignment is imperative to success recognizing that most strategies fail due to a breakdown in execution



Organization and Strategy: Leadership & Strategic Direction (continued)

- Organization strategy is increasingly focused around the "Quintuple Aim", with Equity & Inclusion the most recent addition to the "Quadruple Aim" as a result of COVID-19's spotlight on care inequities in the current health care system
  - The external and internal environment makes it increasingly difficult to achieve such goals
- Practices cannot achieve these aims without a focus on performance improvement, unless they are already there, but few are
  - Those that arrive early deliver superior value to their stakeholders and enjoy a competitive advantage



Organization and Strategy: Provider Complement Strategy

Assess current hospital-provider alignment

- Current service area providers (external and internal)
- Level of engagement and alignment
- Types of alignment strategies:
  - Buy: purchase physician-owned practices
  - Build: organically build practices through employment
  - Partner: Professional Services Agreements, affiliations, etc.

Identify and quantify community need for services

- Compare market share to overall supply and demand
- Quantify all providers within the service area, especially primary care, to more accurately predict supply and demand
- Compare internal demand and competencies of providers to market demand
- Evaluate referral patterns

Evaluate potential designation and/or partnership options

- When market demand does not support employment of needed specialty care, seek arrangements to partner
- Evaluate primary care options to determine the feasibility and projected impact associated with converting the clinic to an alternative designation (provider-based clinic, provider-based Rural Health Clinic, etc.)
- Enhance alignment with the area primary care providers that strengthens clinic decisions rights, improves functional alignment and creates partnership opportunities

Organization and Strategy: Practice Managers

- With a continued push towards performance improvement and more challenging and evolving external environments, effective practice managers are of increasing importance
  - There is increased competition for quality practice managers
  - Role expectations, responsibilities and practice lead capabilities should reflect that of a manager vs. supervisor
- If current practice management is and/or operates like a supervisor, the importance of physician and administrative leadership is tenfold

Roles & Responsibilities	
Manager • Responsible for the overall success of the practice and is actively engaged in financial management • Engage with leadership and physicians, and are trusted to make decisions • Execute on strategic plans, reinforce culture and regularly communicate with stakeholders • Address issues as they arise • Think strategically about improvements • Actively review gaps relative to best practice	**Supervisor** • Monitor scheduling and budgets • Respond to staffing issues such as absences • Produce reports

Operations: Performance Improvement & Data-Driven Decision Making

- An emphasis on performance improvement requires understanding the current state, establishing the baseline, and determining a desired future state informed by incremental performance gains to achieve organizational goals and benchmarks
  - "Reporting" is distinct from meaningful data measurement that informs decision making
- Leadership, providers and practice managers must collaborate as a team to understand what is happening with:
  - Organizational strategies/goals
  - Overall practice performance
  - Provider engagement, contracts & compensation
  - Staff engagement & staffing
  - Patient care
  - Scheduling
  - Patient throughput
  - Payer contracts
  - Revenue cycle process
- Management must establish finance & operations dashboards that monitor:
  - Budget to actuals
  - Gross collection rate
  - Net collection rate
  - Overhead ratio
  - Individual category expense ratio
  - Days in accounts receivable
  - Visits and wRVUs per provider
  - Scheduling metrics – no shows, cancellations, etc.
  - AR per FTE physician/provider
  - Staff ratio
  - Average cost and revenue per patient/wRVU/visit
  - Aging of accounts receivable by payer
  - Payer mix ratio
  - CPT code distributions
  - Charting information – deficiencies and denials rates
- Track performance internally between actual to budget, internal best quartile and relevant benchmarks

Operations: Provider Engagement

- First and foremost, provider engagement is about relationships and bi-directional communication

- Providers must be engaged/engage around their productivity, contracts/compensation and the financials of the practice
  - Provider contracts and compensation (previously reviewed on June 3rd) can serve as an enhancement to provider-clinic alignment, or be a disservice

- Performance dashboards should be reviewed with providers monthly (in top performing practices real-time or weekly dashboards are available through a provider portal)
  - Productivity reports should include:
    - wRVUs, visits, charges, collections – broken out into categories (ancillary, office visits, surgeries, etc.)
    - Comparison to survey data (MGMA percentile)
    - Comparison to other physicians in the hospital/practice
  - Financials
    - Revenue – YTD, budget, trendlines
    - AR issues
    - Payer mix
    - Expenses – staffing issues

- Regular and timely feedback on billing or coding issues must be provided

Operations: Overall Clinic Operations

Clinic operations are critical to unlocking productivity potential and improving the patient experience

Standardization around *best practices* across hospital and clinics improves alignment and efficiency

- Certain policies and practices will apply across the whole organization (e.g., point of service collections)
- However, standardization does not mean "one size fits all"
- Other policies and practices will apply within a specialty (e.g., standardization of appointment blocks by primary vs. specialty care)

Critical areas of operational impact include:

- Scheduling
- Staffing
- Finance and Revenue Cycle
- Privacy
- Technology

Today's focus

Operations: Scheduling

Service Philosophy

- 1 in 5 patients say they have switched doctors due to long wait times[1]
- 30% of patients have left a doctor appointment due to long wait time[1]
- Accessibility and convenience is essential

Key Performance Indicators ("KPI")

- Examples: Time spent in practice for a particular exam, face-to-face with any staff member and face-to-face with provider and clinical support staff, no show/cancellations/reschedule, etc.
- Today's standards:
  - ≤20-minute wait time from front door to face-to-face with provider
  - ≤1 week for non-urgent, non-emergent, ≤24 hours urgent, and immediate for emergency appointment
  - Scheduling issues are still primarily handled by phone, but patients are increasingly demanding technology to ease this

Best Practices

- Identify current state and develop goals for appointment system and patient satisfaction
- Develop a realistic appointment schedule, use appointment scheduling techniques (e.g., standard rotation) and customize
- Develop policies and checklists for effective scheduling & throughput and periodically examine performance
- Send appointment reminders
- Scheduling is directing impacted by staffing, as well as facilities and communications

1. Vitals' 9th Annual Physician Wait Time Report

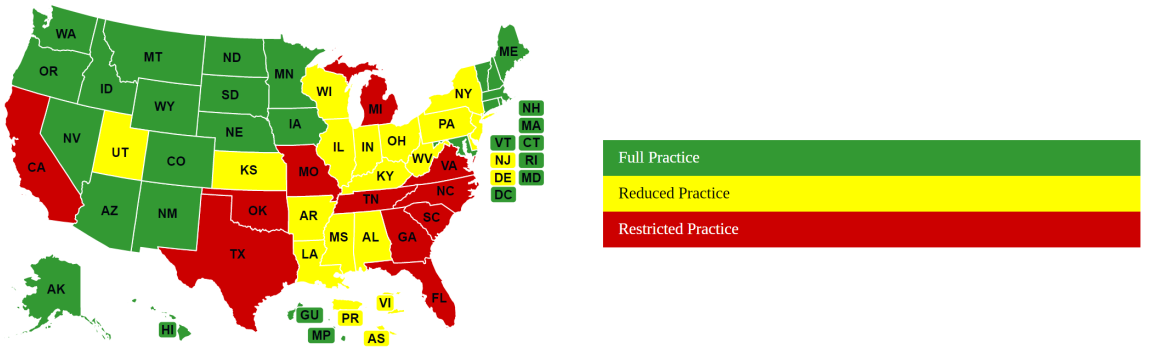
Operations: Staffing

- A time motion analysis in minutes for a physician demonstrated that 44% of the physician's time was wasted (2.6 hours per day)
- Hiring clinical support staff enabled the provider to see more patients and function at the top of license
- High performing clinics employ more advanced practice providers ("APPs"), especially RHCs and/or clinics in full practice states, and clinical support staff to optimize staffing efficiency
  - The outcomes:
    - Providers operate at the top of their license
    - Practices run on time
    - Productivity and compensation for providers is increased due to efficiency gains
    - Improved quality of life for physicians
    - Practice expenses are reduced
    - Cost of care is reduced
- Hospital-owned practice staffing is unique from a business operations and ancillary staff perspective
  - Staff is shared with hospital and other practices
  - FTE allocations must be reviewed for adequacy

Time Motion Analysis Example

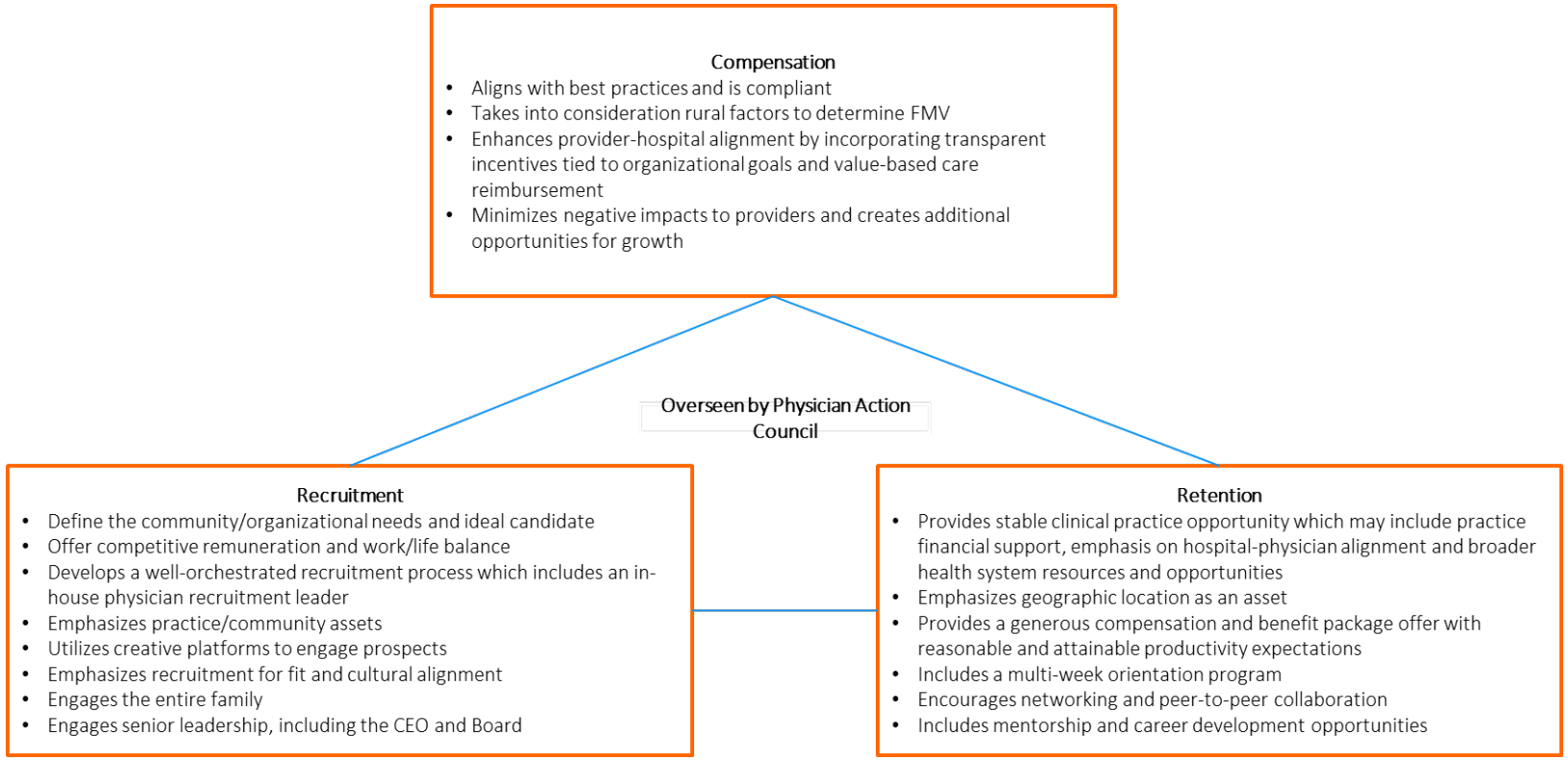
Task	Elapsed	Time	Able to Delegate	Wasted
Patient workup	5.25		5.25	
Look for nurse	0.75			0.75
Doctor phone call	2.50	2.50		
Patient examination	7.50	7.50		
Dictate chart/type EMR	1.50	1.50	?	
Walk to lab	1.50			1.50
Look for lab results	1.00			1.00
Talk to patient in hall	2.50			2.50
Patient examination	5.25	5.25		
Walk to X-ray	1.10		1.10	
Wait for X-ray	2.50			2.50
Dictate chart	1.75	1.75		
TOTAL MINUTES	**33.10**	**18.50**	**6.35**	**8.25**

State Practice Environment



Operations: Staffing (continued)

- Staffing in rural communities is a challenge, particularly for providers, recently exacerbated by COVID-19
  - While 20% of the US population lives in rural communities, only 11% of physicians practice in such areas
  - Rural physicians are nearing retirement, with projected ¼ fewer practicing by 2030
  - Medical school matriculants from rural areas have declined 28% between 2002 and 2017[1]
  - It takes ~250 days to recruit a primary care physician and >400 days to recruit a specialist physician to rural communities
- Organizations must have 5+ year recruitment and retention plan



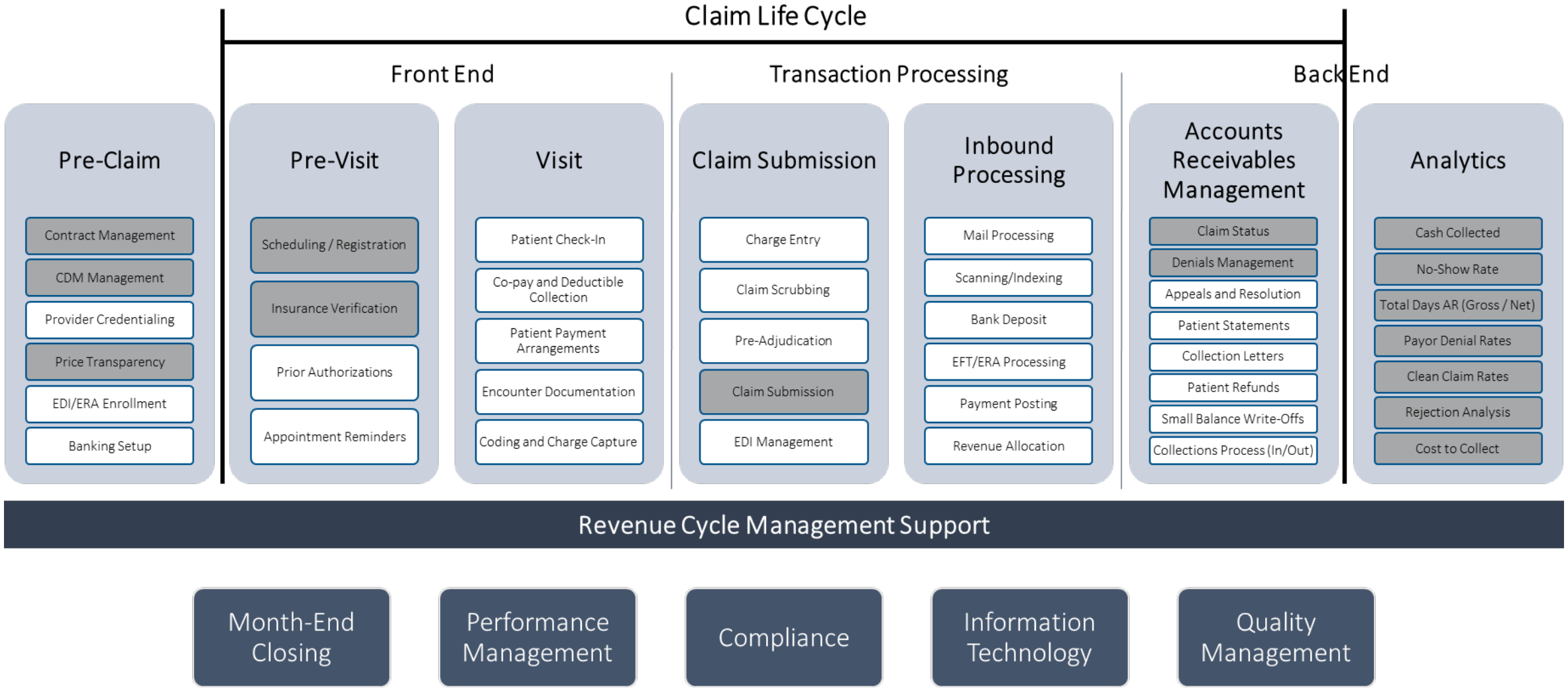
1. https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine

Operations: Finance & Revenue Cycle

- Cost to Collect has become a critical metric for hospitals and provide insight into not only revenue cycle efficiencies, but guides important management decisions around budget rationalization, productivity and efficiency management, and the overall financial solvency of the organization
  - Due to increased importance, HFMA has built Cost to Collect into its MAP Keys initiative due to the ability of the metric to measure efficiency and productivity
    - HFMA defines Cost to Collect as: "Total" Revenue Cycle Cost divided by "Total Cash Collected" with an option to include or exclude IT costs as a part of the calculation
    - Total costs include: patient accounting, patient access, HIM, benefits, subscription fees, outsourcing, and software/IT costs
    - Total cash includes: patient related settlements/payments and bad debt recoveries
  - It is important to note that Cost to Collect is one metric of many to evaluate revenue cycle performance and the cost to collect does not specifically factor fixed costs associated with each organization
- Although HFMA categorized certain costs, there remains much variation throughout the industry as to what exactly is included in the overall Cost to Collect

USUALLY INCLUDED	OFTEN INCLUDED	SOMETIMES INCLUDED
Patient Access	Revenue Integrity	Full Benefits Cost
Third Part Vendor Fees	Clinical Documentation	Depreciation
Collections	Pre-access Financial Clearance	Administrative Overhead
Billing	Revenue Cycle Specific Software	Patient Accounting Software
Posting Costs	HIM	IT Hard/Soft Costs

Operations: Finance & Revenue Cycle (continued)



Operations: Finance & Revenue Cycle (once more)

Revenue Cycle "To Do List":

- Reorient the overall managerial focus on the revenue cycle process to the "front end" of the value chain (e.g., pre-authorizations, scheduling, registration, etc.) and a measurement culture
- Establish a measurement system and set targets for all KPIs and strategies put in place to specifically address improving KPIs to targeted levels
- Implement a revenue cycle task group as a subgroup that meets at least bi-weekly that includes representatives from clinical, financial, administrative, medical staff, health information management, and the business office to oversee and drive improvements regarding the revenue cycle process
- Establish workflow to pre-register all scheduled services including appointment verification, insurance verification, and a co-insurance discussion with patient
- Ensure 100% of outpatient procedures are scheduled and pre-registered with proactive communication of patient co-payment expectations/estimated costs

Operations: Finance & Revenue Cycle (final)

Revenue Cycle "To Do List":

- Implement a bad debt policy that establishes when claims will be deemed worthless and uncollectable for inclusion on the cost report

- Prioritize improvement of POS cash collection amounts and hold staff accountable through the creation of POS collection goals
  - Establish similar POS cash collections in hospital-owned physician practices
  - Use current revenues as the basis for establishing POS collection goals for each department

- Implement a quick pay discount that matches the average commercial discount to increase cash flow and reduce bad debt

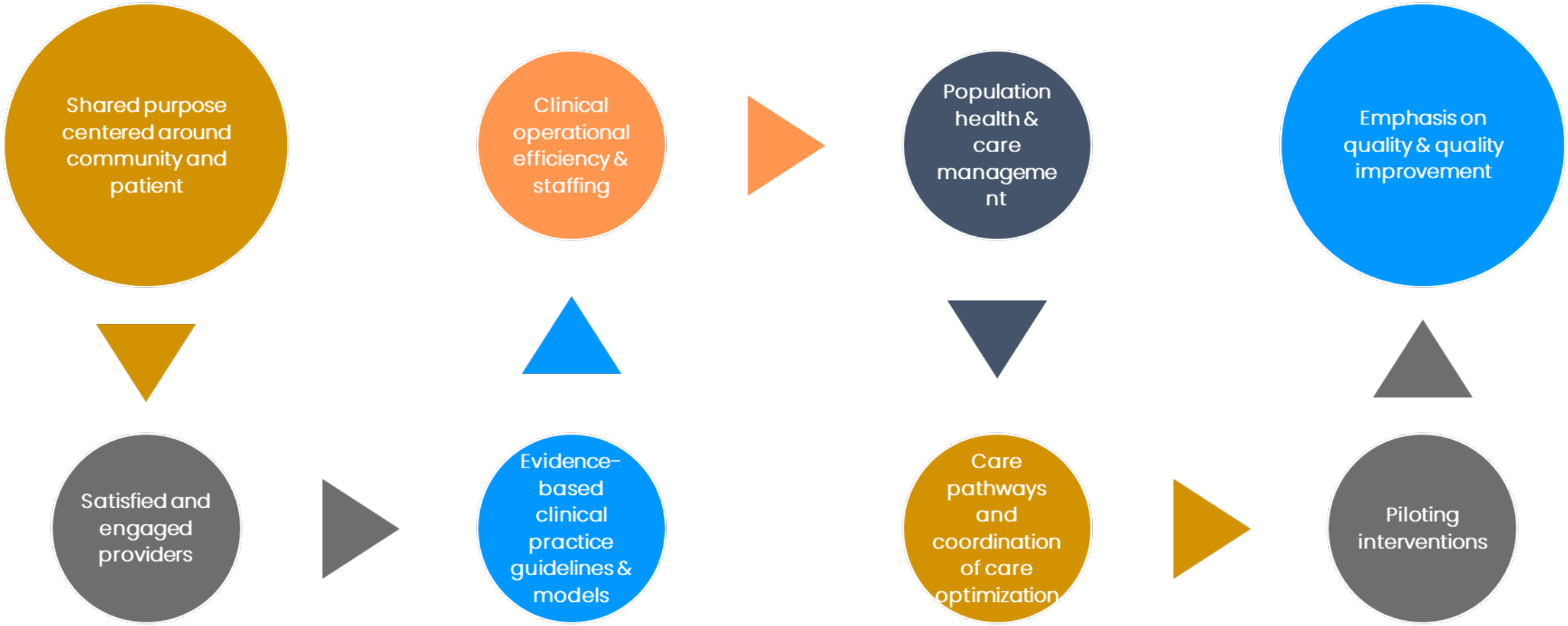
- Conduct a comprehensive annual review of chargemaster ("CDM") to ensure charge level appropriateness, targeting levels of 150-175% of Medicare pricing or at a level that is competitive within the market

Productivity

Productivity is generally not about working "harder"

- Productivity is a function of:
  - Service area supply & demand;
  - Internal systems, resources and staffing (collectively, operations);
  - Transparency and alignment; and
  - Clear and adequate incentives
- Engaging around productivity requires tying to financial performance of organization, self interest (i.e., financial), operations and patient care
  - The provider needs to be tackling the biggest issues for a patient but not be the one taking blood pressure
    - When providers spend productive time in non-provider clinical work, they often end up rushed in later appointments, potentially impacting the patient care for these patients or incurring significant overtime costs associated with working later hours or reduced patient satisfaction due to long wait periods and rescheduling
  - Staffing ratios, team-based care and practice operations directly impact productivity
  - Merit/annual bonuses or other rewards associated with achieving specific metrics are a powerful incentive, especially in absence of physician ownership
  - Providers must understand contracts and regularly review productivity with practice management

Value: Key Components to Create Value for Patient



Key Takeaways

- Losses on physician practices are not prudent nor always necessary
  - Financial losses cannot be sustained by hospitals or practices
  - Ongoing financial losses may present program integrity concerns under Stark Law
  - Assessment requires:
    - Identification
    - Quantification
    - Mitigation
    - Justification
  - Identify what factors the providers can impact and engage providers around the solution
- Organizational buy-in and alignment is essential to achieving strategies and goals
- High performing practices emphasize strategic planning and forward-looking thinking, vs. reactionary day-to-day management
- High performing practices optimize all areas: strategies, people (providers, staff, leadership), resources, processes/operations, technology and data management/measurement
  - Using meaningful data measurement to inform data-driven decision making (vs. reporting for the sake of reporting) is critical
- Financial performance is a byproduct of these elements

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Post-Polling Questions

I am ___ in my understanding of the shared attributes of high performing clinics.

I am ___ in my understanding of how to identify potential performance improvement opportunities.

I am ___ in my understanding of tools and performance metrics that can be used to better manage physician practices.

I am ___ that I will apply the knowledge gained from this educational training to improve my organization's financial performance.

Contact Information

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Get to know us better:
http://www.ruralcenter.org