RHC Benchmarks and Performance Measurement with Gregory Wolf

Sponsored by Lilypad

June 23, 2022

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WEBINARS AND SEMINARS

We offer a selection of educational seminars and webinars throughout the year to guide you through the challenges of RHC startup, billing and cost reporting. To stay up to date with whats coming up, you can follow our blog or register for our email newsletter **here.**

RHC Benchmarks and Performance Measurement with Gregory Wolf

June 23, 2022

Join us for a webinar that outlines the nation's largest RHC-specific benchmarking system, and shares state and regional comparative analytics in financial, operational, productivity and compensation domains. With the future push for public reporting, it is a growing imperative for RHCs to track and use benchmark data to demonstrate quality and value. Opportunities to receive RHC-specific benchmark reports for your clinics (at no cost) will be discussed.

Please register for **RHC Benchmarks and Performance Measurement with Gregory Wolf** on **Jun 23, 2022 1:00 PM EDT** at:

https://attendee.gotowebinar.com/register/4769266249011852300

RURAL HEALTH CLINIC INFORMATION EXCHANGE LUNCH AND LEARN WEBINAR SERIES

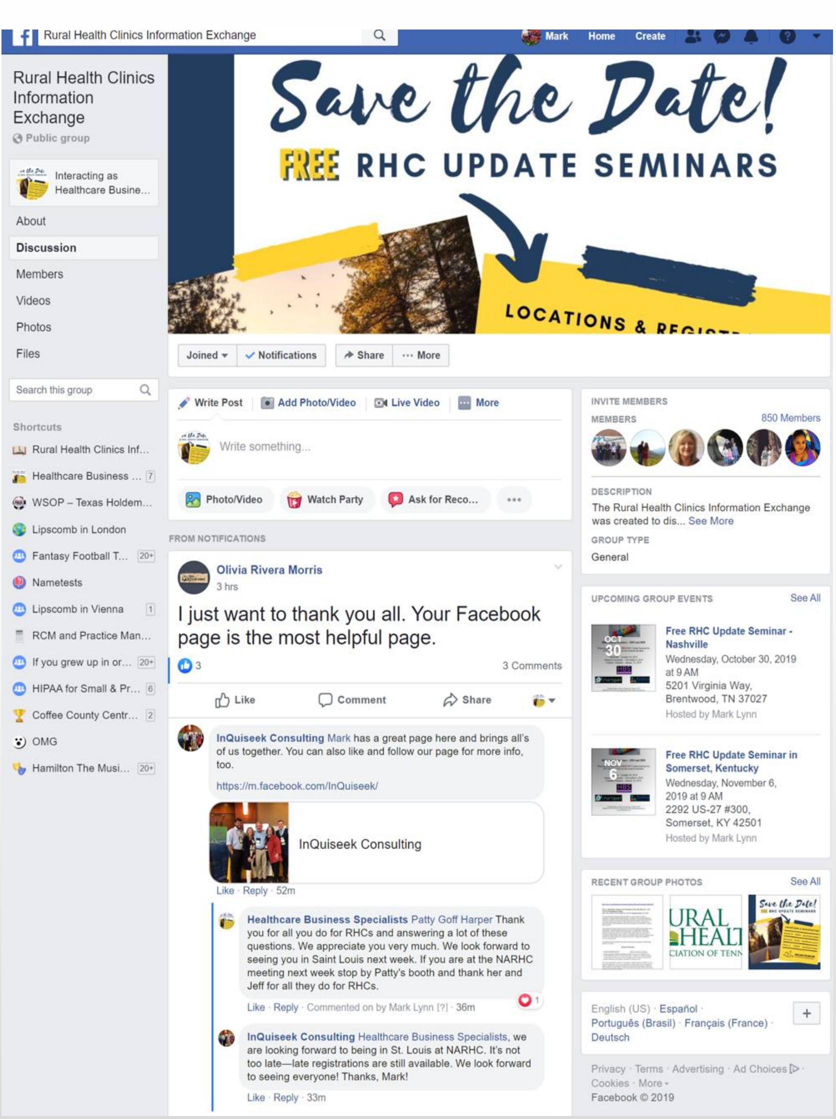
Spring, 2022

The Rural Health Clinic (RHC) Information Exchange Facebook Group is conducting a series of lunch and learn webinars in the winter/spring of 2022. These webinars are free and will focus on rural health clinic billing and updates for the RHC community.

Each webinar is set up as a stand-alone webinar, so you will have to sign up for each of them to attend. Each will be recorded for later viewing and the slide presentations and recordings may be found at www.ruralhealthclinic.com. Each webinar will have speakers and panelists to help with questions and to provide insight or perspective to the material presented. The billing sessions (except the Update session) are designed for people new to RHC billing and each session will build on the previous sessions. If you have not yet joined the Facebook Group, here is the link: (https://www.facebook.com/groups/1503414633296362)

SLIDES & RESOURCES

https://www.ruralhealthclinic.com/webinars-and-seminars



RHC Information Exchange Group on Facebook

Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs.

https://www.facebook.com/groups/1503414633296362/

Q&A

Please type your questions in the Questions area of Go To Webinar. Additionally, we will open up the lines for questions at the end of the 45-minute webinar.

SPEAKER

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Wintergreen
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RHC Benchmarks and Performance Measurement

Today's Speakers

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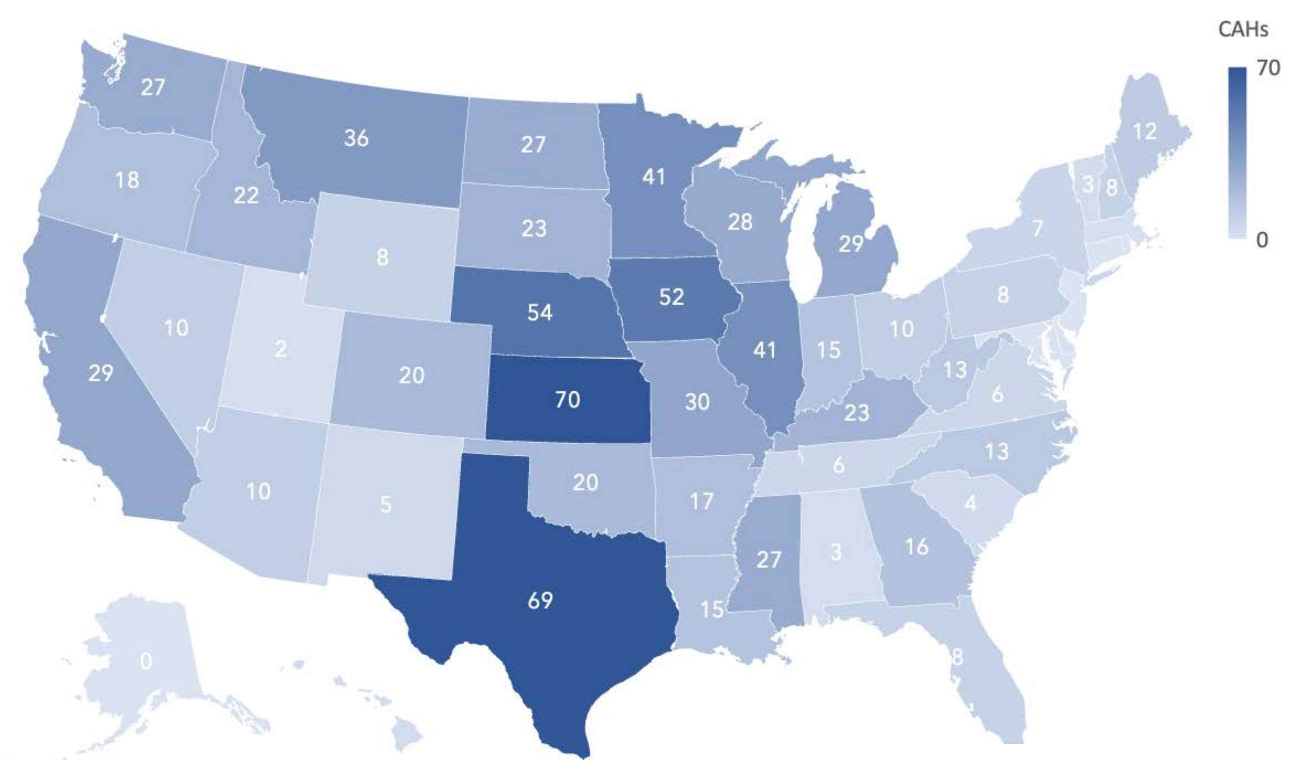
Context

The relevance of rural primary care and RHCs

CAHs with Provider-based RHCs by State

Map A: State Comparison of CAHs that Own Provider-based Rural Health Clinics



890

In 2019, there were approximately **1,350** Critical Access Hospitals in the US. Among those organizations, **890** owned and operated at least one Provider-based Rural Health Clinic. Collectively, these CAHs owned **1,649** PB-RHCs. The distribution of PB-RHCs largely reflected the distribution of CAHs across rural America, with a large percentage of PB-RHCs located in the Midwest.

Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

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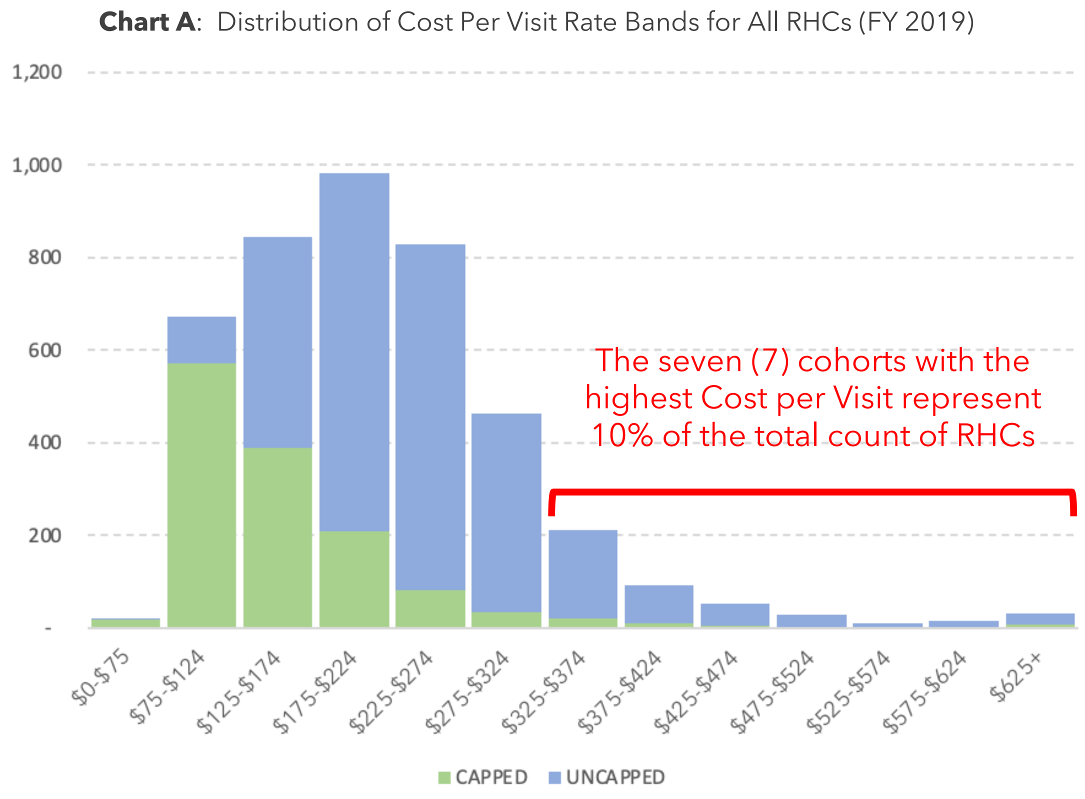
RHC Cost Per Visit Rate Bands



90%

Chart A displays cohorts based on cost per visit rates calculated as Total Costs divided by Total Visits. We constructed 13 bands based on the cost per visit rates for all RHCs for FY 2019. This analysis includes all RHCs (Independent and Hospital-owned) and excludes those clinics whose Medicare cost reports contained material errors, omissions or irregularities (n=293). For each band we calculated its percentage of total RHCs.

In FY 2019 for the 4,254 RHCs that had complete, reliable and traceable Medicare cost report submissions, **90%** of RHCs report a Cost per Visit rate lower than $325

Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

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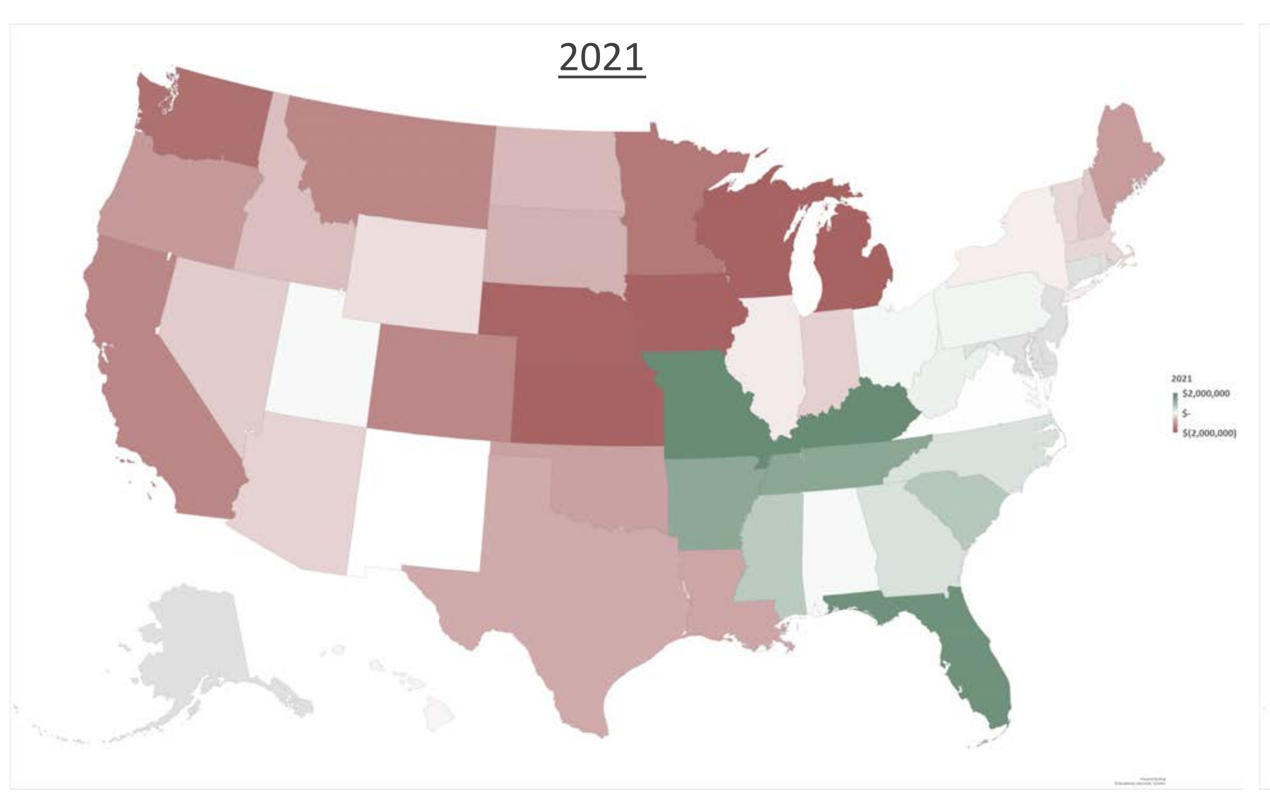
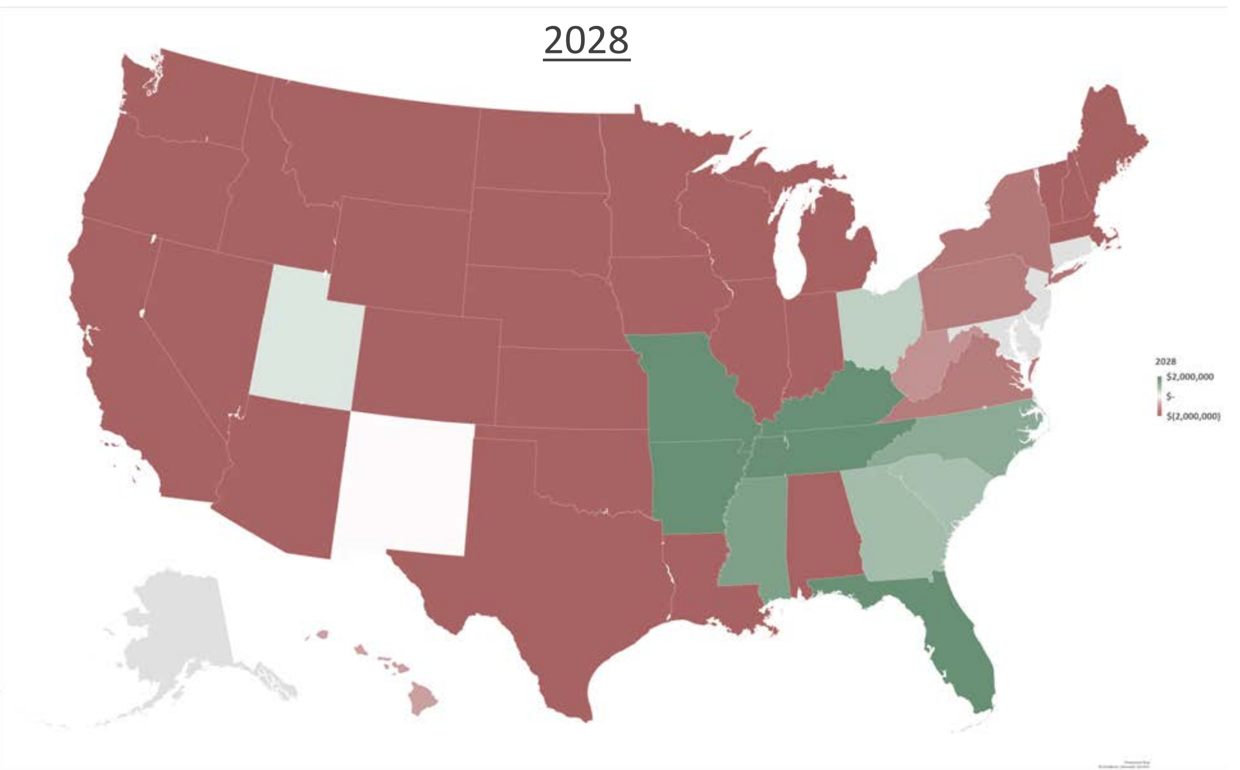
Projected RHC Reimbursement Impact

- **Projected RHC Reimbursement Impact**
  - The following map reflects the impact of the new reimbursement methodology on each state





See Appendix 2 for the impact to each state

Data Source: December 2021 Medicare Cost Report release for hospital and RHC fiscal year 2020; and December 2021 CMS Provider of Services (POS) data file.

NRHA Grassroots Update

Aug 19, 2021 2:54 PM
Mason Zeagler

Hello NRHA members,

We want to provide a few updates on legislative packages making their way through Congress and inform you of NRHA's newest advocacy campaign.

The House of Representatives is expected return to Washington, D.C. next week to begin consideration of the $1 trillion bipartisan infrastructure package. Timeline for final passage of the bipartisan legislation is still unsure in the House of Representatives, but NRHA will keep members apprised of all developments.

Additionally, Congress has begun negotiating the details of the $3.5 trillion Build Back Better (BBB) reconciliation package, and **NRHA is advocating Congress include funding and support for rural health care providers and patients within the legislation**. We believe support for the rural health workforce and rural health safety net providers should be an integral part of this bill, which aims to improve what President Biden has dubbed "human infrastructure."

NRHA is advocating Congress include provisions within the BBB to:

- Provide capital funding to improve rural health care infrastructure using the framework provided within the LIFT America Act (**H.R. 1848**), which includes $10 billion for hospital infrastructure. Congress must include a 20 percent carveout for rural providers in any hospital capital investment.
- Make substantive changes to rural Medicare GME policies and other rural workforce programs through inclusion of the Rural Physician Workforce Production Act of 2021 (**S. 1893**).
- Improve rural maternal health and health care access through inclusion of the Rural Maternal and Obstetric Modernization of Services Act (**H.R. 769** / **S. 1491**).
- Permanently extend CARES Act telehealth flexibilities for rural health clinics and federally qualified health centers and increase their reimbursements for telehealth services, as is done through the Protecting Rural Telehealth Access Act (**S. [illegible]**) and the CONNECT for Health Act of 2021 ([illegible]).
- Establish an Office of Rural Health within the Centers for Disease Control and Prevention (CDC).
- Modernize and improve the rural health clinic program by removing the cap for provider-based rural health clinics in exchange for voluntarily submitting to quality measure reporting.

We encourage you to utilize our **advocacy campaign** to urge your Members of Congress to include rural health provisions within the BBB reconciliation package. By using the campaign, you can reach your members of Congress with one click, while customizing content as needed, to allow you to maintain your unique voice.

Sincerely,

Thursday, August 19, 2021 at 2:54 PM

"Modernize and improve the rural health clinic program by removing the cap for provider-based rural health clinics **in exchange for voluntarily submitting to quality measure reporting**."

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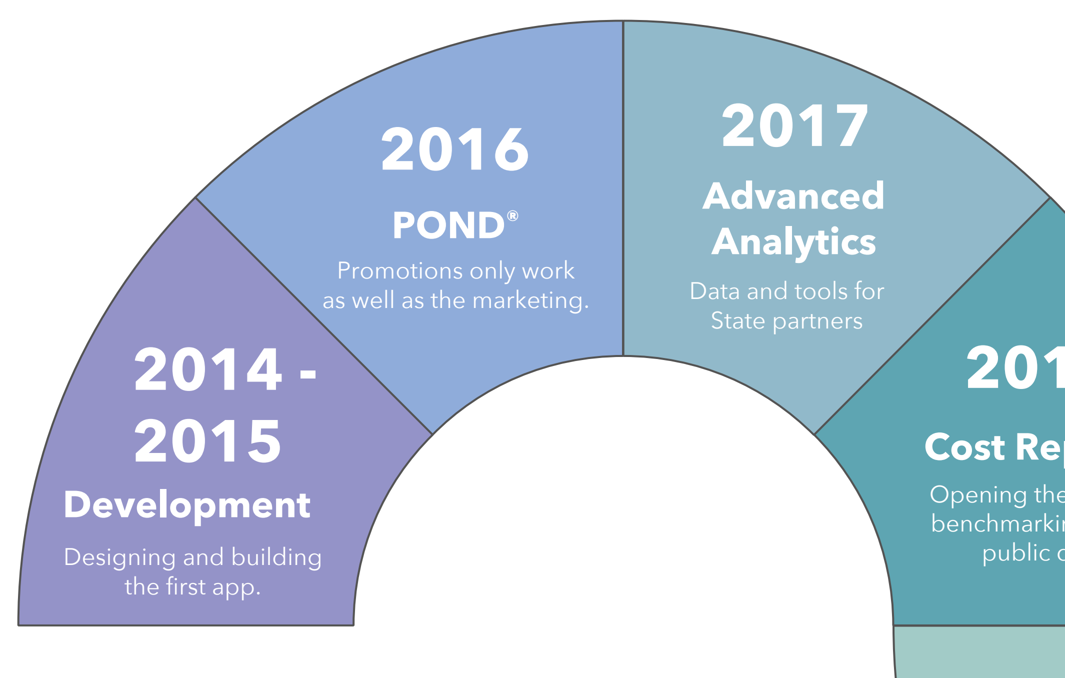
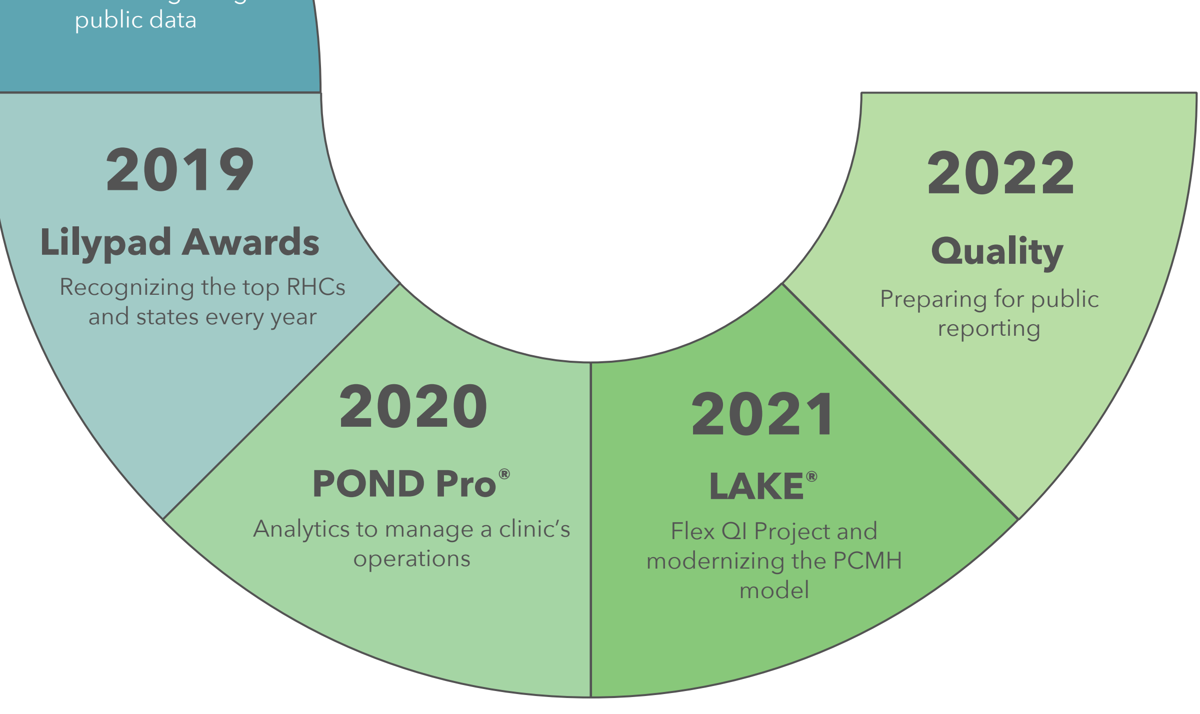
POND®

Benchmarking system for rural primary care practices



Our History

Every year we try to get better, grow and add new data products and tools to address what we see as rural clinic needs



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Our Current States

WA MT ND MN ME
OR ID WY SD WI MI VT NH
NY MA CT RI
NV UT CO NE IA IL IN OH PA NJ
CA KS MO KY WV MD DE VA
AZ NM OK AR TN NC SC
TX LA MS AL GA FL
AK HI

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How Does It Work?

Advanced Analytics

State Scorecards

Clinic Scorecards

POND®

Clinic Scorecard

Interactive Tools

To gain access to these reports and tools the required data must be entered into the POND web application

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POND Reports

Lilypad's flagship report, the **POND Summary Report** includes RHC-specific financial, staffing, provider compensation, productivity and clinical metrics with customized peer group and national benchmarks.

The **Cost Report Scorecard** includes multi-year trended volume, financial, cost and staffing ratios as well as state, regional and national benchmarks from all US RHCs based on current Medicare Cost Reports.

The **Site Audit** combines data from multiple public sources to provide summary statistics as well as a proprietary Medicare Cost Report integrity analysis and an evaluation of the out-of-pocket obligations for Medicare patients.

The **Lilypad Award Ranking Report** displays your RHC's annual performance in five weighted rural-relevant performance metrics according to the industry's only comprehensive RHC ranking and ratings program.

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POND® Technical Assistance

Report

Enter data into POND to generate a set of management and benchmark reports

Validate your data

Review

30-60 Zoom session with us to review your POND reports and discuss options

Go over your reports

Plan

30-60 Zoom session to answer questions and help identify priorities

Discuss opportunities

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Gratuitous Praise

"I could not be happier with the ease of use and functionality of POND. Data entry was straightforward and easy to follow. The support team has answered all questions that I have had and provided help any time that I have needed them in a timely manner."

Casey Stanley, CRHCP

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20 Questions

How to Utilize the POND® Summary Report

RHC Performance Model

Value to Community

Strategy (10, 16)

Operations (1, 8)

Financial (5, 11, 14)

Quality (6, 13)

Revenue (4)

Expense (9)

Productivity (3, 18, 19)

Compensation (7, 17)

Staffing (2, 12, 15, 20)

Strategy: Rural Health Clinics, regardless if they are Independent or Provider-based, serve an essential and unique role in the rural healthcare safety net. Organizations that have direct control or contractual alignment with its service area's primary care provider network can shape and guide how prevention, education and patient care processes are implemented across the service area.

Productivity: In rural America, we've learned to do more with less. This principle should apply to the clinic's providers where your clinical team all practice at the top of their license and are busy and efficient.

Compensation: Compensation scale and design are key drivers of performance and satisfaction. How providers are paid can vary widely but compensation models should be tailored to your market realities.

Staffing: The clinic team (staff and providers) is an RHC's single most important asset and should be the primary focus for practice managers. Having the right mix of motivated professionals is the key to performance.

Quality: Long an elusive goal, a consensus-driven set of RHC quality measures is starting to emerge. The monitoring and target-setting process for rural relevant primary care quality measures represents for many RHCs a new priority and challenge. Quality measures will also increasingly influence reimbursement via Value Based Payment programs.

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20 Essential Questions for RHCs

1. **Why do visit volumes matter so much?**
2. What is the right mix of physicians and APPs?
3. Are our providers "busy"?
4. What is the difference between gross charges and net revenue?
5. How come our clinic does not make money?
6. What quality measures should we track?
7. Are our providers appropriately compensated?
8. Do we have the right number of support staff?
9. How can we control our cost per visit?
10. Why is important to track "new patients"?
11. **What is most important? Managing visits, revenue or expenses?**
12. What is the right mix of clinical and non-clinical staff?
13. What level of performance should we expect for quality measures?
14. How do we increase our profit margin per patient visit?
15. Should performance standards be different for PA and NPs?
16. How does patient panel factor into overall performance?
17. What is the best model to compensate physicians?
18. How does visit volume relate to Work RVUs?
19. Why are our productivity scores low?
20. Do we need to hire more providers?

Purpose
We distill the complexity of RHC operations into a small set of key factors that can be evaluated by practice managers, providers and executive leaders to help identify opportunities for performance improvement

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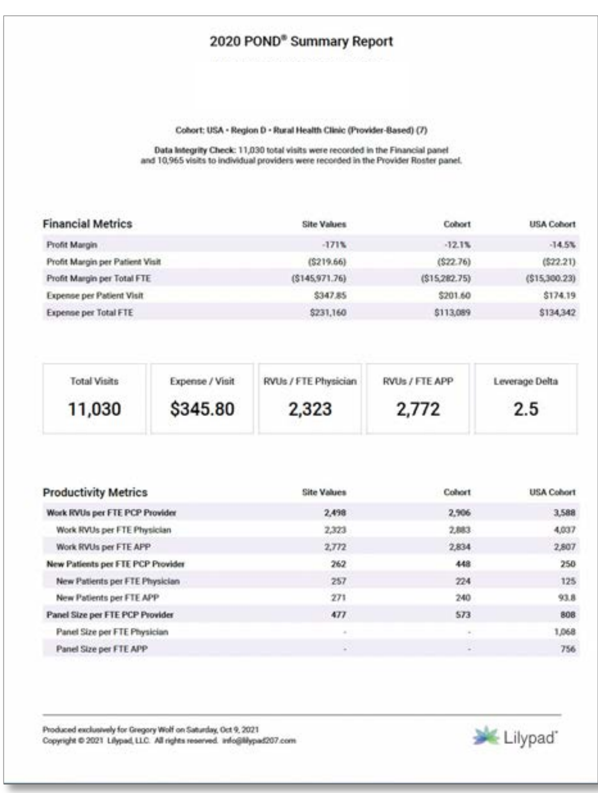
POND Summary Report

Financial Metrics
Five (5) key profit, expense and revenue ratios

Summary Statistics
Key metrics designed to reflect overall performance

Productivity Metrics
Three (3) categories dealing with utilization and growth



2020 POND® Summary Report

Cohort: USA • Region D • Rural Health Clinic (Provider-Based) (7)

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Financial Metrics	Site Values	Cohort	USA Cohort
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Productivity Metrics	Site Values	Cohort	USA Cohort
Work RVUs per FTE PCP Provider	**2,498**	**2,906**	**3,588**
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New Patients per FTE PCP Provider	**262**	**448**	**250**
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New Patients per FTE APP	271	240	93.8
Panel Size per FTE PCP Provider	**477**	**573**	**808**
Panel Size per FTE Physician	-	-	1,068
Panel Size per FTE APP	-	-	756

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

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

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

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

Staffing Metrics
Six (6) metrics

Quality Metrics
Placeholder

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Why do visit volumes matter so much?

From a financial and operational perspective, a clinic's visit volume is the single most important and sensitive factor because it is the denominator in most performance ratios. And while alternative payment models beckon and population health strategies persist, we still generally operate in a fee-for-service, volume-based healthcare environment.

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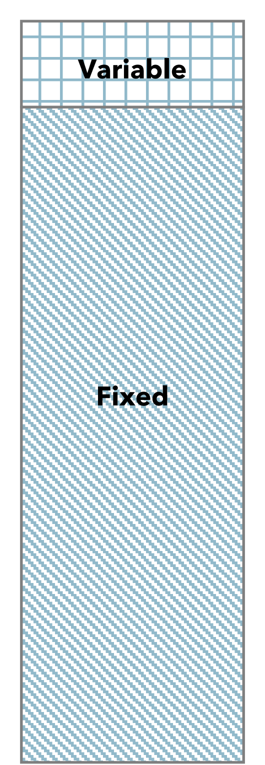
Why do visit volumes matter so much?

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

~10 percent

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

~90 percent



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

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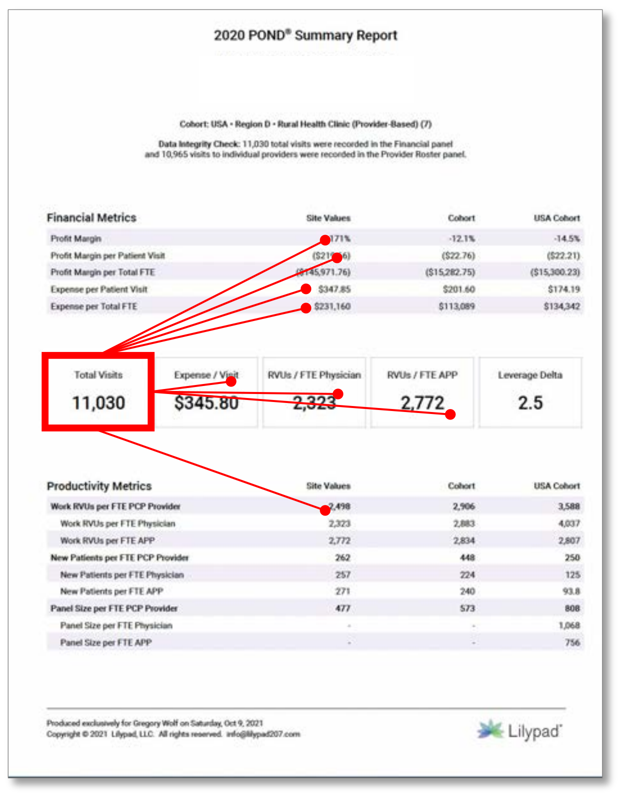
Why do visit volumes matter so much?



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In a fee for service world, volumes fix most problems and improve performance across multiple metrics:

Profit	Variable costs are low compared to fixed costs
Revenue	Increased volume results in increased revenue
Expense	Spreads costs over more services and revenue
Staffing	Demonstrates greater staff efficiency
Productivity	Providers optimize their time and increase access

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What is the right mix of physicians and APPs?

40 years ago, the Rural Health Clinic designation was created, and with that, advanced practice providers (APP) were elevated as key clinicians. The regulations require APPs to provide care in RHCs and in most cases, offer most services. But every organization and market is different – how your RHC sets goals for the balance of physician vs. APP visits is a function of several variables.

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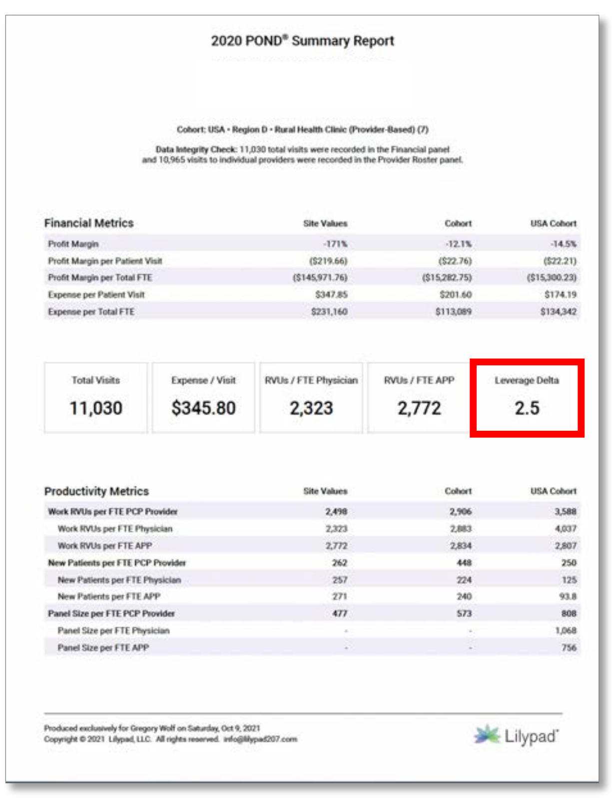
What is the right mix of physicians and APPs?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We designed a novel metric that looks at the proportion of APP FTEs relative to Physician FTEs. The Leverage Coefficient sets a numeric standard of a 3:1 ratio of APPs to Physicians, and the **Leverage Coefficient Delta** measures the distance between the clinic's ratio and that standard.

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Are our providers "busy"?

"Busy" is a subjective term. All providers have different set points and expectations and most consider themselves busy. The more effective and objective term is "productive" because it reflects the measurable output of the provider's work and has a direct impact on practice performance. But productivity itself is a measure that requires careful consideration.

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Are our providers "busy"?

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

The goal is always to maximize visit volumes

4,200
Physicians

2,100
APPs

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

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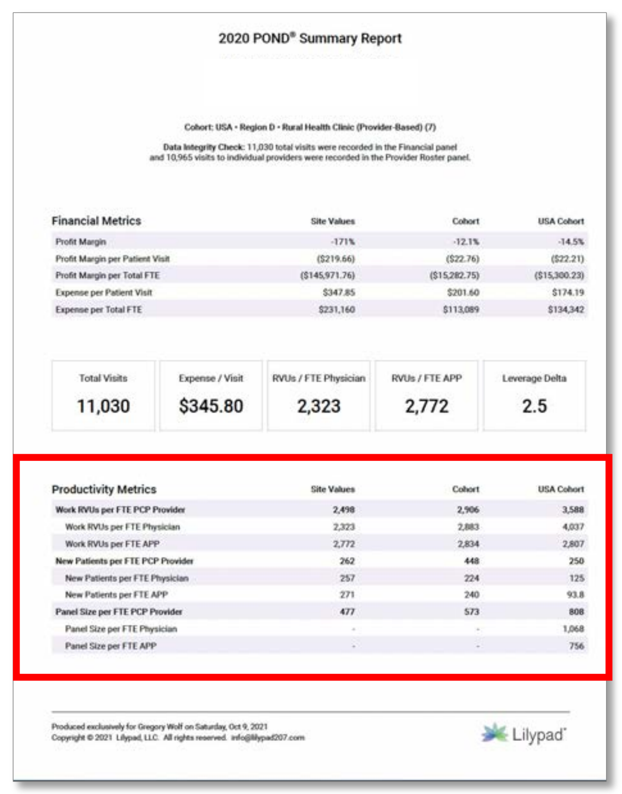
Are our providers "busy"?



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$$\frac{\text{Work RVUs PCP Providers}}{\text{PCP FTE Providers}}$$

Some RHCs continue to track solely visits as a measure of productivity. Work RVUs are a more effective way to assess productivity because they are designed to reflect the resource intensity of a specific visit. Most provider compensation packages include targets and incentives based on Work RVUs.

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What is the difference between gross charges and net revenue?

Among its many idiosyncrasies, the US healthcare system does a poor job with enabling consumers to make educated decisions based on valid, reliable price information. This is one reason we are slowly moving toward an era of price transparency. In the meantime, RHCs manage two dimensions of payment that uniquely impact the cost of care: gross charges and net revenue.

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What is the difference between gross charges and net revenue?

Gross Charges are the retail prices assigned to all medical services and procedures via the hospital or clinic Chargemaster

Net Revenue is the amount of actual income (dollars) generated by the hospital or clinic

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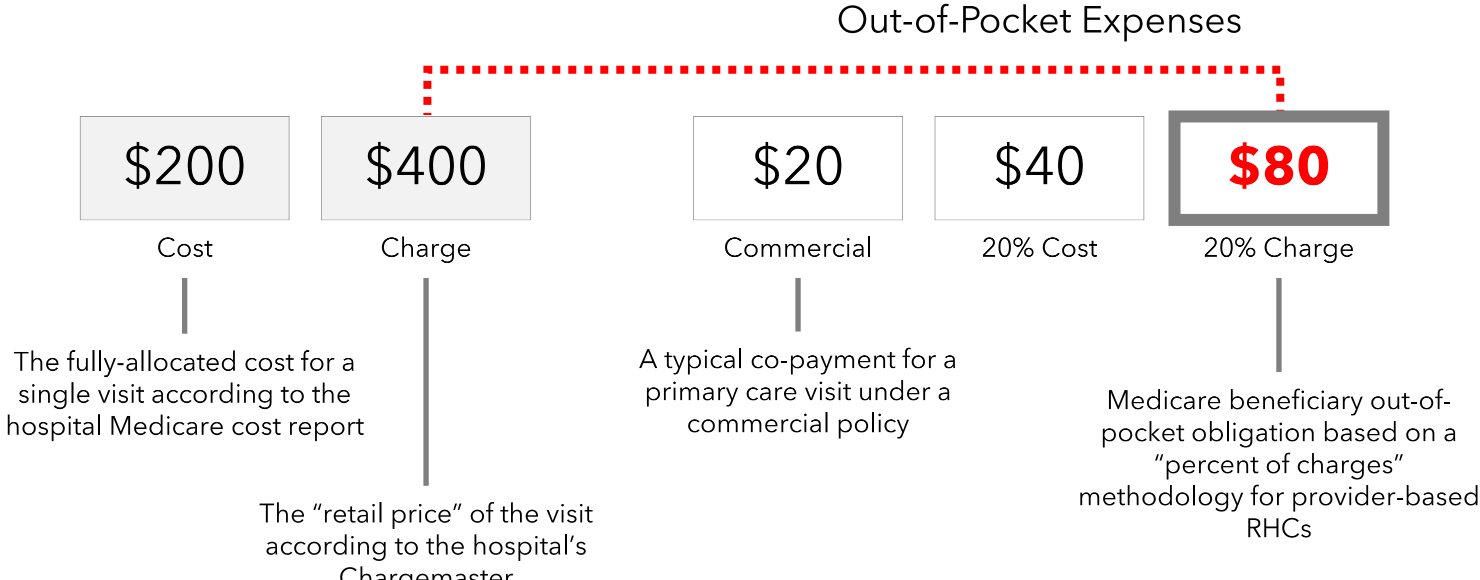
What is the difference between gross charges and net revenue?



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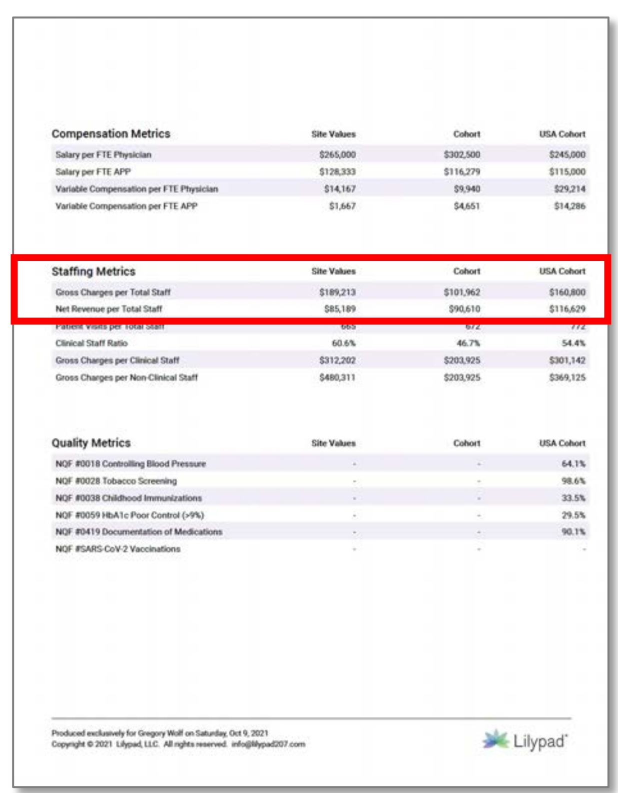
What is the difference between gross charges and net revenue?



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

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

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

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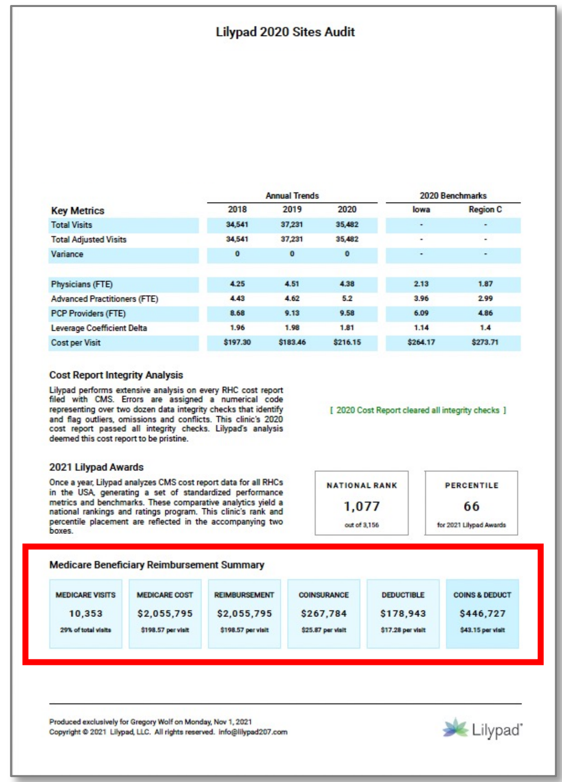

Lilypad 2020 Sites Audit

Key Metrics	Annual Trends			2020 Benchmarks	
	2018	2019	2020	Iowa	Region C
Total Visits	34,541	37,231	35,482	-	-
Total Adjusted Visits	34,541	37,231	35,482	-	-
Variance	0	0	0	-	-
Physicians (FTE)	4.25	4.51	4.38	2.13	1.87
Advanced Practitioners (FTE)	4.43	4.62	5.2	3.96	2.99
PCP Providers (FTE)	8.68	9.13	9.58	6.09	4.86
Leverage Coefficient Delta	1.96	1.98	1.81	1.14	1.4
Cost per Visit	$197.30	$183.46	$216.15	$264.17	$273.71

Cost Report Integrity Analysis

Lilypad performs extensive analysis on every RHC cost report filed with CMS. Errors are assigned a numerical code representing over two dozen data integrity checks that identify and flag outliers, omissions and conflicts. This clinic's 2020 cost report passed all integrity checks. Lilypad's analysis deemed this cost report to be pristine.

[2020 Cost Report cleared all integrity checks]

2021 Lilypad Awards

Once a year, Lilypad analyzes CMS cost report data for all RHCs in the USA, generating a set of standardized performance metrics and benchmarks. These comparative analytics yield a national rankings and ratings program. This clinic's rank and percentile placement are reflected in the accompanying two boxes.

NATIONAL RANK	PERCENTILE
1,077	66
out of 3,156	for 2021 Lilypad Awards

Medicare Beneficiary Reimbursement Summary

MEDICARE VISITS	MEDICARE COST	REIMBURSEMENT	COINSURANCE	DEDUCTIBLE	COINS & DEDUCT
10,353	$2,055,795	$2,055,795	$267,784	$178,943	$446,727
29% of total visits	$198.57 per visit	$198.57 per visit	$25.87 per visit	$17.28 per visit	$43.15 per visit

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$43.15

The **POND Site Audit** combines data from multiple public sources to provide summary statistics as well as a proprietary Medicare Cost Report integrity analysis and an evaluation of the out-of-pocket obligations for Medicare patients.

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How come our clinic does not make money?

This is a philosophical, systems-based question because primary care provides a unique function in the healthcare delivery system. In many rural markets, RHCs are the funnel through which patients access the healthcare delivery system and the value they create is not wholly financial. Therefore, it plays a specialized role in the holistic safety net as well as the organization's strategy, and its profitability as a stand-alone business unit is only one consideration.

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How come our clinic does not make money?

Value to Community

Strategy

Operations

Financial

Quality

Revenue

Expense

Profit Margin ultimately reflects the overall financial performance of the RHC. But there are additional considerations in terms of expectations and in some ways an even more important question:

Should we expect the clinic to be profitable?

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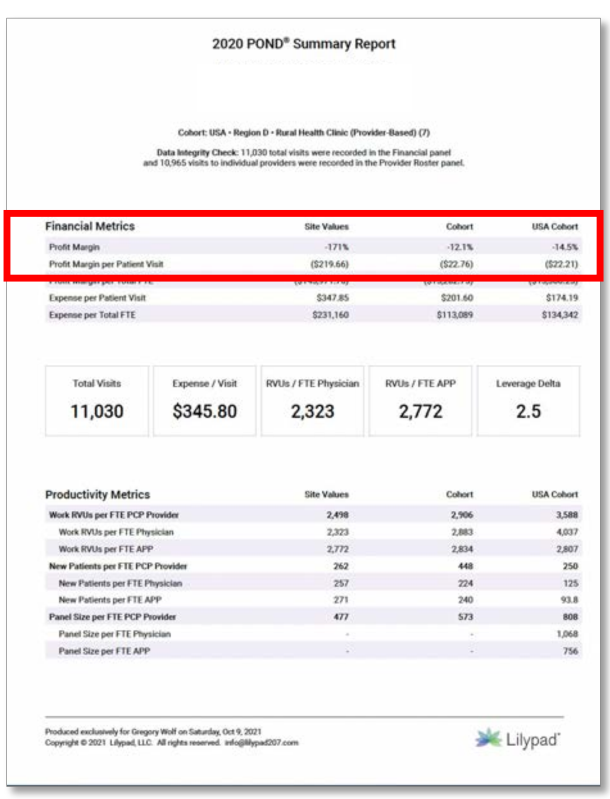
How come our clinic does not make money?



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Panel Size per FTE PCP Provider	477	573	808
Panel Size per FTE Physician	-	-	1,068
Panel Size per FTE APP	-	-	756

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$$\frac{\text{Net Revenue - Expense}}{\text{Net Revenue}}$$

Key Drivers

- Visit volumes
- Provider productivity
- Commercial contracts
- Provider compensation
- Staffing model
- Overhead allocation

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What quality measures should we track?

One of the chief deficits related to RHCs from a public policy perspective is the lack of public reporting and value-based purchasing arrangements. However, a small set of National Quality Forum (NQF) measures have emerged as a core set of rural relevant measures based. Those five targeted measures are included in the POND® program.

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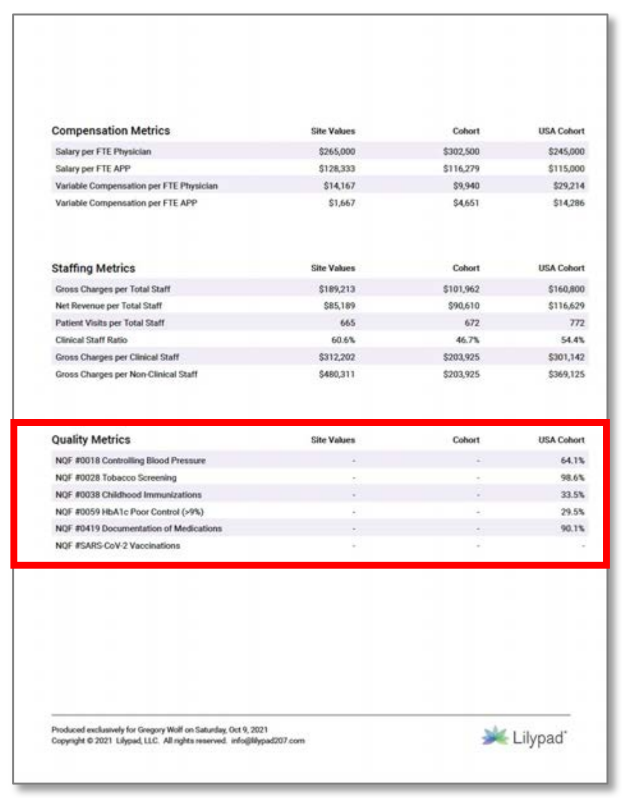
What quality measures should we track?



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

John Gale, Director of Policy Engagement
john.gale@maine.edu

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

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Are our providers appropriately compensated?

Notwithstanding fair market valuation regulations, in most instances the market and basic supply and demand dynamics drive provider compensation. Increasingly, RHC physicians and APPs are migrating away from straight salary arrangements toward productivity-based arrangements and in some cases, value-based compensation models. The challenge for RHC operators is how to balance and accelerate these different types of compensation plans in a delicate rural healthcare market.

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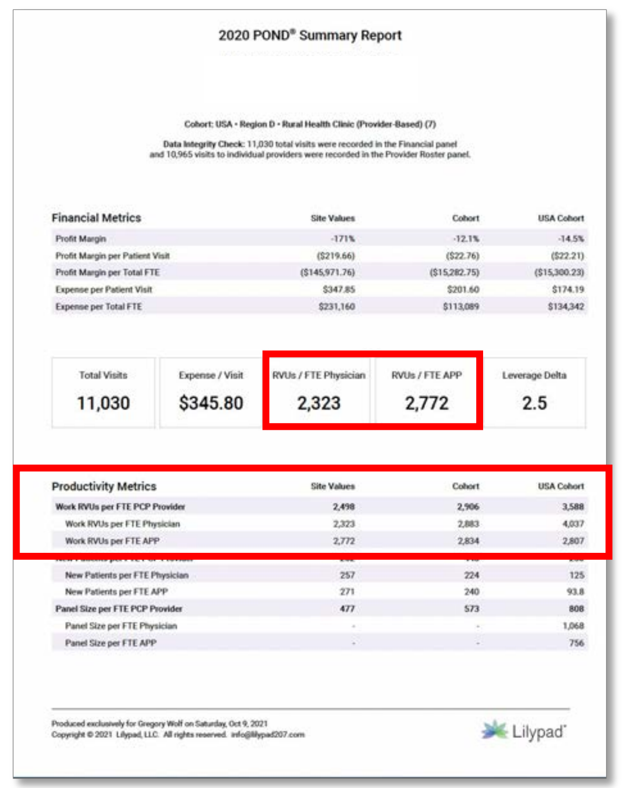
Are our providers appropriately compensated?



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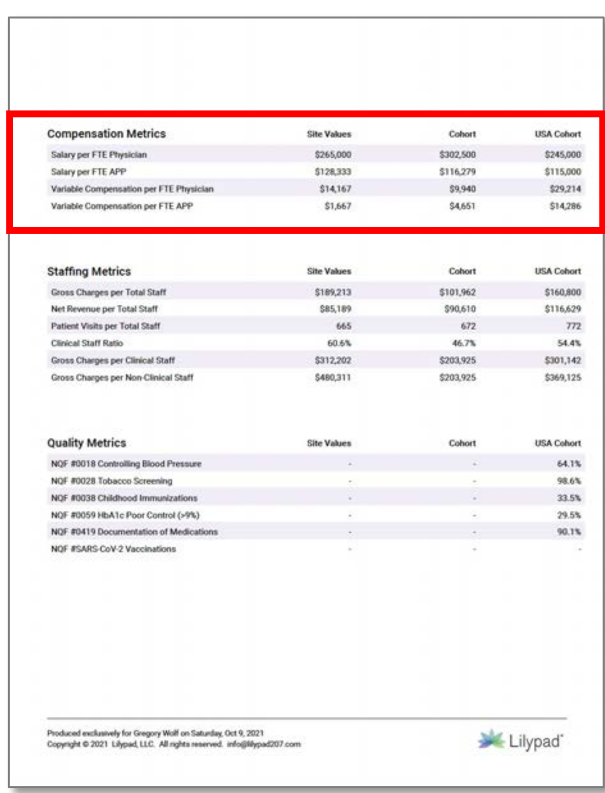
Productivity Metrics
Three (3) categories dealing with utilization and growth

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



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NQF #0419 Documentation of Medications	-	-	90.1%
NQF #SARS-CoV-2 Vaccinations	-	-	-

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Do we have the right number of support staff?

The most valid way to answer this important question is to evaluate how the clinic performs financially, operationally and clinically because there is no single staffing model that guarantees success. Staffing ratios are a reflection of the RHC's clinical model, organizational culture and strategic purpose.

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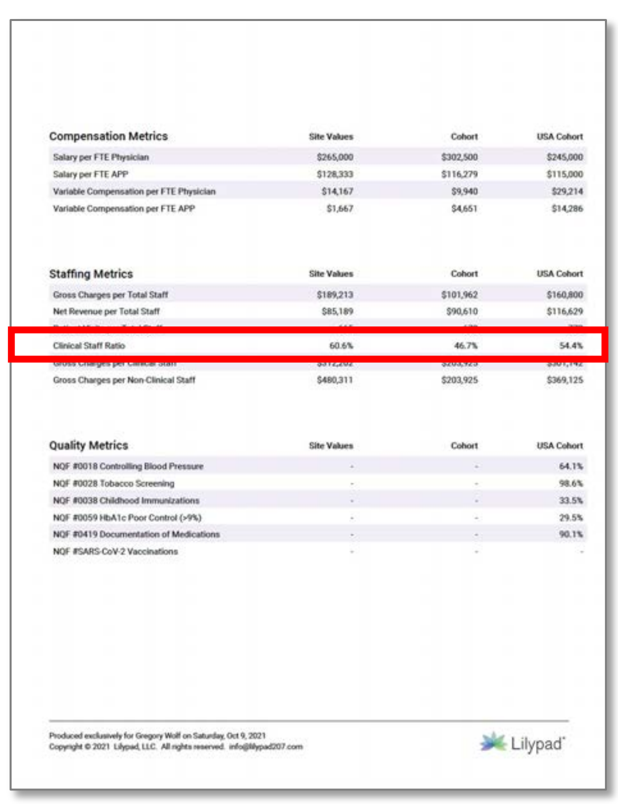
Do have the right number of support staff?



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NQF #SARS-CoV-2 Vaccinations	-	-	-

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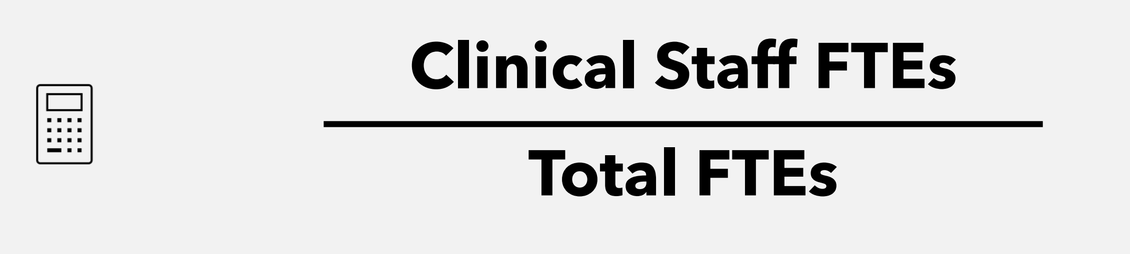

This metric shows the percentage of staff that provide clinical or diagnostic services. A higher number suggests a greater proportion of resources (people, time, funding) is allocated to patient care relative to administrative functions.

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How can we control our cost per visit?

Major cost drivers for small rural practices center on fixed costs, primarily clinical and non-clinical staff. The relationship between provider expenses (salary and bonuses) and visit volumes is the key factor influencing a large set of performance ratios. As is the case with so many areas of RHC performance, visit volumes drive results.

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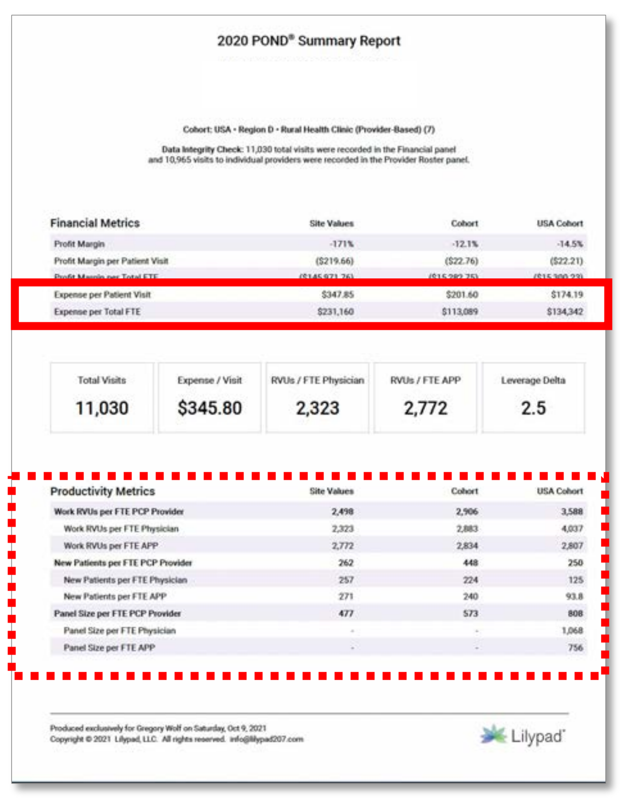
How can we control our cost per visit?



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Total Visits	Expense / Visit	RVUs / FTE Physician	RVUs / FTE APP	Leverage Delta
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Productivity Metrics	Site Values	Cohort	USA Cohort
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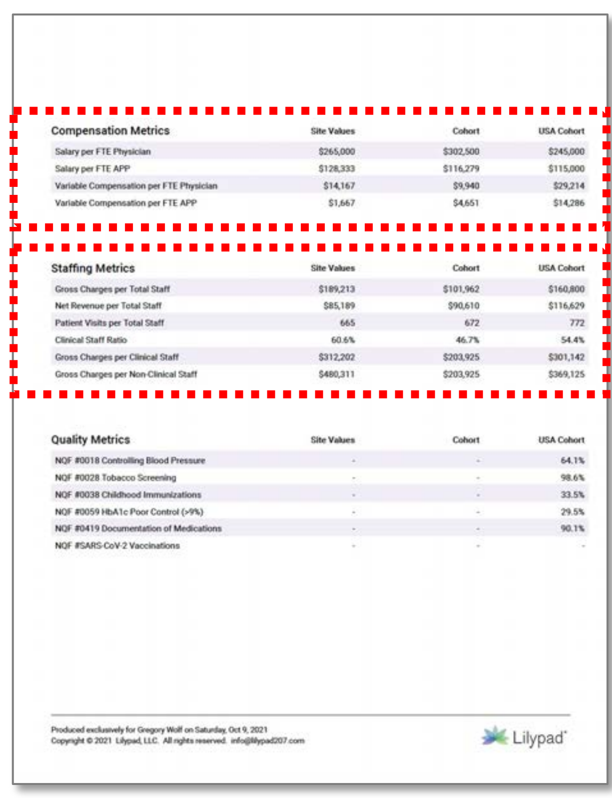
Expense Ratios
Two (2) key metrics that provide a high-level view of RHC performance

Productivity Metrics
Three (3) categories dealing with utilization and growth

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

Staffing Metrics
Six (6) metrics



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Why is it important to track “new patients”?

When a practice has “new” patients, it is often a signal of growth, whether through new markets, new services or additional providers. An increase in new patients is almost always a positive sign and annual targets should factor in the desirability of expanding practice size, provided the clinical staff has the necessary resources.

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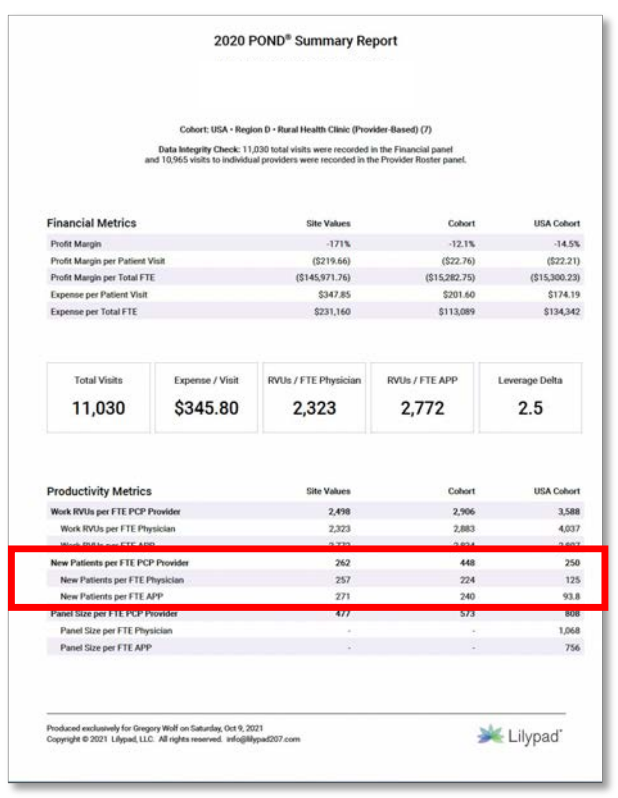
Why is it important to track "new patients"?



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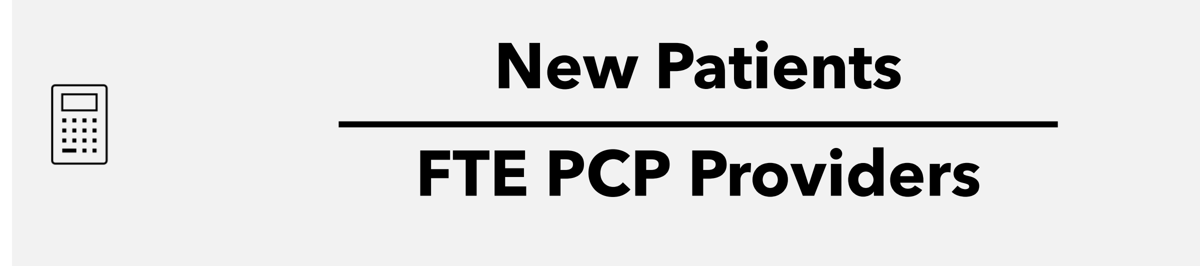

The high-level metric shows how many **new** patients have been registered in the practice for the period. A higher number reflects a growing practice that may be expanding its service area or adding new providers.

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What is most important: Managing visits, revenue or expenses?

All three factors are foundational to clinic performance, but because visit volumes are part of most operational ratios, the amount of throughput (visits) is the dominant driver. Expenses are key because they enable the RHC to operate effectively in the future under the MEI-based reimbursement growth rate methodology, and revenue ties to visit volume, revenue cycle performance and payer mix

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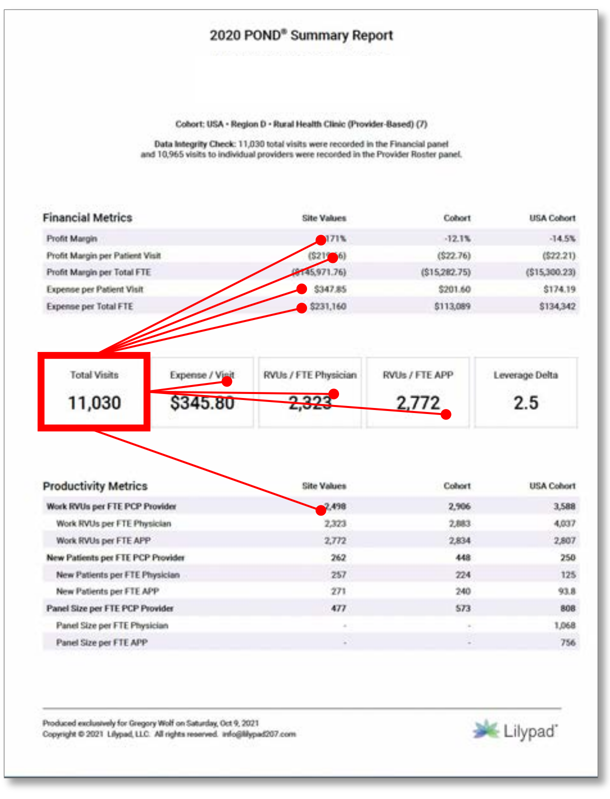

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11,030	$345.80	2,323	2,772	2.5

Productivity Metrics	Site Values	Cohort	USA Cohort
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In a fee for service world, **volumes fix most problems** and improve performance across multiple metrics:

Profit	Variable costs are low compared to fixed costs
Revenue	Increased volume results in increased revenue
Expense	Spreads costs over more services and revenue
Staffing	Demonstrates greater staff efficiency
Productivity	Providers optimize their time and increase access

Practice managers can most directly control visit volumes as opposed to costs and revenue

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What is the right mix of clinical and non-clinical staff?

Understanding that challenges around staffing dominate practice management and clinic performance, the goal is to optimize the care team. That means every staff person performs at the top of their license and that physicians, nurse practitioners and physician assistants embrace some sort of Team-based Care model.

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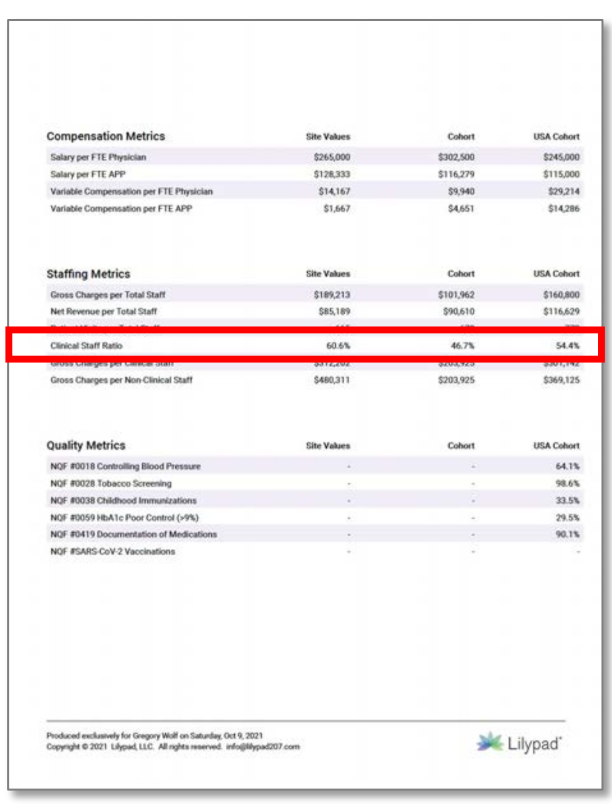
What is the right mix of clinical and non-clinical staff?



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Variable Compensation per FTE Physician	$14,167	$9,940	$29,214
Variable Compensation per FTE APP	$1,667	$4,651	$14,286

Staffing Metrics	Site Values	Cohort	USA Cohort
Gross Charges per Total Staff	$189,213	$101,962	$160,800
Net Revenue per Total Staff	$85,189	$90,610	$116,629
[illegible]	[illegible]	[illegible]	[illegible]
Clinical Staff Ratio	60.6%	46.7%	54.4%
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NQF #0419 Documentation of Medications	-	-	90.1%
NQF #SARS-CoV-2 Vaccinations	-	-	-

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A practice with a lower Clinical Staff Ratio may have greater efficiency and higher throughput

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What level of performance should we expect for quality measures?

Setting performance standards is the ultimate mix of art and science. In healthcare, most quality improvement specialists will suggest that clinical measure targets should be set at 100% as the goal is to prevent all harm, always. Others adopt a more customized approach and apply a series of stretch goals that factor in current performance against a consensus-driven, achievable level of improvement.

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What level of performance should we expect for quality measures?

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A measure without a target is like a joke without a punchline

Maine Rural Health Research Center

John Gale, Director of Policy Engagement
john.gale@maine.edu

Lilypad® LAKE PDSA Initiative

SGOH Acquisition, Inc.

Hemoglobin A1C Control NQF# 0059

Clinical Quality

Active Until	Improvement	Valid Measures	Results Expected
Jan 10, 2023	Yes	Yes	Yes

Goal: Less than 25% of patients ages 18-75 with a diagnosis of diabetes (type 1 or 2) who had a Hemoglobin A1c >9.0% within 12 months. This is an inverse measure so a lower rate is optimal.

Background: Reducing A1c blood level results by 1 percentage point helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) by as much as 40 percent (CDC Estimates 2011).

PDSA Cycle	Duration	Start	End
[illegible]	[illegible]	Jan 9, 2022	Jan 10, 2023

Sites	Team Members	Measures	Tasks	Observations
3	2	1	3	0

Team Leader: Kristen Ogden

Team Member: Jessica Schroeder

Participating Sites: OCH Anderson Rural Health Clinic, OC[illegible] McDonald County Clinic, OCH Goodman Family Clinic

Data Collection Plan: Data analysts will identify patients [illegible]ges 18-75 with a qualifying visit and a diagnosis of diabetes to calculate the denominator. The total number of patient[illegible] from that group with Hemoglobin A1c values that are > 9.0% make up the numerator. Analyst ensures that patients wit[illegible] exclusionary diagnoses are removed from the calculation.

Measure: A1C's >9

37%	25%	35%
Baseline	Target	Final

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How do we increase our profit margin per patient visit?

The three major drivers of profit margin for rural health clinics are visit volumes, revenue cycle management and payer mix. In most cases, most of the reimbursement is from payers with fixed, or cost-based rates. Therefore, opportunities to generate positive margin frequently derive from non-cost-based payers (e.g., commercial insurance plans).

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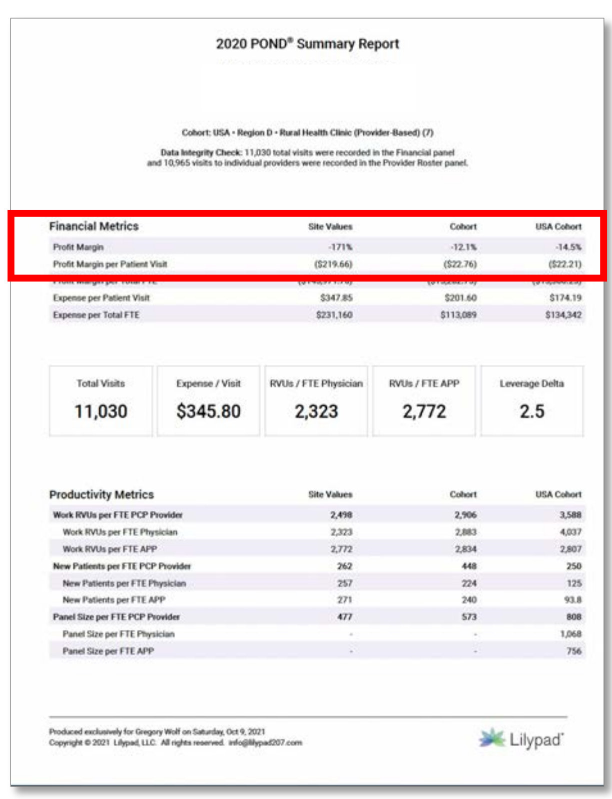
How do we increase our profit margin per patient visit?



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$$\frac{\text{Net Revenue - Expense}}{\text{Net Revenue}}$$

Key Drivers

- Visit volumes
- Provider productivity
- Commercial contracts
- Provider compensation
- Staffing model
- Overhead allocation

Dysfunctional revenue cycle processes can easily undermine all these drivers because **if you do not get paid for the work you do**, no RHC will be exceptional

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Should performance standards be different for PAs and NPs?

CMS sets utilization expectations for provider-based RHCs. These standards help define a license-specific baseline level of productivity. However, several factors influence the ability of providers, whether physicians or advanced practice providers, to meet or exceed these performance thresholds.

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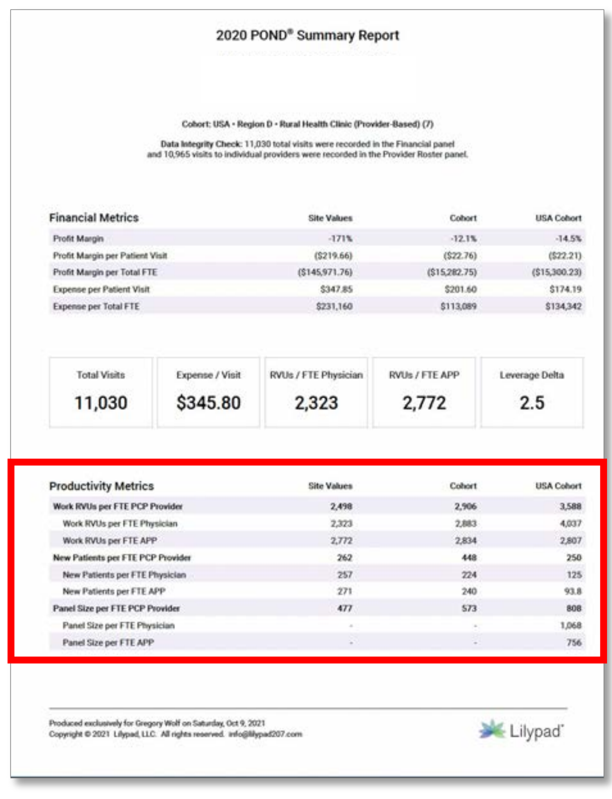
Should performance measures be different for PAs and NPs?



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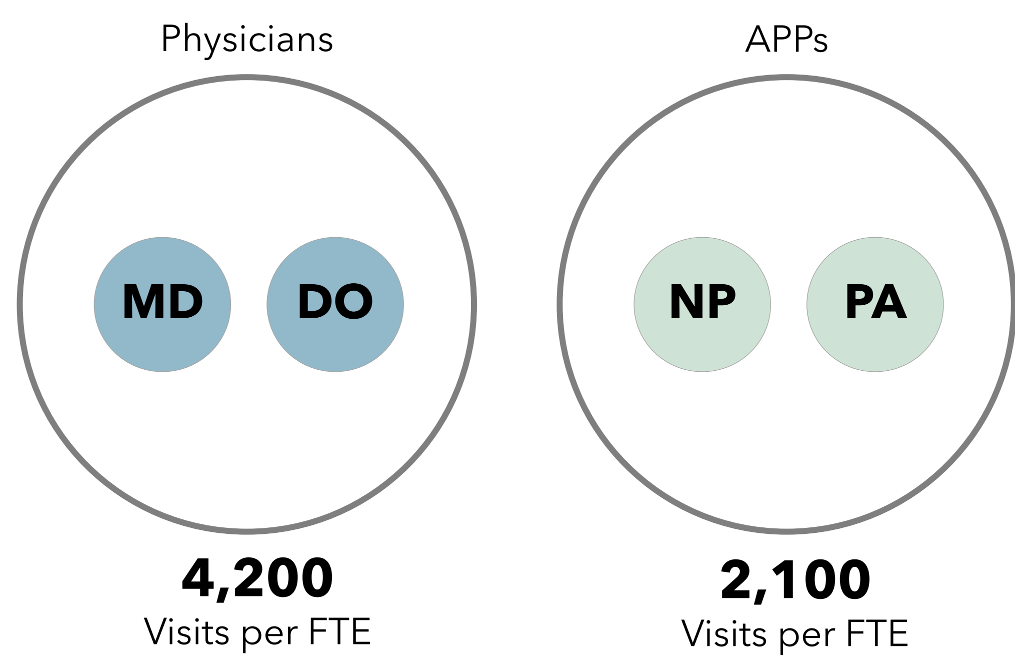

CMS views NPs and PAs as equals in determining their minimum visit thresholds

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How does patient panel size factor into overall performance?

In an era of population health, the ability to grow and maintain patient panels is essential because the unit of strategic and economic value is attributed lives. This is an increasingly relevant value point for the rural primary care delivery systems – and therefore an important factor in practice management and increasingly, provider contracting.

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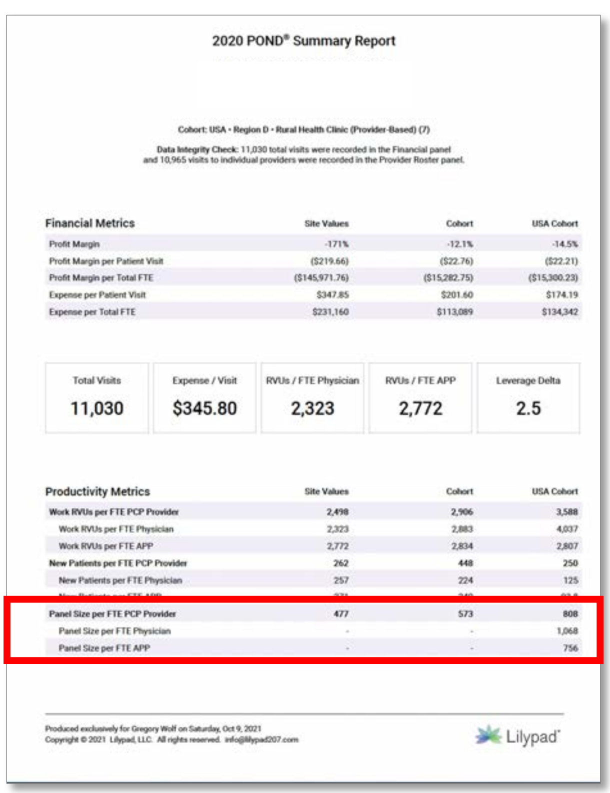

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Chronic Care Management (CCM)

CCM services are non-face-to-face care management and coordination services for Medicare beneficiaries with two or more chronic conditions

Transitional Care Management (TCM)

TCM services support patient's transition from inpatient, SNF, inpatient rehab, outpatient observation or partial hospitalization settings to home or community settings

Behavioral Health Integration (BHI)

General BHI is a defined model of care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions

Note: Internal Target = Count of annual wellness visits equal to Patient Panel size for each provider

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What is the best model to compensate physicians?

There is no "best" way to compensate providers, especially in rural America. For many years, providers were compensated based almost entirely on base salary. Increasingly, however, providers are being compensated under more creative packages that include a mix of several different factors.

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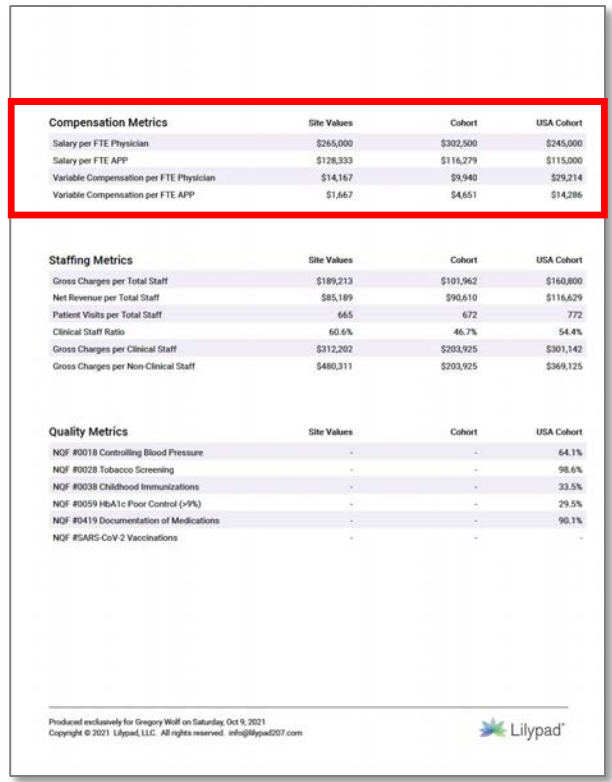

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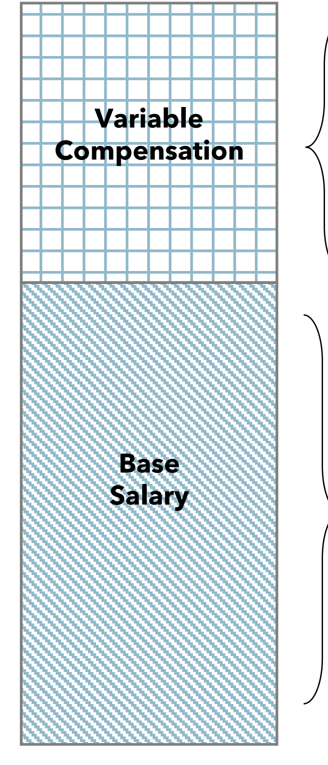
Base salary ranges are based on geographic wage factors, fair market value, tenure, etc.



Panel size
Patient satisfaction
Clinical quality
Relative Value Units (RVUs)

Base salary frequently represents the majority of overall compensation for RHC providers. However, this percentage has decreased over the past several years. In some more progressive practices, many providers operate with no guaranteed base pay but instead receive compensation on a strictly work RVU basis, often referred to as an "**eat what you kill**" environment.

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How does visit volume relate to work RVUs?

Provider utilization typically is monitored and reported according to both patient visits as well as relative value units (RVUs) which are a measure of value used in the Medicare reimbursement formula for physician services. RVUs are a part of the resource-based relative value scale (RBRVS) and are designed to adjust according to the amount of resources required to treat a patient. One visit does not equal one RVU.

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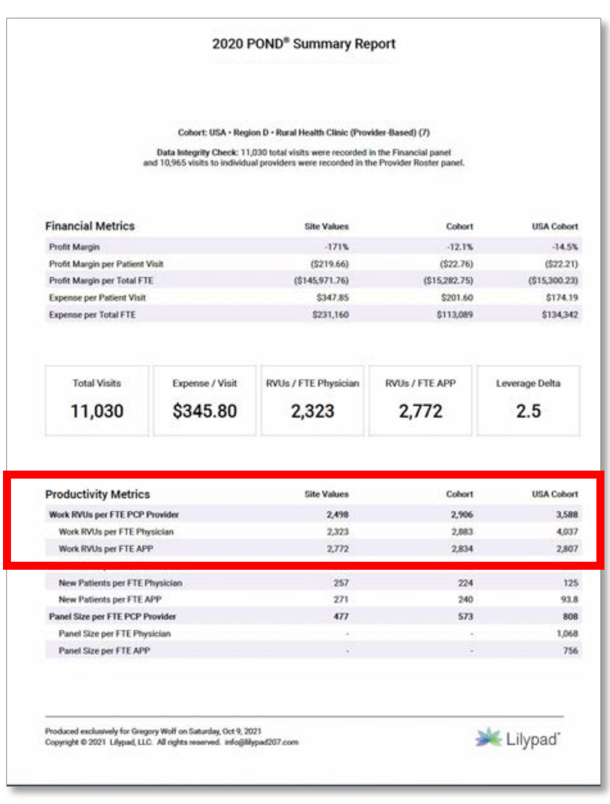

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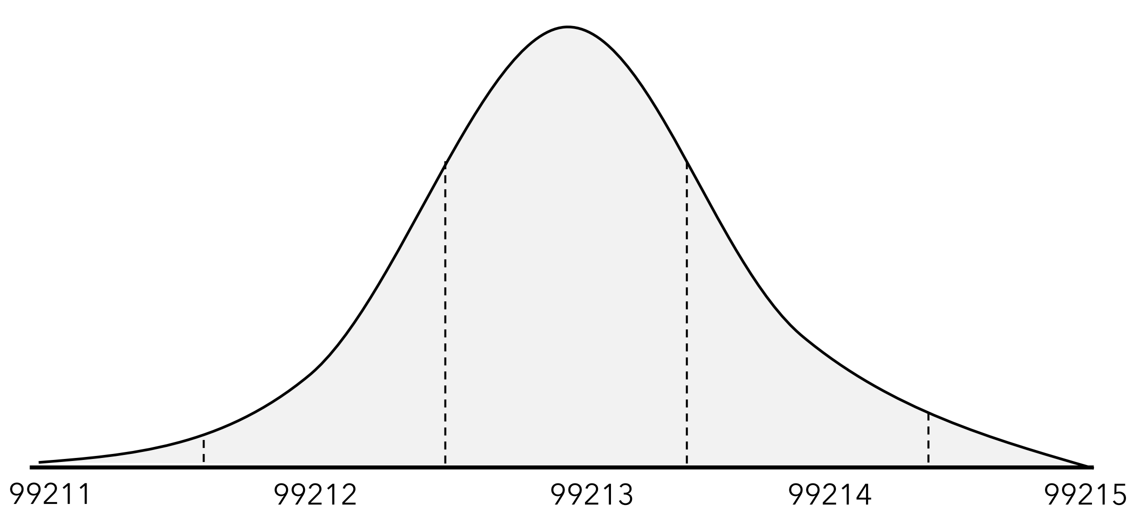

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Why are our productivity scores low?

Productivity scores are based on Work RVUs which reflect the resource requirements of patient visits. Several factors can contribute to low productivity scores, but the most common causes are an imbalance between supply and demand for services and scheduling models. Poor coding and documentation can also impact the integrity of the data.

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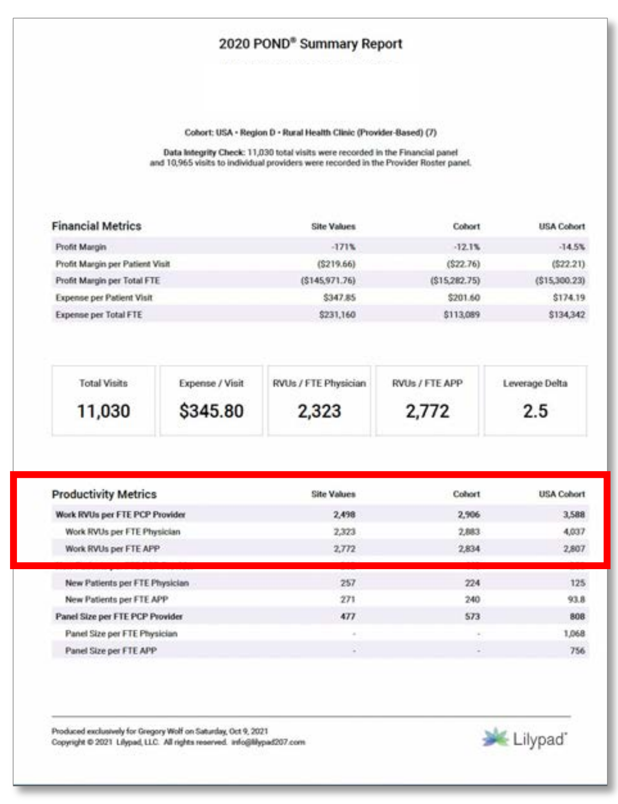
Why are our productivity scores low?



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Supply and Demand

Supply describes the number of eligible providers, their availability in terms of office hours and ability to take on new patients. **Demand** derives from the service area population and its underlying health status.

Scheduling

In too many RHCs, the scheduling system is structured to accommodate patient visits with time slots that are too long. When intervals exceed 15-20 minutes per visit, it creates a self-limiting environment.

Data Integrity

For provider-based RHCs, the amount of time spent in the clinic (scheduled time) dictates the FTE values on the Medicare cost report. Too often, hospitals fail to track actual "available time" accurately.

Coding and Documentation

Because many patient visits are reimbursed on a cost-basis, the reliability of coding – especially billing codes – is sub-standard. This has the potential to over- or under-represent actual utilization.

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Do we need to hire more providers?

In some ways this question is the ultimate luxury for a rural health clinic because it suggests a growing demand for services and more important, an ability to effectively recruit high-quality physicians or advanced practice providers.

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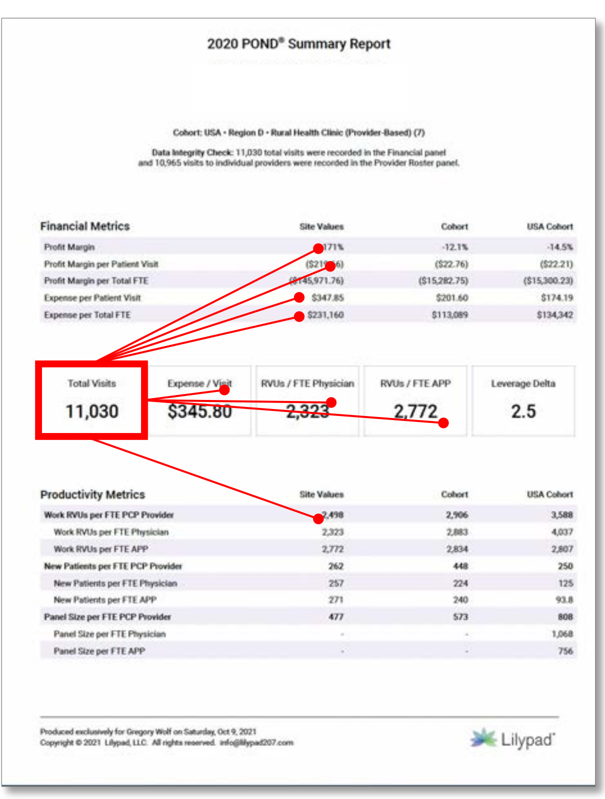
Do we need to hire more providers?



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Alternatives

Greater provider leverage
Team-based care
Increased operational efficiency
Chronic disease management
Telemedicine

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Lilypad is a Maine-based analytics firm that provides mobile and web-based applications for rural primary care practices. We adhere to a core business principle that accountable physicians/clinical leaders and administrators require sound data and simple, innovative tools to be successful in their roles within the emerging value-based care delivery environment.

Gregory Wolf, President
gwolf@lilypad207.com