Elevating Operations & Organizational Alignment

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Meet the Presenters

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Director

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Learning Objectives

Highlight operational focus areas and their impact on organizational performance

Provide an overview of market impacts

Provide updates regarding Rural Health Clinics

Elevating Operations

Focusing on Key Operational Areas

Clinic Operations

- Patient throughput, including:
  - Triage
  - Rooming
  - Provider activity
- Quality gap closure
- Patient experience
- Administrative costs and overhead expenses
- Clinic staff standard work
- Communication plans

Provider Access

- Provider productivity (wRVU benchmarking)
- Patient access barriers and opportunity including
  - No-show processes
  - Scheduling templates
  - Patient panel size
  - Same day/walk-in access

Staffing

- Assignment of responsibilities
- Clinic leadership positions
- Staff to provider benchmarking
- Span of control benchmarking

Revenue Cycle

- Charge capture and entry
- Claim submission and follow-up
- Denial management
- A/R follow-up
- Insurance enrollment and credentialing

Front End Operations

- Check-in/-out staff and processes
- Point of service collections
- Insurance verification
- Patient scheduling protocols
- Telephone protocols

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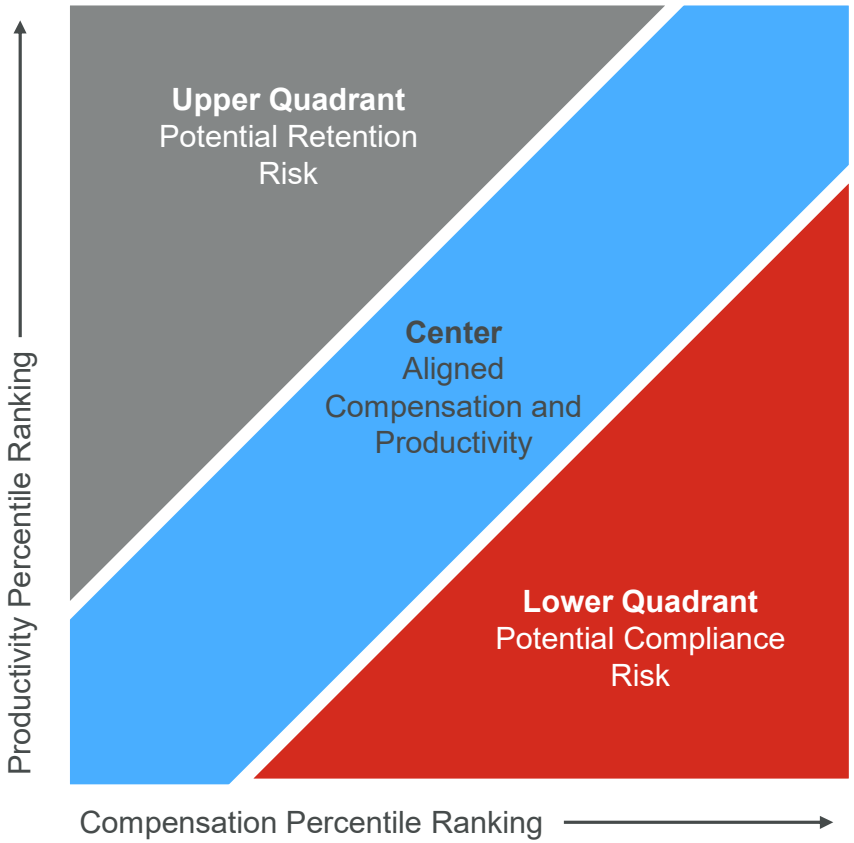
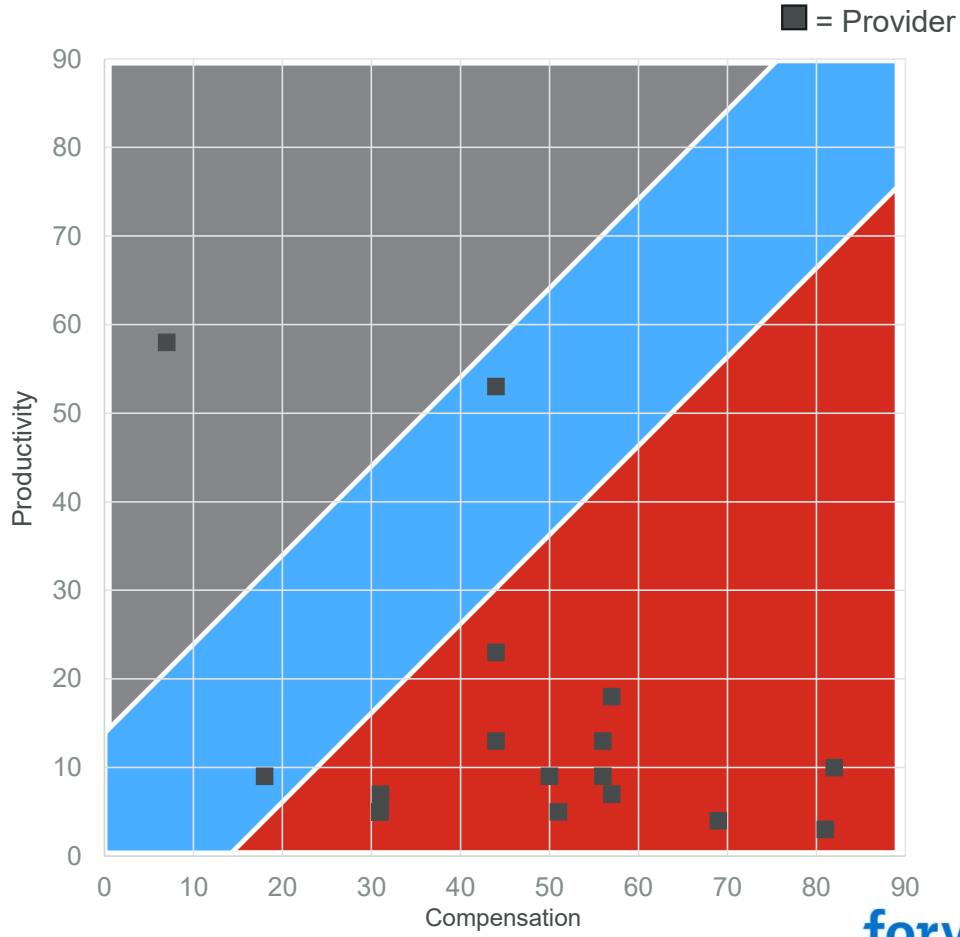
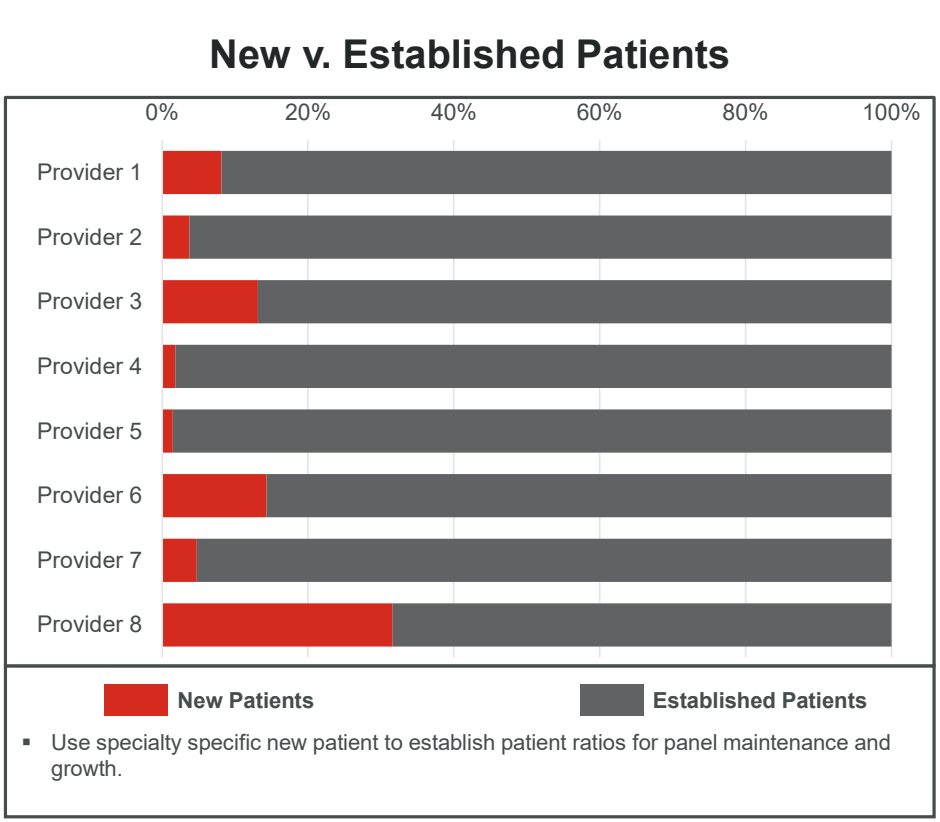
Aligning Provider Productivity and Compensation

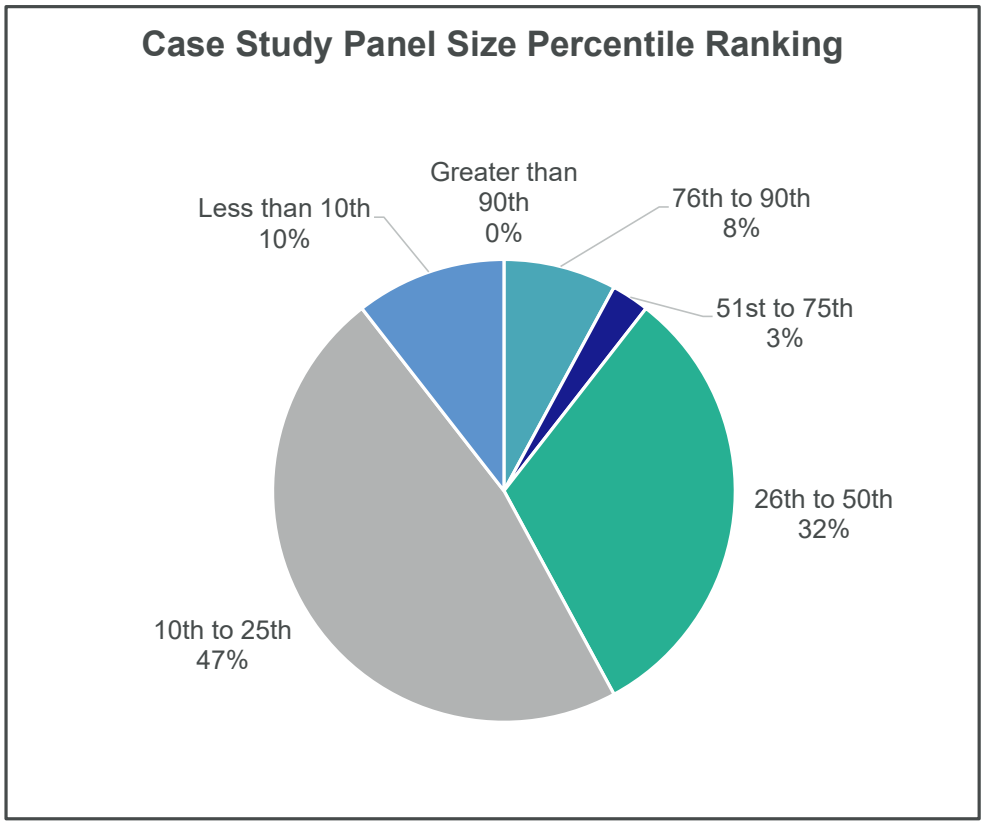




Understanding Your Provider Access

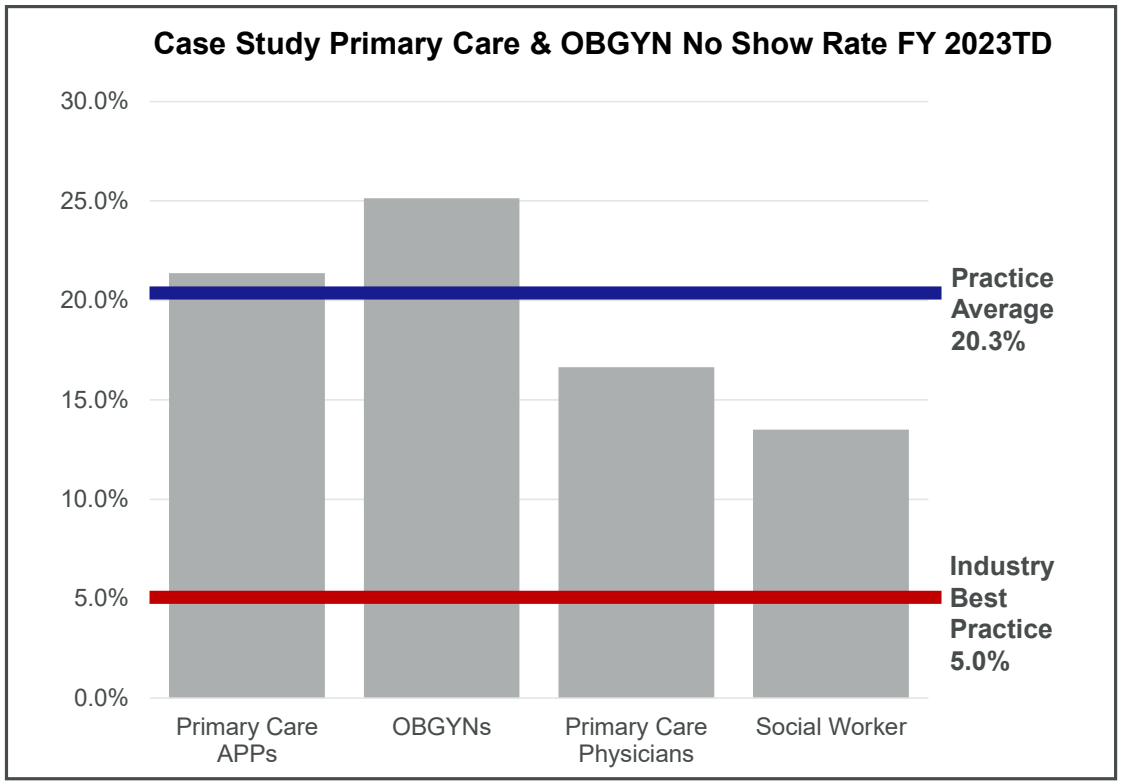


- Use specialty specific new patient to establish patient ratios for panel maintenance and growth.

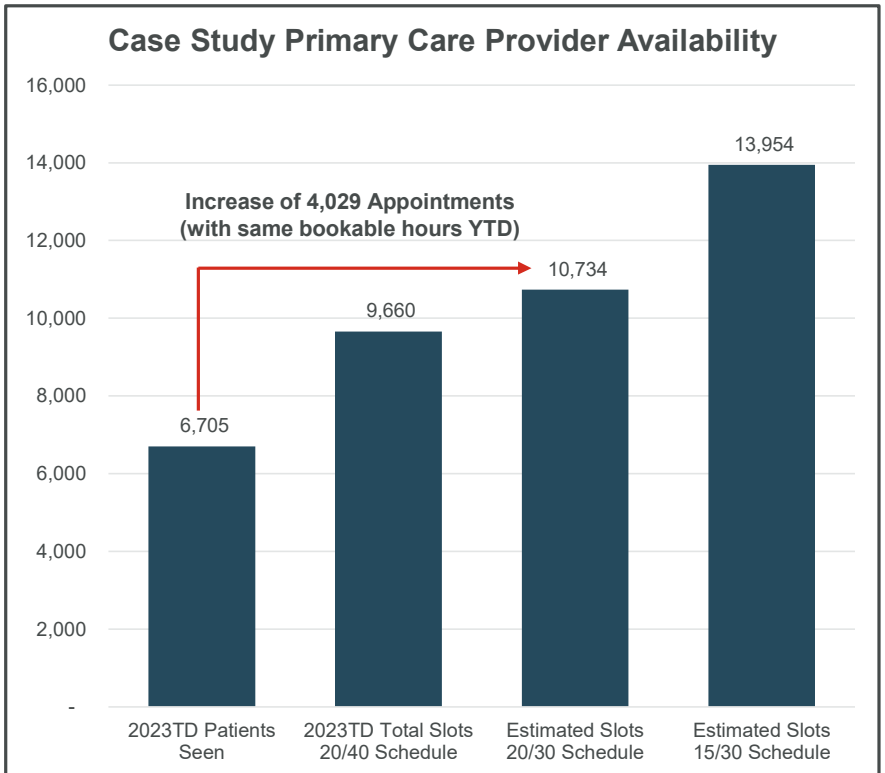


Provider Access Reporting Continued

No-Shows

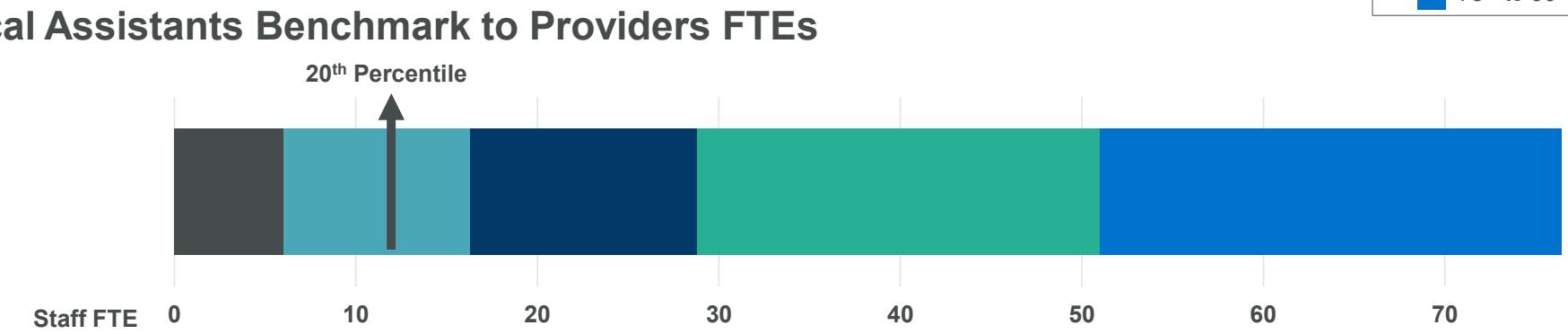


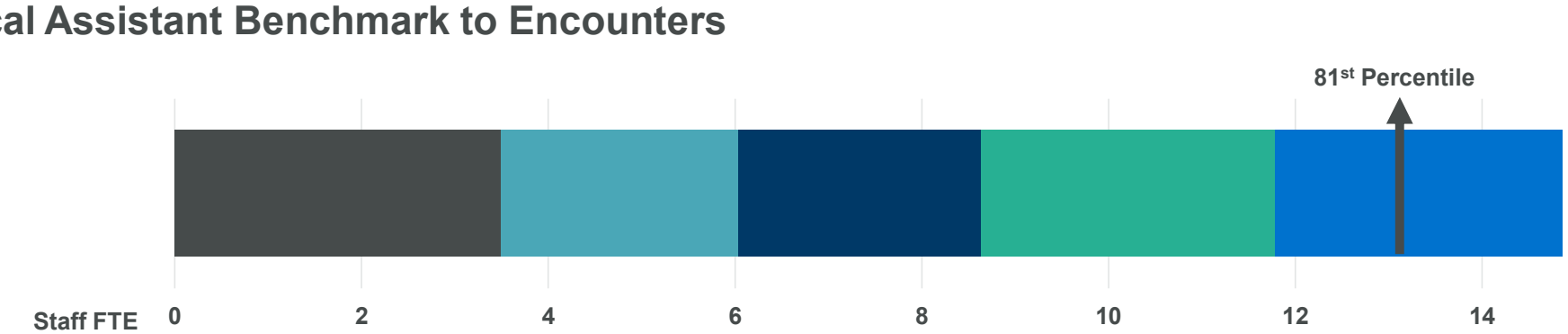
Template Optimization



- With the current 20/40 scheduling, we would estimate each provider has 18 appointments open per 8-hour day.
- Moving to a 20/30 schedule, will allow for 20 patient appointments per 8-hour day.
- In industry best-practice schedule, providers would be scheduled in a 15/30 template. This would allow for an estimated 26 patients per 8-hour day.

Staffing Ratios





Operations Assessment & Implementation Outcomes

Increase Provider Productivity

The case study health system has seen a 15% growth in provider wRVU productivity. Other clients have reported 10%+ in a 3-month timeframe.

Reduction in Practice Subsidy

The provider volume increases have increased the bottom line and decrease subsidy required.

Align and Standardize Compensation Model

Align compensation with work expectations. Reduced opportunity for error and increased ease of compensation adjudication.

Increase Provider Engagement

Provider efficiencies at or above market median increasing recruitment and retention.

Aligning Organizational Strategy

Overall Strategic Market Impacts

Workforce Shifts

Today’s physician workforce remains fragile

Physician workforce is…

FEELING DISSATISFIED

49% Of physicians report feeling **burnout** in 2024

33% Of academic physicians indicate moderate or higher **intent to leave** in two years

CUTTING BACK

40% Of physicians plan to **reduce clinical hours** in the next year

CHANGING JOBS

8% Median physician **turnover** in 2022

2 years Average time physicians who finished training in the last six years **spent in their first job**

Advisory Board Sources: McKenna J. Medscape Physician Burnout & Depression Report 2024: ‘We Have Much Work to Do’. *Medscape*. January 26, 2024; Ligibel J et al. Well-Being Parameters and Intention to Leave Current Institution Among Academic Physicians. *JAMA Network*. December 15, 2023; Shanafelt T et al. Career Plans of US Physicians After the First 2 Years of the COVID-19 Pandemic. *Mayo Clinic Proceedings*. November 2023; Benchmarking. *AAPPR*. Early-Career Physician Recruiting Playbook. *Jackson Physician Search & MGMA*. October 2023.

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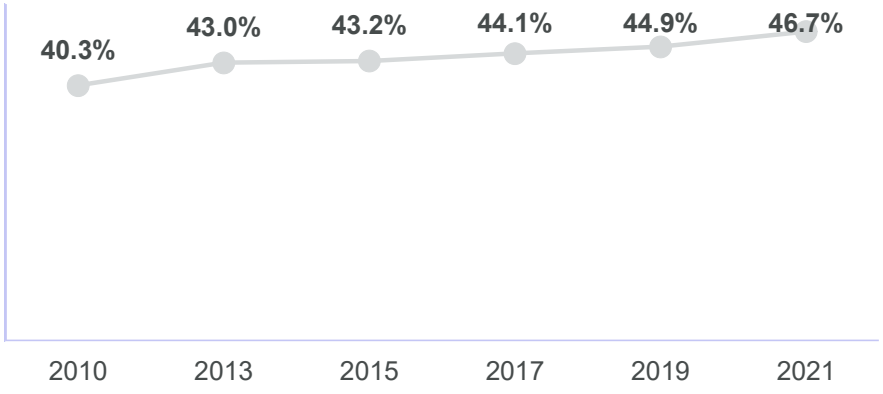
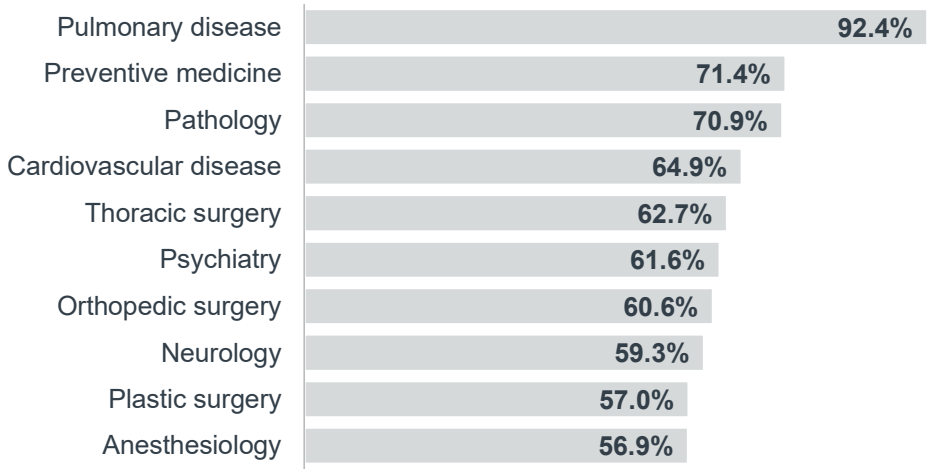
Workforce Shifts Continued

Retirement wave will shift workforce makeup, preferences

Percentage of active physicians 55+
(2010–2021)



Specialties with highest percentage of doctors 55+



Advisory Board Source: Physician Specialty Data Report: Active Physicians by Age and Specialty, 2021. *AAMC.* 2021.

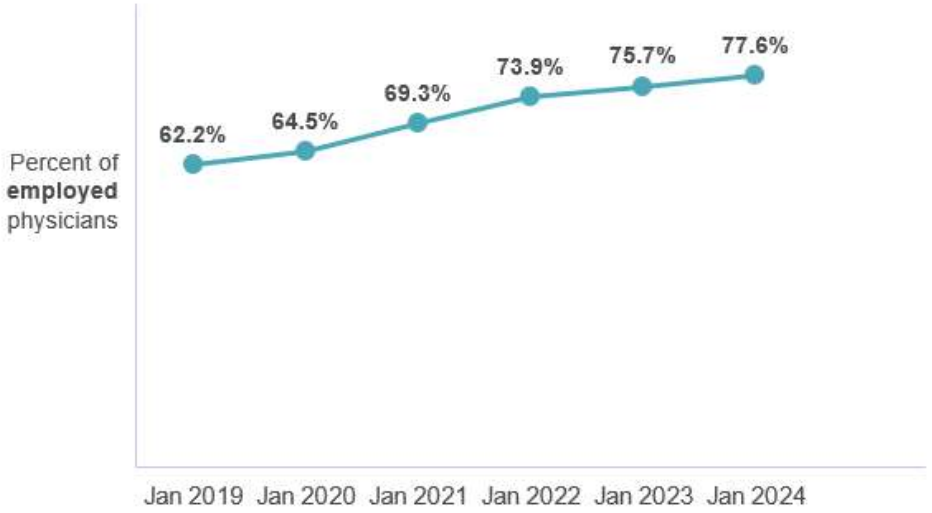
Workforce Shifts Continued

Employment solidified as predominant practice model

Young doctors continue to prefer employment

1. Final-year residents were asked, “Which of the following practice settings would you be most open to?” and were allowed to select two choices.

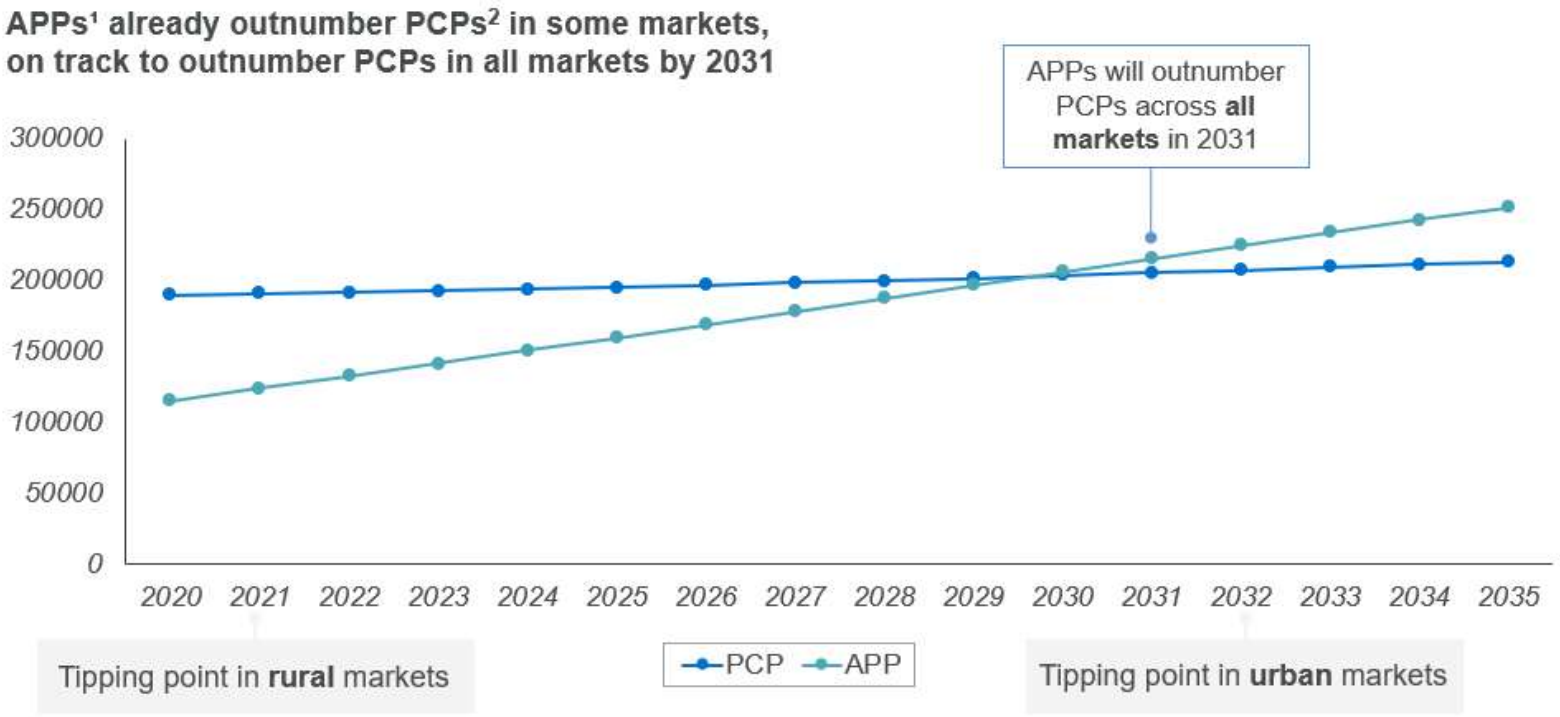
Percent of physicians employed by hospitals or corporations *(2019–2024)*



Advisory Board Sources: Survey of Final-Year Medical Residents: Many Job Choices, Many Reservations. *AMN Healthcare.* 2023; Avalere Health. Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023. *Physicians Advocacy Institute*. April 2024.

Workforce Shifts Continued

APP autonomy enables team-based care models

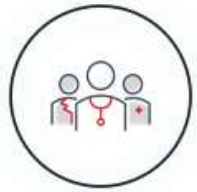


1. Advanced practice providers.
2. Primary care physicians. Defined as family medicine and internal medicine physicians.

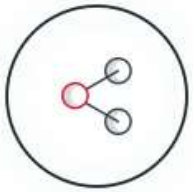
Advisory Board analysis of data from Workforce Projections. *Health Resources & Services Administration.*

Focus on Performance

All medical groups — corporate or not — face same set of evergreen challenges



Running an **integrated** medical group



Managing **referrals** and network leakage

Maximizing return on physician **investment**

Rightsizing level of physician **autonomy**

Rural Health Clinic Reminders and Updates

Significant Rural Health Clinic Changes Effective 1/1/2025

- No longer have a provider productivity requirement (effective for cost report periods beginning on or after January 1, 2025)
- Primary Care will no longer need to be 51%+ of services provided
- Two of the six required labs have been removed (Hemoglobin and hematocrit and examination of stool specimens for occult blood)
- Can bill and be paid by Part B for preventive vaccines and their administration
- Care Coordination can be billed using individual CPT codes and add-on codes
- CMS will continue to allow telecommunication services rendered via interactive audio and video
- Intensive Outpatient Program (IOP) payment for when four or more services are offered per day
- Dental reimbursement at the AIR rate

2025 Medicare Physician Fee Schedule Final Rule Impact on RHCs | Forvis Mazars

RHC Requirements

- RHC approved provider types
  - Physicians
  - Nurse Practitioners
  - Physician Assistants
  - Certified Nurse-Midwives
  - Clinical Psychologists
  - Clinical Social Workers
  - Marriage and Family Therapists (new in 2024)
  - Mental Health Counselors (new in 2024)
- Face to face visits within the RHC required for AIR payment with minimal exceptions

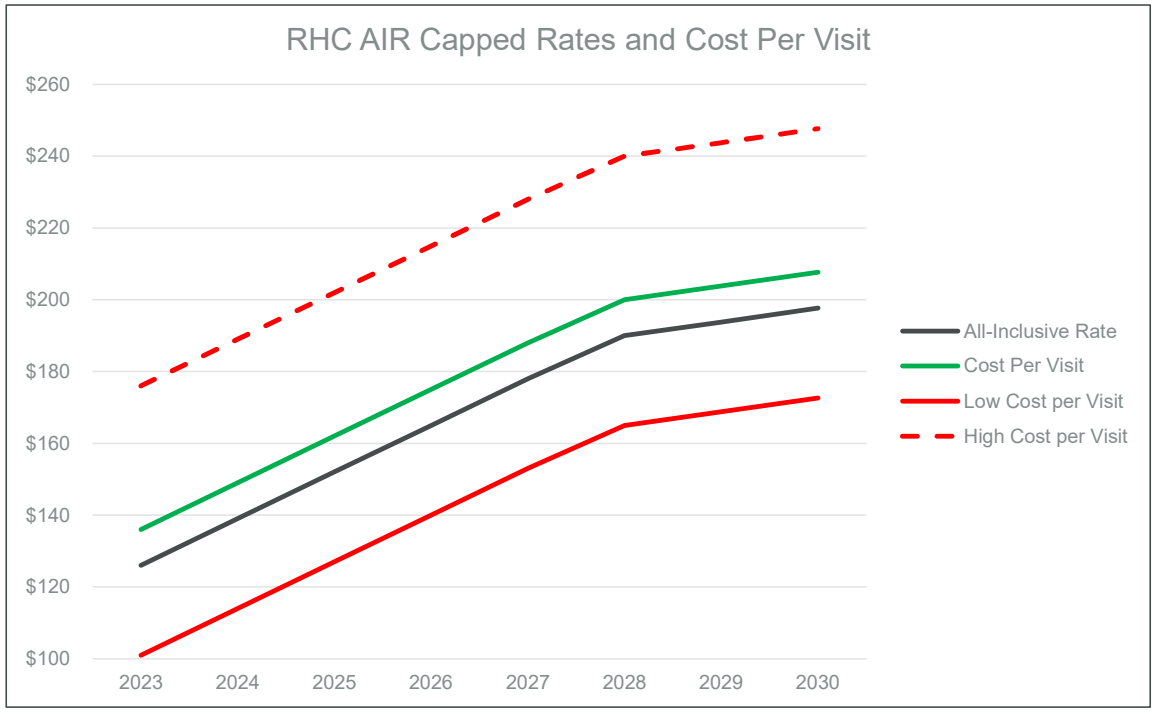
Advantages of RHC Reimbursement and Strategic Considerations

2021 CAA Introduced AIR Caps

- Applicable to all newly certified RHCs
- Existing provider-based RHCs where bed availability was less than 50 beds not subject to caps
  - Rate based on finalized 2020 cost report and increases by MEI
  - If bed count exceeds 50 beds grandfathered rate is forfeited
- Periodic reviews needed to maximize benefits

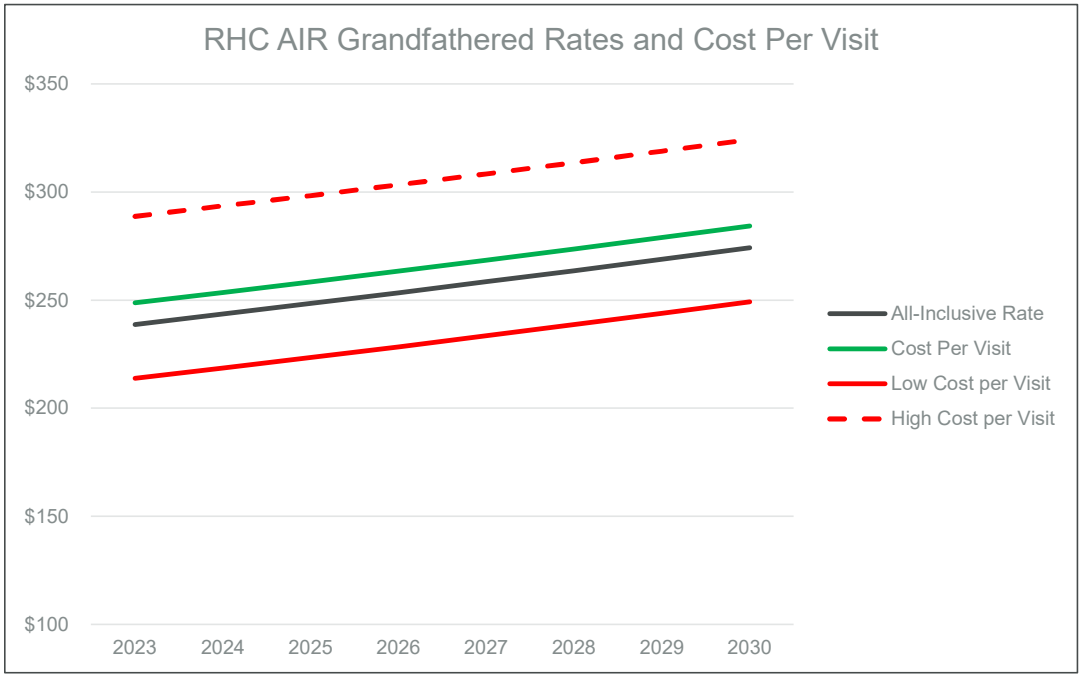
Year	AIR Cap
2023	$126
2024	$139
2025	$152
2026	$165
2027	$178
2028	$190
2029 and Beyond	MEI (1% - 3%)

RHC AIR Strategy – Capped Rates



	2024 AIR	2024 CPV
AIR	$139	$114
Visits	5,000	5,000
Total Revenue	$695,000	$570,000
Revenue Variance		($125,000)

RHC AIR Strategy – Grandfathered Rates



Assumes 2020 Rate of $225 and MEI of 2% per Year

	2024 AIR	2024 CPV
AIR	$244	$219
Visits	5,000	5,000
Total Revenue	$1,220,000	$1,095,000
Revenue Variance		($125,000)

E&M Reimbursement Variance

CPT Code	2024 MPFS	2024 AIR	AIR Variance	2025 MPFS	2025 AIR	AIR Variance	2026 MPFS	2026 AIR	2026 Variance
99212	$53	$139	$86	$54	$152	$98	$56	$165	$109
99213	$85	$139	$54	$88	$152	$64	$90	$165	$75
99214	$120	$139	$19	$124	$152	$28	$128	$165	$37
99215	$170	$139	$(31)	$175	$152	$(23)	$180	$165	$(15)

CPT Code	CPT Volume
99212	106
99213	3,426
99214	5,186
99215	415

AIR Methodology Benefit by Year	
Year	**Estimated Benefit**
2024	$279,789
2025	$365,315
2026	$454,161
Total Estimated Benefit	**$1,506,945**

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Additional Reimbursement Opportunities

- 340B for provider-based RHCs if parent hospital participates
  - RHCs not subject to provider-based location requirements
- COVID, flu, and pneumonia vaccines reimbursed at 100% via cost report each year
- RHC-specific value-based payment models
- Medicare bad debts reimbursed at 60% via cost report
- Ability to have costs reimbursed via cost report

Changing RHC Physical Location

- Existing RHCs may change location and retain existing AIR
  - New location must meet all location requirements
  - RHC status may be lost if new location does not qualify
  - Conditions of participation must be met and survey may be required
- Suite within a building with same “parent” address can be added onto the existing enrollment

RHC Consolidation

- It is possible to consolidate multiple RHCs into one, but organizations have to carefully select which will survive
  - One RHC will terminate enrollment via 855A application
    - Termination of other enrollments following approval of 855A
  - Signage present on clinic door indicating where patients can go to receive services
  - Surviving RHC will update CMS-29 form indicating increased staffing levels
- Items to consider when consolidating
  - Patient access to care and potential outmigration
  - Payor mix of clinics in question
  - AIR of clinics in question
  - Footprint of clinics in question

Thank you!

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