Rural Health Clinic

Revenue Cycle and Financial Improvement

OVERVIEW

Interdependence of Major Drivers

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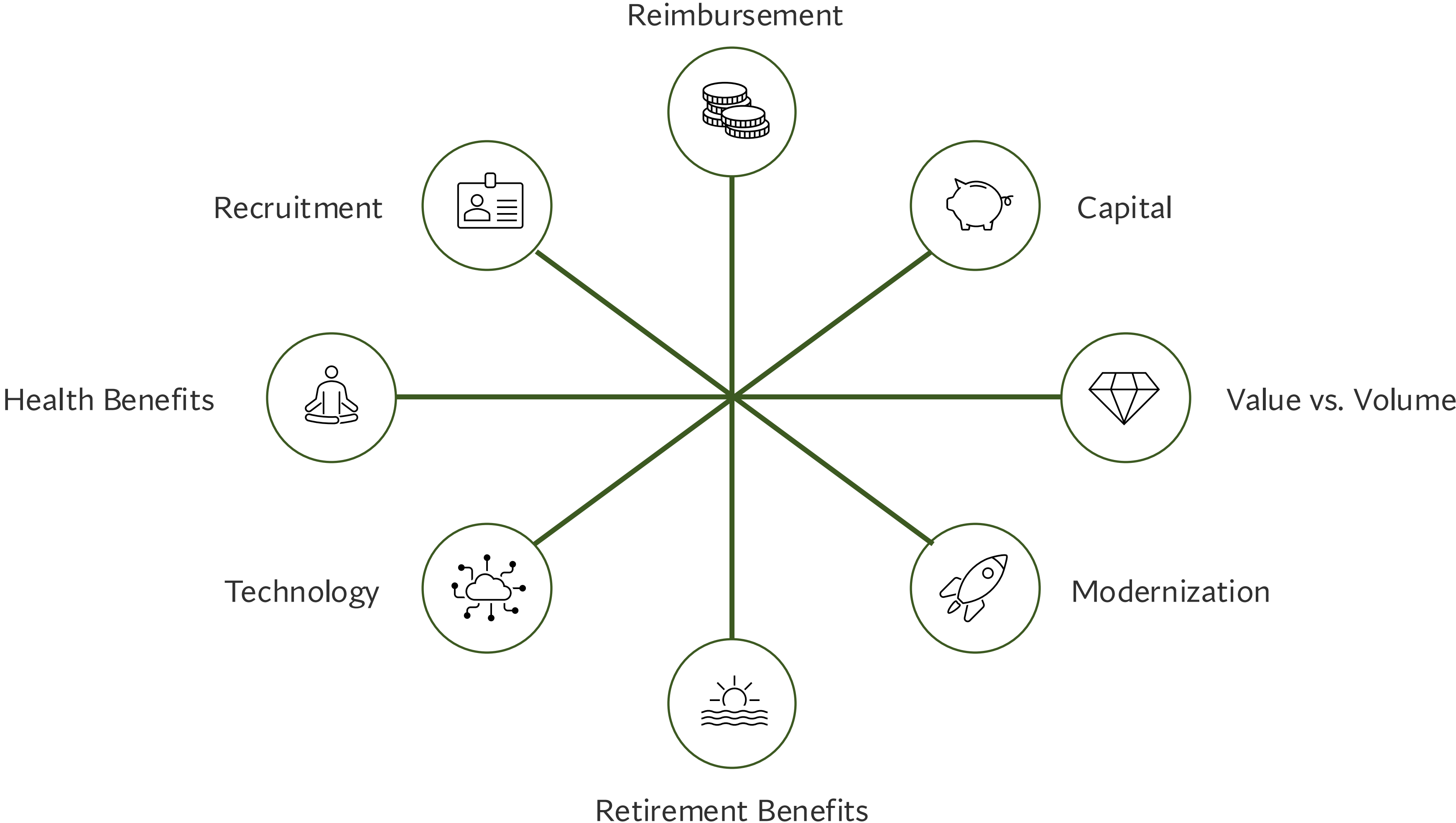
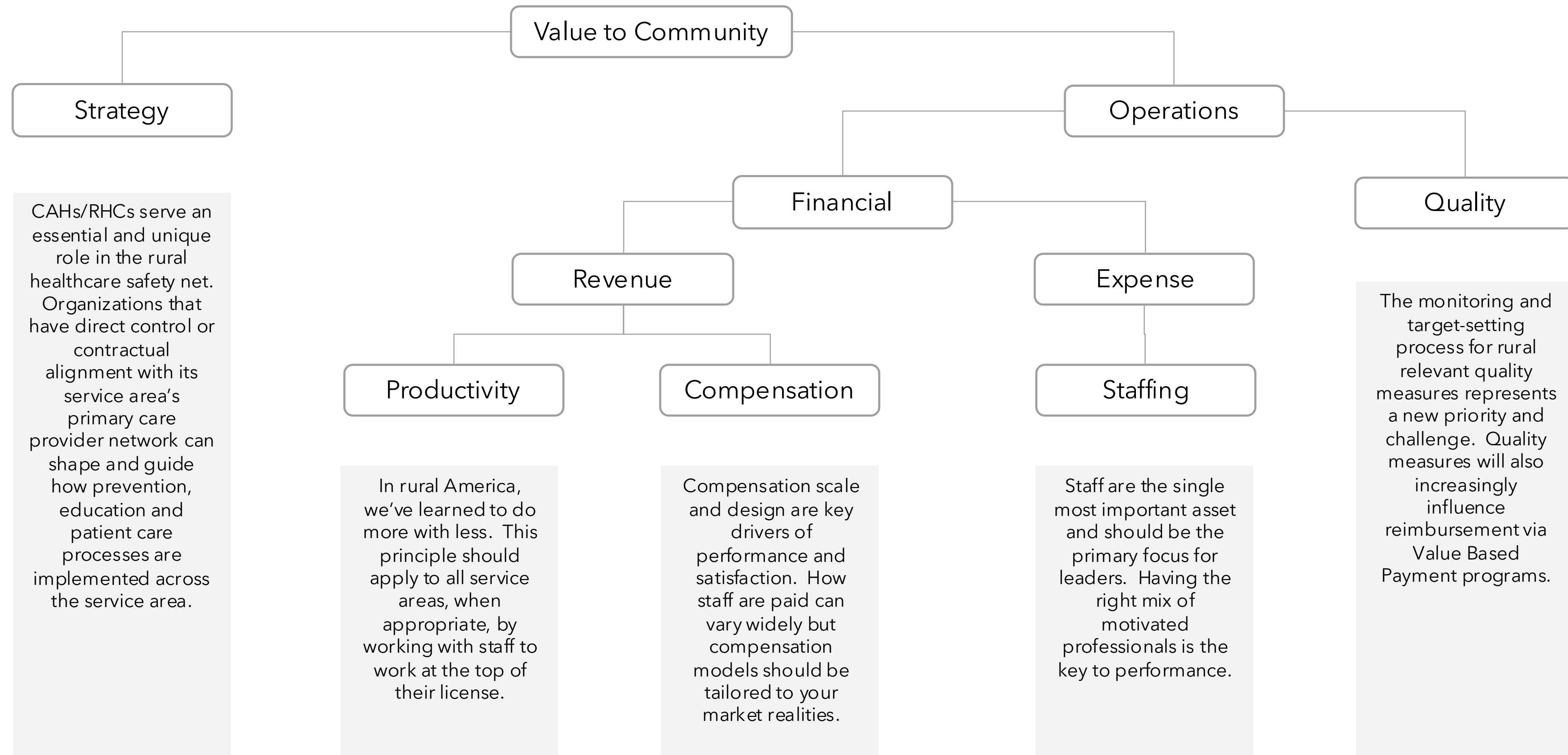


DOING MORE WITH LESS

Performance Model



Evolution of Improvement Model

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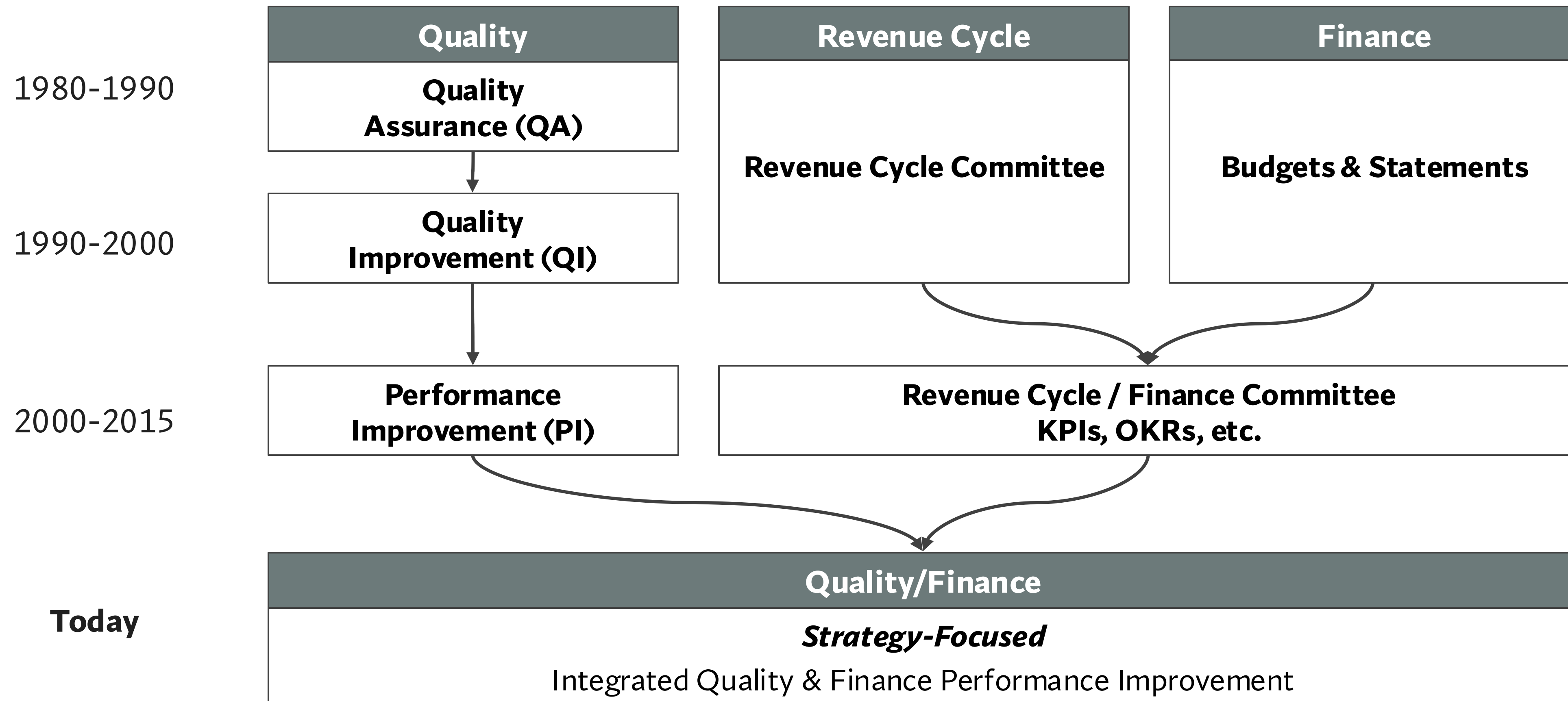
- Healthcare is a segmented industry where quality and finance continue to operate as separate business units with limited integration



Alignment and Designation Strategies

- Due to the changing healthcare landscape, healthcare entities must leverage additional revenue opportunities, including reimbursement methodologies, to drive improved financial performance
- Healthcare entities can leverage the following to improve reimbursements when those practices can meet certain eligibility requirements:
  1. Periodically evaluate and convert practices to a designation that will improve the net financial position of that practice
  2. Establish system strategy and realign practices, when possible, to leverage alternative designation types
  3. Consolidate practices by integrating specialty practices and providers, when possible, within a PBC or RHC to realize operational efficiencies and leverage alternative reimbursement methodologies
  4. Pursue acquisition of independent practices to leverage reimbursement and revenue opportunities afforded to rural hospital providers
     - **Note:** *An RHC owned and operated by a hospital that qualifies for 340B does not have to meet the provider-based rules at 42 CFR 413.65 to be registered as a child site for 340B purposes*

Practice Alignment and Designation

- The following table shows the net financial impact of different designations on a hospital:

Summary Data	Scenario #1 PBC	After 2019 OPPS Final Rule (PBC)	Before Change: Scenario #2 PB-RHC >50 Beds	Before Change: Scenario #3 PB-RHC <50 Beds	After Change: Scenario #4 RHC Post 4/1/21
Medicare / Medicaid Average	$ 149.06	$ 136.86	$ 86.32	$ 187.82	$ 127.92
Annual Visits	28,294	28,294	28,294	28,294	28,294
Reimbursements Received	$ 4,217,643	$ 3,872,319	$ 2,442,338	$ 5,314,296	$ 3,619,368
340B Benefit	n/a	n/a	n/a	n/a	n/a
Variance w/ Before 2019 PBC (Scenario #1)		$ (345,324)	$ (1,775,305)	$ 1,096,653	$ (598,275)
Variance w/ After 2019 PBC (Scenario #1)			$ (1,429,981)	$ 1,441,977	$ (252,951)

- <u>Outcomes:</u>
  - Prior to the change in the RHC reimbursement methodology, the PB-RHC would have been the most advantageous designation; however, under the new reimbursement methodology, the practices would be better served to remain as a PBC until the RHC UPL surpasses the average PBC rate
    - Since the practices were already PBCs, there was no additional 340B benefit by converting the practices to RHCs

Performance Improvement Opportunities

Organizations must focus and establish plans for each of the four identified areas to improve the organizational position

Operating

- Demand-Based Staffing tools
- Departmental performance improvement
- Revenue cycle and coding
- Cost report optimization
- Practice / clinic designations
- Process improvement
- Supply chain & purchasing

Financial

- Define performance gaps
- Integrate department leaders into budgeting process
- Determine cash position and run rates
- Establish actionable metrics
- Pricing transparency and patient engagement

Value

- New market entry and increased competition
- Explore clinically integrated model
- Ambulatory network establishment
- Increase access to care
- Direct contracting
- Improve patient engagement and satisfaction

Market

- Payor contract reviews
- Value-based initiatives
- Population-based strategy
- Self-insured insurance plan offering
- Medicare Advantage negotiations
- Establish payor and provider partners
- Manage overall cost of care

Practice Management

- **Practice Management To Do List**
  - Work with your practice managers and physicians as a team to understand what is happening with:
    - Physician contracts
    - Physician compensation
    - Scheduling
  - Set up management dashboard that monitors the following:
    - Gross collection rate
    - Net collection rate
    - Overhead ratio
    - Individual category expense ratio
    - Days in accounts receivable
    - wRVUs per provider
    - Accounts receivable per FTE physician
    - Staff ratio
    - Average cost and revenue per patient
    - Aging of accounts receivable by payor
    - Payor mix ratio

RHC Cost Structure

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Variable Costs: Those costs that increase as visit volumes increase. Examples include supplies and medications.

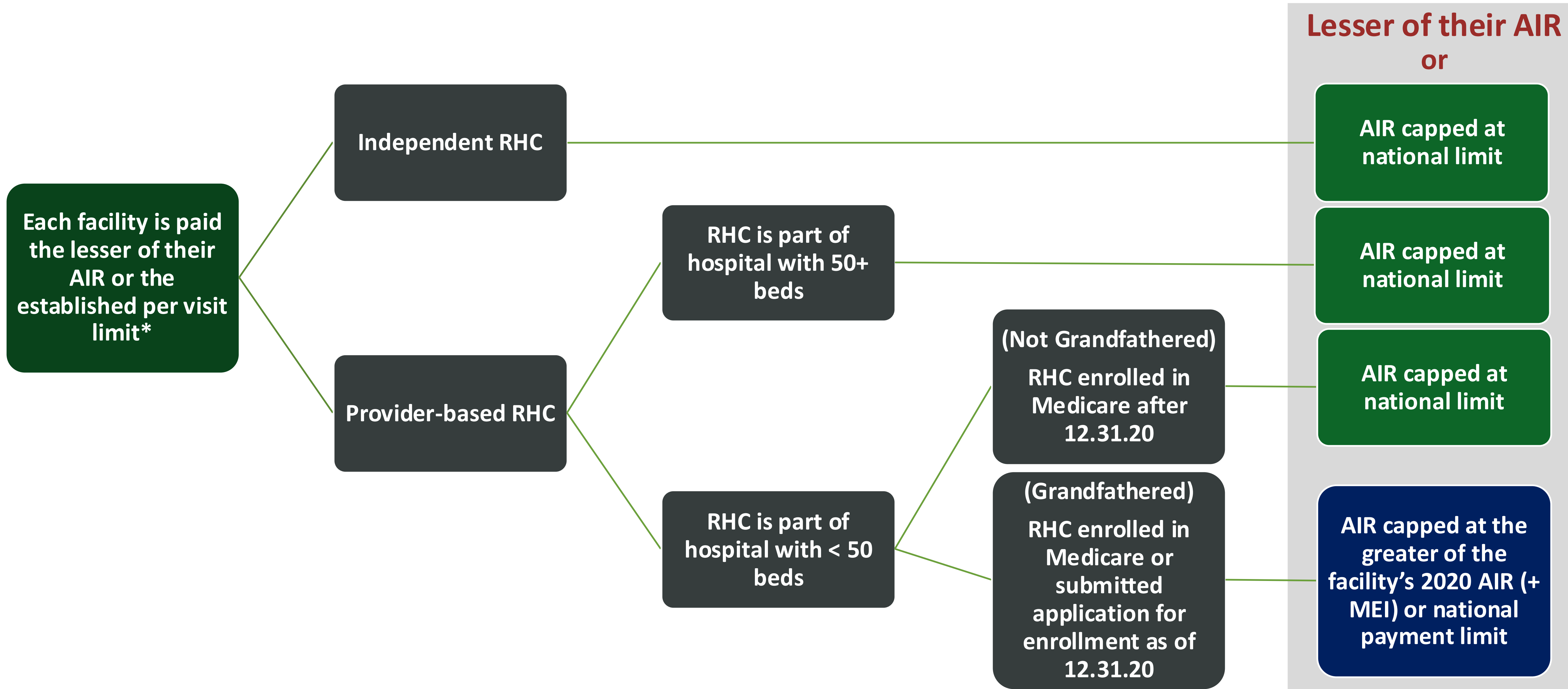
~10 percent

Fixed Costs: Those costs that **do not** increase as visit volumes increase. Examples include salaries, benefits and overhead expenses such as utilities and administration.

~90 percent

Fixed costs are especially important for provider-based RHCs because they represent one of the key reimbursement opportunities for the hospital. Various organization-wide costs are allocated from what is typically considered traditional hospital operations to the clinic (e.g., hospital administration salaries). This is why we often see provider-based RHCs with larger expense structures and lower profit margins.

RHC Rate Establishment



https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_fqhc_final_sec.pdf

Medicare Economic Index (MEI)

- The Medicare Economic Index (MEI) was developed in 1975 and is the baseline for each year's payment update calculation
  - The following table presents the MEI from 2014 through 2023

Medicare Economic Index[1]	CY 15[2]	CY 16[3]	CY 17	CY 18	CY 19	CY 20	CY 21	CY 22	CY 23	CY24	AVERAGE
Market Basket Update	0.8	1.1	1.2	1.4	1.5	1.9	1.4	2.1	3.8	4.6	2.0

1. Physician payments were updated annually based on the MEI starting in 1992
   - The Medicare Economic Index has always included a productivity adjustment
2. The Medicare Access and CHIP Reauthorization Act of 2015,ended use of the SGR and replaced with defined annual update factors from 2015 through 2025. https://www.congress.gov/bill/114th-congress/house-bill/2/text
3. The MEI market basket was used to update FQHC PPS payments in CY 2016

RHC Charge Structure

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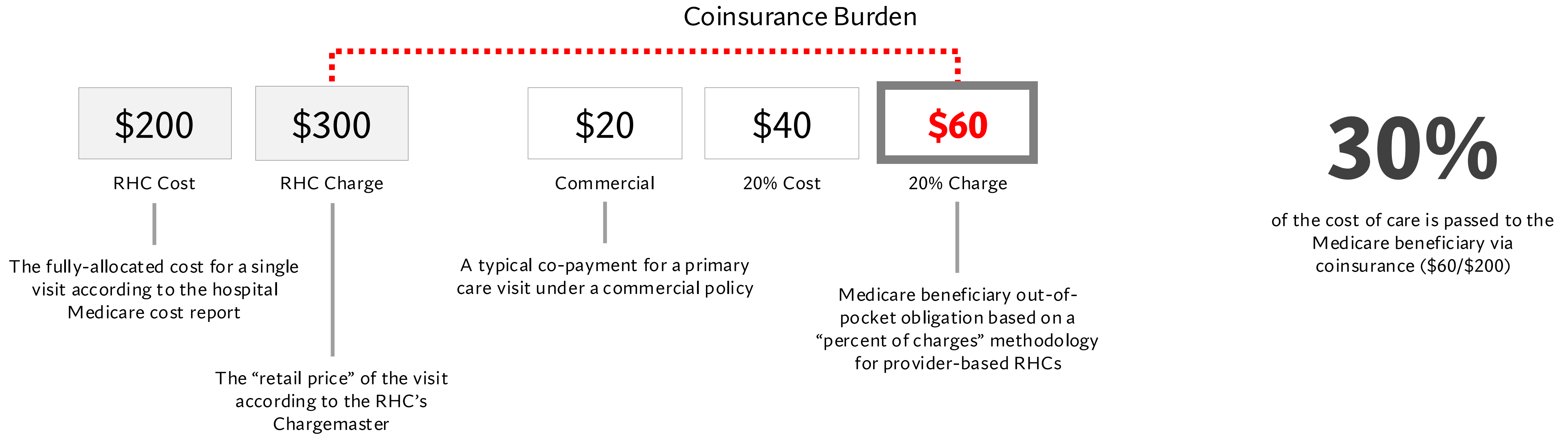

30%

of the cost of care is passed to the Medicare beneficiary via coinsurance ($60/$200)

High prices disproportionately impact Medicare Beneficiaries

Provider Complement

- Evaluate the integration of additional primary and specialty care providers into the RHC to leverage reimbursement advantages
  - Due to the increase in the UPL for independent RHCs, those practices now have additional opportunities to bring in specialty providers which before was often unsustainable

- Catalog all providers within the primary and secondary service area to better understand patient demand and provider availability
  - In today's market, organizations must also include telehealth providers when cataloging providers

- Implement team-based initiatives to increase efficiencies and create an environment where staff operate at the top of their license
  - RHCs must leverage a complement of CMAs, RNs, APPs, and Physicians, based on patient need, to optimize care delivery models

- Leverage available data sources, such as the Medical Group Management Association (MGMA), to benchmark provider productivity and drive performance improvement initiatives

Provider Productivity and Engagement

CMS defines a minimum expected number of patient visits for physicians and advanced practice providers (Nurse Practitioners and Physician Assistants)

4,200	**2,100**
Physicians	APPs

Note: Providers with regular scheduled time are subject to the Minimum Productivity standards
Note: Providers with non-regular scheduled time are <u>not</u> subject to the Minimum Productivity standards
Note: Contracted physician volumes are not included in the calculation
Note: If clinics do not meet productivity standards, the clinic will not get full cost-based reimbursement, subject to CAA provisions

RHCs must engage providers about their performance

Provider Contracts

- Notwithstanding fair market valuation regulations, in most instances the market and basic supply and demand dynamics drive provider compensation
  - Increasingly, RHC physicians and APPs are migrating away from straight salary arrangements toward productivity-based arrangements and in some cases, value-based compensation models
- The challenge for RHC operators is how to balance and accelerate these different types of compensation plans in a delicate rural healthcare market
  - Provider contracts now often include the following components:
    - Base Salary
    - wRVUs
    - Panel Size
    - Quality Scores
    - Patient Satisfaction Scores

Compensation Metrics
Salary and bonus metrics to assess and compare provider costs

Compensation Metrics	Site Values	Cohort	USA Cohort
Salary per FTE Physician	$265,000	$302,500	$245,000
Salary per FTE APP	$128,333	$116,279	$115,000
Variable Compensation per FTE Physician	$14,167	$9,940	$29,214
Variable Compensation per FTE APP	$1,667	$4,651	$14,286

Staffing Metrics	Site Values	Cohort	USA Cohort
Gross Charges per Total Staff	$189,213	$101,962	$160,800
Net Revenue per Total Staff	$85,189	$90,610	$116,629
Patient Visits per Total Staff	665	672	772
Clinical Staff Ratio	60.6%	46.7%	54.4%
Gross Charges per Clinical Staff	$312,202	$203,925	$301,142
Gross Charges per Non-Clinical Staff	$480,311	$203,925	$369,125

Quality Metrics	Site Values	Cohort	USA Cohort
NQF #0018 Controlling Blood Pressure	-	-	64.1%
NQF #0028 Tobacco Screening	-	-	98.6%
NQF #0038 Childhood Immunizations	-	-	33.5%
NQF #0059 HbA1c Poor Control (>9%)	-	-	29.5%
NQF #0419 Documentation of Medications	-	-	90.1%
NQF #SARS-CoV-2 Vaccinations	-	-	-

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Cost Report Opportunities

- RHCs must get away from viewing the Cost Report as an administrative function and realize the Cost Report has a direct impact on reimbursements received
  - Due to the new reimbursement methodology and UPLs, RHCs can quickly see their cost structure surpass reimbursements received from Medicare

4090 (Cont.) FORM CMS-2552-10 11-16

ALLOCATION OF OVERHEAD TO HOSPTIAL-BASED RHC/FQHC SERVICES	PROVIDER CCN: ______ COMPONENT CCN: ______	PERIOD: FROM ______ TO ______	WORKSHEET M-2

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1-3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4-7)						8
9	Physician Services Under Agreements						9

Hierarchy of Quality Measurement (QM)

- **Structural measures**
  - The foundation of QM - evaluates infrastructure/capacity of health care organizations to provide care (e.g., equipment, personnel, or policies)
  - Examples - % of providers using an electronic health record, % of diabetics tracked in a patient registry, staff to patient ratio

- **Process measures**
  - The building blocks of QM that focus on evidence-based steps that should be followed to provide good care
  - When executed well, increases the likelihood of a desired outcome
  - Examples – medication reconciliation, colorectal cancer screening, use of aspirin for patients presenting with ischemic vascular disease

Hierarchy of Quality Measurement (QM)

- **Outcome measures**
  - Evaluate/assess the results of care on a patient’s health, such as clinical events, recovery, or health status
  - Outcome measures are slots into which process blocks fit
  - Process and outcome measures go hand in hand as improving a process can result in an improved outcome
  - Examples: optimal asthma control, long-term complications of diabetes, controlling high blood pressure

- **Composite measures**
  - Combines individual measures to produce one result that gives a more complete picture of quality for a specific area or disease
  - Examples – comprehensive diabetes care, substance use screening and intervention, optimal vascular care

What Quality Measures Should We Track?

Compensation Metrics	Site Values	Cohort	USA Cohort
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The **National Quality Forum** is responsible for coordinating the development and ratification of clinical quality measures. The following five NQF metrics have been identified via research by John Gale from the Maine Rural Health Research Center as the most rural relevant.

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The PQRS and then MIPS public reporting programs for physician practices included 100+ potential measures, most of which were relevant to large urban practices and multi-specialty practices. Few of the metrics were rural relevant and/or valid for small volume clinics.

Optimize Revenue Cycle Tasks and Functions

- Evaluate and improve revenue cycle functions by ensuring a fair distribution of work, clearly defined roles and task automation or improvement
  - Make sure no matter how tasks are divided among departments, core task elements are incorporated and monitored

Revenue Cycle Administrative Functions
- Contract Negotiation
- CDM Fee Schedule and Pricing
- EDI Transactional Enrollment
- Provider Enrollment and Credentialing

Pre- Registration
- Scheduling and Financial Clearance
- Pre-Registration and Coordination of Benefit Review
- Financial Counseling/Charity and Pre-Service Collections
- Identification of Patient Health Outcome Delinquencies and need for services
- Appointment Management and Care Management Enrollment Identification

Registration
- Patient Check In
- Confirmation of Financial Counseling, Balance due assessment
- Patient Check Out – Verification of Patient Services ordered, scheduled, referred.
- Encounter Documentation and Charge Capture
- Beneficiary Notice Identification

Coding
- Charge Reconciliation and Documentation review
- Correct Hierarchal coding
- Physician Query – Medical Necessity
- Charge Entry as needed

Patient Accounting - Claims
- Claim Scrubbing
- Error Correction
- Claim Submission

Patient Accounting - Follow-up
- EDI management
- Remittance Posting
- Denials Management
- Appeals and Recovery
- Payor Credit Reconciliation

Collections
- Patient Statement management
- Charity Care Management
- Bad Debt Management
- Patient Balance Management

Data and Analytics
- Benchmarking and Reports
- Performance Improvement Activities
- Strategy and Workflow focus and management

Revenue Cycle

- **<u>Revenue Cycle</u>**
  - Transition managerial focus to the “front end” processes of revenue cycle (e.g. pre-authorizations, scheduling, registration, etc.) while driving an overall measurement culture
    - Organization should have the appropriate workflows to pre-register patients, facilitate point-of-service collections, review contracts, adjudicate claims, etc.
    - Ensure scheduling of outpatient services and prior authorizations received before the patient presents for services
  - Implement and maintain a performance measurement system that evaluates key areas throughout revenue cycle
    - Macro and Micro measurement necessary to drive performance improvement
  - Review price list (charge description master) at least annually to ensure the defensibility and accuracy of the price list
    - Organizations must also address meet pricing transparency requirements
  - Prioritize point of service (POS) collections to improve cash flow
    - Staff must be held accountable for achieving POS goals

Additional Opportunities

- Leverage claims data to better understand opportunities for improved patient outcomes, the demand for additional service providers, and revenue capture opportunities
  - Data remains one of the valuable, but underutilized, resources available to RHCs that can drive strategy and performance improvement efforts

- Pursue the Patient Centered Medical Home (PCMH) model to drive patient outcomes
  - Negotiate with third-party payors to ensure the clinic receives PMPM payments

- Implement Chronic Care Management (CCM), Transitional Care Management (TCM), and Behavioral Health Intervention (BHI), among other opportunities, based on patient demand and available providers to improve patient outcomes and generate incremental revenue

- Explore the expansion of services to include Behavioral Health

- If eligible, pursue the 340B program to drive additional revenue

QUESTIONS

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