Attacked From All Sides: The Current State of Rural Practice Management + An Action Plan for Reducing Losses

Presented to: Critical Access Hospital Performance Improvement Network

Tennessee Hospital Association

Presented by: Opal H. Greenway

ATLANTA | NASHVILLE | PORTLAND, ME

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Stroudwater Associates
800-947-5712
www.stroudwater.com

Agenda

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- Current State of Rural Providers
- Practice Management – Reducing Losses
- Plan of Action

CURRENT STATE OF RURAL PROVIDERS

Attacked From All Sides

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- Regulatory changes with MACRA
- Reduced reimbursement from government and commercial payers
- Shift from volume measures to value
- Consolidation of hospitals
- Lack of interoperability of IT systems
- Physician shortages
- Physician burnout is at an all-time high
- Patient access and service is low
- High turnover amongst staff
- Major investments from private equity and healthcare disrupters in advanced medical groups with digital technology to compete

Overall Physician Supply Shortages

- Nationwide shortages:
  - 42,600 to 121,300 physicians by 2030
  - 14,800 to 49,300 primary care physicians
    - TN currently has 3,977 PCPs, or 60.7 per 100,000 people (national average is 64 PCPs)
- Contributing factors:
  - Population and demographic trends
  - Reduced physician hours
  - Reduced physician residency programs
  - Physician retirements (30% of the current supply within in the next 10 years)
  - Demand created by population health initiatives

Source: 2018 Update: The Complexities of Physician Supply and Demand: Projections from 2016 to 2030 (Association of American Medical Colleges); AMA Master File/MMF List

Rural Areas Hit Hardest

- Financial hit is undeniable (lost revenue of over $400K per physician), 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 July 2018, 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
- 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%

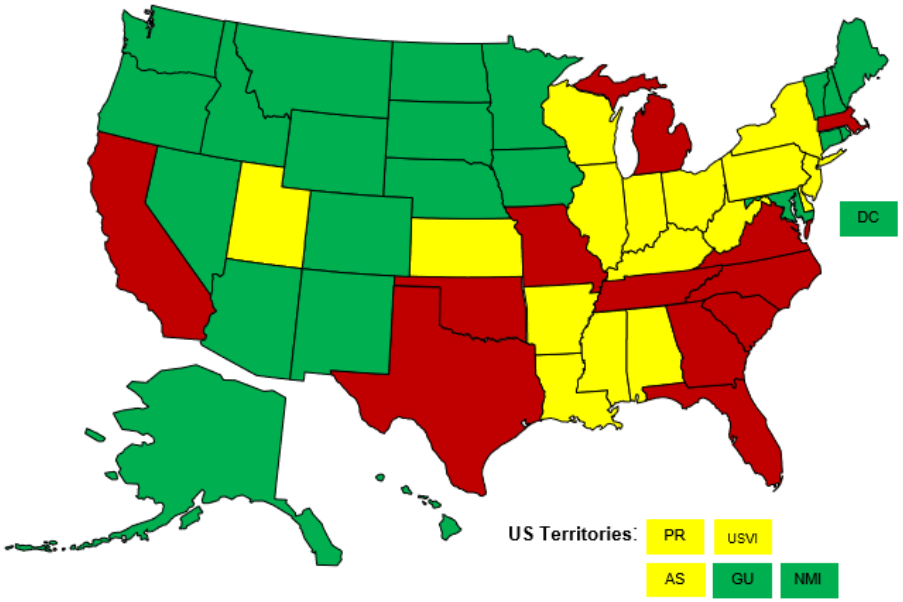
Sources: Merritt Hawkins 2017 Survey of Final-Year Medical Residents and 2017 Survey of Physician Appointment Wait Times

Every Decision is Expensive

- Rural hospitals must **always be recruiting** physicians
  - Vacancies result in lost revenue and increased turnover
  - Each new/replacement physician spot can create $200K-$300K in expense
  - Independent physician groups look to hospitals to help with the cost of recruitment
- But losses in physician practices cause hospitals to be hesitant regarding employing physician practices
- We need physicians but how do we afford them?
  - True practice management
  - Effective physician leadership/engagement

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
- TN has some of the highest restrictions on use, so can only augment physician work, not replace
- TN Nurses Association has been pushing for Full Practice Authority – not currently on the legislative priorities for 2018
- 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.

PRACTICE MANAGEMENT – REDUCING LOSSES

Losses in Hospital-Owned Practices

- Hospitals are increasingly concerned with large subsidies paid to cover practice losses – particularly in primary care
- Current average loss across all specialties is $196K per FTE physician
- Most hospitals "host" practices rather than manage them

Infrastructure Change
- Higher benefits
- Staff & management expense
- IT Investment
- **Physician gives up ancillary revenue**
- GPO

Poor Pre-Purchase Due Diligence
- **Understanding culture & operations**
- Payor mix
- Not comparing productivity to salary
- Inaccurate proforma
- Reimbursement

Lack of Consolidation
- Buy and stay
- No network planning for locations

No Standards & Measures
- **Multiple one-off employment contracts**
- **Compensation model**
- Vague work out language
- Inadequate performance standards
- **Poor operations and management**

Revenue Cycle Mismanagement
- Poor overall RCM performance
- Poor on-boarding and credentialing
- **No RCM integration with operations**
- Bad pro fee contracts
- **Change in payor mix**

Sources: MGMA 2018 Cost and Revenue Report

Proforma Comparisons

	Current State	Proj. Employed State
Revenue		**Revenue**
Patient Revenue FFS	400,000	570,000
Revenue Capitation	100,000	-
Revenue Other	5,000	-
Subtotal	$ 505,000	$ 570,000
Expense		**Expense**
Staff salaries	102,400	141,720
Benefits & Tax	20,480	38,264
401K	-	2,004
Medical Supplies	1,200	1,764
Office Supplies	1,500	11,880
Professional Services	2,000	-
Housekeeping	1,800	2,500
Rent	48,000	87,000
Billing	20,200	51,300
Malpractice	12,000	11,000
Travel/CME/Dues	2,500	5,000
Other	1,000	2,000
IT (EMR/Tele)	7,200	5,832
Allocated Cost	N/A	21,144
Management Fee	N/A	57,000
Expense Subtotal	220,280	438,408
Net P/L before Phy Sal	284,720	131,592
Physician Salary	284,720	300,000
Benefits/tax/401K	59,791	81,000
Net Physician Salary	224,929	
Net Profit (loss)	0	**(249,408)**

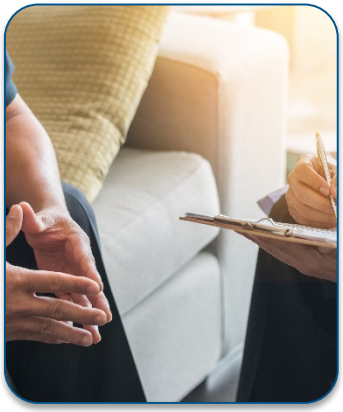
Proforma changes:

- Additional staff and salary and wage adjustments
- Additional rent
- Additional IT cost/data migration
- Additional billing cost
- Higher benefit and/or additional benefit costs
- Physician salary at FMV still more than previously earned
- Hospital allocated costs
- Management fee allocation

On top of this, most planning does not fully understand the revenue of the practice

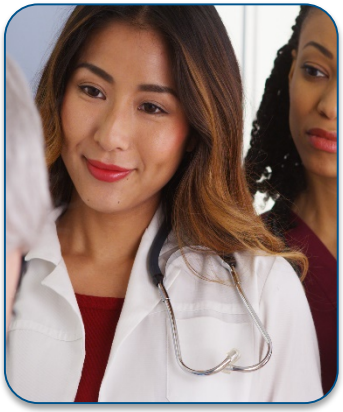
- Technical fees for procedures are usually removed from the practice proforma
- Ancillary services are moved to the hospital

Standards and Measures – Contracts



Know your physician contract

- Most rural hospitals have negotiated each physician contract at the individual level; there is no standard contract
  - Some even have verbal agreements
- 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 (or worse – the hospital does not have an independent FMV report)
- Stark applies to ALL physician financial relationships so pay attention to contracts with independent physicians



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
  - Even rural hospitals are under scrutiny by the OIG for Stark compliance (remember the penalty is $15,000 for EVERY claim that violates Stark (up to $45,000 if knowing and willfully committed)

Standards and Measures – Compensation

- Key to physician recruitment and retention is to have a model that is uniform across all physicians within a specialty
- 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
    - Stoplight compensation model relies on clear metrics and timely feedback
- Consider non-salary compensation
  - Spousal employment assistance
  - Housing allowance
  - Educational loan forgiveness
  - Flex scheduling
- Most importantly, the compensation model must be clear, understandable, and logical

Source: American Medical Association 2016 Physician Benchmark Survey

Standards and Measures – Practice Management

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- Lack of due diligence prior to acquiring a practice or hiring a physician usually cannot be undone
- Focus on going forward, by knowing your practice

What is done in the practice?	• Services – clinic visits, procedures, labs, diagnostics • Scheduling • Billing and coding
Who is doing what?	• Accurate job descriptions and training • Team-based care model • Quality measurements
Who is really in charge?	• Physicians? • Practice manager? • Hospital administration? • Best practice will use a collaborative model

Standards and Measures – Scheduling and Workflow

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- Basic workflow needs policies for effective practice management
- Standardize the patient flow from sign-in to rooming to scheduling the next visit
- Basic checklists will move mountains for hitting quality metrics and moving toward population health
- Policies will make no impact if they are not enforced – perform regular audits to make sure policies are sticking (particularly if turnover is a problem)
- Example: Scheduling
  - Practice manager should work with the physicians to have a set scheduling template (number of scheduling blocks dependent on number of rooms per provider)
  - Policy must address the following:
    - Creating an appointment
    - Deleting an appointment – cancellation and no show policies
    - Waiting list
    - Appointment reminders
    - Appointment prep (required signatures, payments, waivers, insurance verification)
    - Delinquent balances
    - Patient wait time monitoring
    - Walk-ins
    - Follow-up appointments
    - Same-day appointments

Standards and Measures – Practice Management

- Underperforming IM practice with budgeted losses of ($731,510), or ($182,877) per physician

	Patient Scheduled Hours						Opportunity based on 47 weeks per year at 32 hours per week					
Provider	Mon	Tues	Wed	Thu	Fri	Total Hours	New Hours	Additional Hrs/Wk	Additional Patients/Wk	Avg. Collections Per Visit X New Pts/Wk	X 47 wks	Opportunity
Dr. A	9:30-12:15	1:30-4:45	9:30-12:15	9:00-12:15	9:00-12:15							
	1:30-3:30		1:30-3:15	1:30-4:45	1:30-4:45	27.25	32	4.75	14.25	$ 1,069	$ 50,231	
Dr. B	Off	8:30-12:15	7:00-12:00									
	(8 hr PCMH Di	1:30-4:45	12:45-3:00	6:000-8:45	1:30-4:45	25.25	32	6.75	20.25	$ 1,777	$ 83,516	
Dr. C	8:00-12:15	OFF	12:30-4:45	8:00-12:15	8:00-12:15							
	1:30-4:45			1:30-4:45	1:30-4:45	29.50	32	2.50	7.5	$ 768	$ 36,096	
Dr. D	12:30-4:45	7:30-12:15	7:30-12:15	OFF	8:00-12:15							
	6:000-8:45	1:30-4:45	1:30-4:45		1:30-4:45	27.50	32	4.50	13.5	$ 1,017	$ 47,797	
NP				8:00-12:00	8:00-12:00							
				1:00-4:00	1:00-4:00	16.00	16	0.00	0	$ -	$ -	
Total Practice Patient Care Hours Per Week:						125.5	**144**				**New Revenue:**	**$ 217,640**

Employment contracts state "reasonable full time hours"

Opportunity based on 47 weeks per year at 40 hours per week					
New Hours	Additional Hrs/Wk	Additional Patients/Wk	Avg. Collections Per Visit X New Pts/Wk	X 47 wks	Opportunity
40	12.75	38.25	$ 2,869	$ 134,831	
40	14.75	44.25	$ 3,883	$ 182,498	
40	10.50	31.5	$ 3,226	$ 151,603	
40	12.50	37.5	$ 2,825	$ 132,769	
16	0.00	0	$ -	$ -	
176				**New Revenue:**	**$ 601,702**

Standards and Measures – Practice Management

Opportunities	Scenario 1 @ 32 Horus		Scenario 2 @ 40 hours
Increased Provider Productivity	$ 217,640		$ 601,702
Less Expense of additional staff	$ (33,282)		$ (66,563)
Total Improvement Opportunity	$ 184,359		$ 535,138
Projected Loss	$ (731,510)		$ (731,510)
Net Loss w/ Improvements	$ (547,151)		$ (196,372)
Per Physician	$ (136,788)		$ (49,093)

Financial scenario at **32 hours** of patient time per week per provider

Increasing patient hours by 4.62 hours per physician per week reduces losses from ($731,510) to ($547,151) or ($136,788) per physician without any other practice improvements

Financial scenario at **40 hours** of patient time per week per provider

Increasing patient hours by 12.62 hours per physician per week reduces losses from ($731,510) to ($196,372) or ($49,093) per physician without any other practice improvements

Key Takeaways:

- Be prepared to make investments to off-load work by physicians
- Be aware of barriers to increased patient panels
- Reduce variability in patient flow

Revenue Cycle

Critical components at the macro-level

- Review charge master on annual basis for changes in RVUs
- Review third party contracts on an annual basis taking into account transitioning RVUs
- Target charges being set between 125% and 150% of Medicare fee schedule
- At least quarterly, compare E&M coding distribution for full practice and individual providers
- Know where we each component of revenue cycle is being performed
  - Common mistake is to over-centralize the RCM function for practices into the hospital
  - Timely feedback to physicians about coding and documentation is critical to collections

Common mistakes at the practice level

- Insurance eligibility verification
- Prior authorization process is overly complex
- No one is monitoring the status of submitted claims
- Not collecting co-pays and asking for balance payments at each appointment

PLAN OF ACTION

Work Harder Is NOT the Solution

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- The solution is not: "Work Harder – Increase Productivity…or Else!"
  - Physicians balk at demands of increased productivity – not because they are lazy, but because it is not a solution
  - Low productivity is a symptom of other issues
    - ✓ Change in physician incentives/alignment
    - ✓ Poor patient flow in the practice
    - ✓ Poor patient/provider scheduling
    - ✓ Increased time demands for EHR
    - ✓ Increased competition
    - ✓ Too many providers/improper utilization of APPs
    - ✓ Understaffing
- Must engage physicians around true solutions—identify the actual problems that have created the symptom (physicians love to triage and treat!)

Engaging Individual Physicians

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- 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

Finding the Physician Leaders

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Increased competition in a limited supply market for physicians

- Can compensate for leadership opportunities – but it should be more than a stipend (great way to align with independent providers!)
  - Metrics tied to expectations of leadership
- Employed physicians who previously owned their practices

THE PHYSICIAN ACTION COUNCIL

- Team of physician leaders representative of the practices/specialties
- Purpose is to collaborate on issues and solve problems
- This is the team that creates the buy-in to address everything
- Should develop and implement the physician dashboard/monthly reports

What compromises will you make with physicians to ensure success?

- Example: physicians who are against scheduling templates and EHR requirements; engage around one to make the case for the other

Bottom Line: Treat physicians like owners and they will act like them

Practice Management Problems

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Increased competition for quality practice managers, as opposed to supervisors

Managers

- 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

Supervisors

- 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 To Do List

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- 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 (53.73%)
  - Net collection rate
  - Overhead ratio
  - Individual category expense ratio
  - Days in AR (52% should be 0-30 days)
  - WRVUs per provider (4,804 for physicians; 2,883 for NPs)
  - Accounts receivable per FTE provider ($99,098 per physician; $67,225 per provider)
  - Staff ratio
  - Average cost and revenue per patient
  - Aging of AR by payor
  - Payor mix ratio

Source: MGMA 2018 Provider Compensation Report and 2018 Cost and Revenue Report – Data provided is for Family Medicine practices

Key Takeaways

- **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
  - Use metrics to create target improvements and engage all staff around performance targets
- Typical launching a new a 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