Improving Operations: The Toolbox, Part 1

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Agenda

The challenge: significant headwinds are eroding margins while new demands to employ providers and address regulatory, consumer and technology needs pose daunting investment requirements.

- National Trends Overview
- The Operational Tool Box
- The Clinic Designation Opportunity
- The Revenue Cycle Imperative
- Questions

INDUSTRY TRENDS

Industry Overview: Disruptive Trends

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Affordable Care Act

- More insured
- Reduced FFS price (relative to costs)
- Accountable care payment models

MACRA

- Reduced FFS payment to physicians
- Value based incentives (MIPS)

High Deductible Health Plans

- Increased focus on value with patients becoming consumers
- Value = Quality/Cost

Underinsurance

- Increased bad debt/charity care

Recovery Audit Contractors (RAC)

- Focus on reducing short stay inpatient admissions

Reduced Re-admissions

- Result of Value Based Payment program

Accelerating shift to outpatient care

- Transition from traditional inpatient focused hospital care to outpatient care

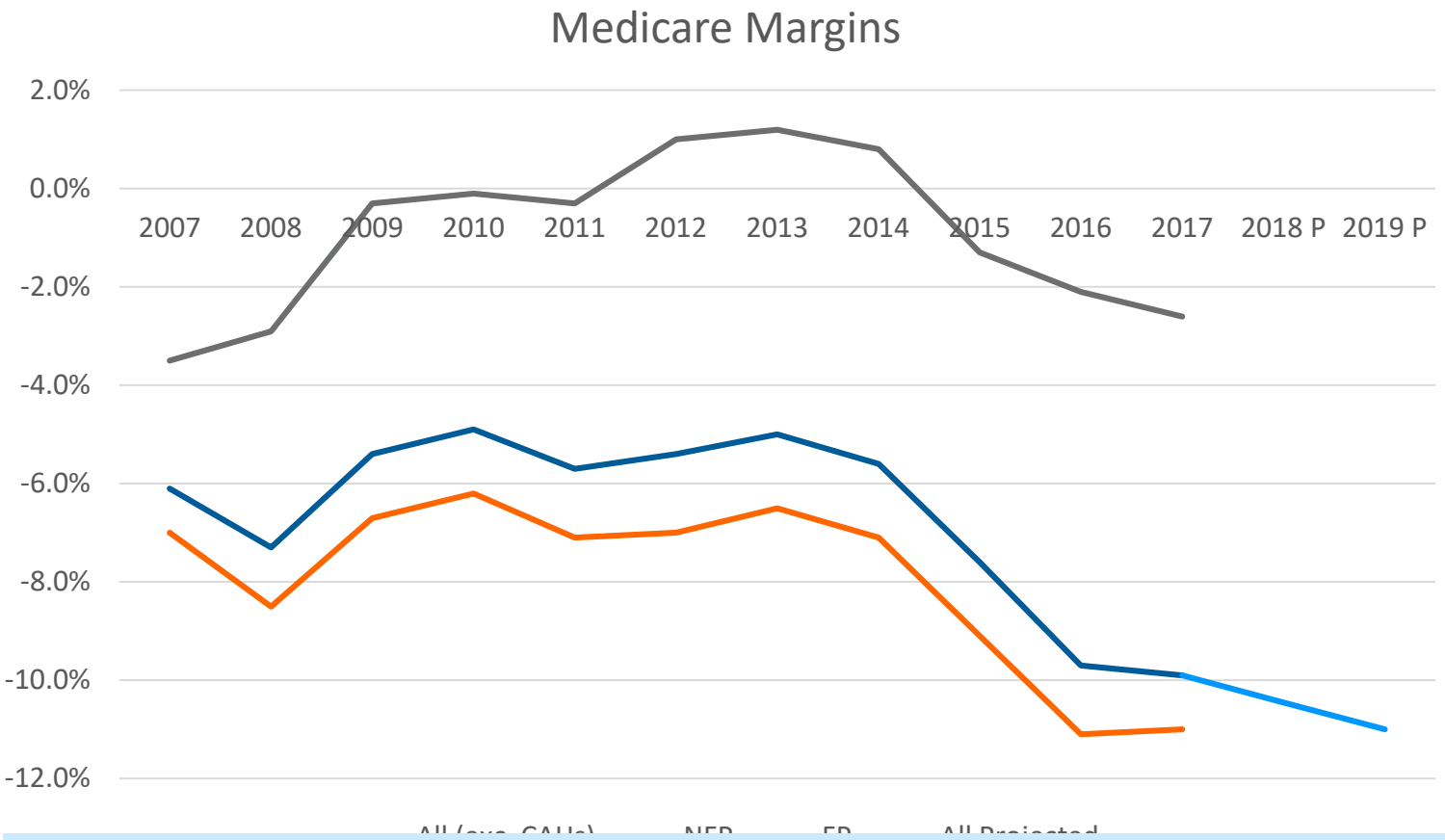
Market Consolidation and New Entrants

- Aetna/CVS
- Walmart/Humana
- Haven (Amazon/Berkshire/JP Morgan)

Consumerism

- Retail mindset
- Convenience
- Transparent pricing

Fee-For-Service Financial Model – Results



Medicare margins are expected to decline due to a tightening labor market and other sources of cost inflation projected to outpace growth in payment rates.

Private commercial insurers are also applying pressure to control and limit growth in reimbursement.

Source: MedPac Annual Report to Congress, March 2019

Moody's Issues Negative Outlook for Nonprofit Hospitals in 2019

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- Moody's Investors Service has issued a negative outlook on the nonprofit healthcare and hospital sector for 2019, reflecting Moody's expectation that **operating cash flow in the sector will be flat or decline and bad debt will rise**
- Moody's predicts **operating cash flow will either remain flat or decline by up to 1 percent in 2019**, depending how well hospitals manage expense growth
  - The agency expects cost-cutting measures and lower increases in drug prices to cause expense growth to slow, but said **expenses will still outpace revenues** due to several factors, including the ongoing need for temporary nurses and continued recruitment of employed physicians
- Hospital **bad debt is expected to grow 8 to 9 percent in 2019** as health plans place greater financial burden on patients

MOODY'S INVESTORS SERVICE

Source: Becker's Hospital Review, *Outlook is negative for nonprofit hospital sector, Moody's says,* Ayla Ellison, 12/5/18
https://www.beckershospitalreview.com/finance/outlook-is-negative-for-nonprofit-hospital-sector-moody-s-says.html

The Risks Are Real: Hospital Closures

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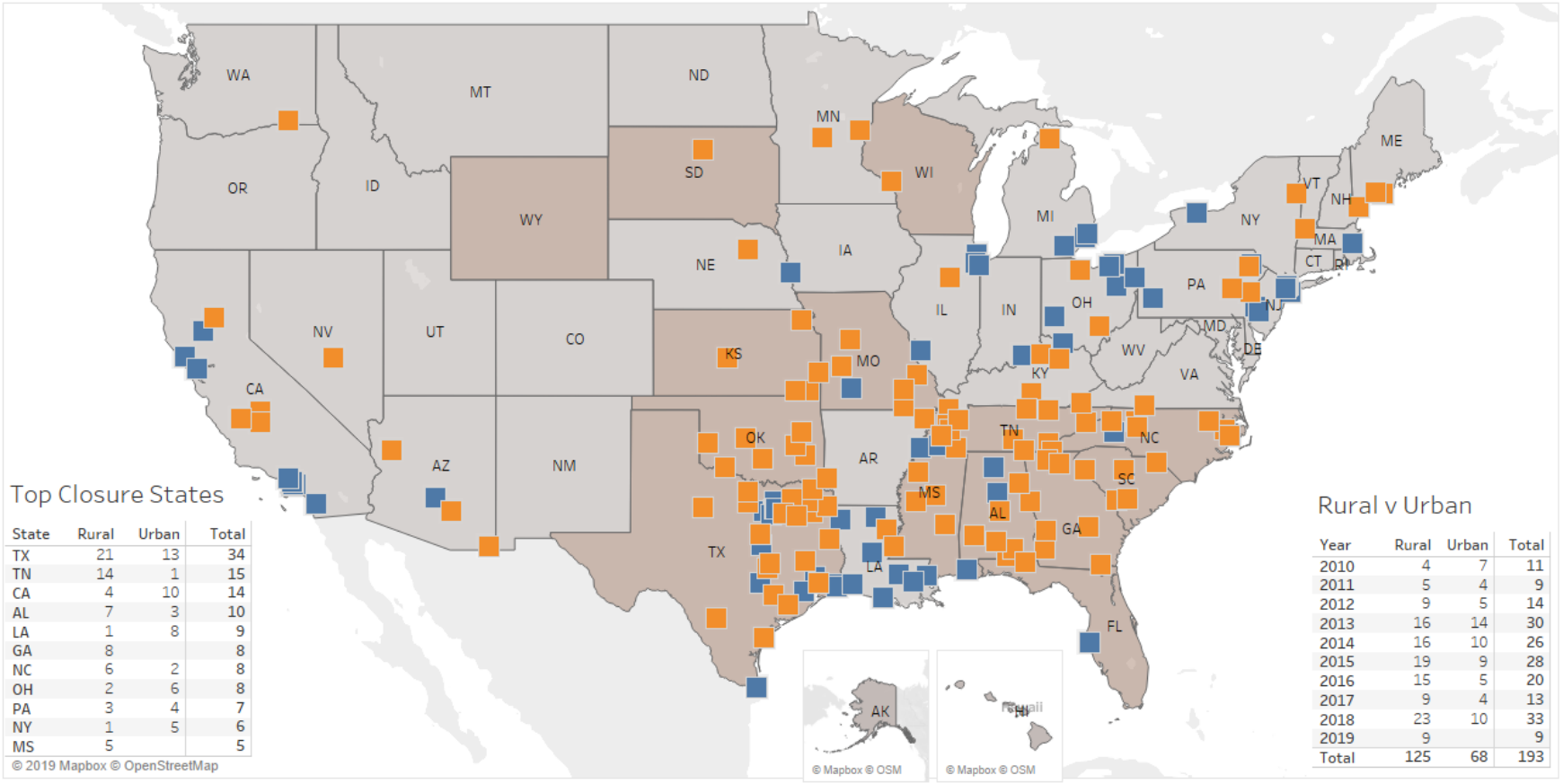
Rural and Urban Hospital Closures since 2010



Top Closure States

State	Rural	Urban	Total
TX	21	13	34
TN	14	1	15
CA	4	10	14
AL	7	3	10
LA	1	8	9
GA	8		8
NC	6	2	8
OH	2	6	8
PA	3	4	7
NY	1	5	6
MS	5		5

Rural v Urban

Year	Rural	Urban	Total
2010	4	7	11
2011	5	4	9
2012	9	5	14
2013	16	14	30
2014	16	10	26
2015	19	9	28
2016	15	5	20
2017	9	4	13
2018	23	10	33
2019	9		9
Total	125	68	193

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Rural v Urban
- Rural
- Urban

Rural v Urban based on cost report designation

Sources: Cost Report data, The Cecil G. Sheps Center for Health Services Research, KFF.org (Updated 6/4/2019)

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The map above shows closures – it does not show those hospitals that have had to curtail operations or mission driven activities or been forced into bankruptcy.

The Consequences of Failing to Act

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- Researchers examined outcomes in California hospital service areas (HSAs) with and without closure(s) between 1995-2011 both before and after the closure year.
- Adjusted inpatient mortality was studied for time-sensitive conditions: sepsis, stroke, asthma/chronic obstructive pulmonary disease (COPD) and acute myocardial infarction (AMI).
- To the researchers' best knowledge, this is also the first paper explicitly studying patient outcomes of California's rural closures.
- Results suggest that when treatment groups are not differentiated by hospital rurality, closures appear to have no measurable impact.
- However, estimating differential impacts of rural and urban closures shows that rural closures increase inpatient mortality by 0.46% points (an increase of 5.9%), whereas urban closures have no impact.

Impact of Rural and Urban Hospital Closures on Inpatient Mortality.
NBER Working Paper No. 26182, Issued in August 2019; Kritee Gujral, Anirban Basu.

Polling Question #1

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- What best described your organization?
  - **Healthy**: Adequate cash flow to fund needed investments and initiatives; healthy top line revenue growth and good expense management; positive operating margin; strong and stable market position
  - **Compromised**: Struggling to keep expenses in line with top line revenue; negative operating margin in danger of swamping portfolio returns or tax proceeds; signs of weakness in market position
  - **Stressed**: 2+ years of material deferred investment; 2+ years of top line revenue growth less than 3% annually; negative total margin; market position beginning to erode
  - **Distressed**: 3+ years of material deferred investment; 3+ years of top line revenue growth less than 2% annually; negative cash flow; reserves are being depleted; market position materially eroded; trajectory cannot be sustained

OPERATIONAL PERFORMANCE IMPROVEMENT TOOL BOX

Strategic Risk & Operational Improvement

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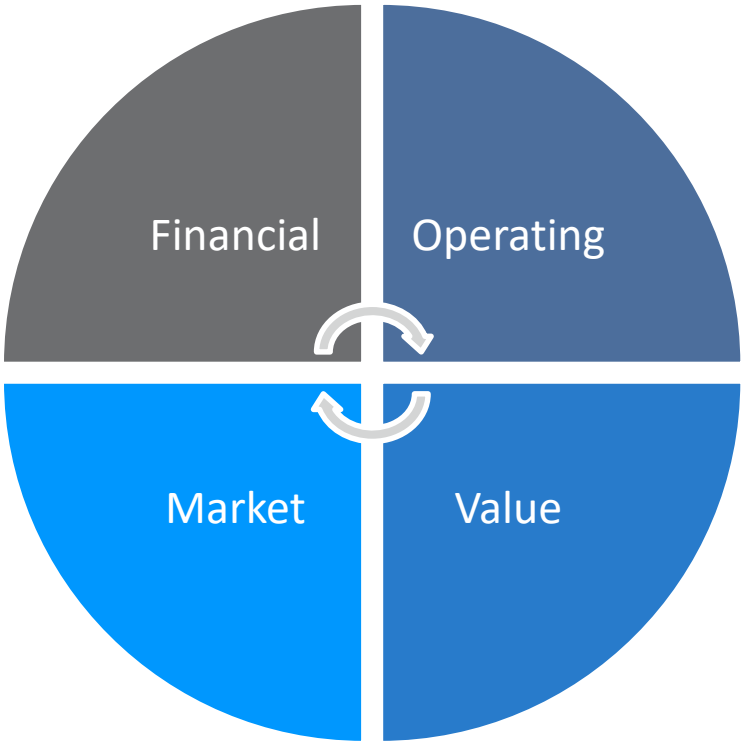
- Define “gaps” in performance
- Develop budget consistent with “sustain” threshold
- Quantify cash “run rate”
- Examine five-year trends at least annually



- Demand-Based Staffing tools
- Provider practice operations improvement
- **Revenue cycle and coding**
- Cost report reviews (CAHs)
- **Practice / clinic designations**
- Process redesign
- Supply chain & purchasing

- Identify growth opportunities
- Invest in aligned provider base
- Develop ambulatory network
- Address industry disruptors
- Implement retail pricing, access strategy
- Direct contracting
- De-escalate conflict between Boards

- Annual payor contract reviews
- Contracting strategy re: payor products and value-based models
- Value-based payment strategy
- Self-Insured population tools
- Medicare Advantage products
- Define need for payor and provider partners
- Manage total cost of care
- Address industry disruptors

Each of the four strategic and operating risk vectors have potential mitigating management responses. We are going to focus on two powerful performance improvement tools today.

OPERATIONAL PERFORMANCE IMPROVEMENT TOOLBOX: THE CLINIC DESIGNATION OPPORTUNITY

Systems Approach to Revenue Optimization

- With declining reimbursements, all systems need to leverage available reimbursement opportunities to improve financial performance
- The following opportunities are available to hospitals and systems to improve reimbursements when those practices can meet certain eligibility requirements:

  Opportunity 1: Convert eligible practices within a health system or at a hospital to a designation that provides the most advantageous reimbursement opportunity

  Opportunity 2: Realign practices within a health system to leverage reimbursement advantages and additional revenue available to the system

  Opportunity 3: Integrate specialty practices, when possible, with PB-RHCs under a hospital with fewer than 50 beds to leverage cost-based reimbursement

  Opportunity 4: Acquire independent practices to leverage provider-based reimbursement opportunities and other additional revenue streams available to hospitals

    - This opportunity may not lead to a net positive return; however, it will increase functional, contractual, and governance alignment and the attributed lives associated with the hospital / health system

Primary Care Clinic Designation Types

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- The following table highlights four clinic designations and the possible revenue opportunities associated with each one

Reimbursement Options	FQHC	CAH	<50 Beds	FSHC
		PBC	PB-RHC	
330 Grant	Yes	No	No	No
340B Pharmacy	Yes	Yes	Yes*	No
Un-Capped Technical Charge	No	Yes	Yes	No
Method II Billing	No	Yes	No	No
Tort Reform - Malpractice Savings	Yes	No	No	No
Enhanced PPS Reimbursement	Yes	Yes	Yes	No

* For non-CAHs, hospital needs to meet DSH % to qualify for 340B

Opportunity 1: Practice Conversion

- The following highlights the net impact on reimbursements received by converting the available practices from provider-based clinics (PBC) to provider-based Rural Health Clinics (PB-RHC):

Summary Data	Scenario #1 PBC	Scenario #2 PB-RHC >50 Beds	Scenario #3 PB-RHC <50 Beds
Medicare / Medicaid Average	$ 143.17	$ 82.30	$ 183.42
Annual Visits	27,338	27,338	27,338
Reimbursements Received	$ 3,913,934	$ 2,249,917	$ 5,014,296
340B Benefit	n/a	n/a	n/a
Variance w/ PBC (Scenario #1)		$ (1,664,017)	$ 1,100,362

- **Study Outcomes:**
  - Operating five locations as PB-RHCs under a hospital with fewer than 50 beds led to the highest average reimbursement from Medicare and Medicaid

Opportunity 2: Practice Realignment

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- The following highlights the net impact on reimbursements received by realigning and converting the available practices from free-standing health clinic (FSHC) to provider-based Rural Health Clinics (PB-RHC):

Summary Data	Scenario #1 FSHC	Scenario #2 PB-RHCs under STAC	Scenario #2 PB-RHCs under CAHs
Practices Impact			
Medicare / Medicaid Average	$ 109.58	$ 179.82	$ 181.32
Annual Visits	75,174	75,174	75,174
Reimbursements Received	$ 8,237,552	$ 13,517,880	$ 13,630,349
Critical Access Hospital Impact			
Medicare / Medicaid Reimbursement	$ -	$ -	$ (1,879,112)
340B Revenue	-	-	3,577,538
Reimbursements Received	$ -	$ -	$ 1,698,426
Variance w/ FSHC (Scenario #1)		**$ 5,280,328**	**$ 7,091,223**

- **Study Outcomes:**
  - Operating the three locations as PB-RHCs led to the highest average reimbursement from Medicare and Medicaid
  - The STAC in Scenario #2 did not have a high enough DSH% to qualify for the 340B program

Opportunity 3: Specialty Integration

- The following highlights the net impact on reimbursements received by integrating a specialty provider-based clinics (PBC) into a provider-based Rural Health Clinics (PB-RHC):

Summary Data	Scenario #1 PB-RHC & PBE	Scenario #2 PB-RHC
Specialty Practice		
Medicare / Medicaid Average	$ 217.55	$ 235.57
Annual Visits	2,954	2,954
Reimbursements Received	$ 642,655	$ 695,874
Primary Care Practice		
Medicare / Medicaid Average	$ 174.30	$ 235.57
Annual Visits	7,378	7,378
Reimbursements Received	$ 1,285,949	$ 1,738,036
Variance w/ PB-RHC & PBE (Scenario #1)		**$ 505,306**

- **Study Outcomes:**
  - Integrating the specialty practice (PBC) with the PB-RHC would lead to an increase in reimbursements of $505K from Medicare and Medicaid

Opportunity 4: Practice Acquisition

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- The following highlights the net impact on reimbursements received by acquiring and converting a free-standing health clinic (FSHC) to a provider-based Rural Health Clinics (PB-RHC):

Summary Data	Scenario #1 FSHC	Scenario #2 PB-RHC
Independent FSHC		
Medicare / Medicaid Average	$ 97.03	$ 197.89
Annual Visits	2,833	2,833
Reimbursements Received	$ 274,889	$ 560,622
Critical Access Hospital		
Medicare / Medicaid Reimbursement	$ 10,044,434	$ 9,971,421
340B Revenue	-	183,240
Reimbursements Received	$ 10,044,434	$ 10,154,661
Variance w/ FSHC (Scenario #1)		**$ 395,960**

- **Study Outcomes:**
  - Acquiring and operating the clinic as a PB-RHC would lead to an increase in reimbursements of $396K from Medicare and Medicaid

Polling Question #2

- Have you implemented any of the strategies?
  (Check all that apply)
  - Opportunity 1: Convert existing practices
  - Opportunity 2: Realign practices within a system
  - Opportunity 3: Specialty Integration
  - Opportunity 4: Practice Acquisition
  - None of the above

Key Takeaways

- Due to continued changes in reimbursement, organizations must continue to evaluate the designations and alignment of practices to optimize reimbursement
  - Although the strategies may be similar across hospitals and systems, there is no one-size-fits-all approach to realize these benefits
- Engage your state agencies, whether hospital associations or the state offices of rural health, to help with HPS
  - Most of these programs require a rural area designation, health professional shortage area (HPSA), and or some other designation to qualify
- Continue to evaluate all opportunities available to the hospital/system to improve reimbursements and financial position

OPERATIONAL PERFORMANCE IMPROVEMENT TOOLBOX: THE REVENUE CYCLE IMPERATIVE

Why Do Clients Contact Us?

- Issues with their “revenue cycle”
- Business office/revenue cycle staffing issues
- Lack of focus/results/reports/accountability
- Coding/compliance concerns
- Reality is that most of our clients have multiple needs but use generic/catch all phrasing to describe their concerns

“We have problems with our revenue cycle”

What Is the Revenue Cycle, Really?

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The first component of every conversation, proposal and engagement is to help the client focus on what they really need

One way we do this is to help them define the concept of revenue cycle

Our Definition:

- The revenue cycle comprises all non-clinical activity that surrounds the provision of services to patients. Best practice revenue cycles use results and outcomes to govern the quality of actions and inputs. All components of the revenue cycle are interdependent, requiring the consistent feedback, attention and participation of all revenue cycle participants.

The reality within most hospitals is that they experience pockets of revenue cycle activity that are independent and provide little to no guidance

Our goal is to facilitate the development of a data driven, quality focused and customer centered revenue cycle

Tales from the Field:
On-Site Revenue Cycle Leadership

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Statement of Service:

- On-site leadership takes the form of either Revenue Cycle Director or Business Office Manager roles.
- The goal of the service is to have SRCS resources work directly alongside hospital administration, department heads and revenue cycle participants in partnership to prioritize activities which provide the greatest impact and act on those priorities.
- SRCS will customize project plans to meet customer needs, facility culture and administrative priority to ensure short- and long-term sustainable results.

Tales from the Field:
On-Site Revenue Cycle Leadership

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- Every Revenue Cycle Leadership engagement begins with a comprehensive assessment
- The assessment includes:
  - Initial Data Review and Provision of Foundational Reports
    - Chargemaster
    - Pricing
    - Utilization
  - Specific departments are selected based on visibility, and financial importance
    - Emergency Room
    - CT Scan
    - MRI
    - Operating Room
  - Reports provide objective, unemotional “it is what it is” results

Tales from the Field:
On-Site Revenue Cycle Leadership

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- Initial Review/Assessment Components
  - Assessment components provide enough detail to generate ROI
  - Assessment scope is based on hospital training, culture and priorities
  - For example:
    - Client One started with an assessment of the ER: Documented ROI $1.2 million
    - Client two started with a detailed assessment across multiple modalities: Documented ROI $2.3 million
    - Clients three and four treated the assessment as Phase 1 of a larger strategic and financial improvement project: Documented ROI of $2.85 million $3.65 million, respectively

Tales from the Field:
On-Site Revenue Cycle Leadership

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How we make a difference

- During the engagement we focus on four distinct access points:
  - Administration involvement, command and control
  - Departmental accountability and ownership
  - Sustainable systematic operational improvement
  - SRCS activity
- SRCS becomes a part of hospital staff
  - We become part of “us” rather than “them”
- The establishment of trust and becoming part of the team are critical components for success
- SRCS doesn’t just manage the process—we participate in the process

How We Make A Difference

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Administration involvement, command and control

- An engaged, informed administrative team is a project imperative
- We provide data components and information necessary to manage the revenue cycle and create a culture of accountability
- We work directly with administration and become part of their management team. We attend staff meetings and make recommendations on operational priorities.
- Establish revenue cycle mission statement
- Create a culture where “everything counts” and “everything is measured”
- Identify and prioritize opportunities and facilitate action

How We Make A Difference

Departmental accountability and ownership

- SRCS develops “one on one” relationships with all departmental leaders
- We create individual training and education plans for department leadership to improve their ability to be accountable
- We implement administration’s revenue cycle mission and establish a formal revenue cycle process
- The revenue cycle process is:
  - Data driven
  - Quality focused
  - Customer centric
- We provide data components and information necessary to:
  - Manage the revenue cycle and create a culture of accountability
  - Implement benchmarks
- Identify and prioritize opportunities and facilitate team action

How We Make A Difference

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Sustainable systematic operational improvement

- We develop relationships with ancillary revenue cycle components
  - Registration
  - Financial Counseling
  - Business Office
  - Coding
  - Scheduling
- Process reviews identify opportunities for redesign, modification and improvement
- Goal of the improvements are to eliminate process variability, ease the patient experience, improve the quality and consistency of result
- Process reviews facilitate:
  - Claim audits
  - Claim resubmission
  - Improved compliance
  - Improved clean claim submission rates

How We Make A Difference

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SRCS revenue cycle performance improvement activities:

- Thorough review of revenue cycle processes and performance
- Where necessary, SRCS will conduct reviews and take action outside of the formal revenue cycle process
- Actions include:
  - Use expert coders to identify claims for resubmission
  - Use expert billers to reprocess accounts
  - Contacting payors to resolve disputes and address long standing issues
  - Work with system vendors to improve reliability, functionality and productivity
  - Update the chargemaster to reflect best practice
- These steps improve cash flow, create a stable revenue cycle platform and generate distinct value for the client

Tales from the Field:
On-Site Revenue Cycle Leadership

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Project Reconciliation:

SRCS Summary as of May '18 (Month 5)

Project	Gross Improvement	Net Improvement
Operational Revenue Cycle Improvement	$5,600,000.00	$3,550,000.00
OR review	$4,200,000.00	$1,160,000.00
Discontinue billing capital equipment	-$173,740.00	-$41,697.60
Infusion	$9,000.00	$2,400.00
PACU procedures	$34,368.00	$6,873.60
Nurse visit for infusions	$1,440.00	$345.60
Nebulizer treatments	-$278,463.60	-$75,000.00
PICC lines and midlines	$145,000.00	$29,000.00
OB - Hospital		$150,000.00
Nursery	$350,000.00	$50,000.00
OB Practice	$50,000.00	$10,000.00
Pre OP EKG	$25,000.00	$9,000.00
	$9,962,604.40	**$4,850,921.60**

Tales from the Field:
On-Site Revenue Cycle Leadership

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Final Project ROI for two recent clients:

Client One	**Initially losing $700k per month**
	After 10 months, net $200K+ per month
	Reduced credit balances
	Total documented ROI $6.75 million
Client Two	**Gained $1 million net per month for 12 straight months**
	Eliminated credit balances over 30 days
	Reduced FTE without a RIF through attrition, better personnel management and improved workflows

Polling Question #3

- Areas of greatest concern *(Check all that apply)*:
  - Chargemaster
  - Coding
  - Collections
  - Revenue Cycle Leadership / Systems
  - Pricing Transparency

QUESTIONS?

Questions & Thank You

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- Strategic Facility Planning
- Capital Planning & Access
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- Provider Practice Operations Improvement
- Revenue Cycle Solutions
- Post-Acute Care Operations
- Payor Contracting Advisory
- Staffing & Productivity Improvement
- Cost Report Reviews and Analysis

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