Missouri
RHC Financial and Operational Best Practices

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Overview

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- Current State of Rural
- Financial and Operational Best Practices
- Questions

CURRENT STATE OF RURAL

New RHC Reimbursement Methodology

- On December 27, 2020, the President signed into law, the "*Consolidated Appropriations Act, 2021 (CAA)"* which changed the reimbursement methodology for Rural Health Clinics (RHC) 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;
    i) 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, 2019, 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 provider-based RHCs (PB-RHC), efforts are underway to change certain provisions
  - On April 14, 2021, the President signed H.R. 1868 into law which fixed some of the grandfathering issues caused through the change of the RHC reimbursement methodology in the Consolidated Appropriations Act, 2021

Missouri Statewide RHC Performance

- Provider practices, especially RHCs, must constantly evaluate provider and practice performance to ensure continued financial solvency
  - Due to certain regulatory requirements surrounding the RHC program, such as the minimum productivity threshold, RHCs can lose material reimbursements due to inefficiencies among staff and low patient volumes
- Benchmarking overall practice and provider performance is critical and provides practice managers with information and direction as to specific areas for improvement
- Since many RHCs serve as safety net providers, the failure to maintain a solvent financial position directly impacts the access and continuity of care for patients

2019 Lilypad Cost Report Scorecard
State of Missouri

Summary Statistics	State of Missouri			NOSORH Region C		
	HB-RHC	RHC	TOTAL	HB-RHC	RHC	TOTAL
Unique RHC Sites (CMS POS)	237	110	347	1244	367	1,611
Completed Cost Reports / Incomplete	169 / 33	83 / 5	252 / 38	1007 / 248	283 / 46	1,290 / 294
RHCs Meeting Min Productivity	100	67	167	590	192	782
% Meeting Min Productivity	59.2%	80.7%	66.3%	58.6%	67.8%	60.6%
Total Visits	1,913,332	1,163,376	3,076,708	11,045,003	3,724,205	14,769,208
Total Adjusted Visits	2,037,051	1,181,570	3,218,621	11,692,861	3,817,810	15,510,671
Variance	(123,719)	(18,194)	(141,913)	(647,858)	(93,605)	(741,463)
Cost per Visit	$207.02	$130.53	$178.10	$241.49	$145.67	$217.33
Cost per Adjusted Visit	$194.45	$128.52	$170.25	$228.11	$142.10	$206.94
Variance	$12.57	$2.01	$7.85	$13.38	$3.57	$10.39
Medicare Visits	440,612	289,965	730,577	2,749,611	912,523	3,662,134
Visits Subject to UPL of $84.70	152,786	286,224	439,010	170,354	903,999	1,074,353

$126,438,092	$99,034,699	$27,403,393
COST	REIMBURSEMENT	LOSS
for Medicare Patients	for Medicare Patients	in Medicare Reimbursements

Sources: https://www.lilypad207.com

Rural Areas Hit Hardest

- Financial hit is undeniable (lost revenue of over $400K per physician during the time between losing a physician and replacing them), but the primary impact is on quality of care
  - Delays in getting care (average wait time for appointment is 54.3 days for family practice)
  - Poor continuity
  - Lack of specialty services
  - Lack of patient education

- As of June 2020, HRSA projects that it would take over 17,000 additional primary care physicians to achieve target ratio of 1 primary care physician per 3,000 patients in the current 6,739 HPSAs

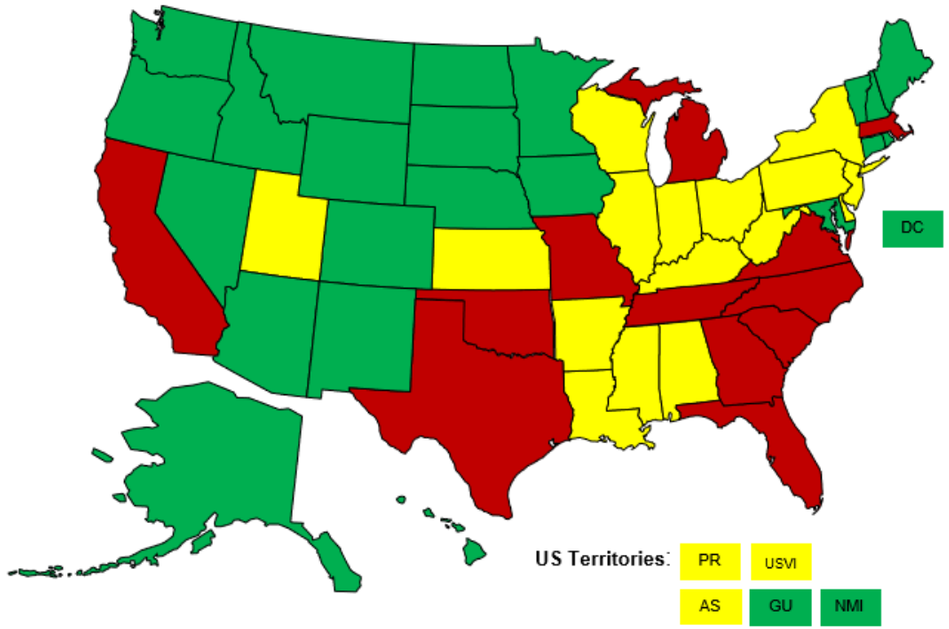
- Practice losses continue to cause hesitancy among hospitals to increase and maintain provider practices
  - RHC reimbursement change only compounds this issue

- Difficulty recruiting to rural areas
  - Spouse employment difficulties
  - Lifestyle impact (call schedule, access to colleagues, etc.)
  - Low preference among newly trained physicians

Final-Year Medical Resident Practice Location Preferences by Community Size	
10,000 or less	1%
10,001 – 25,000	2%
25,001 – 50,000	5%
50,001 – 100,000	9%
100,001 – 250,000	16%
250,001 – 500,000	20%
500,001 – 1 million	24%
Over 1 million	24%

Leveraging APPs Can Reduce the Strain

- Using APPs (nurse practitioners and physician assistants) can reduce the strain of the provider shortages
- Common practice utilization in rural areas (required usage in rural health clinics – 2,100 visits/year/APP)
  - Physician can supervise multiple APPs to expand their panel size
- In states with highest restrictions on use, APPs can only augment physician work, not replace
- Payor contracts tend to be more restrictive on how they can be used and what is the best way to bill for their services – know your contracts!



Full Practice
State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications and controlled substances—under the exclusive licensure authority of the of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine and National Council of State Boards of Nursing.

Reduced Practice
State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care or limits the setting of one or more elements of NP practice.

Restricted Practice
State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team-management by another health provider in order for the NP to provide patient care.

Sources: https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment

FINANCIAL AND OPERATIONAL BEST PRACTICES

Practice Management

- **Practice Management**
  - With a continued push towards operational and financial improvement within provider practices, especially RHCs, an effective practice manager is of increasing importance

INCREASED COMPETITION FOR QUALITY PRACTICE MANAGERS, AS OPPOSED TO SUPERVISORS

Managers	Supervisors
• Responsible for the overall success of the practice • Engage with physicians and are trusted to make decisions • Address issues as they arise • Think strategically about improvements	• Monitor scheduling and budgets • Respond to staffing issues such as absences • Produce reports

If you have a supervisor and not a manager, the importance of physician leadership is tenfold

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
    - Payor contracts
    - Revenue cycle process
  - 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
  - Practices must track performance internally and also compare to publicly available data
    - The table to the right provides certain RHC information that will allow RHCs to compare to other RHCs within the state of Missouri

2019 Lilypad Cost Report Scorecard

	State of Missouri			NOSORH Region C		
Visit and Cost Metrics (Actual)	PB-RHC	RHC	TOTAL	PB-RHC	RHC	TOTAL
Physician Visits per FTE Physician	3,968	4,729	4,222	3,813	4,534	3,977
Physician Cost per Physician Visit	$100.56	$76.77	$91.66	$113.44	$77.16	$104.02
APP Visits per FTE APP	2,993	3,298	3,104	2,895	3,202	2,968
APP Cost per APP Visit	$46.84	$39.39	$32.81	$55.18	$43.03	$52.05
Leverage Coefficient Delta (3.0)	1.856	1.707	1.806	1.852	1.78	1.835
PCP Visits per PCP FTE	3,448	3,922	3,614	3,322	3,802	3,434
Cost per PCP FTE	$735,184	$525,476	$661,971	$847,013	$565,069	$781,139
General Metrics (Actual)						
Medicare Percent of Visits	23%	24.9%	23.7%	24.9%	24.5%	24.8%
Total Overhead per Visit	$29.15	$52.14	$38.00	$28.48	$56.10	$35.73
Total Visits per Vaccination	19.6	23.2	20.8	14.4	17.9	15.2
Medicare Patients per Vaccination	5.4	5.7	5.6	4.1	4.7	4.2
Cost per Vaccine Injection	$144.13	$98.33	$128.56	$125.94	$98.73	$120.12

Sources: https://www.lilypad207.com

Provider Complement

- **Provider Complement**
  - Conduct a primary care options assessment 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.)
    - Conduct Return on Investment (ROI) analysis on the consolidation and inclusion of the specialty practices into rural practices to leverage reimbursement advantages, when available
  - Continue to evaluate and explore relationships with specialty providers to increase both the access and number of services offered within the primary service area
  - Create a catalog of all primary care providers with the service area to gain a better understanding of primary care need
  - Continue to enhance alignment with the area primary care providers that strengthens clinic decisions rights, improves functional alignment and creates partnership opportunities
    - Engage all providers to ensure balanced participation
    - Review and revise Medical Staff By-Laws as needed to establish clear delineation of responsibilities and accountabilities

Provider Complement

- **Provider Complement**
  - Conduct annual fair market value assessments and Stark Rule analyses for all employed physicians to comply with federal requirements
  - Implement OPPE (Ongoing Professional Practice Evaluation) and FPPE (Focused Professional Practice Evaluation) to ensure all providers meet hospital clinical performance standards necessary to maintain privileges
  - Evaluate opportunities to implement team-based care to improve efficiency of practice and patient experience
  - Utilize Medical Group Management Association (MGMA) provider benchmarks as guidelines for assessing provider efficiency levels, service growth, and contract production incentives
    - Establish productivity goals in conjunction with providers and review on a monthly basis

Provider Contracts

- **Provider Contracts**

Know your Physician Contract

- Most rural hospitals have negotiated each physician contract at the individual level; there is no standard contract
- Several hospitals are missing contracts or are operating on expired contracts
- Changes are not reflected in contracts
- Reality does not mirror the contracts
- Contracts do not match fair market valuation reports

Consequences

- Poor contracts with physicians hinder practice management
- Can be costly
- Example: FMV report put an overall cap on compensation for physician producing at the 90th percentile; report referenced a per WRVU rate that was used in the contract
- Result: overpaid the physician by $600K; had to self-report; damaged relationship with physician by asking for the money back

Provider Compensation

- **Provider Compensation**
  - Establish and implement a provider compensation model that is uniform across all providers within a specialty
    - Variation can lead to staff retention and productivity issues within the clinic
  - Best practice historically is to tie to productivity, but movement to value-based care requires more compensation to be tied to outcomes and cost of care
    - Currently only 2.5% of total physician compensation is tied to quality or outcomes
    - Use of withholds and clawbacks in a stoplight compensation model
  - When implementing standards, realize productivity is not the same for specialists and primary care
    - Specialists: Common set up is a base salary + WRVU bonus
    - Key consideration – what should the base be? Where do we set the productivity threshold?
    - Also, when integrating specialty providers, remember the 51% primary care requirement
  - What about primary care?
    - Panel size becomes a key measurement for primary care physicians
    - These can be combined with WRVU productivity and quality components, but will differ in size from specialists
  - Paying APPs? Hourly? Salary? Productivity? All are currently being used so you must consider how are you using your APPs

Provider Engagement

- **Provider Engagement**
  - Engage physicians around their productivity and the financials
  - Reports should be reviewed with physicians monthly (in top performing practices real-time or weekly dashboards are available through a physician portal)
    - Productivity reports should include:
      - WRVUs, 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
      - Accounts Receivable issues
      - Payor Mix
    - Expenses – staffing issues
    - Regular and timely feedback on billing or coding issues

Cost to Collect

- **Impact on Overall Cost to Collect**
  - 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

Revenue Cycle Management

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Claim Life Cycle

Front End

Pre-Claim

- Contract Management
- CDM Management
- Provider Credentialing
- Price Transparency
- EDI/ERA Enrollment
- Banking Setup

Pre-Visit

- Scheduling / Registration
- Insurance Verification
- Prior Authorizations
- Appointment Reminders

Visit

- Patient Check-In
- Co-pay and Deductible Collection
- Patient Payment Arrangements
- Encounter Documentation
- Coding and Charge Capture

Transaction Processing

Claim Submission

- Charge Entry
- Claim Scrubbing
- Pre-Adjudication
- Claim Submission
- EDI Management

Inbound Processing

- Mail Processing
- Scanning/Indexing
- Bank Deposit
- EFT/ERA Processing
- Payment Posting
- Revenue Allocation

Back End

Accounts Receivables Management

- Claim Status
- Denials Management
- Appeals and Resolution
- Patient Statements
- Collection Letters
- Patient Refunds
- Small Balance Write-Offs
- Collections Process (In/Out)

Analytics

- Cash Collected
- No-Show Rate
- Total Days AR (Gross / Net)
- Payor Denial Rates
- Clean Claim Rates
- Rejection Analysis
- Cost to Collect

Revenue Cycle Management Support

- Month-End Closing
- Performance Management
- Compliance
- Information Technology
- Quality Management

Revenue Cycle Management

- **Revenue Cycle**
  - 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 KPI 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

Revenue Cycle Management

- **Revenue Cycle**
  - 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, with particular focus in all outpatient departments, 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

Cost Report Opportunities

- **Cost Report**
  - The Medicare Cost Report plays a critical role in determining the reimbursements received by a Rural Health Clinic (RHC)
    - The following are some examples of how errors made on the Medicare Cost Report can impact reimbursements received by an RHC:
      - Consolidating RHCs for cost report purposes to remove reimbursement variances

	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Clinic 6	Clinic 7	Combined Totals	Consolidated Totals	Variance
RHC Allowable Cost	$ 397,089	$ 451,751	$ 309,335	$3,014,634	$4,326,832	$2,978,745	$ 349,383	$ 11,827,769	$ 11,827,769	$ -
Visits	1,432	1,883	1,761	15,845	23,906	8,967	1,731	55,525	55,038	(487)
Cost / Visit	$ 277.30	$ 239.91	$ 175.66	$ 190.26	$ 180.99	$ 332.19	$ 201.84	$ 193.61	$ 214.90	$ 21.29
Medicare Visits	395	498	512	4,061	6,260	315	249	12,290	12,290	-
Totals	$ 109,532	$ 119,475	$ 89,937	$ 772,637	$1,133,020	$ 104,640	$ 50,258	$ 2,379,499	$ 2,641,144	$ 261,645

      - It is unknown how the change in RHC reimbursement will impact the ability of RHCs to consolidate their cost reports

      - For hospital-based RHCs, monitor Worksheet E, Part B (Outpatient) and the RHC M Schedules to ensure the hospital is not passing on significant portions of cost to Medicare beneficiaries

Cost Report Opportunities

- **Cost Report**
  - The Medicare Cost Report plays a critical role in determining the reimbursements received by a Rural Health Clinic (RHC)
    - The following are some examples of how errors made on the Medicare Cost Report can impact reimbursements received by an RHC:
      - PB-RHCs will often experience reductions in reimbursement due to the overstatement of FTEs minimum productivity purposes

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

- It is unknown how the change in RHC reimbursement will impact the ability of RHCs to consolidate their cost reports

Population Health Management

- **Population Health Management**
  - Implement the use of evidence-based protocols and care management processes in conjunction with the medical staff to ensure seamless and efficient quality care for all patients
  - Evaluate claims data to better understand opportunities for improved health of the workforce and better efficiencies in plan design
    - Implement a data analytics platform and use employee claims data, once received, as a proxy for a regional care plan to improve outcomes throughout the community
  - Leverage the Patient Centered Medical Home (PCMH) model to improve patient outcomes
    - Ensure that all third-party payers recognize PCMH status, if achieved, and that clinic receives per member per month case management fees
  - Implement Chronic Care Management (CCM), Transitional Care Management (TCM), and Behavioral Health Intervention (BHI) programs and billing codes to generate incremental revenue and build greater loyalty among primary care patients
  - Evaluate the addition of telehealth services to expand access to care
    - Although distant site telehealth services were added as a part of the public health emergency, RHCs can still serve as an originating site for telehealth services

Key Takeaways

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- **Summary**
  - **Always Be Recruiting** – the shortages are not going away, and rural hospitals in particular must always have a current medical staff development plan that is being executed

  - Losses on physician practices, while the status quo, are not always necessary
    - Make sure you understand what is generating the losses
    - Identify what factors the physicians can impact and engage them on how to address (do not just tell them to work harder!)

  - Monitoring of simple metrics monthly can help the practice get in front of issues and must be an ongoing process
    - Setting up the tools to aid management can take as little as 4 weeks depending on your data system
    - Management tools should be monitored every month

  - Typical launching of a new physician action council takes 4-6 months before becoming effective when meeting monthly, but can be the vehicle for improvement to be implemented, to stick and to then focus on strategy

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