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OREGON RHC FINANCIAL INDICATOR BENCHMARKING REPORT

July 2024

INTRODUCTION

"This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Rural Hospital Flexibility Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government."

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PRESENTER

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Fargo, ND

ACKNOWLEDGEMENTS

- This presentation includes information based on best practice conversations from within Oregon as well as several other states.

- We appreciate the Oregon based individuals and facilities that agreed to participate in these conversations.

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PURPOSE OF THE REPORT AND ANALYSIS

- Obtain data from Oregon RHC cost reports (as released by Medicare)
  - 2024 Report : 7/1/2022 – 6/30/2023 submitted cost reports (or most recent in some cases)
- Identified State baseline for benchmarking for each financial indicator and operational indicator.
- Graphs created for each indicator indicating where each RHC ranks in comparison for the State

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ABOUT THE DATA

- As noted, the data is gathered from the cost reports of Oregon RHCs
  - Freestanding RHC Cost Reports
  - Hospital Cost Reports for provider based RHCs

- Cost report rules do allow for combined reporting of multiple RHCs as one on the cost report. When applicable, the individual RHC reports were utilized. Combined reports were used when necessary.

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ABOUT THE DATA

The accuracy of the financial and operational data is only as accurate as the information submitted on the cost reports. In some situations, it was necessary to omit calculations that were significant outliers and/or appeared to contain inaccurate information. We encourage providers to work with their cost report preparers to address potential areas of concern and to address any additional inaccuracies the provider identifies through this process.

ABOUT THE DATA

Due to a lack of accurate data or only one reporting entity, the following financial indicators were not reported in this reporting cycle:

- CNM Visits per FTE
- Visiting Nurse Visits per FTE
- Clinical Psychologist Visits per FTE (Freestanding)
- CNM Cost per Provider FTE
- Visiting Nurse Cost per Provider FTE
- Clinical Psychologist Cost per Provider FTE (Freestanding)

These financial indicators should continue to be reviewed in any subsequent reporting periods for consideration to be reported and have benchmarks established.

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BASELINES AND BENCHMARKS

Initial baseline averages, medians, 25th and 75th percentiles were identified. Initial benchmarks are at the 75th percentiles in first year. We recommended aggregate improvement goals be established for the next three reporting periods. Overall improvements in a Year 2 of reporting period would be expected to be minimal in nature as some reporting periods would be completed prior to the reporting for Year 1 while others only had a small window of time to implement improvement strategies.

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INDIVIDUAL FACILITY IDENTIFIERS

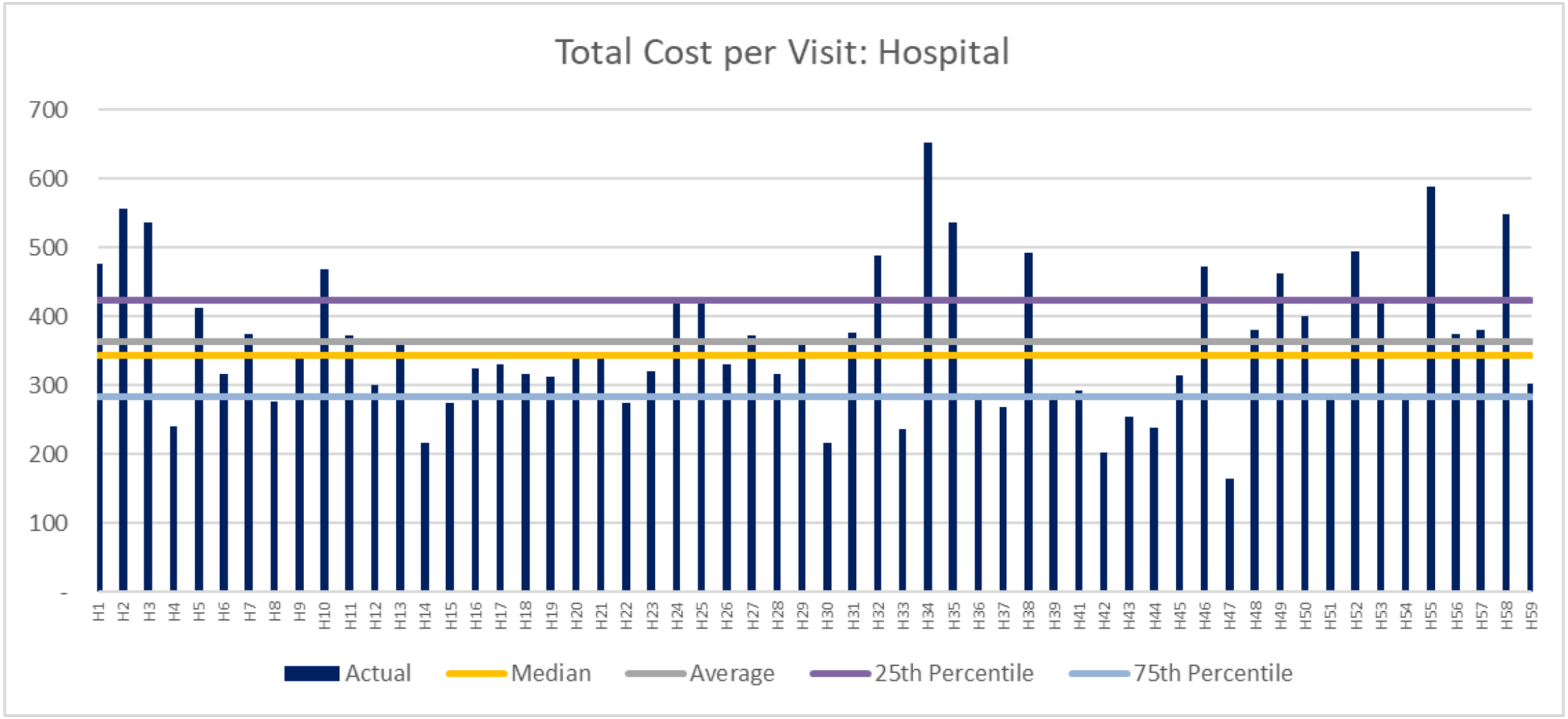
- Each RHC has been assigned a nondescript identifier.
  - H's are for hospital-based providers
  - F's are for freestanding providers
  - Providers reported in a combined format on the cost report were assigned a single identifier
- Each facility has been sent their identifier

TOTAL COST PER VISIT

TOTAL COST PER VISIT

- Higher cost per visits lead to lower profitability for other payors
  - May also impact Medicaid
  - Remember the Medicare 80/20 calculation limitation
  - Costs over Medicare caps are not reimbursed by Medicare

- Lower cost is favorable over time
  - Initial impact on Medicaid



Max = 654
Min = 165
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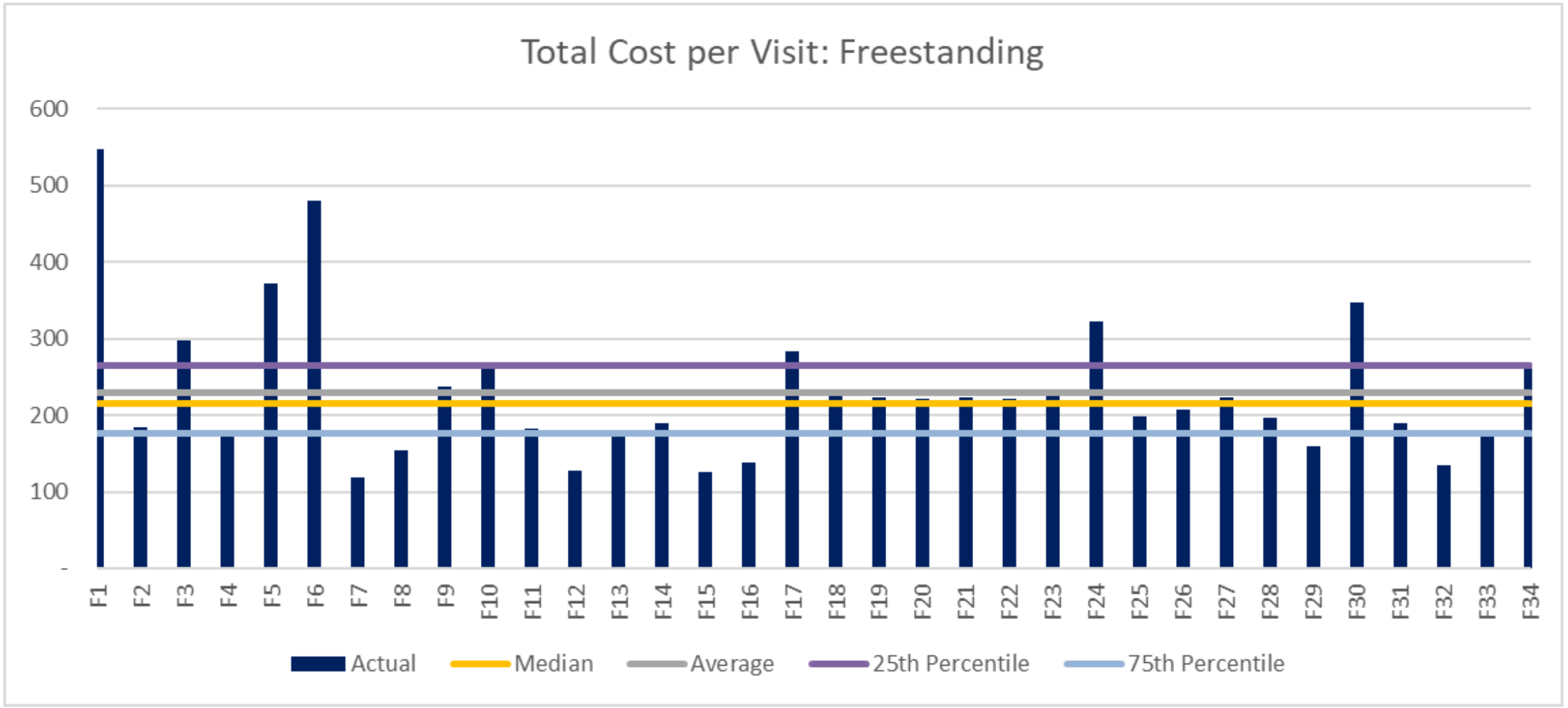
Median = 343
25th Percentile = 423
75th Percentile = 284



Max = 547
Min = 118
Average = 230

Median = 215
25th Percentile = 265
75th Percentile = 176

TOTAL COST PER VISIT – COMPARISON

	Hospital Based	Free Standing
Max	$654	$547
Min	$165	$118
Average	$363	$230
Median	$343	$215
25th %	$423	$265
75th %	$284	$176

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COST PER VISIT STRATEGIES BEST PRACTICES

- Commitment of providers to patients and staff drives culture and volumes.
- Longevity of team and loyalty of patients
- They understand value-based concepts, but realize the importance of volumes
- Monitoring of budgets – not the highest paying
- EHR implementation helped with scripting, templates, etc.
- 4-day work schedules
- Provision of urgent care services (only one in area) / large number of walk-ins
- Extended hours drive volumes

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COST PER VISIT STRATEGIES BEST PRACTICES

- Utilization of and adherence to templates drives the ability to maximize volumes
- Large volume of walk-ins / urgent care results in lower acute that can be seen in less time per patient
- Strong medical director as leader
- Heavy reliance on APPs
- Management of supply cost and minimization of waste
- Lower cost building occupancy cost
- Having a larger provider base to spread fixed costs across

COST PER VISIT STRATEGIES

- Employ strategies identified in
  - NP/PA FTEs to Total FTEs
  - Provider visits per FTE
  - Cost per FTE Provider
- Review other staffing levels for appropriateness
- Review overhead costs
  - Department specific
    - Staff
    - Supplies
    - Pharmacy
    - Etc.
  - Facility specific
    - Building cost
    - Utilities
    - Administrative and General

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HEALTHCARE STAFF COST PER VISIT

HEALTHCARE STAFF COST PER VISIT

- Includes
  - Direct Staffing
    - Providers
    - Ancillary support
  - Supplies
  - Pharmacy
  - Medical Equipment
  - Professional Liability

- Does not include
  - Facility costs
  - Administration

- Higher cost per visits lead to lower profitability for other payors
  - May also impact Medicaid
  - Remember Medicare 80/20 calculation limitation and impact of caps

- Lower cost is favorable over time
  - Initial impact on Medicaid Higher cost per visits lead to lower profitability for other payors

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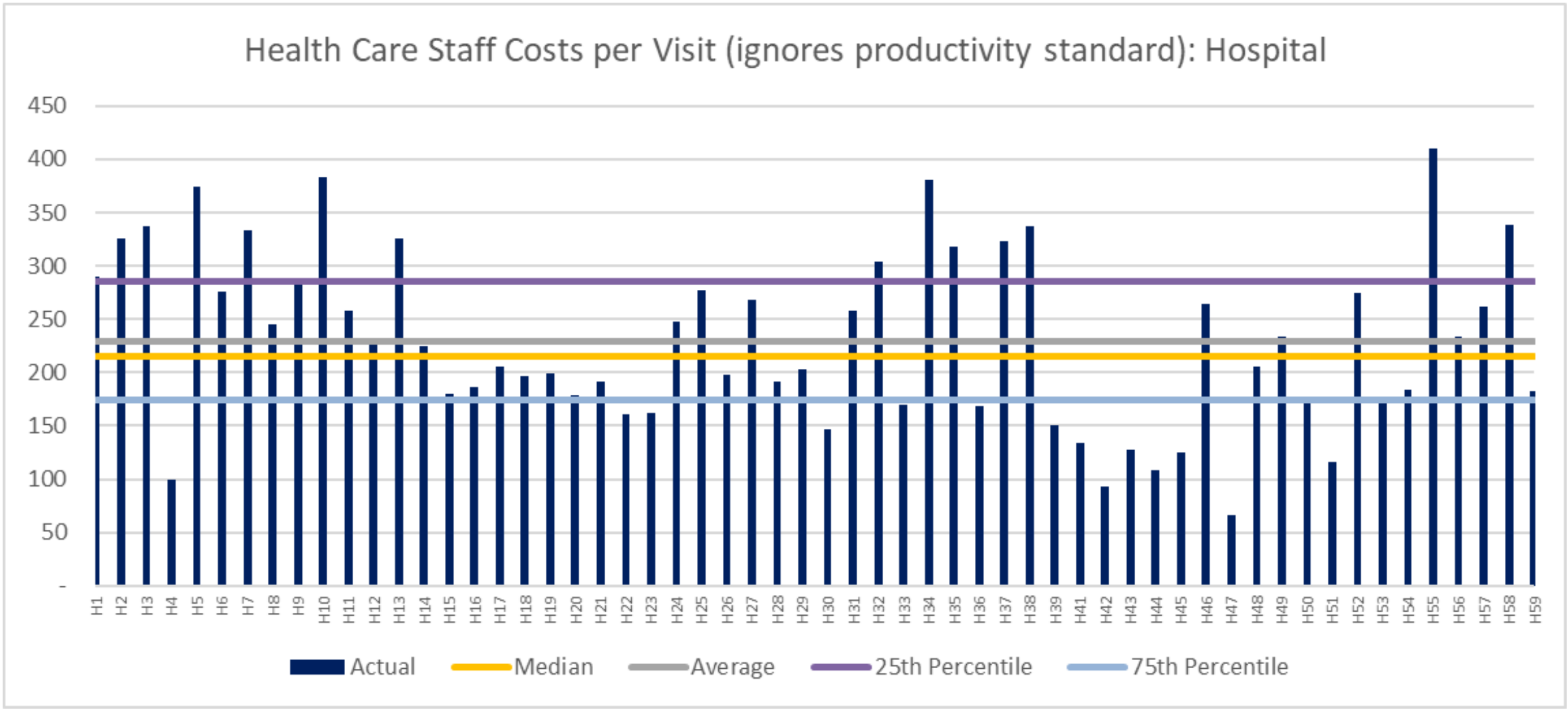
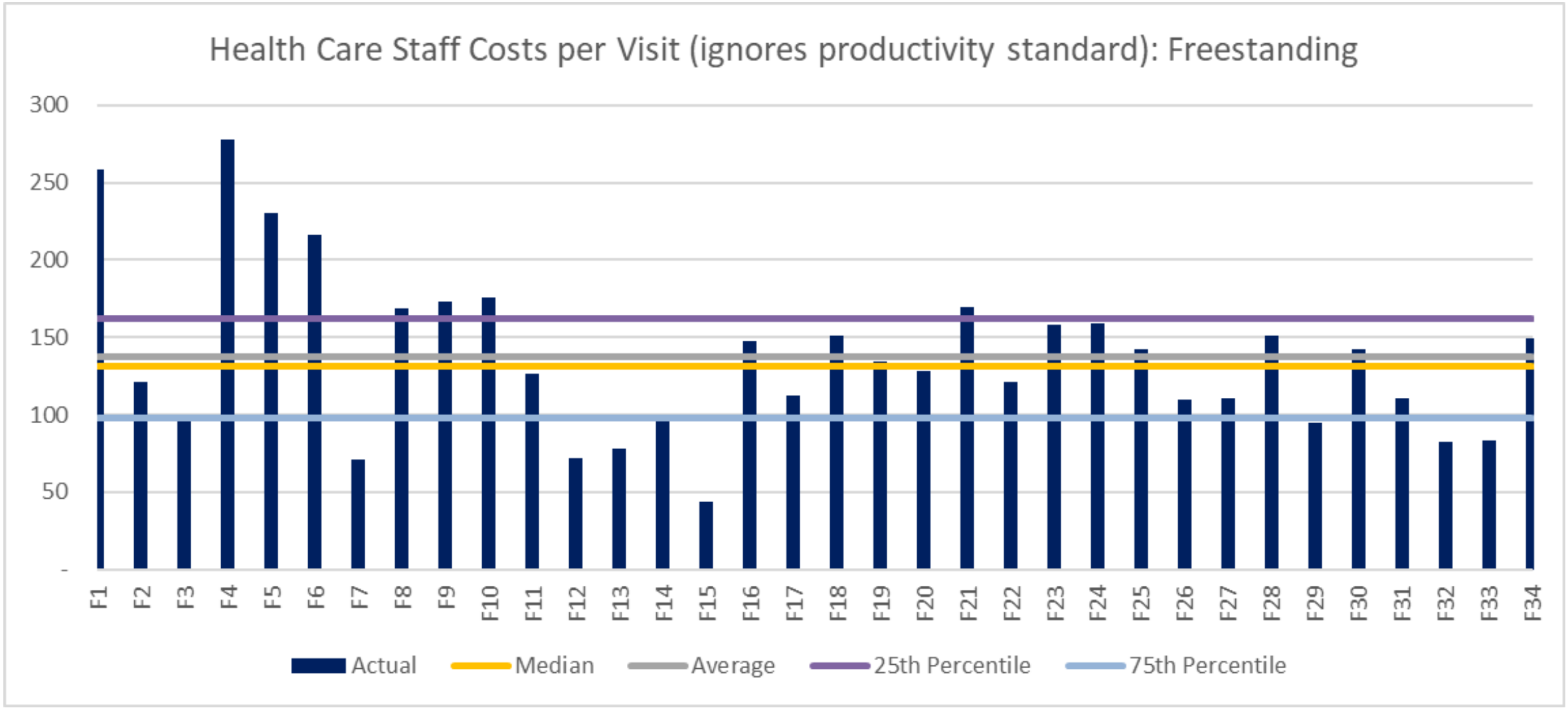


Max = 410
Min = 66
Average = 229

Median = 215
25th Percentile = 286
75th Percentile = 174



Max = 278
Min = 44
Average = 137

Median = 132
25th Percentile = 162
75th Percentile = 98

TOTAL HEALTHCARE COST PER VISIT – COMPARISON

	Hospital Based	Free Standing
Max	$410	$278
Min	$66	$44
Average	$229	$137
Median	$215	$132
25th %	$286	$162
75th %	$174	$98

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HEALTHCARE STAFF COST PER VISIT BEST PRACTICES

- Focus on efficient processes
- Right mix of providers/nurses
  - Limited number of RN's
- Focus on staffing ratios
- Repositioning of staff based on volumes
  - Providers and Nurses
- Staffing physician onsite 1 day every three weeks
- Core staffing at remote locations
  - 1 provider, 1 nurse, 1 receptionist (1 clinic with no receptionist)
- Staff that are willing and able to engage

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HEALTHCARE STAFF COST PER VISIT BEST PRACTICES

- Working on CCM, AWV and TCM services – increases volumes to spread costs

- Being transparent with care team
  - Sharing visit counts
  - Working on sharing quality data
  - Can build healthy competition

- Utilizing an APP as clinic leader – different perspective

- Culture/Sharing of Data/Financials
  - No salary increases due to costs
    - Asked team for input and ideas on how to save costs
  - Built in buy in

- Increase reliance on APPs

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HEALTHCARE STAFF COST PER VISIT BEST PRACTICES

- Maximizing functionality of staff
- Utilization of Visiting Nurse Program
- Great culture allowing for control of salary levels

HEALTHCARE STAFF COST PER VISIT STRATEGIES

- Employ strategies identified in
  - NP/PA FTEs to Total FTEs
  - Provider visits per FTE
  - Cost per FTE Provider
- Review other staffing levels for appropriateness
  - Nursing
  - Delicate balancing act
- Review department specific costs
  - Staff
  - Supplies
  - Pharmacy
  - Etc.

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OTHER COST PER VISIT

OTHER COST PER VISIT

- Includes
  - Facility costs
  - Administration

- Does not include
  - Direct Staffing
  - Supplies
  - Pharmacy
  - Medical Equipment
  - Professional Liability

- Higher cost per visits lead to lower profitability for other payors
  - May also impact Medicaid
  - Remember Medicare 80/20 calculation limitation and impact of caps

- Lower cost is favorable over time
  - Initial impact on Medicaid

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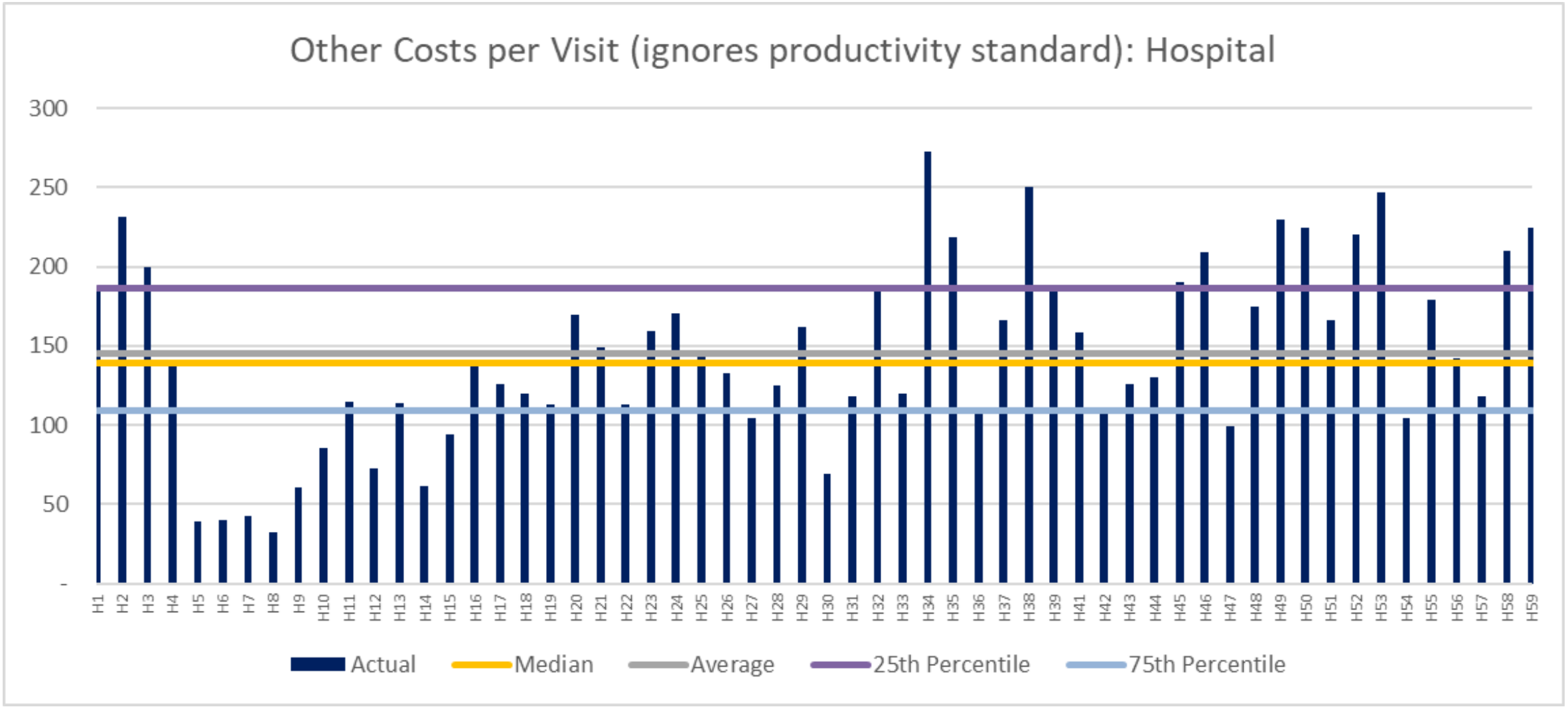
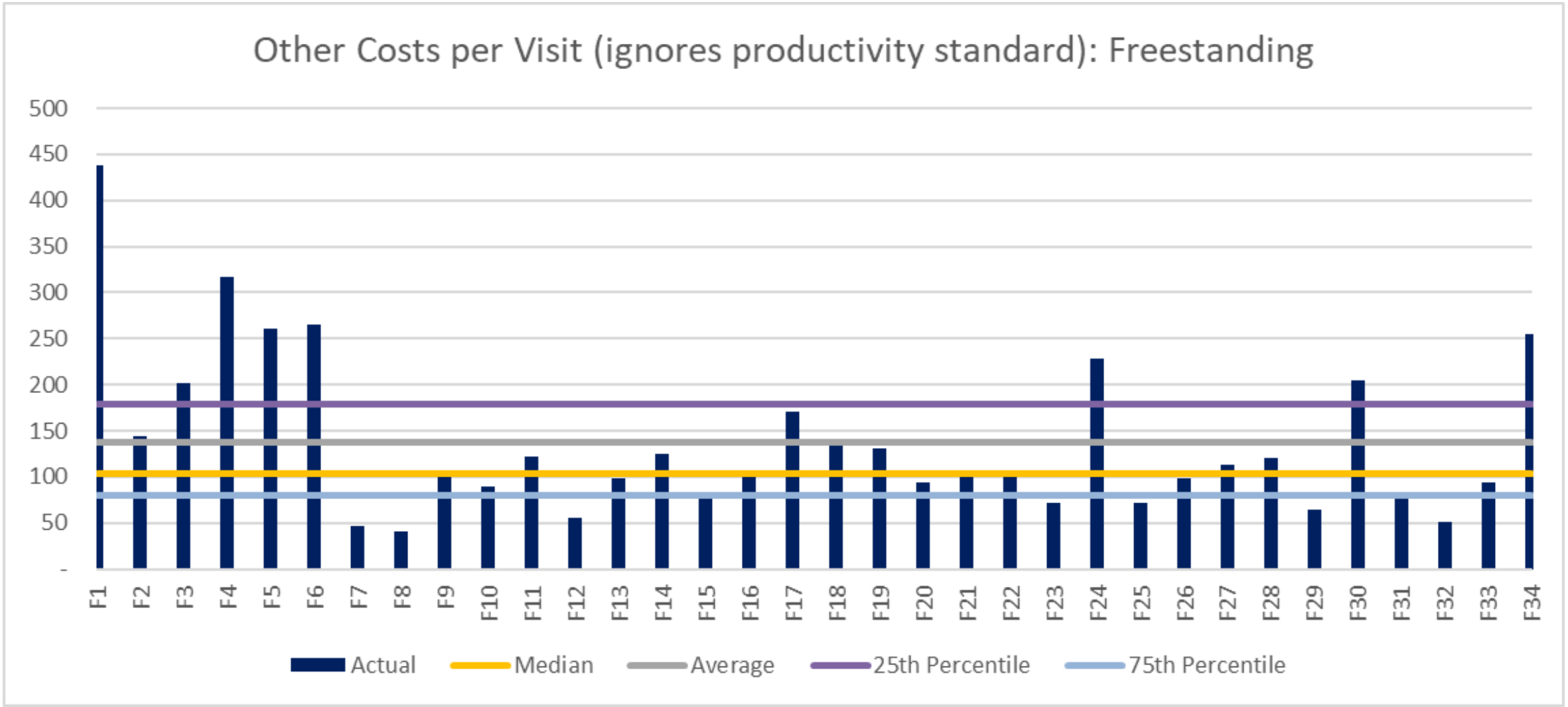


Max = 273
Min = 32
Average = 145

Median = 139
25th Percentile = 186
75th Percentile = 109



Max = 438
Min = 41
Average = 138

Median = 103
25th Percentile = 179
75th Percentile = 80

TOTAL OTHER COST PER VISIT – COMPARISON

	Hospital Based	Free Standing
Max	$273	$438
Min	$32	$41
Average	$145	$138
Median	$139	$103
25th %	$186	$179
75th %	$109	$80

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OTHER COST PER VISIT STRATEGIES BEST PRACTICES

- Management of supply costs
  - Teams that can have conversations on preferences and costs

- Providers that are not adamant about specialty items

OTHER COST PER VISIT STRATEGIES

- Review overhead costs
  - Building cost
  - Utilities
  - Administrative and General
    - Often ignored
  - Housekeeping
  - Health Information Management

MEDICARE PAYER MIX

MEDICARE PAYER MIX

- May be an indication of profitability

- Lower Medicare payor mix may assist in improving financial performance
  - Impact will vary based on cost per visit versus commercial payment
  - Calculation can be impacted by high Medicare Advantage penetration
  - Higher Medicaid payor utilization may have bigger impact than higher Medicare

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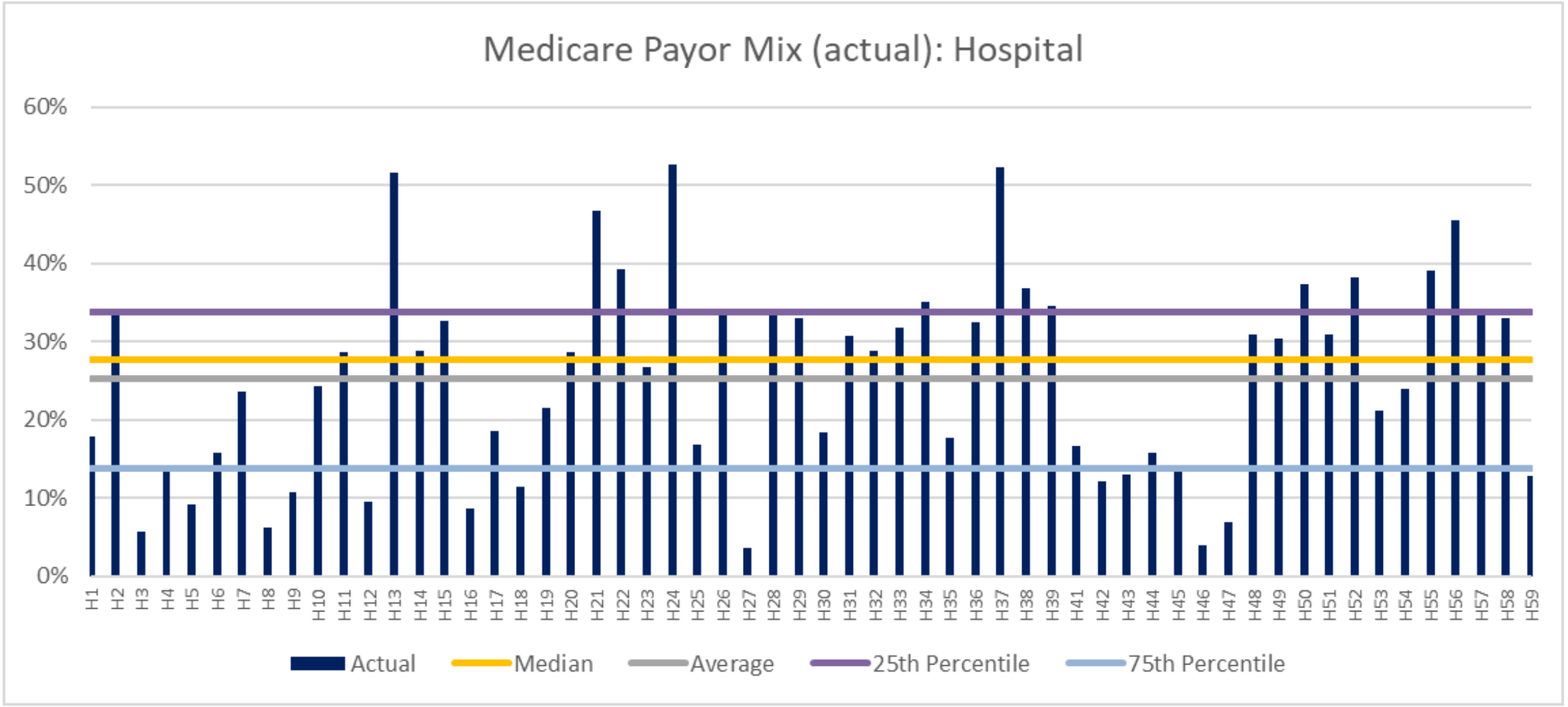
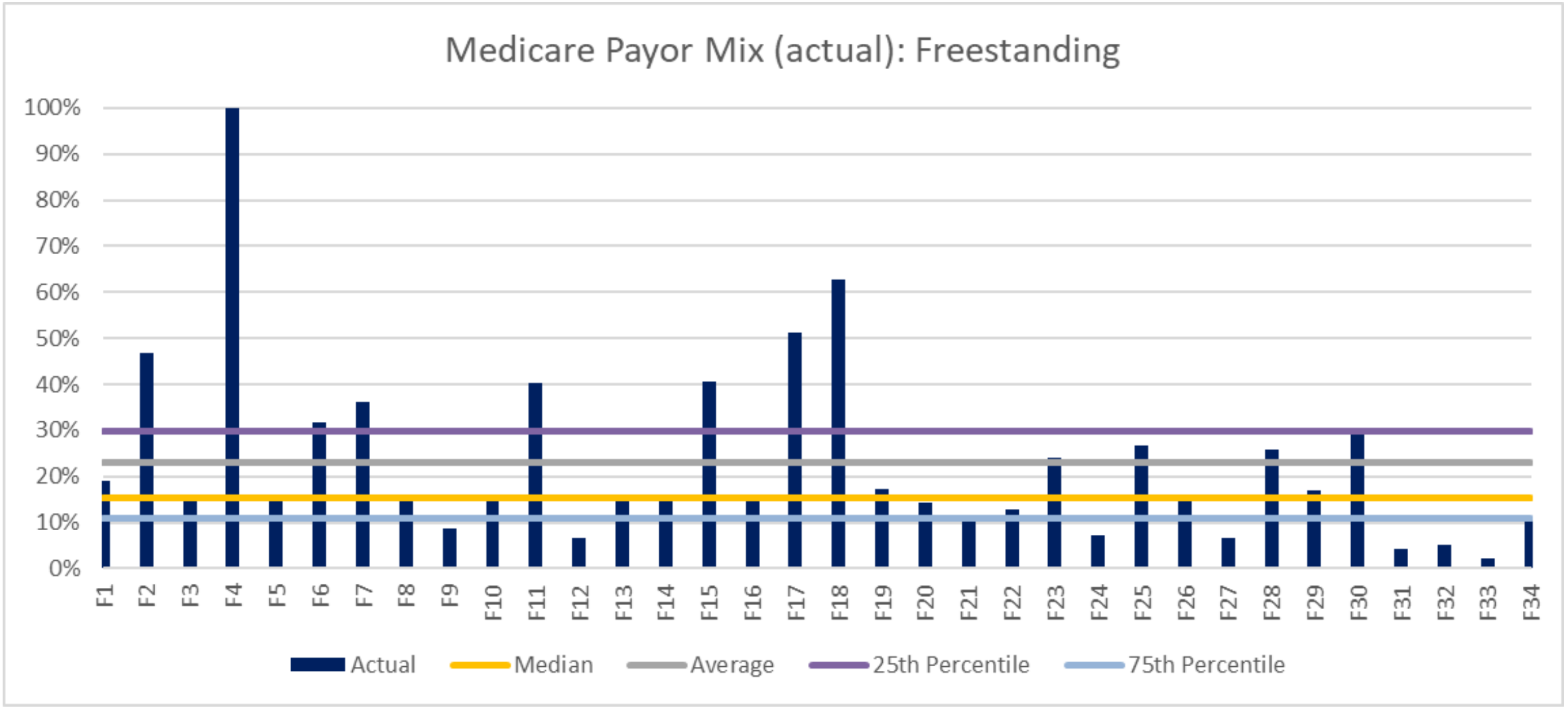


Max = 53%
Min = 4%
Average = 25%

Median = 28%
25th Percentile = 34%
75th Percentile = 14%



Max = 100%
Min = 2%
Average = 23%

Median = 15%
25th Percentile = 30%
75th Percentile = 11%

MEDICARE PAYER MIX - COMPARISON

	Hospital Based	Free Standing
Max	53%	100%
Min	4%	2%
Average	25%	23%
Median	28%	15%
25th %	34%	30%
75th %	14%	11%

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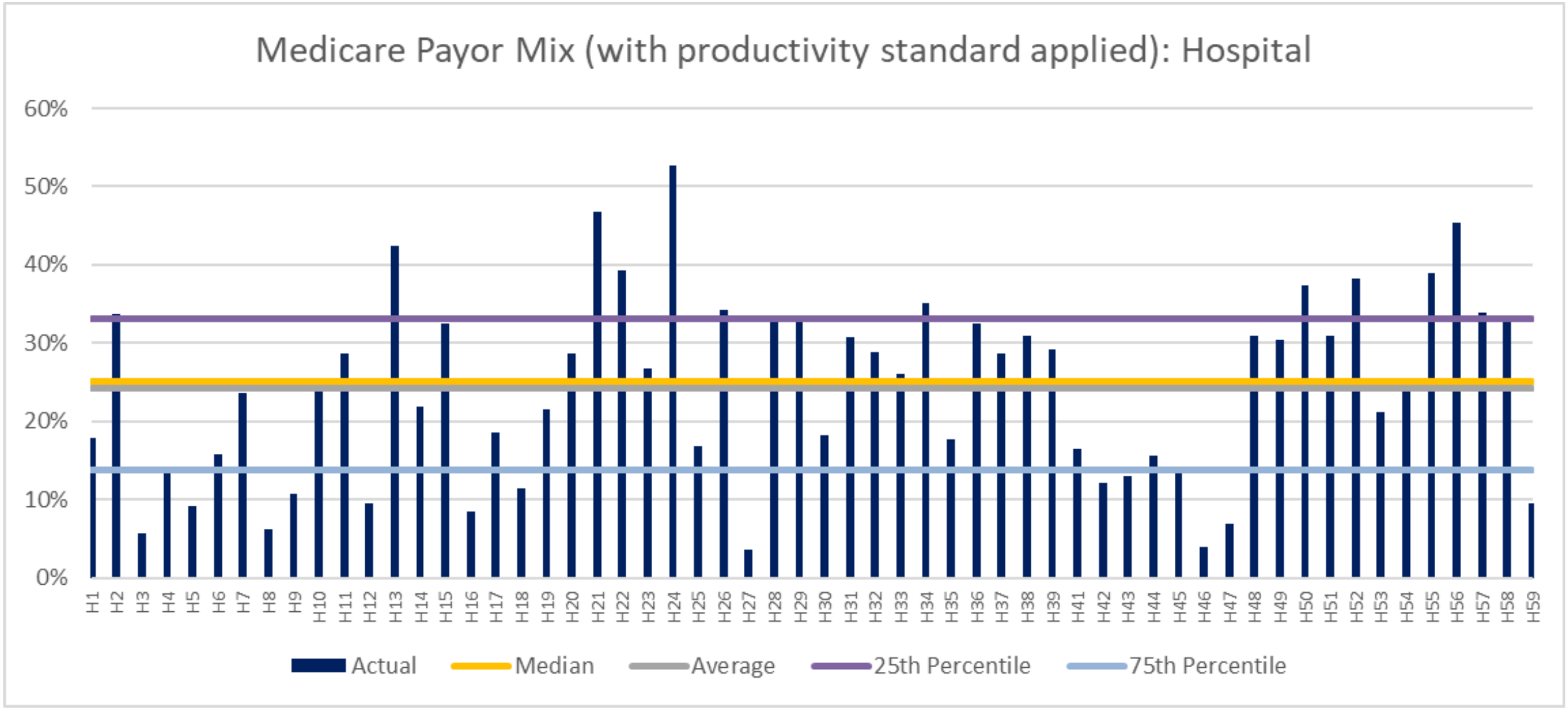
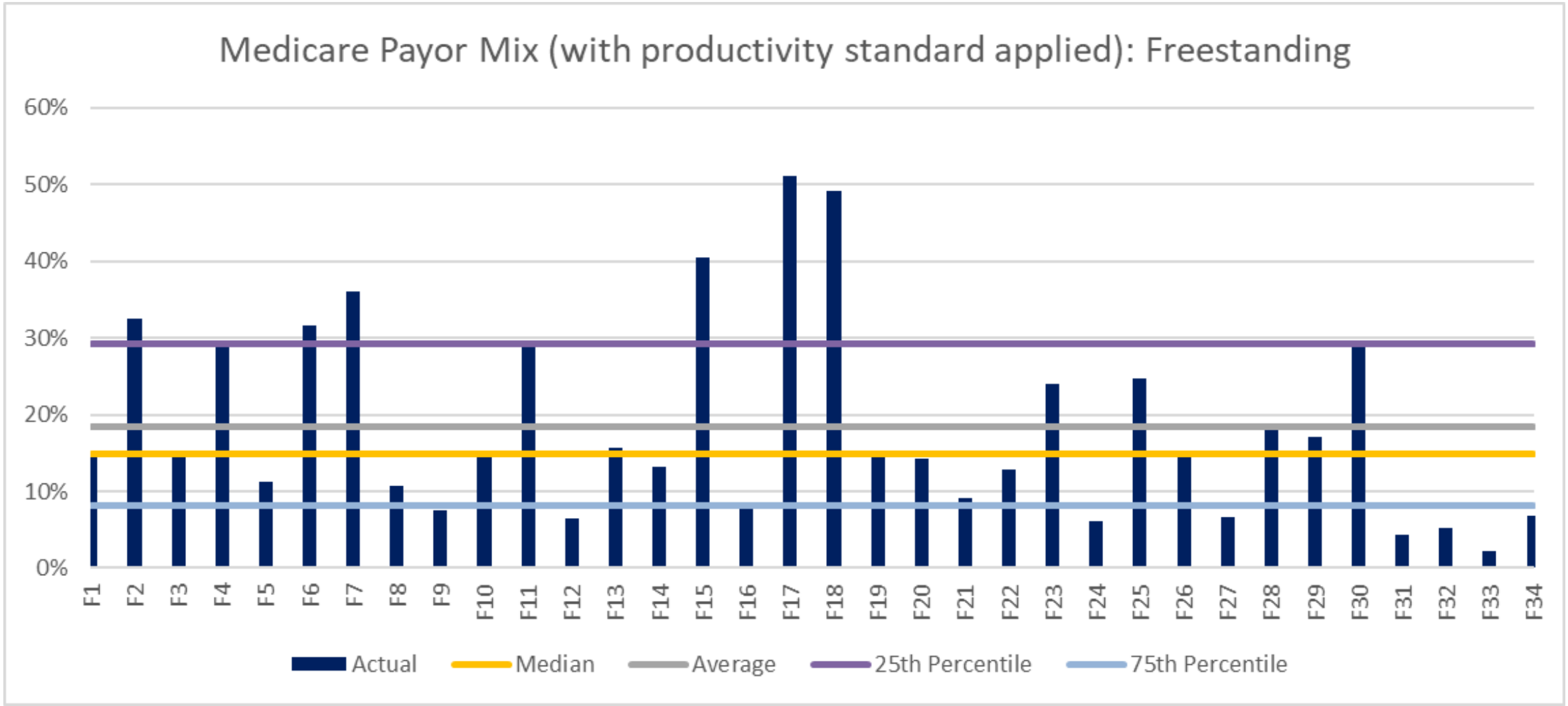


Max = 53%
Min = 4%
Average = 24%

Median = 25%
25th Percentile = 33%
75th Percentile = 14%



Max = 51%
Min = 2%
Average = 18%

Median = 15%
25th Percentile = 29%
75th Percentile = 8%

MEDICARE PAYER MIX – COMPARISON ADJUSTED FOR PRODUCTIVITY STANDARD

	Hospital Based	Free Standing
Max	53%	51%
Min	4%	2%
Average	24%	18%
Median	25%	15%
25th %	33%	29%
75th %	14%	8%

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MEDICARE PAYER MIX STRATEGIES BEST PRACTICES

- Capitalizing on a market where other providers are not accepting new patients
- Increase number of in network providers
- In a market with higher Medicaid
- Located across the street from hospital with some steerage to avoid the emergency room
- In a wealthier community with farmers and others moving into the community

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MEDICARE PAYER MIX STRATEGIES BEST PRACTICES

- New providers focused on a younger population
  - Willing to squeeze in patients
- Newer providers with young families
- Having APPs that were nurses that went back to school
- Providers that are from or married into the community
- APPs previously in private practice attracting a younger population
- Addition of targeted services
  - Weight loss
  - Botox
  - Migraine management

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MEDICARE PAYER MIX STRATEGIES BEST PRACTICES

- Expansion into proceduralists
  - Surgeons
  - Dexa
- Employing ACO practices for all age levels
- With loss of labor and delivery – adding prenatal to a point
  - Transitioning families back
- Adjusted schedules
  - 7:30 am – 5:00 pm schedule with lunch time appointments (walk ins)
    - Open access model – 2 appointments (am/pm) held open for walk ins
- Focus on growth and getting as many patients as possible
  - Promoting sports physicals and wellness
  - Child wellness as a focus

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MEDICARE PAYER MIX STRATEGIES

- Maximize non-Medicare volumes
  - Do not focus on minimizing Medicare volumes
  - Consider marketing efforts
  - Promote wellness activities for all age groups
  - Implement telehealth strategies
  - Explore alternative clinic hours
  - Think access

- Important notes
  - Higher Medicare percentage may appear to be beneficial is there is a high cost per visit
  - Need to think long term versus short term strategy

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VISITS PER FTE

- PHYSICIAN
- NURSE PRACTITIONER
- PHYSICIAN ASSISTANT
- CLINICAL SOCIAL WORKER
- CERTIFIED NURSE MIDWIFE
- VISITING NURSE
- CLINICAL PSYCHOLOGIST

VISITS PER PROVIDER FTE

- Higher visit numbers are an indicator of greater productivity
  - Can lower cost per visit
  - Can improve profitability of services provided to other payors

- Cost per visit calculations are subject to productivity standard as applied by Medicare
  - 4,200 visits per Physician FTE
  - 2,100 visits per Nurse Practitioner/Physician Assistant
  - Applied in the aggregate
  - Productivity Standards do not apply to other providers

- Higher numbers are favorable

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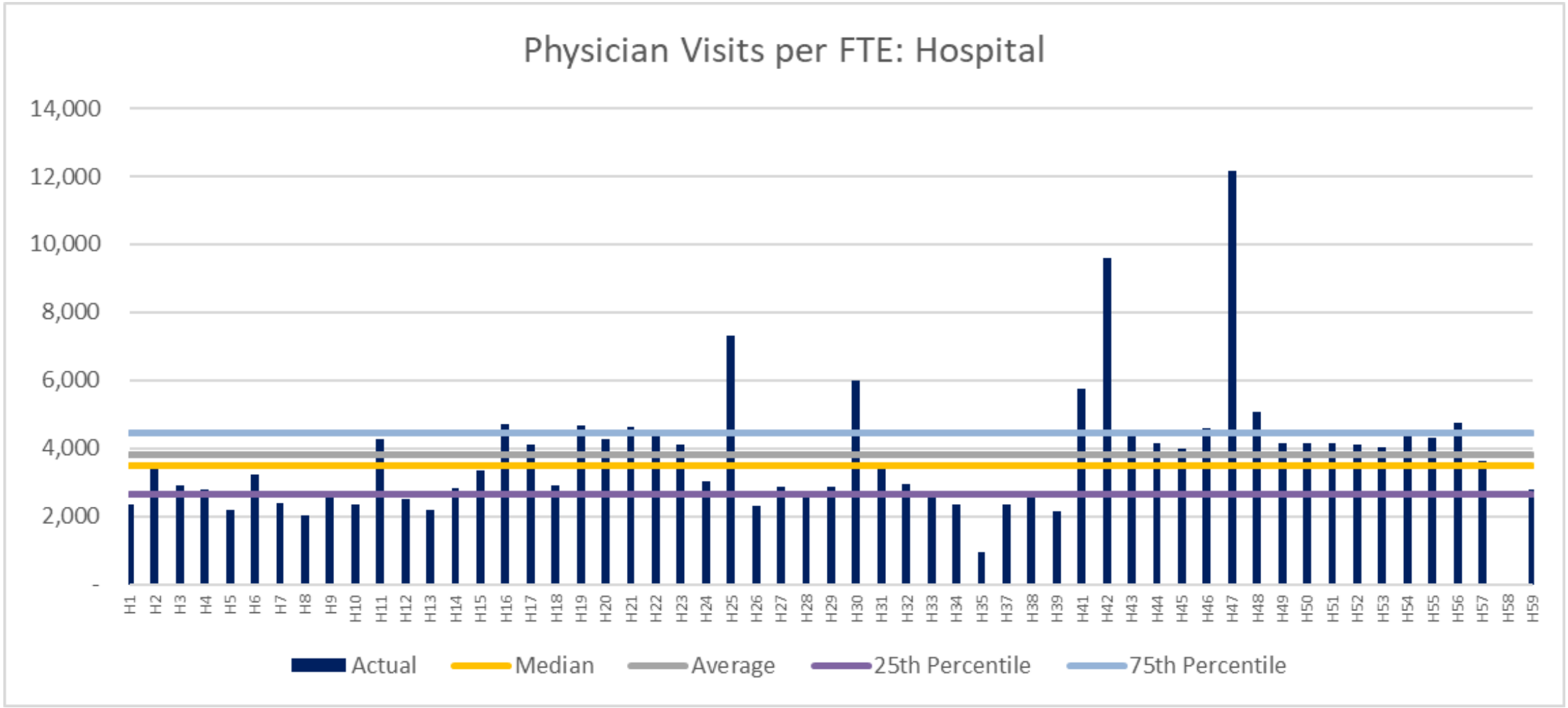
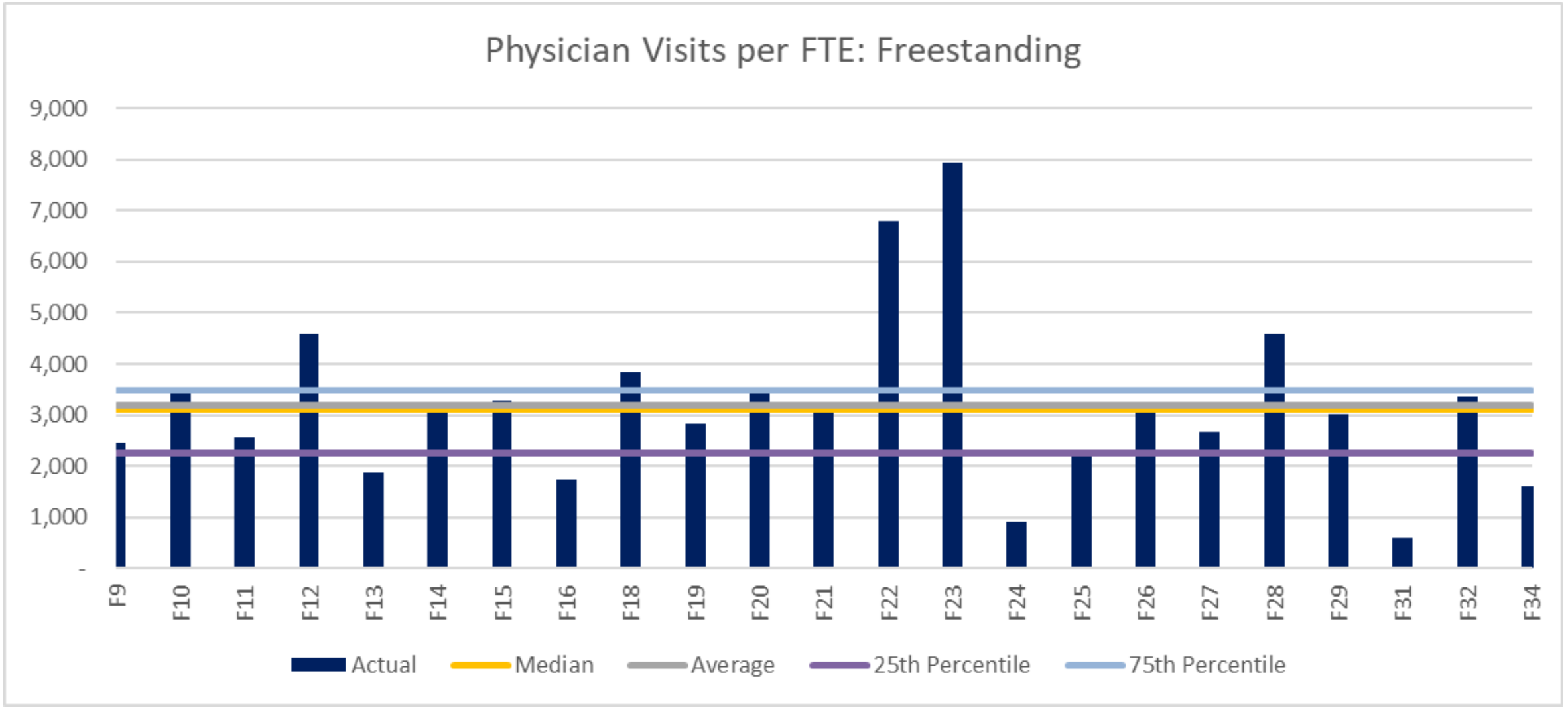


Max = 12,148 Median = 3,486
Min = 942 25th Percentile = 2,634
Average = 3,795 75th Percentile = 4,437



Max = 7,931
Min = 600
Average = 3,192

Median = 3,123
25th Percentile = 2,267
75th Percentile = 3,484

PHYSICIAN VISITS PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	12,148	7,931
Min	942	600
Average	3,795	3,192
Median	3,486	3,123
25th %	2,634	2,267
75th %	4,437	3,484

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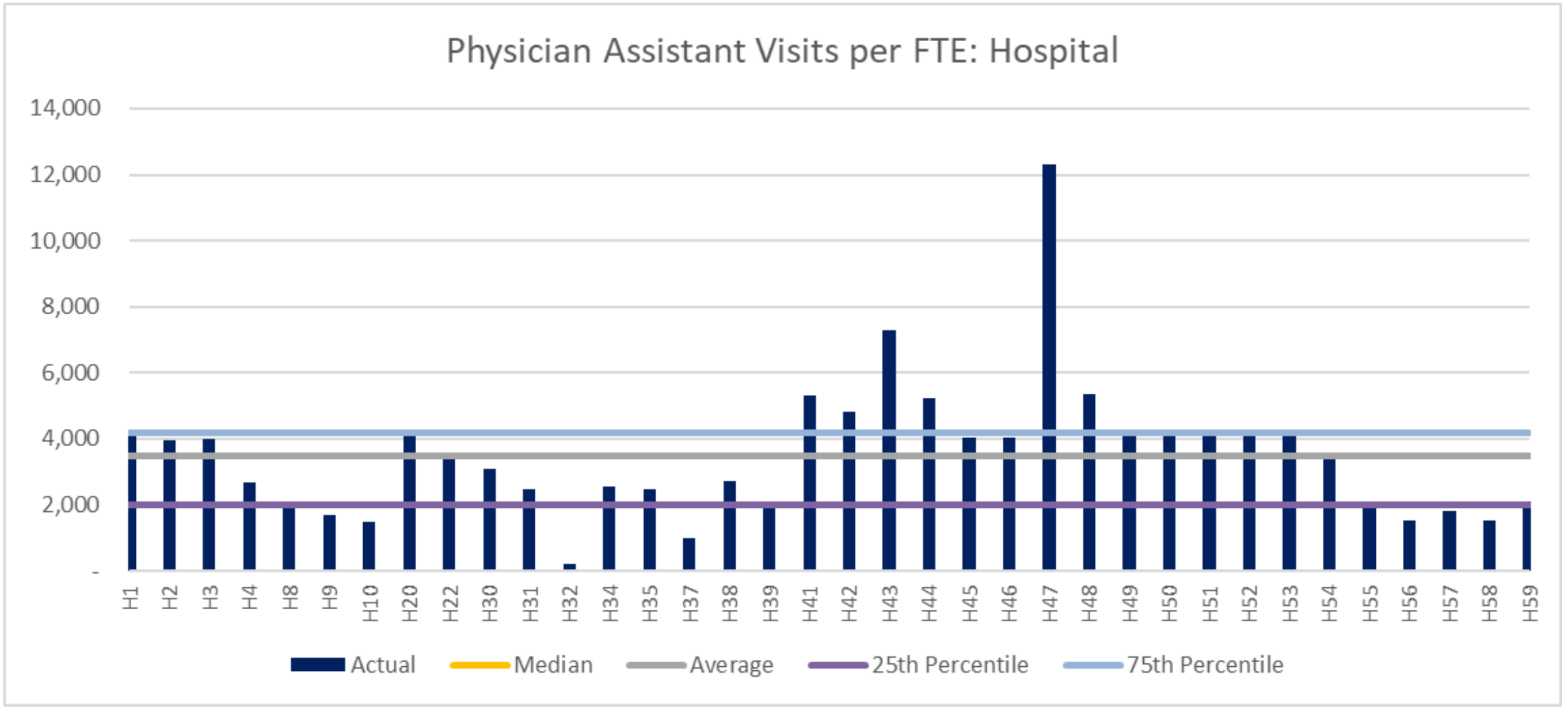
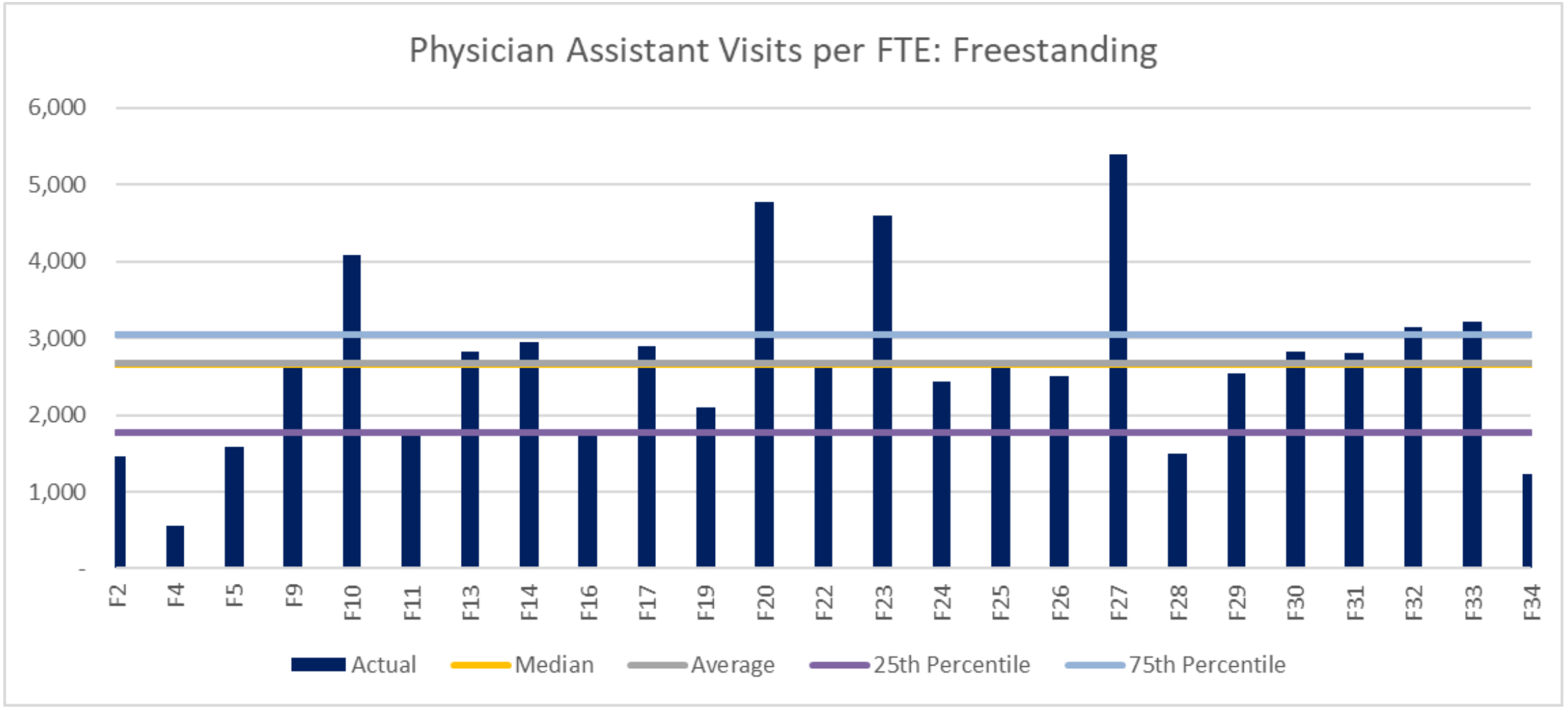


Max = 12,300
Min = 193
Average = 3,491

Median = 3,483
25th Percentile = 2,005
75th Percentile = 4,162



Max = 5,400
Min = 550
Average = 2,681

Median = 2,661
25th Percentile = 1,775
75th Percentile = 3,045

PHYSICIAN ASSISTANT (PA) VISITS PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	12,300	5,400
Min	193	550
Average	3,491	2,681
Median	3,483	2,661
25th %	2,005	1,775
75th %	4,162	3,045

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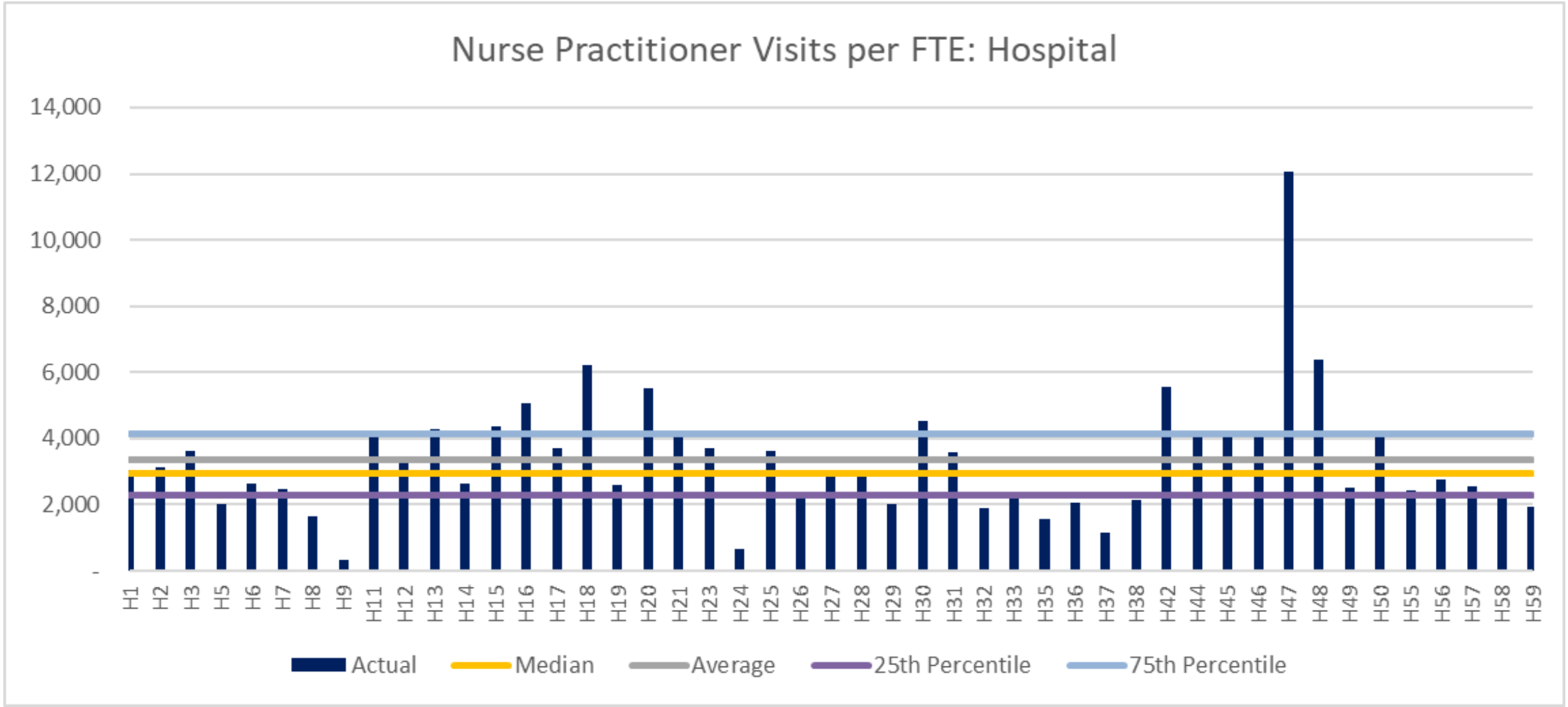
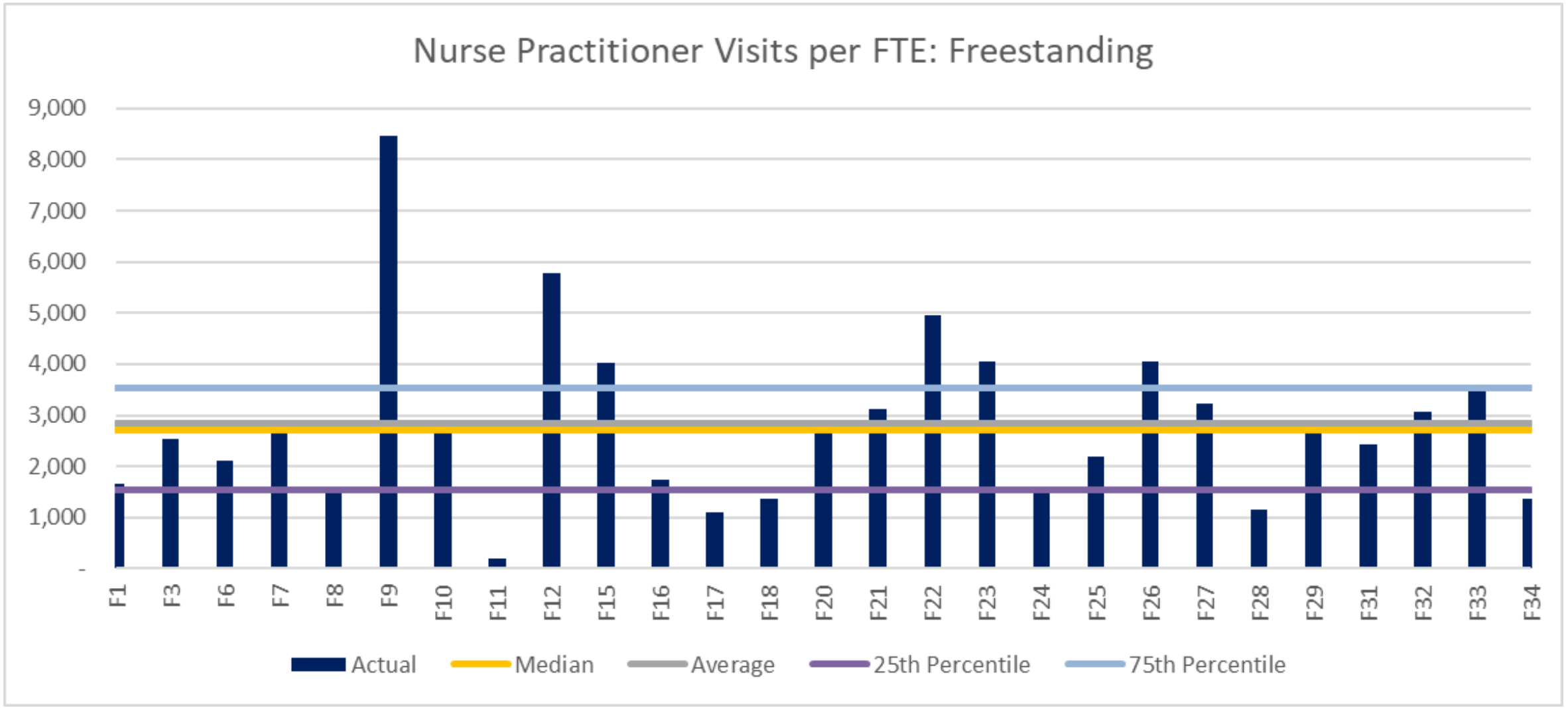


Max = 12,082
Min = 340
Average = 3,343

Median = 2,937
25th Percentile = 2,307
75th Percentile = 4,131



Max = 8,473
Min = 200
Average = 2,829

Median = 2,709
25th Percentile = 1,533
75th Percentile = 3,543

NURSE PRACTITIONER (NP) VISITS PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	12,082	8,473
Min	340	200
Average	3,343	2,829
Median	2,937	2,709
25th %	2,307	1,533
75th %	4,131	3,543

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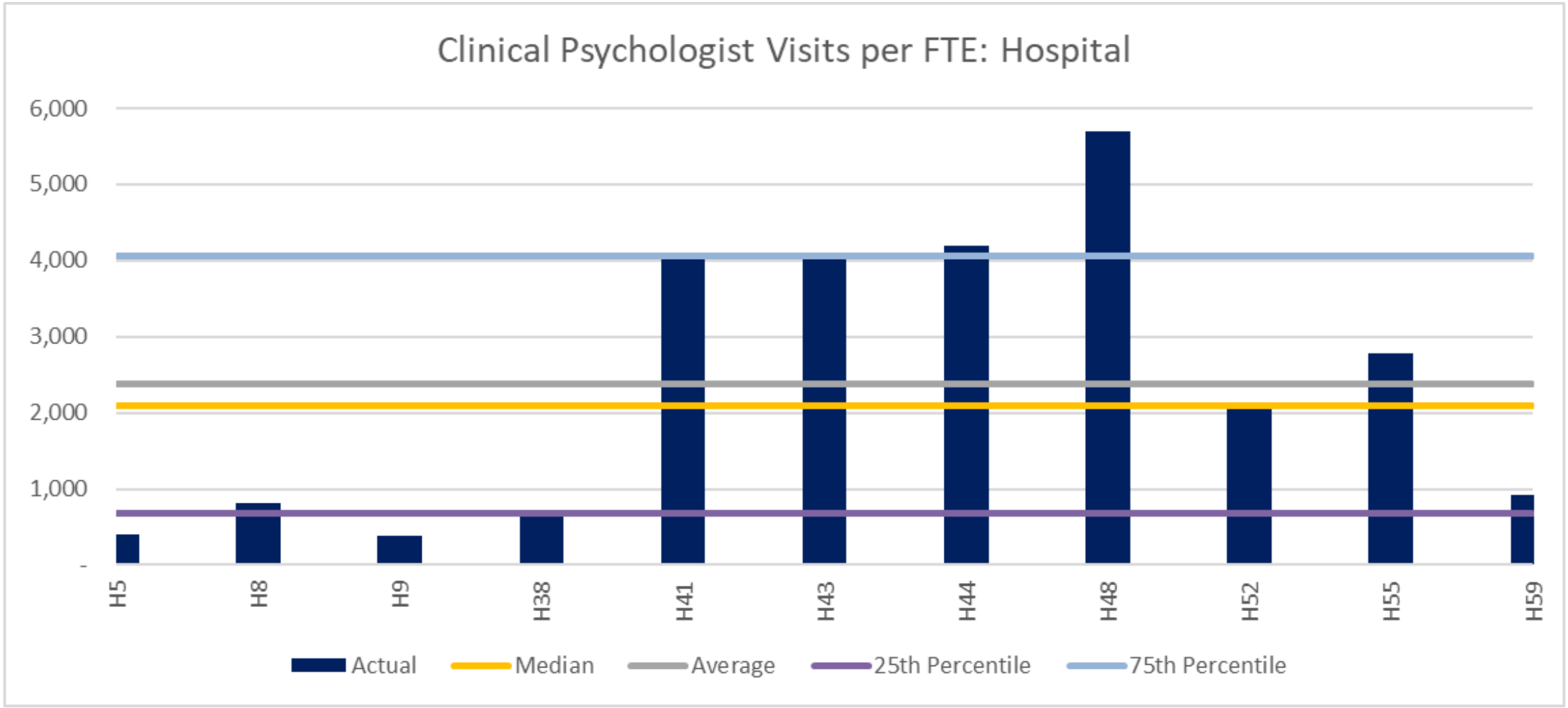

Max = 5,695
Min = 380
Average = 2,370

Median = 2,100
25th Percentile = 683
75th Percentile = 4,064

CLINICAL PSYCHOLOGIST (CP) VISITS PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	5,695	-
Min	380	-
Average	2,370	-
Median	2,100	-
25th %	683	-
75th %	4,064	-

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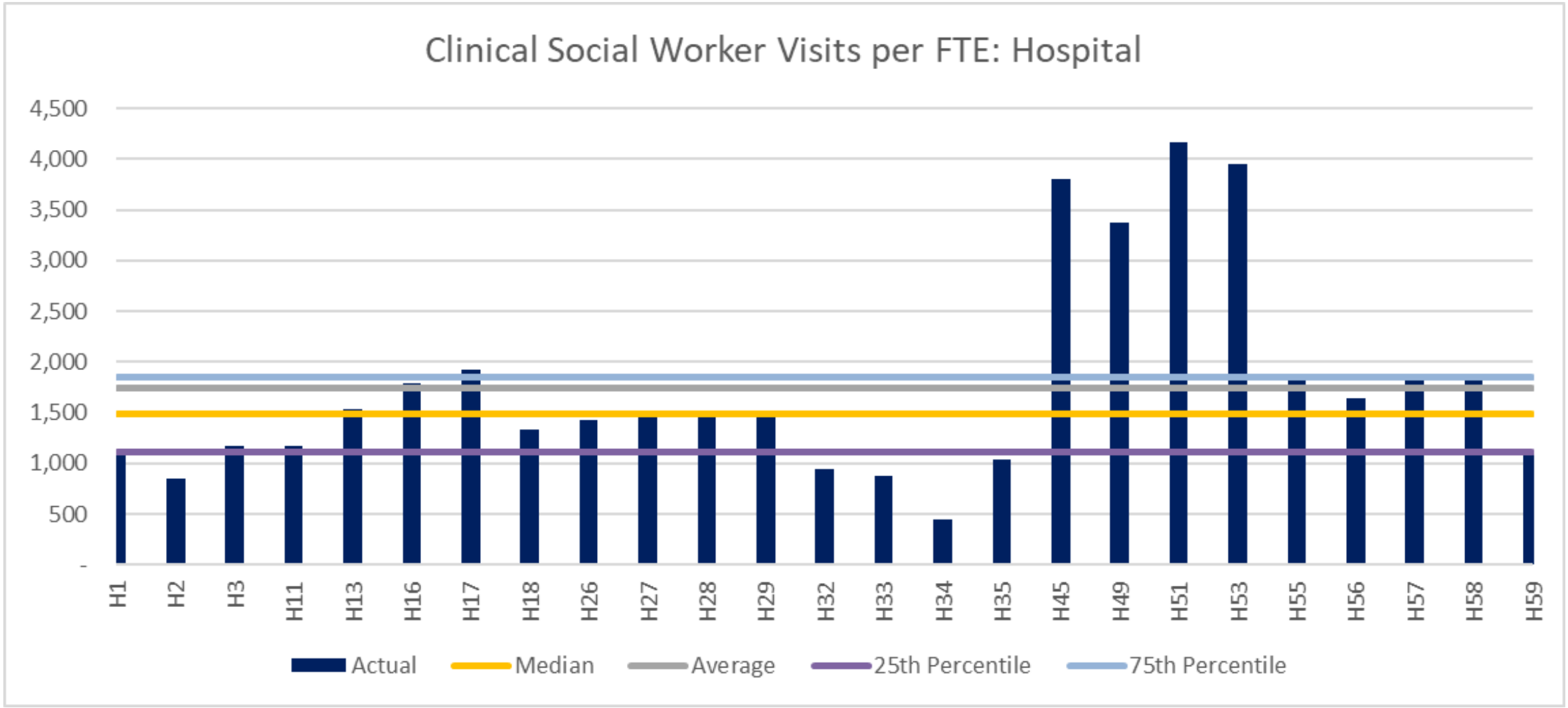
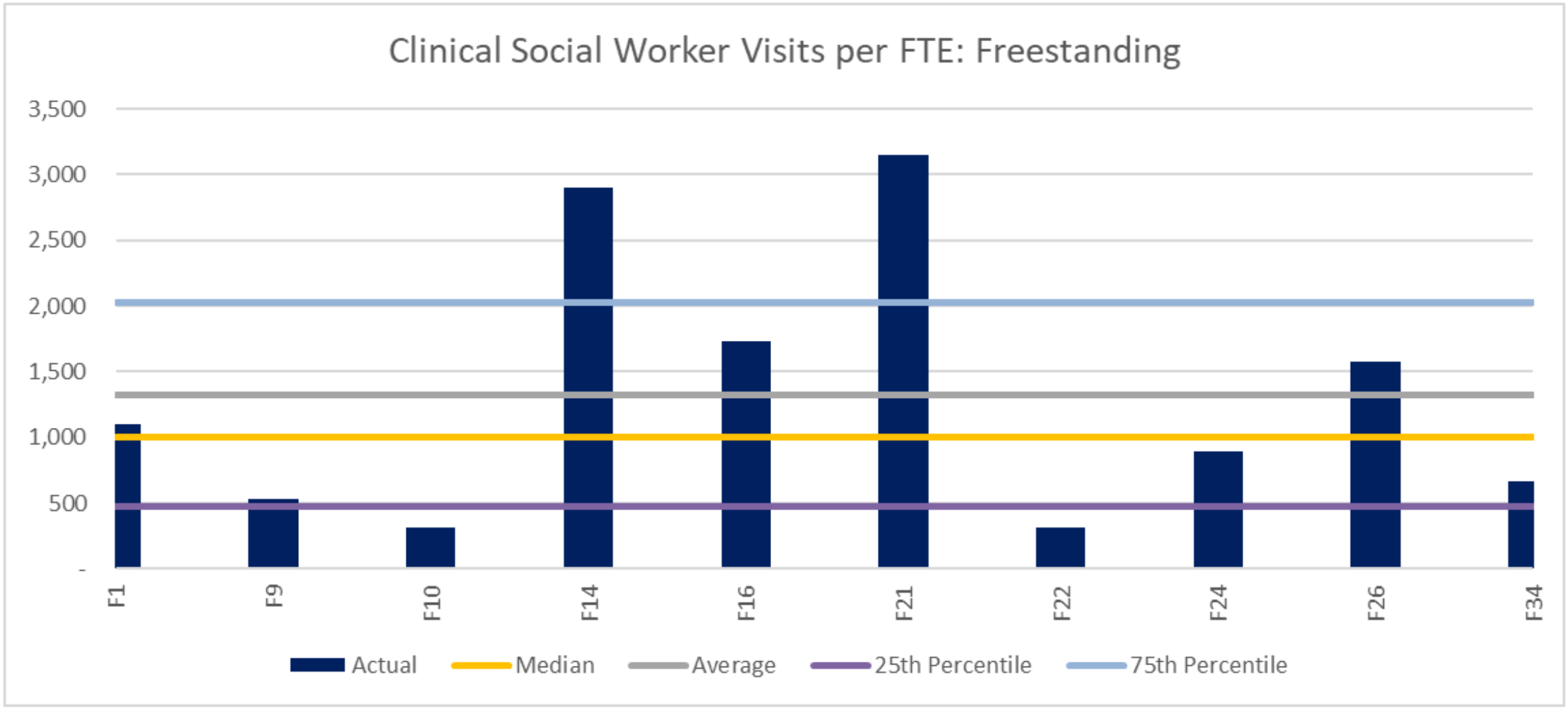


Max = 4,162
Min = 450
Average = 1,745

Median = 1,486
25th Percentile = 1,110
75th Percentile = 1,847



Max = 3,144
Min = 314
Average = 1,318
Median = 999
25th Percentile = 476
75th Percentile = 2,026

CLINICAL SOCIAL WORKER (CSW) VISITS PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	4,162	3,144
Min	450	314
Average	1,745	1,318
Median	1,486	999
25th %	1,110	476
75th %	1,847	2,026

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VISITS PER FTE STRATEGIES BEST PRACTICES

- Having an LPC that has the demand and referral from physicians
- A provider that is also a working manager
- Very good medical assistants
- 3 to 4-day workdays – extended hours on clinic days
- Internal respect of team members / Environment
- Focus on Access
  - Schedules
  - Focus on hours
  - Push to fill appointments
  - Work call-in list to fill no shows
  - Allowing direct scheduling
- Little ability to meddle with templates
- Minimize ability to block off time in calendar
- Watching trends of walk in numbers and adjusting number of walk in slots available
- Sharing budgets and volumes on a weekly basis
- Productivity compensation after 2 years

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VISITS PER FTE STRATEGIES BEST PRACTICES

- Physicians focused on volumes/throughput
  - New
  - Existing
- Focus by management to meet legitimate needs of providers
- Provision of scribe based on need (not solely on desire)
- Acquisition of APPs that have historically had their own private practice
  - Owner mindset
- APPs that fit in well with physician providers
- Providers that are very connected to the community
  - From the community
  - Local family name
  - Not just seen in the clinic setting – part of the community

VISITS PER FTE STRATEGIES BEST PRACTICES

- Printing and sending physical and screening letters
  - Provider completes follow up
- Providers participate in ER coverage to manage RHC FTEs
  - Busier when in clinic
- Focus on APPs drives up APPs visits per APP
- Utilizing video and telehealth services
- Provider compensation based on production (some at 100% production)
  - Shorter scheduled visits
    - 15 and 30 minute visits
  - Managed double booking

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VISITS PER FTE STRATEGIES BEST PRACTICES

- Follow up reminders to drive low no show volumes
- Longevity of providers drives volumes over time – limited turnover
- Online scheduling
- High producing specialty APPs (dermatology / chiropractor)
- Heavy NH volumes drives visits for physician (only contracted for NH visits)
- Has more to do with the provider – look at recruitment process

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VISITS PER FTE STRATEGIES BEST PRACTICES

- Nurse/support staff engagement
- Culture has driven volumes – Egos left at the door
  - Not afraid to squeeze in patients
  - Drives volumes from ER
- Some utilization of extended hours
- Availability of walk-in visits / taking same day requests
- Utilization of 4 versus 5 day workdays – longer/more efficient days
- Utilization of part time providers

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VISITS PER FTE STRATEGIES

- It is more about processes than working harder
  - Processes
  - Accountability

- Longevity can drive loyalty and volumes

- Review scheduling strategies to ensure maximum number of visits available
  - Protocols vary significantly
    - Between practices
    - Between providers in same practices
  - Scheduled time per visit
  - Provider effort versus ancillary support effort
  - Be creative on hours of operation
  - Manage late starts and early departures

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VISITS PER FTE STRATEGIES

- Understand the FTE calculation and determine strategies
  - Supervision time
  - Paid Time Off/Continuing Medical Education
  - Emergency Room call
  - Medical directorships
- Determine appropriateness of support personnel
  - Adequacy of hours
  - Appropriate skillsets
- Review compensation strategy
  - Flat compensation
  - Base plus productivity
  - Productivity only
  - Focus on creating incentive to promote productivity
    - May lead to higher cost per FTE
    - Can drive down cost per visit

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NP & PA FTE AS A PERCENTAGE OF TOTAL PROVIDER FTE

PERCENTAGE OF NP/PA FTES TO TOTAL PROVIDER FTES

- Requirement for minimum coverage by NP/PAs
- Compared to Physicians, NPs and PAs
- Percentage of total FTEs that are NP/PA varies significantly
  - Nationally
  - Statewide
- Potential benefits of higher percentage of NP/PA FTEs
  - Lower cost per FTE
  - Lower productivity standards for NP/PA
  - Control of cost to improve profitability of clinic services to other payors

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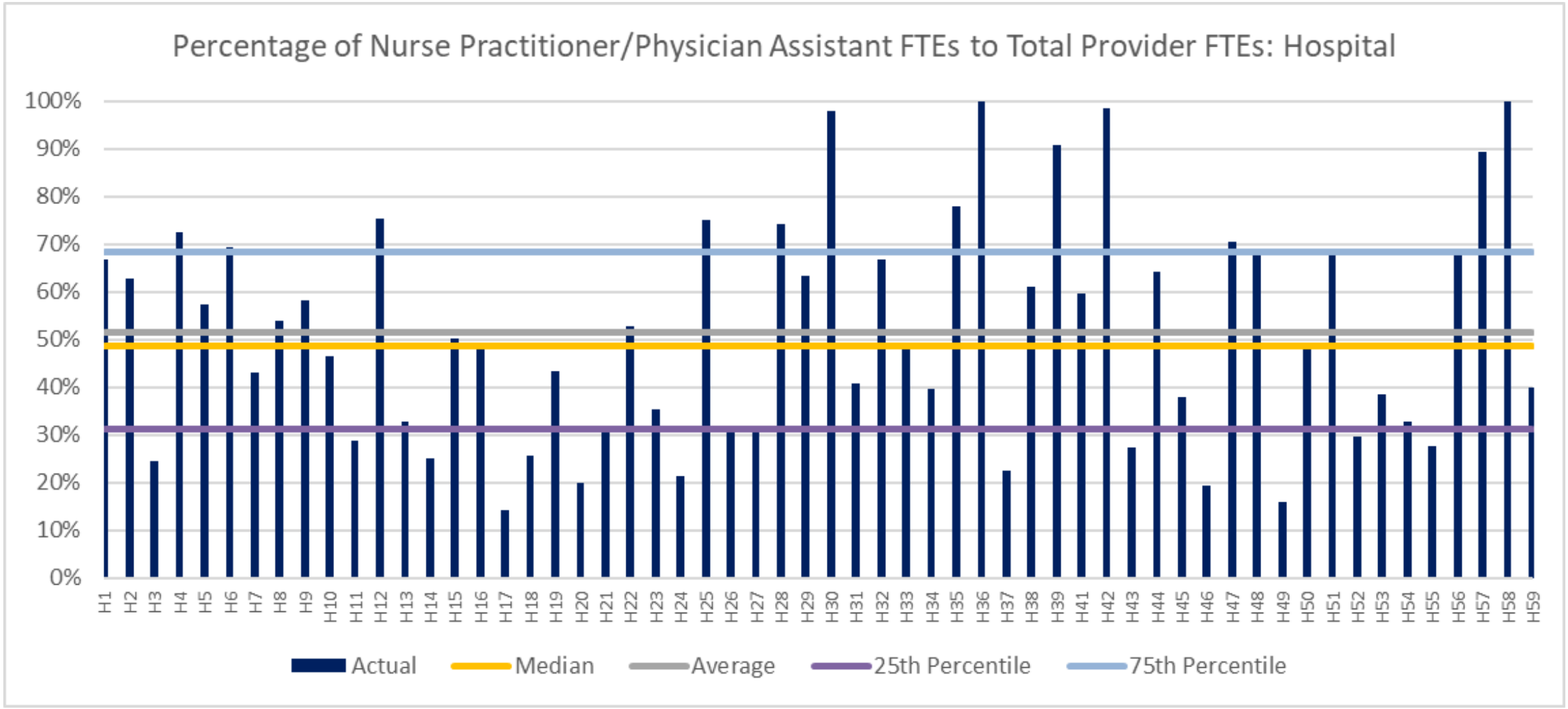
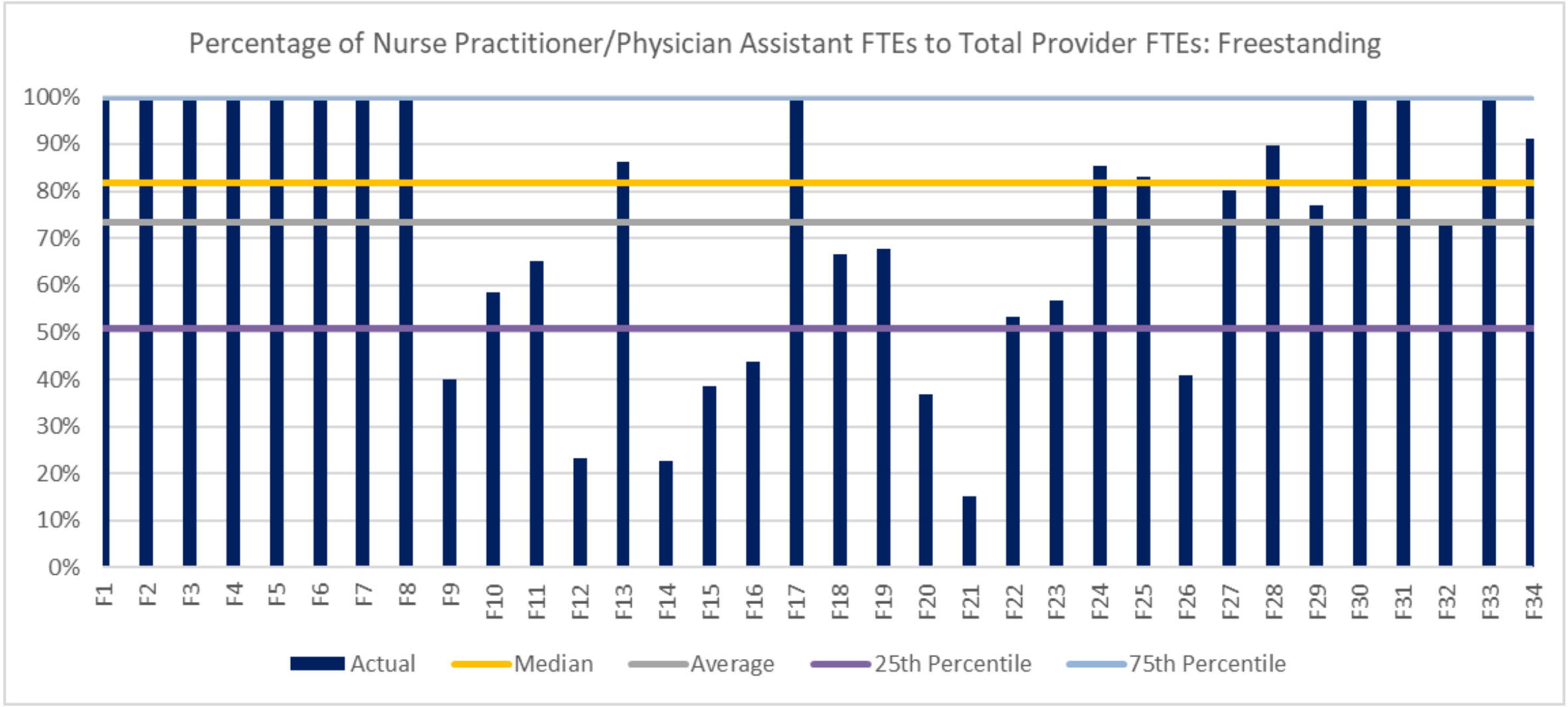


Max = 100%
Min = 14%
Average = 51%
Median = 49%
25th Percentile = 31%
75th Percentile = 68%



Max = 100%
Min = 15%
Average = 73%

Median = 82%
25th Percentile = 51%
75th Percentile = 100%

NP & PA FTE AS A PERCENTAGE OF TOTAL PROVIDER FTE - COMPARISON

	Hospital Based	Free Standing
Max	100%	100%
Min	14%	15%
Average	51%	73%
Median	49%	82%
25th %	31%	51%
75th %	68%	100%

PERCENTAGE OF NP/PA FTES TO TOTAL PROVIDER FTES BEST PRACTICES

- Leaving physicians in main clinics with APPs focused on remote locations
  - Higher acuity and those preferring physicians go to main clinic
- Focus on students coming in and working with APPs
  - Do not have to recruit for providers
    - Autonomy of practice
    - Have own practice
  - Dealing with community pushback
    - Get providers into the community
    - "Doc Talks"
    - Active in emergency room
    - Building relationships
- Be intentional in recruiting
- May have to pay a litter better than average for APPs

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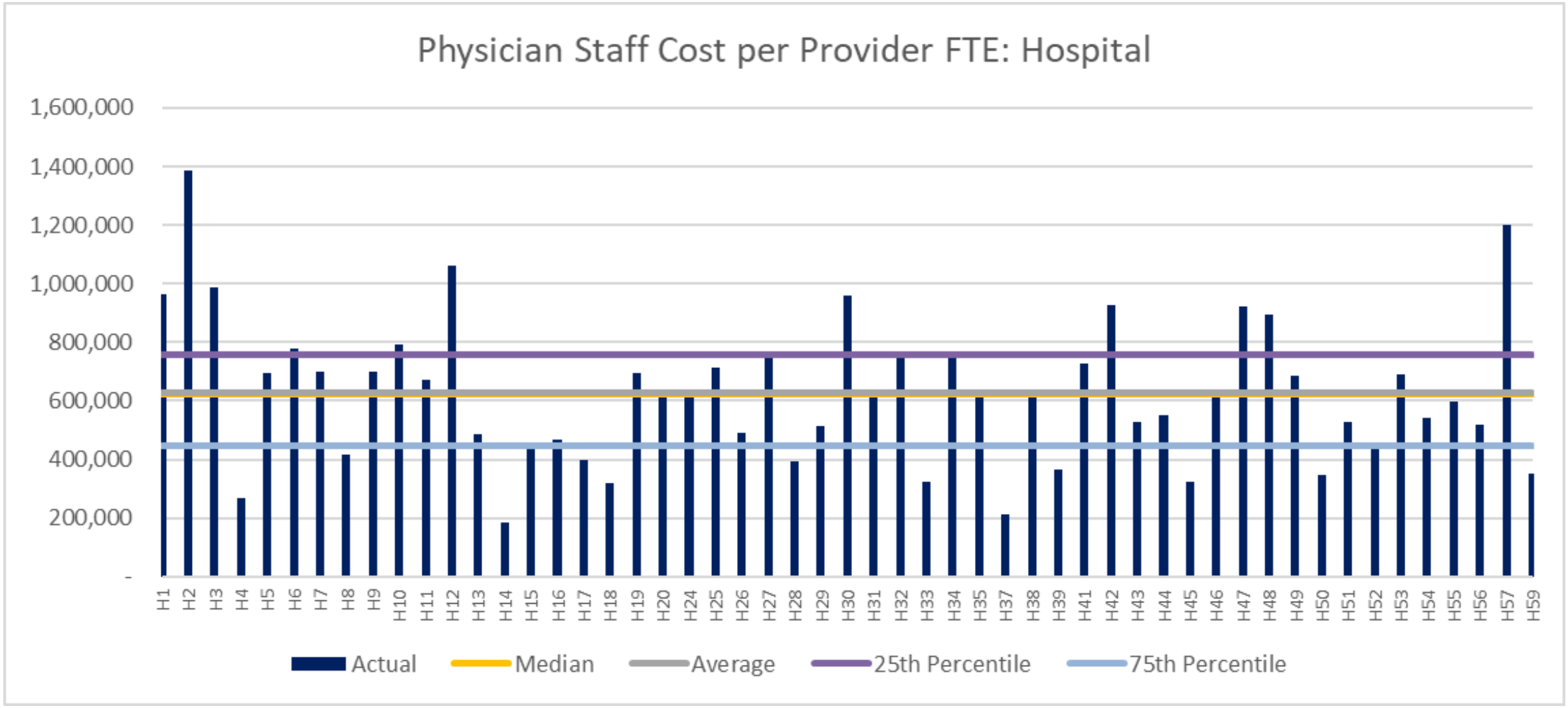
PERCENTAGE OF NP/PA FTES TO TOTAL PROVIDER FTES

- Changes in percentages may take a significant amount of time
- May require a change in mindset
  - Board
  - Physicians
  - Emergency Room Coverage
  - Community
- Requires internal discussion and marketing
- Need high level of engagement by NP/PA's

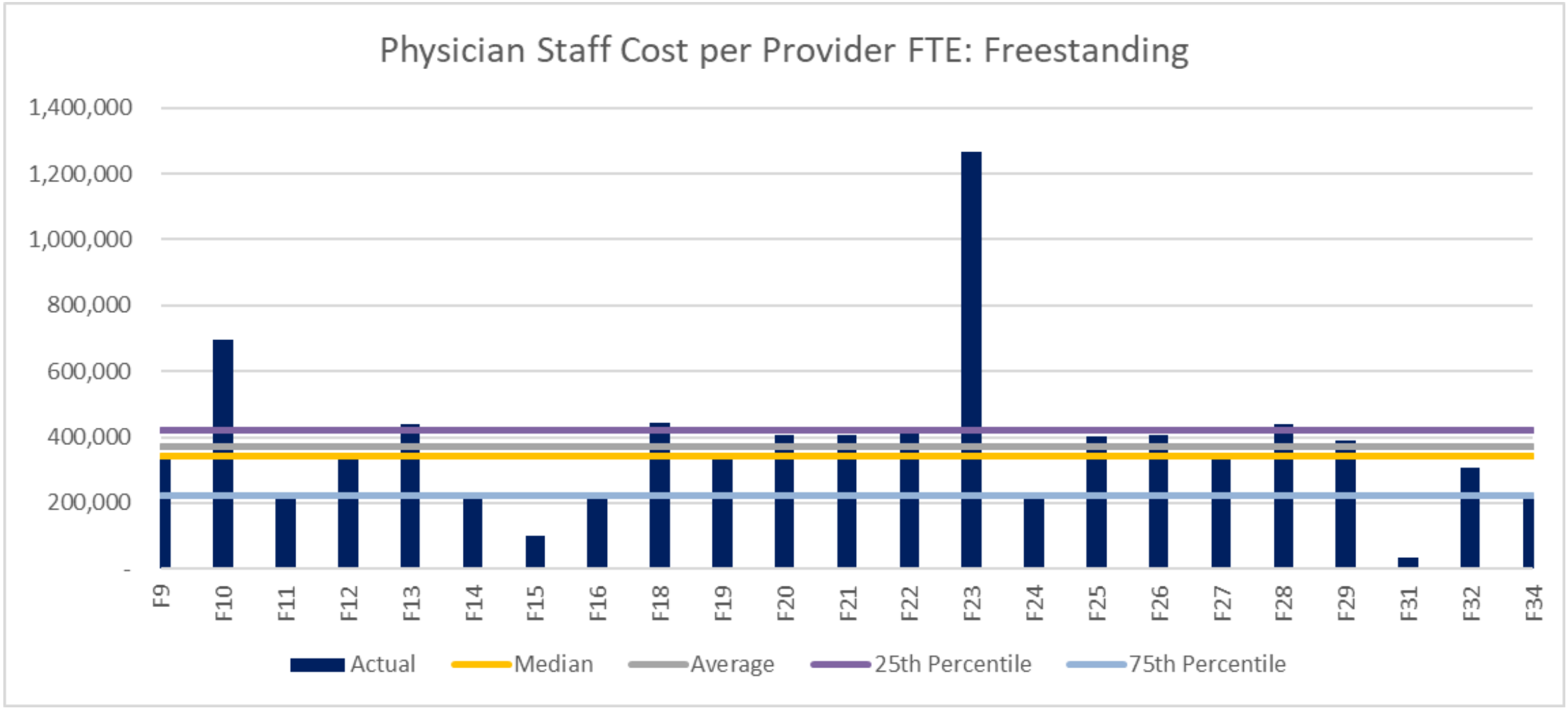
PROVIDER COST PER FTE

PROVIDER COST PER FTE

- Compensation levels vary significantly between RHCs
  - Market driven differences
  - Unknown……
- Lower calculations may:
  - Demonstrate ability to control costs
  - Improve profitability of services to other payors



Max = 1,387,115 Median = 621,592
Min = 182,661 25th Percentile = 757,086
Average = 625,511 75th Percentile = 444,711



Max = 1,267,314 Median = 343,869
Min = 32,800 25th Percentile = 420,950
Average = 373,335 75th Percentile = 221,617

PHYSICIAN COST PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	$1,387,115	$1,267,314
Min	$182,661	$32,800
Average	$625,511	$373,335
Median	$621,592	$343,869
25th %	$757,086	$420,950
75th %	$444,711	$221,617

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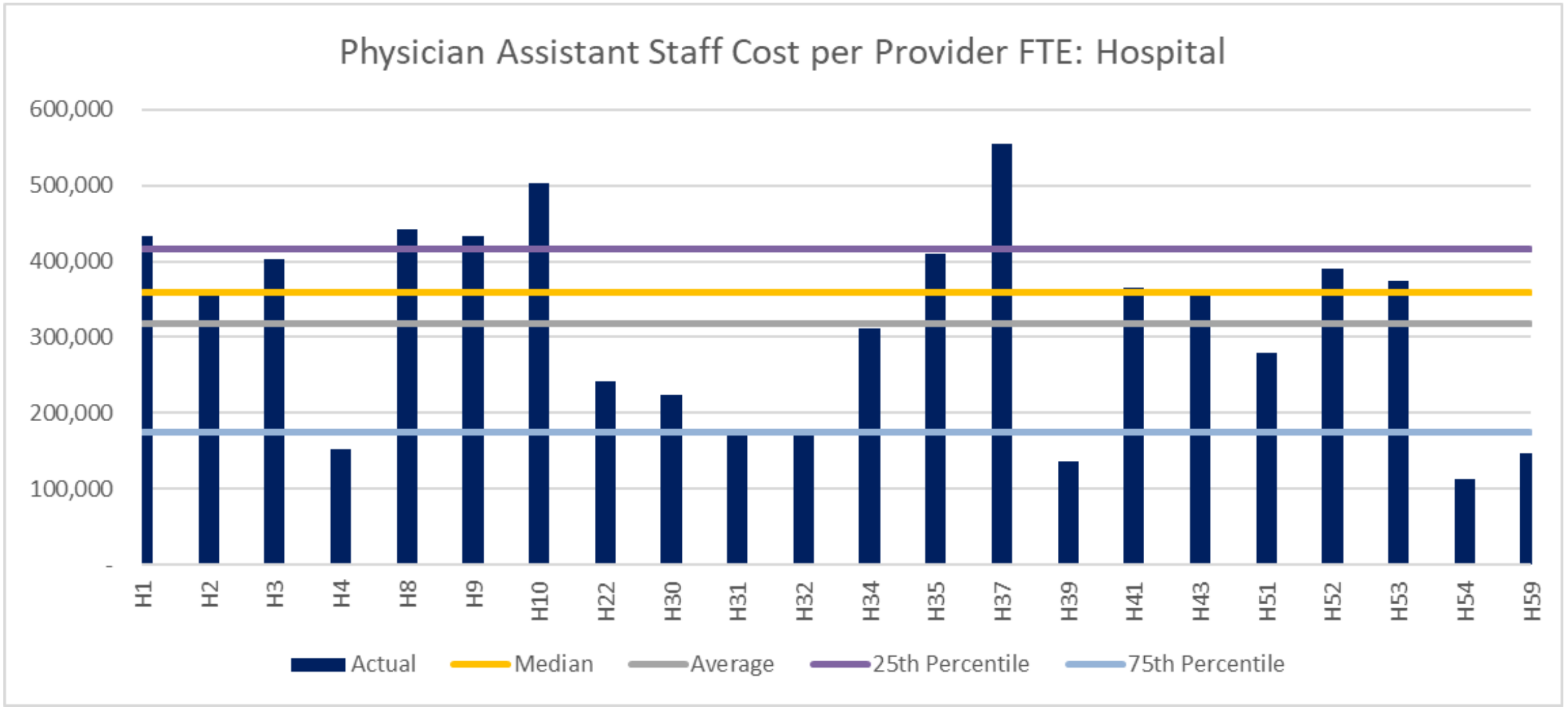
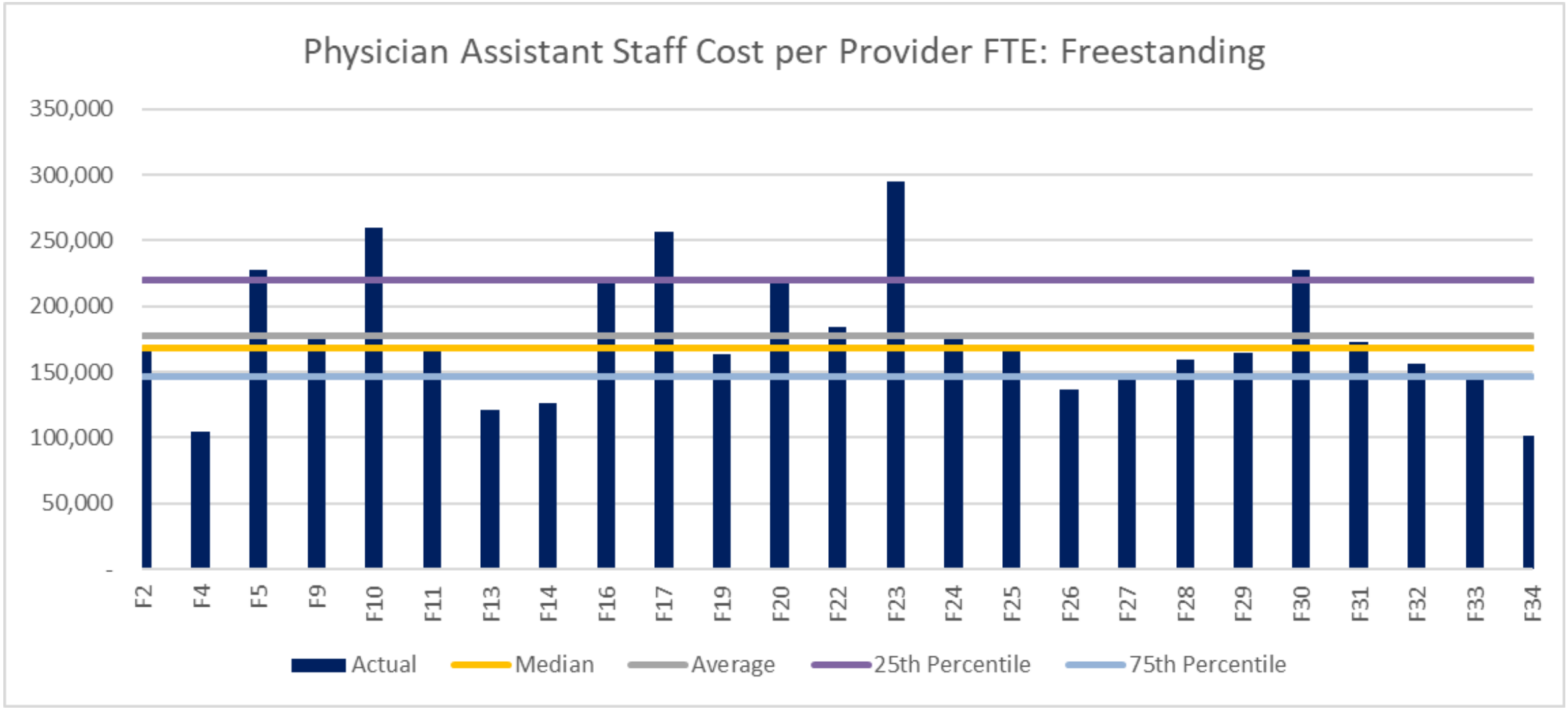


Max = 555,662
Min = 113,851
Average = 317,194

Median = 358,971
25th Percentile = 415,590
75th Percentile = 173,936



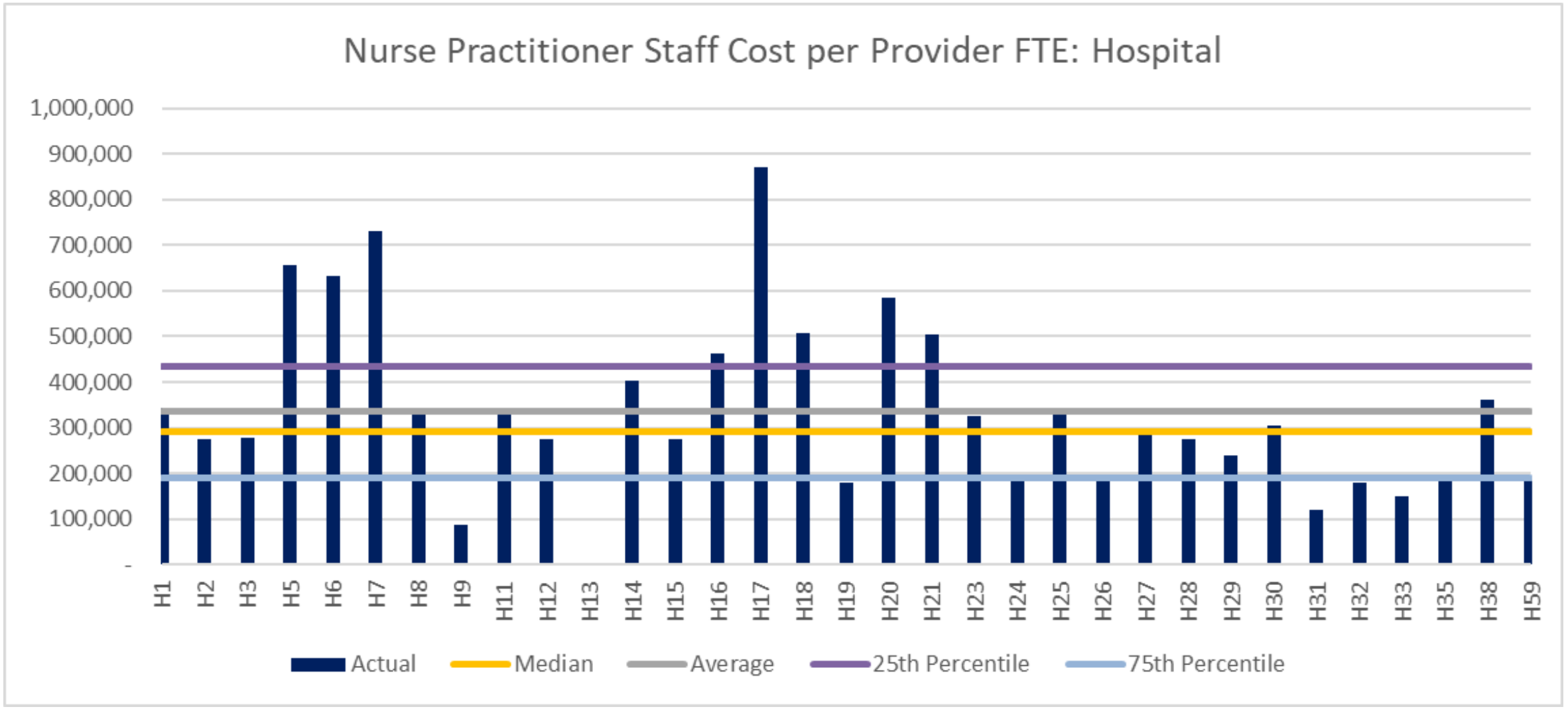
Max = 294,336
Min = 101,563
Average = 177,926

Median = 167,673
25th Percentile = 219,872
75th Percentile = 146,613

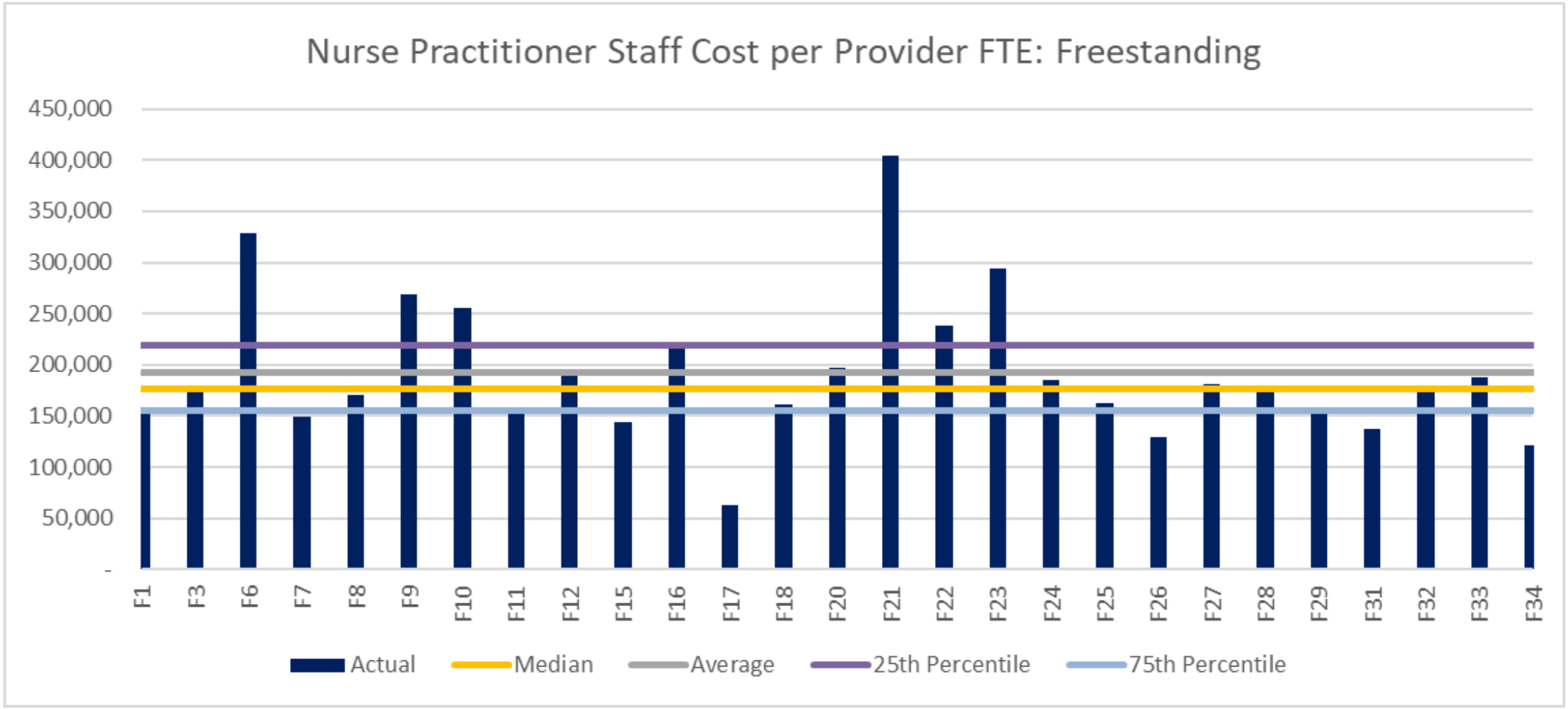
PHYSICIAN ASSISTANT COST PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	$555,662	$294,336
Min	$113,851	$101,563
Average	$317,194	$177,926
Median	$358,971	$167,673
25th %	$415,590	$219,872
75th %	$173,936	$146,613

EideBailly



Max = 870,450 Median = 292,001
Min = 3,478 25th Percentile = 433,278
Average = 336,256 75th Percentile = 189,260

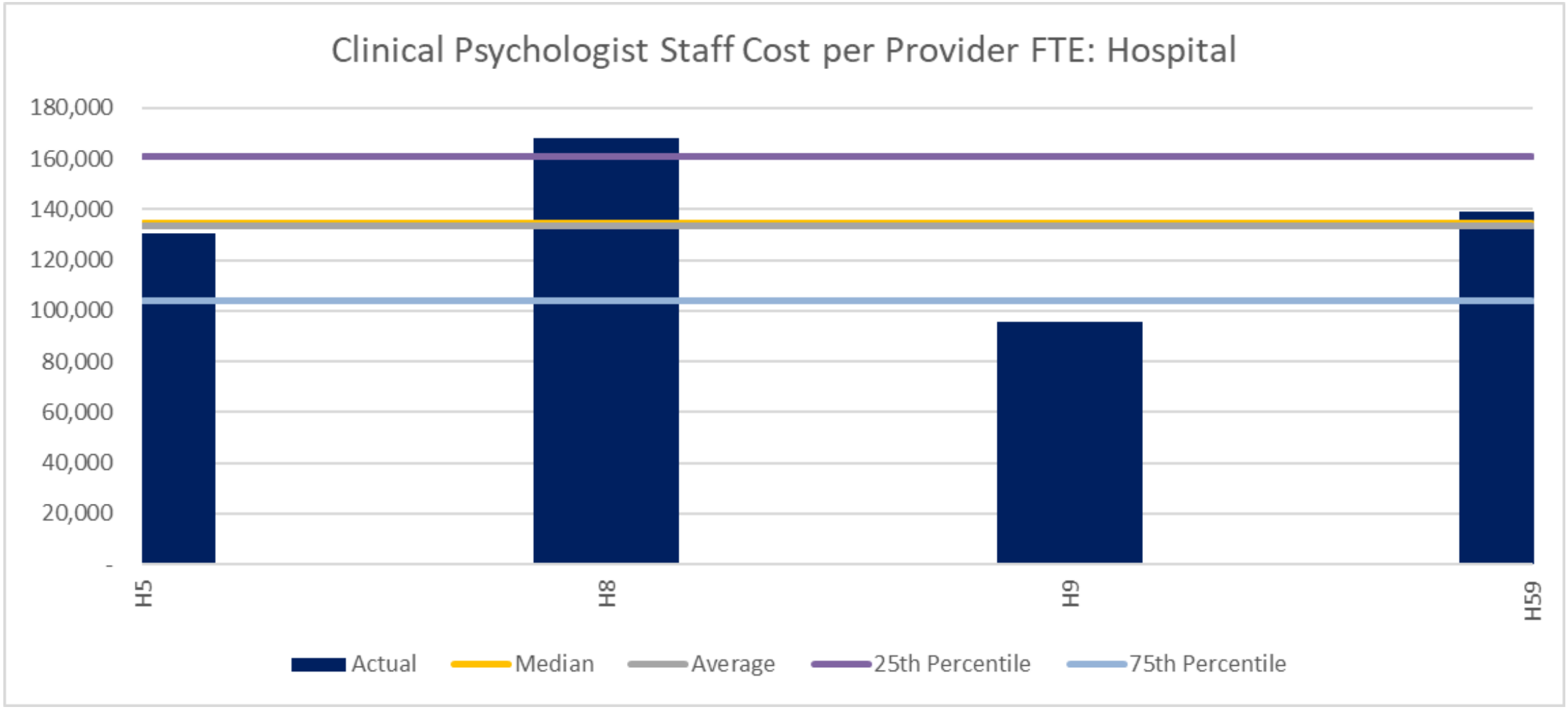


Max = 404,422
Min = 63,000
Average = 192,373

Median = 176,609
25th Percentile = 218,475
75th Percentile = 155,800

NURSE PRACTITIONER COST PER FTE – COMPARISON

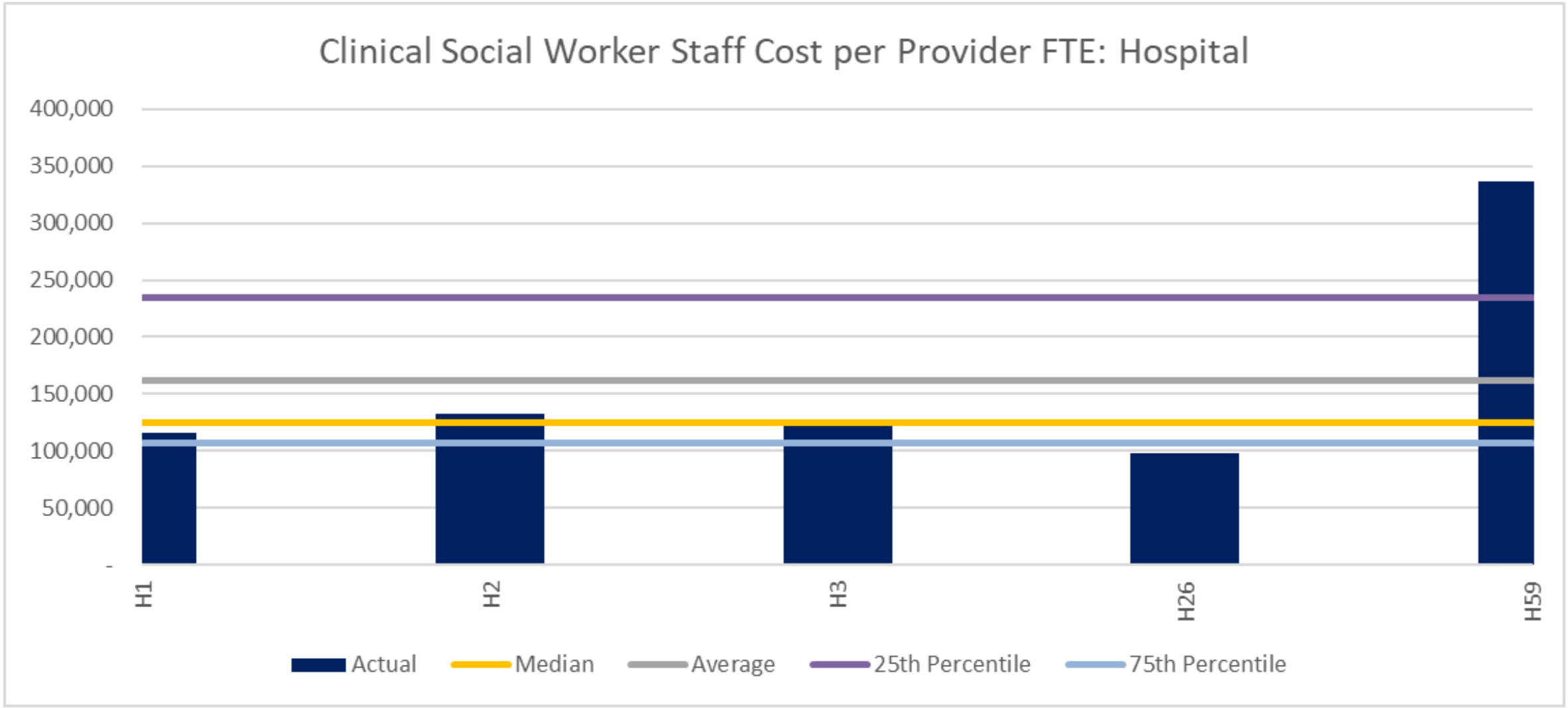
	Hospital Based	Free Standing
Max	$870,450	$404,422
Min	$3,478	$63,000
Average	$336,256	$192,373
Median	$292,001	$176,609
25th %	$433,278	$218,475
75th %	$189,260	$155,800



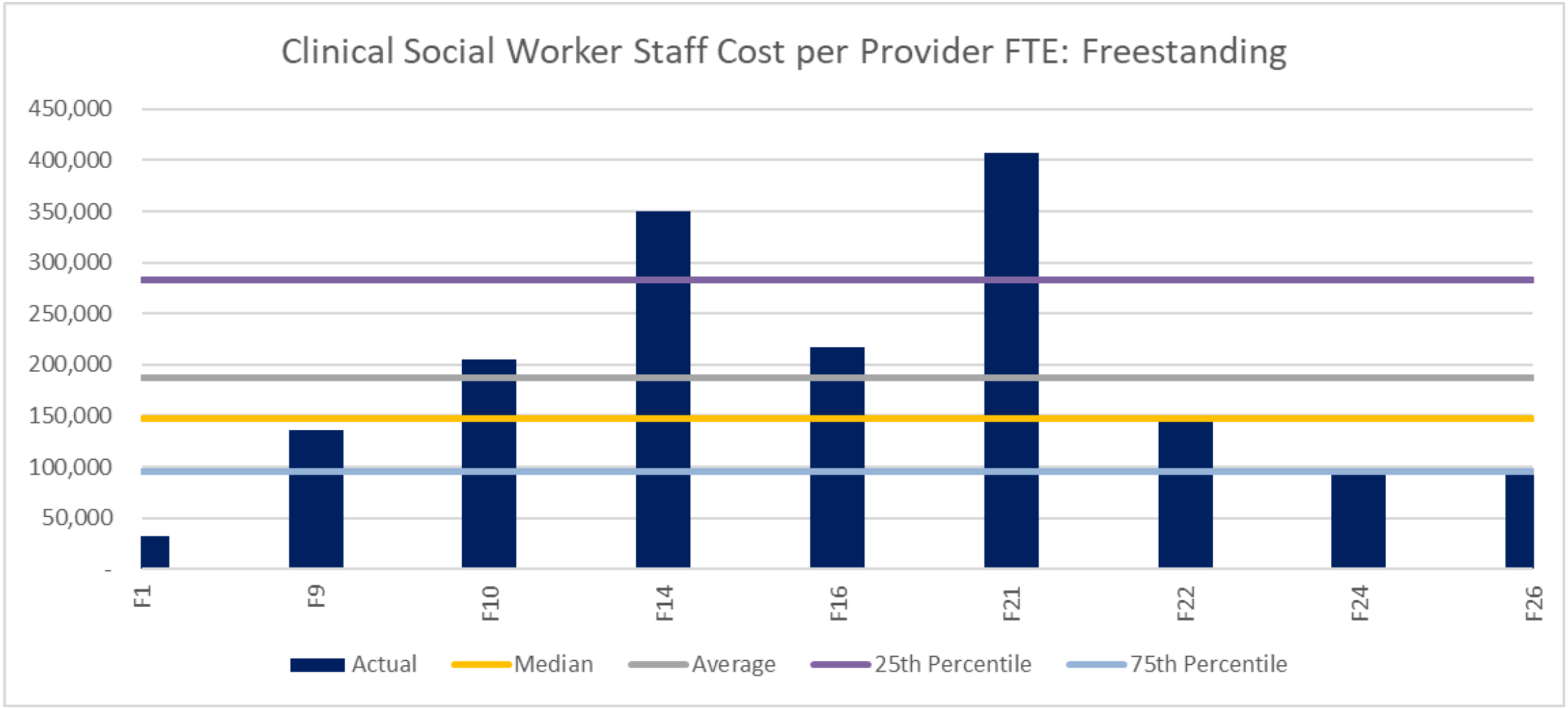
Max = 168,347 Median = 134,765
Min = 95,405 25th Percentile = 161,043
Average = 133,320 75th Percentile = 104,153

CLINICAL PSYCHOLOGIST (CP) COST PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	$163,347	-
Min	$95,405	-
Average	$133,320	-
Median	$134,765	-
25th %	$161,043	-
75th %	$104,153	-



Max = 337,018 Median = 124,548
Min = 97,730 25th Percentile = 234,967
Average = 161,603 75th Percentile = 106,767



Max = 407,156
Min = 32,600
Average = 187,187

Median = 147,168
25th Percentile = 283,484
75th Percentile = 95,063

CLINICAL SOCIAL WORKER (CSW) COST PER FTE – COMPARISON

	Hospital Based	Free Standing
Max	$337,072	$407,156
Min	$97,730	$32,600
Average	$161,603	$187,187
Median	$124,548	$147,168
25th %	$234,967	$283,484
75th %	$106,767	$95,063

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PROVIDER COST PER FTE STRATEGY BEST PRACTICES

- Finding people that want to live in rural
- Training of med students
- Use the Office of Rural Health website – more inclined to desire rural
- Part of a system with same compensation model across system
- Look to providers that have had exposure to local rural area
  - Med students, etc.

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PROVIDER COST PER FTE STRATEGY BEST PRACTICES

- Philanthropic provider just contracted for NH visits
- Minimal physician time in clinic – results in mostly direct cost
- Some use flat salary to control cost
  - Need to balance with production
- Splitting time between ER and Clinic
  - Total compensation may be higher, but allocated over multiple departments
  - Focus on less experienced providers

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PROVIDER COST PER FTE STRATEGY BEST PRACTICES

- Locally recruited providers
- Focus on culture
- Annual and transparent negotiations/evaluations
- Allow providers to “locum” elsewhere
- Self governance of providers

PROVIDER COST PER FTE STRATEGY

- Review compensation methodologies
  - Work to ensure compensation is based on fair market value
  - Access survey data
  - Can be a balancing act between cost per FTE, incentives to enhance productivity, and retention
    - May not be able to maximize performance in all indicators
  - Explore other reasons why your compensation may be higher

AVERAGE CHARGE PER MEDICARE VISIT

AVERAGE CHARGE PER MEDICARE VISIT

- Charges matter!
  - Medicare reimbursement is based on 80% cost and 20% charge
  - Other payors frequently reimburse on lower of charge or fee schedule
  - Higher values tend to be favorable

- Higher values may indicate:
  - Provider has appropriately priced services
  - There is adequate documentation, coding and charge capture

- Lower values may indicate:
  - Pricing is below average
    - Think about other payors!
  - Opportunities to improve documentation, coding and charge capture
  - Less complex patients

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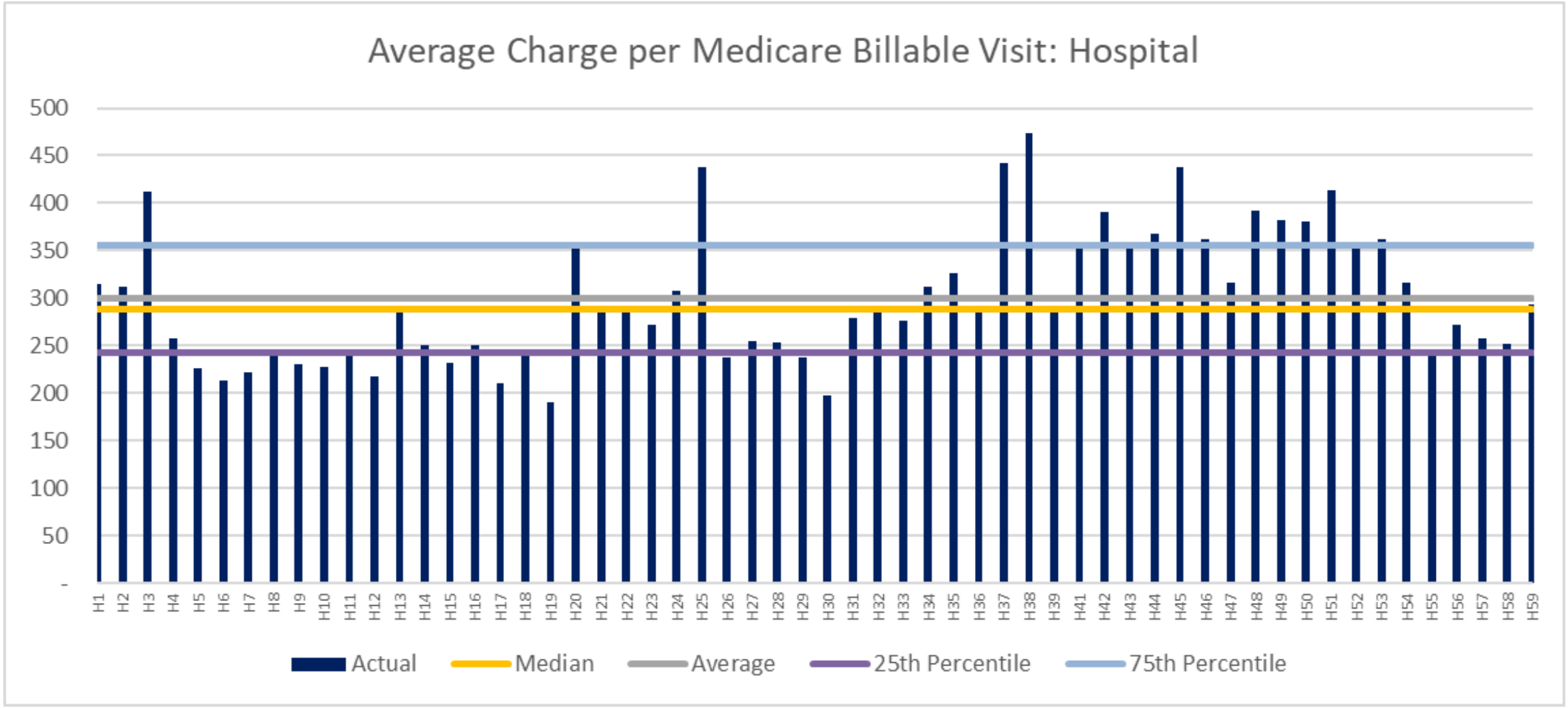
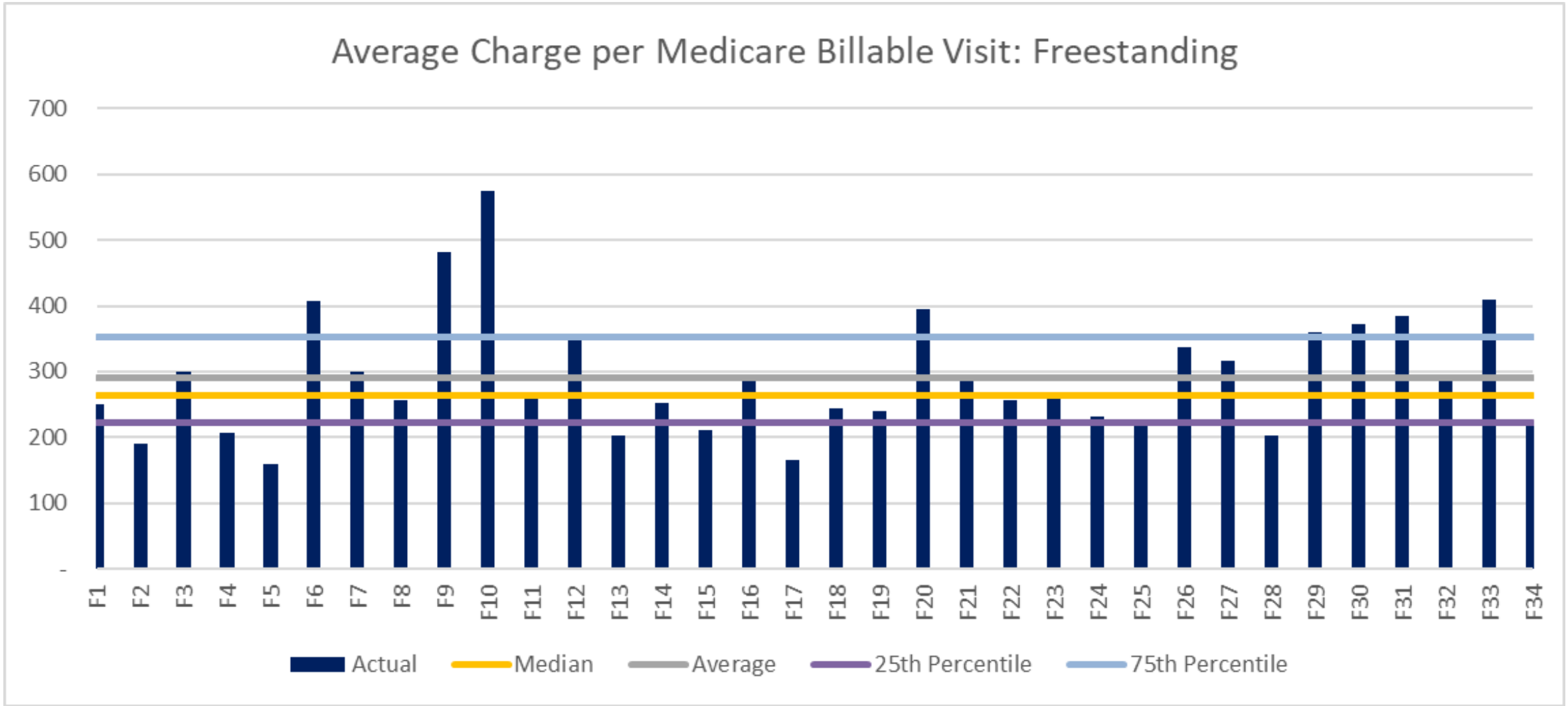


Max = 474
Min = 191
Average = 300

Median = 289
25th Percentile = 243
75th Percentile = 356



Max = 575
Min = 160
Average = 291

Median = 264
25th Percentile = 222
75th Percentile = 352

AVERAGE CHARGE PER MEDICARE VISIT – COMPARISON

	Hospital Based	Free Standing
Max	$474	$575
Min	$191	$160
Average	$300	$291
Median	$289	$264
25th %	$243	$222
75th %	$356	$352

AVERAGE CHARGE PER MEDICARE VISIT STRATEGIES BEST PRACTICES

- Newly established clinics with new chargemaster/pricing
- Inclusion of specialty services by providers to drive up average charges
  - Some injections, procedures, etc.
- Quarterly review by external consultant to identify charge capture opportunities
- Pricing studies and chargemaster reviews to determine accuracy and appropriateness to the market.
  - Regular meetings on charge capture
  - Education, education, education – local as well as National Association of Rural Health Clinics
  - Medical records – follow up and querying
- Reviewing charges and related fee schedules
  - Coding outsourced – Audits and education (90% accuracy goal)
  - Focus on documentation from providers

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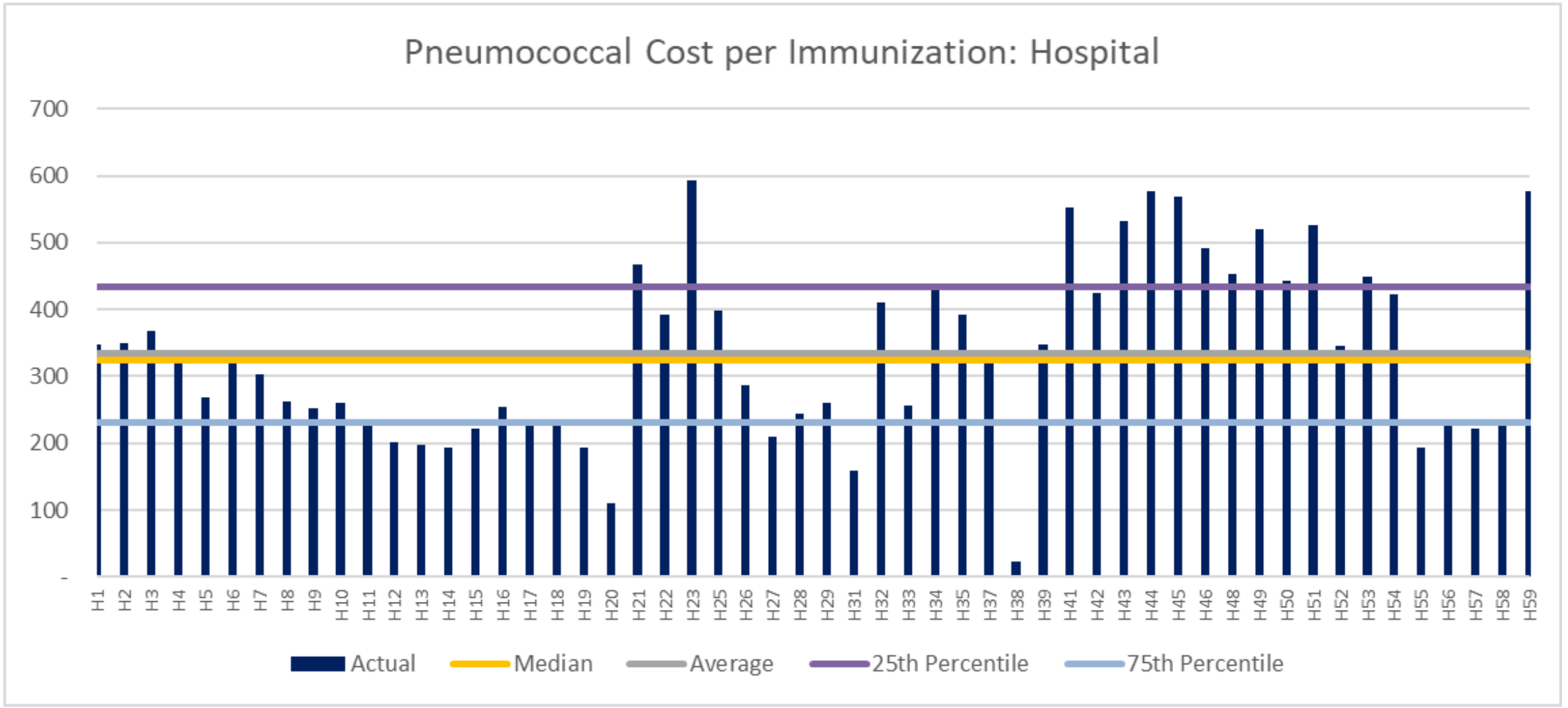
AVERAGE CHARGE PER MEDICARE VISIT STRATEGIES

- Review and verify all services are being documented charges captured
- Review E/M documentation and coding guidelines
- Complete review of pricing against survey data
  - National
  - State
  - Focus is on developing market-based pricing

COST PER VACCINATION

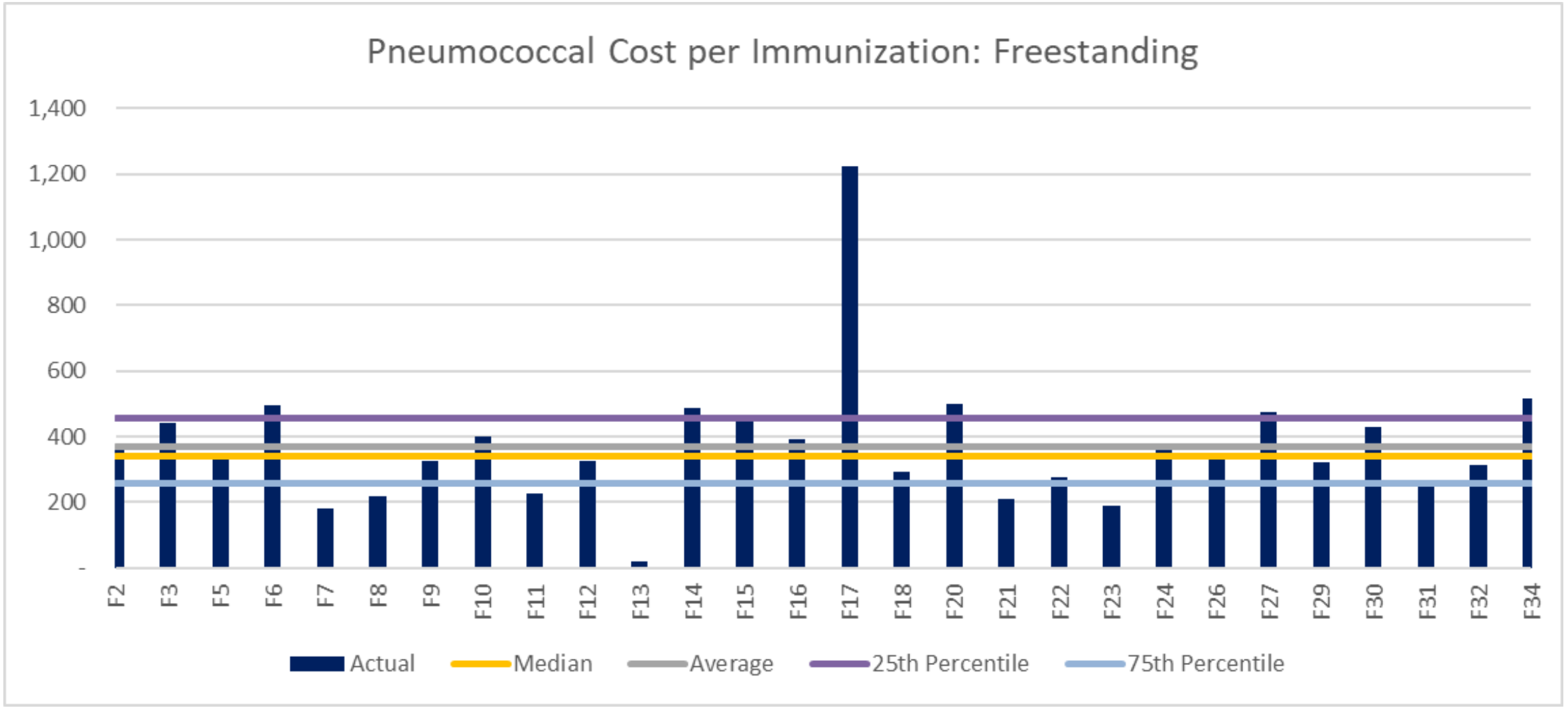
COST PER VACCINATION

- Lower cost per vaccination is favorable as it allows the provider to be more profitable for vaccinations provided to non-Medicare and non-Medicaid patients



Max = 594
Min = 23
Average = 335

Median = 325
25th Percentile = 433
75th Percentile = 230

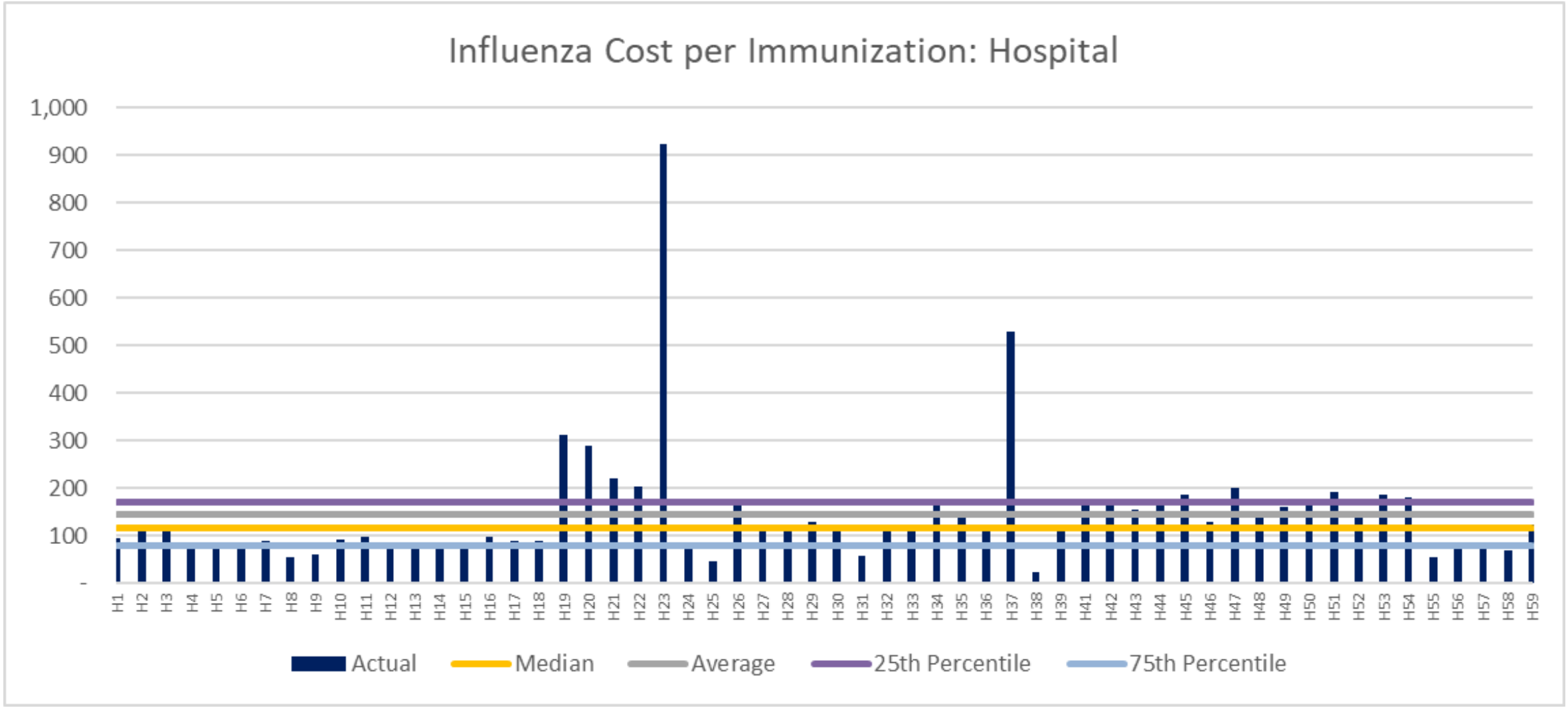


Max = 1,223
Min = 21
Average = 371

Median = 341
25th Percentile = 457
75th Percentile = 257

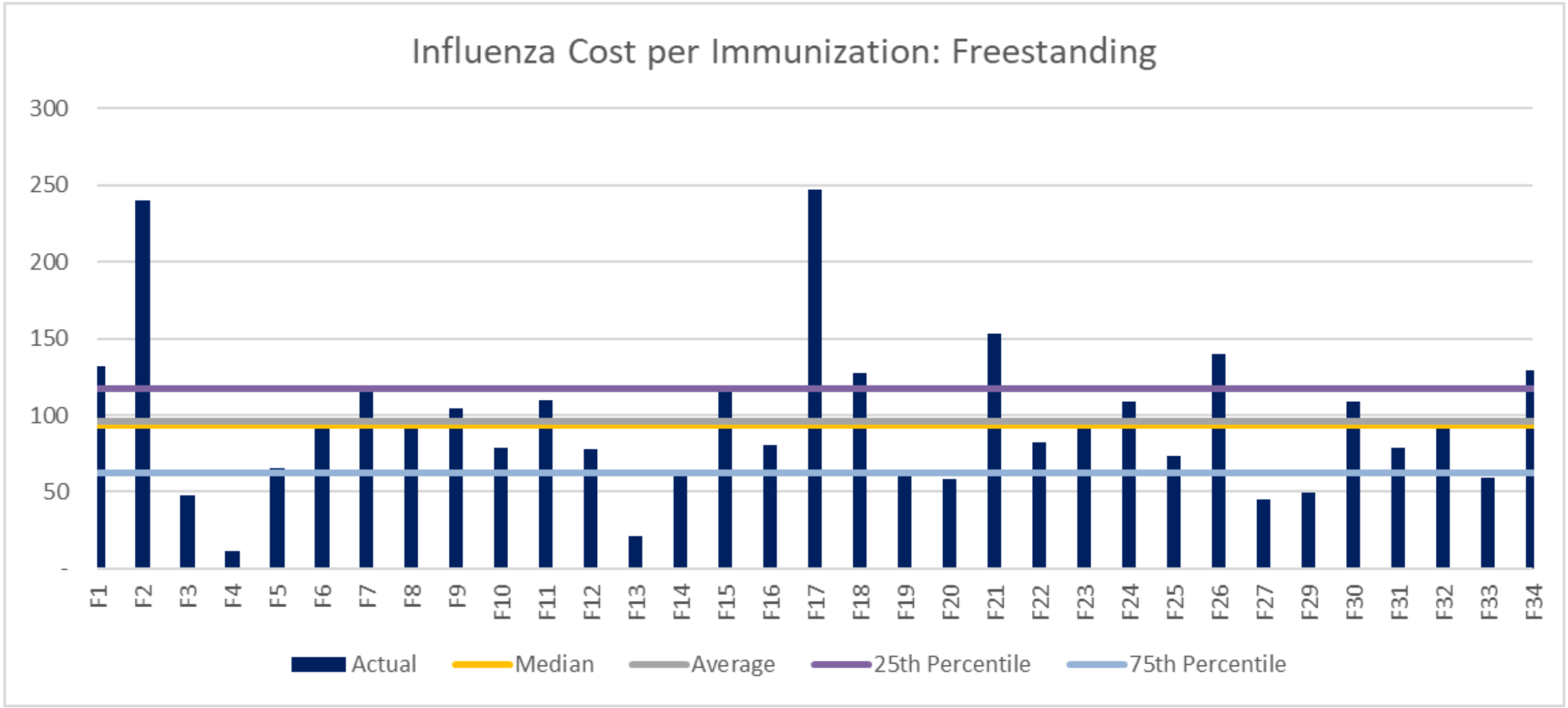
PNEUMOCOCCAL COST PER IMMUNIZATION – COMPARISON

	Hospital Based	Free Standing
Max	$594	$1,223
Min	$23	$21
Average	$335	$371
Median	$325	$341
25th %	$433	$457
75th %	$230	$257



Max =922
Min = 23
Average = 144

Median = 114
25th Percentile = 169
75th Percentile = 78

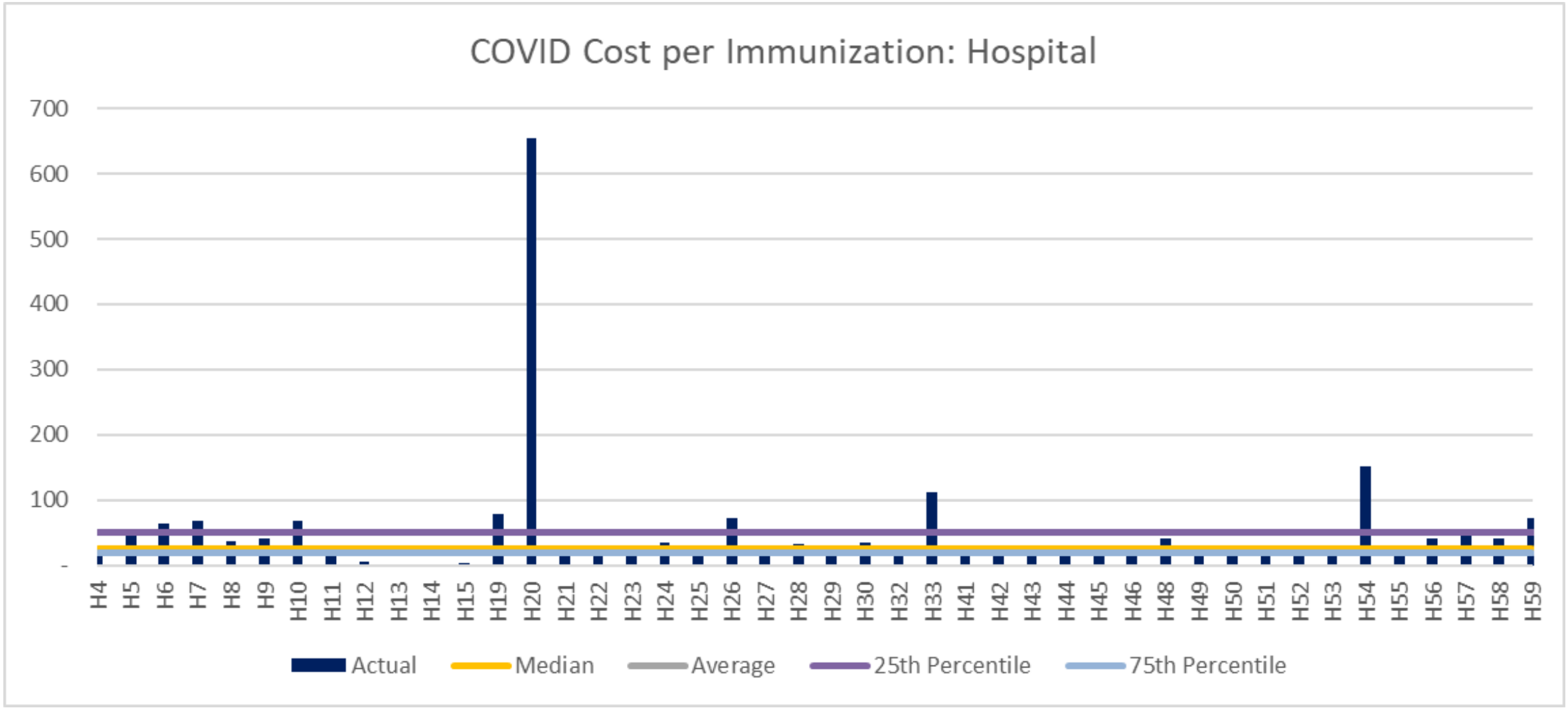


Max = 247
Min = 11
Average = 96

Median = 93
25th Percentile = 117
75th Percentile = 62

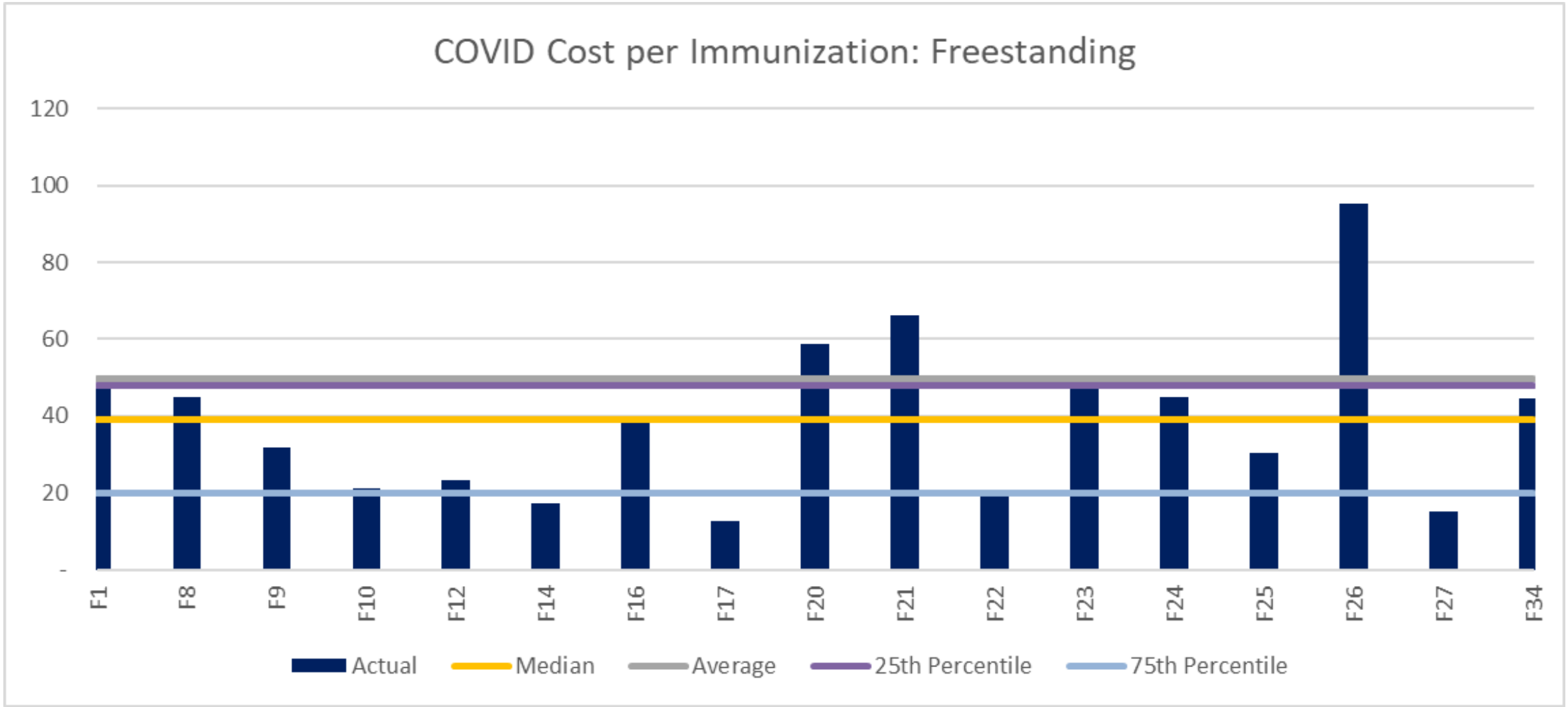
INFLUENZA COST PER IMMUNIZATION – COMPARISON

	Hospital Based	Free Standing
Max	$922	$247
Min	$23	$11
Average	$144	$96
Median	$114	$93
25th %	$169	$117
75th %	$78	$62



Max =654
Min = 2
Average = 50

Median = 26
25th Percentile = 49
75th Percentile = 18



Max = 95
Min = 13
Average = 39

Median = 39
25th Percentile = 48
75th Percentile = 20

COVID COST PER IMMUNIZATION – COMPARISON

	Year 1	Year 2
Max	$654	$95
Min	$2	$13
Average	$50	$39
Median	$26	$39
25th %	$49	$48
75th %	$18	$20

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COST PER VACCINATION

- Effective tracking of staffing and direct cost

- Focus on lowering costs associated with vaccinations
  - Vaccination cost
  - Supply cost
  - Staff cost
  - Overhead costs

DAYS IN ACCOUNTS RECEIVABLE

DAYS IN ACCOUNTS RECEIVABLE (GROSS AND NET)

- For this review, was based on cost report data only.
  - Freestanding cost reports do not contain this data
  - Provider-based cost reports include this data at the facility level only
    - Hospital, RHC, nursing home, etc. combined

- Higher days in accounts receivable can be an indication of issues in
  - Chargemaster
  - Coding
  - Charge capture
  - Communications
  - Processes

- Lower values are favorable

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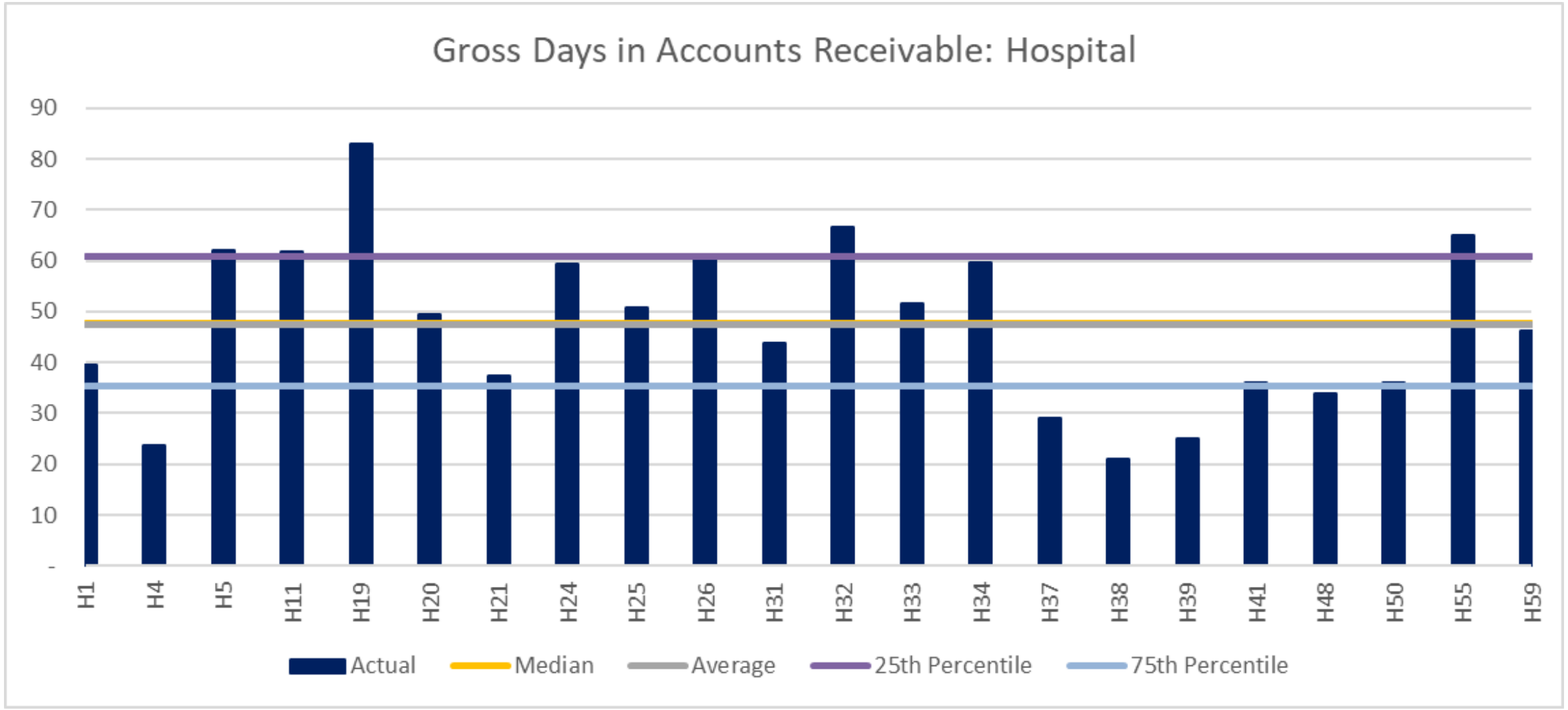
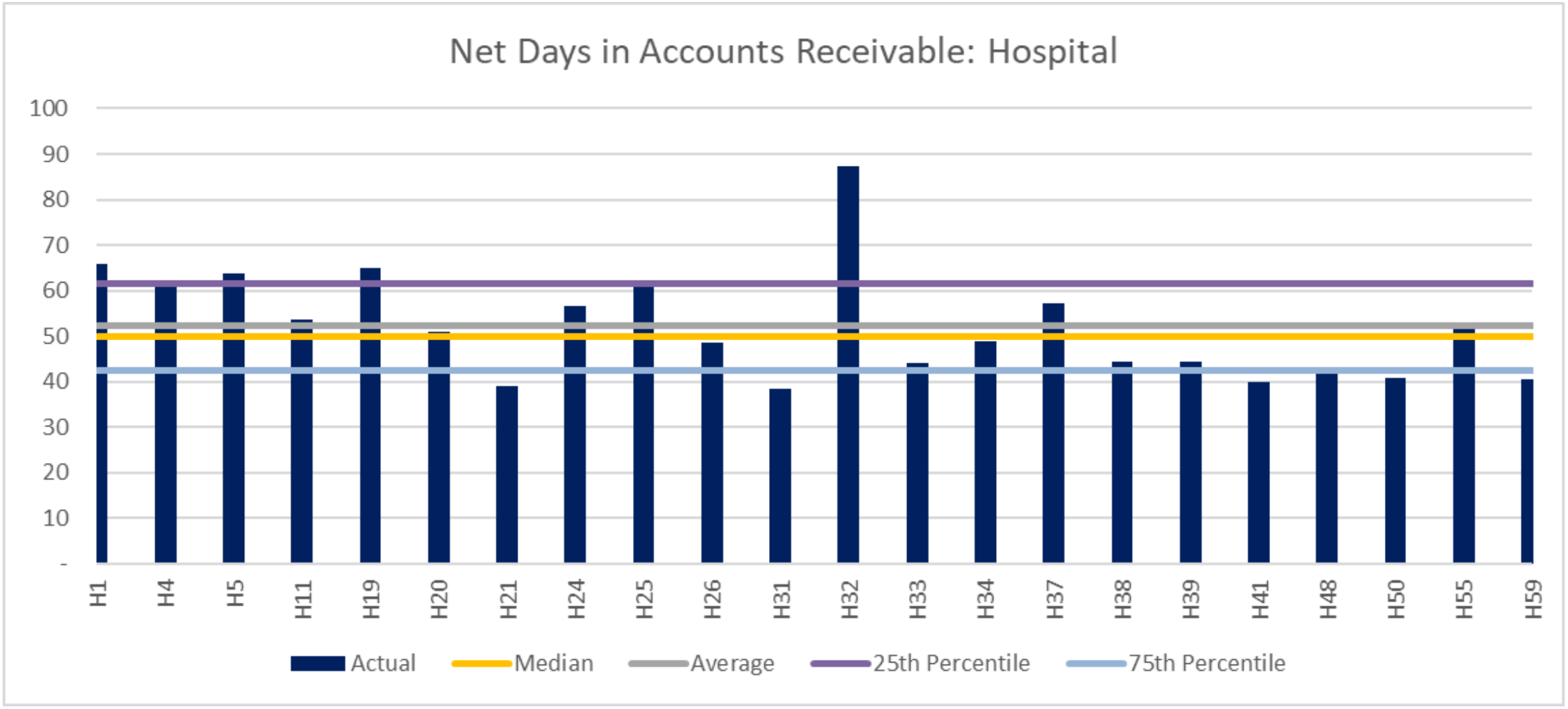


Max = 83
Min = 21
Average = 47

Median = 48
25th Percentile = 61
75th Percentile = 35

GROSS DAYS IN ACCOUNTS RECEIVABLE – COMPARISON

	Hospital Based	Free Standing
Max	83	-
Min	21	-
Average	47	-
Median	48	-
25th %	61	-
75th %	35	-



Max = 87
Min = 38
Average = 52

Median = 50
25th Percentile = 61
75th Percentile = 42

NET DAYS IN ACCOUNTS RECEIVABLE – COMPARISON

	Hospital Based	Free Standing
Max	87	-
Min	38	-
Average	52	-
Median	50	-
25th %	61	-
75th %	42	-

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DAYS IN ACCOUNTS RECEIVABLE

- To manage Days in Accounts Receivable, the RHC must either decrease the accounts receivable balance and/or increase revenues

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES BEST PRACTICES

- Implementation of new claim scrubber with streamlined processes
- Leveraging technology
- Outsourcing some components to outside provider
- Nursing home included in calculation helps
- Focus on key revenue cycle factors
  - High clean claim rate
  - Low denials rate
  - Work with providers to get documentation completed
  - Open communication with HIM
  - Utilization of 3M software
  - Communication on accuracy of demographics

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DAYS IN ACCOUNTS RECEIVABLE STRATEGIES BEST PRACTICES

- Utilizing system generated reports on denials, etc.
- Med Staff pushes to get notes completed
  - CEO that is also an NP is helpful – understands the workload
- Goals established for staffing in billing – monetary rewards
- Training
  - Utilization of online webinars
  - Use of external consulting as needed and appropriate
  - Continual reading of updates
  - Reliance on a network

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DAYS IN ACCOUNTS RECEIVABLE STRATEGIES BEST PRACTICES

- If things start to fall behind – reach out to outside vendors for resolution
- Regular chart audits
- Reduction in paper payments

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES BEST PRACTICES

- Focus
  - Relook at the revenue cycle process as a clinical versus business function
  - Teams include providers in the room
    - Denials
    - Provider charges
  - Addressing outsourcing
    - Disjointedness
  - Address struggles head on – example : lipid panels
  - Outsourcing coding/documentation audits

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Focus on the processes
  - Rework
  - Denials
  - Coding
  - Demographics
- Ongoing communication
  - Clinical
  - Non-clinical

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Regular meetings
  - Trending of accounts receivable reports
  - Denial issues
  - Dig into details and monitor trends

- Utilization of EHR processes
  - Work queues
  - Claim edit builds
  - Error identification
  - Timely resolution
  - Working with EHR vendor on automated solutions

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DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Self pay management
  - Early detection (60-90 days)
  - Establishment of payment plans
  - Identification of need for other financial services
  - Watch for frequent flyers

- Regular CDM reviews
  - Confirm accuracy of CPT/HCPCS
  - Monitor appropriateness of pricing

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DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Understand the capabilities of the billing system
  - Manual versus automated processes
  - Functionality varies by system
    - Understand the system – invest in training
    - Hold vendor accountable to address and fix issues
  - Have seen success and failure on all systems

- Understand and manage your payor contracts
  - Payment methodology
  - Coverage issues
  - Timely filing limitations
  - Collection of copays

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DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Turnover of Staff
  - Strategies to reduce level of turnover
  - Cross training for absences and eventual turnover
  - Exercise care in outsourcing

COST REPORTING

COST REPORT DATA

The accuracy of the financial and operational data is only as accurate as the information submitted on the cost reports.

Inaccurate information input = Inaccurate calculations reported

Work with your cost report preparers to address potential areas of concern and to address any additional inaccuracies the provider identifies through this process.

COST REPORT STRATEGIES

- Incorrect cost report completion can have a significant negative impact
  - Know your cost report
  - Ask questions

- Areas of specific concern/opportunity
  - Calculation of FTEs – Make sure to carve out hours for time not to be included
    - Non-RHC
    - Paid Time Off/Continuing Medical Education
    - Supervision
    - Medical Directors
  - Counting of visits
    - Remember the definition of a billable visit
    - Don't include non-RHC visits
  - Watch for classification of costs in the cost report
    - Pharmacy costs

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COST REPORT STRATEGIES

- Areas of specific concern/opportunity
  - Understand Non-RHC services
    - Telehealth
    - Chronic Care Management
    - Hospital services

SUMMARY

SUMMARY

- Significant variance in financial and operational indicators have been reported

- Financial and Operational improvements can occur when organization can:
  - Identify best practices facilities
  - Share best practices in an open environment
  - Adopt best practices
  - Minimize variation

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QUESTIONS?

This presentation is presented with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns, as the contents of this presentation are intended for general information purposes only. Viewers are urged not to act upon the information contained in this presentation without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and additional information can be submitted to your Eide Bailly representative, or to the presenter of this session.

THANK YOU!

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