Nebraska Rural Health Clinics

Performance Improvement and Measurement

NHA – NeRHA Spring Forum
Wednesday, May 25th

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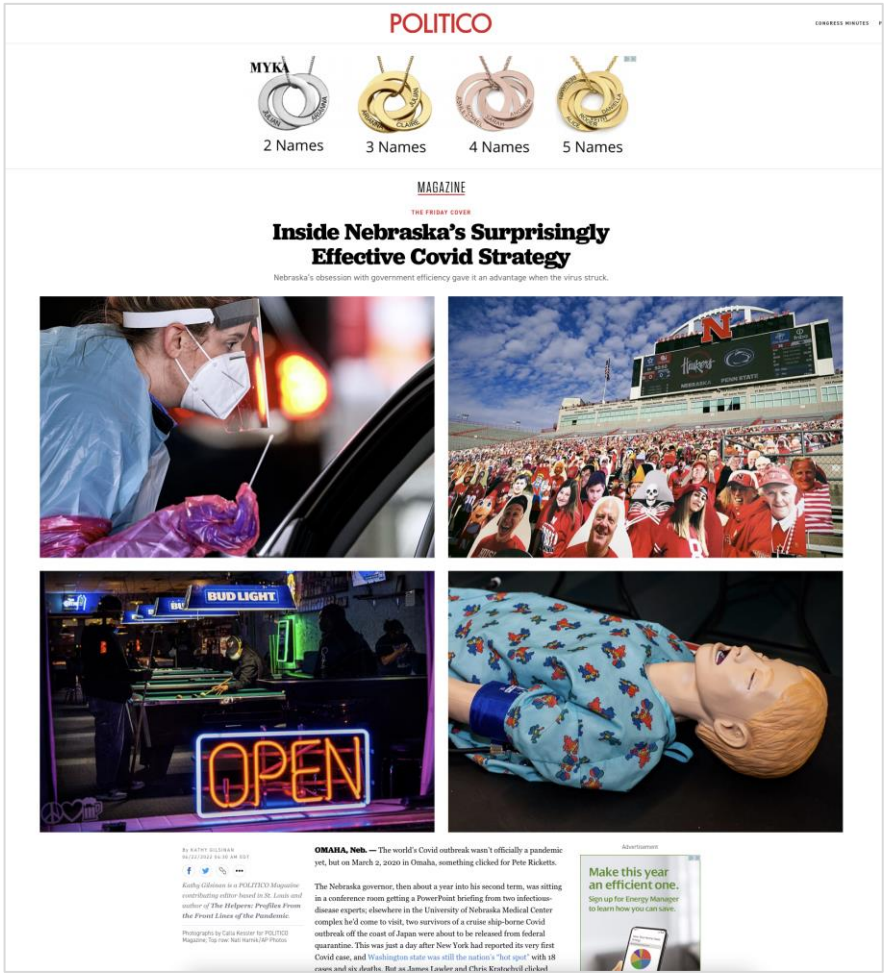
Congrats

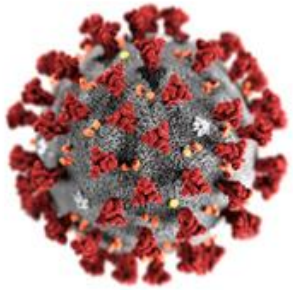


"Subsequent waves have brought subsequent strains on hospitals. When I visited Ricketts in February, he noted that case counts were exploding again in the Omicron wave, and that in roughly the prior month, the state had seen case numbers amounting to about 20 percent of all the cases the state had seen in the entire pandemic — but less than 2 percent of the hospitalizations. The problem, according to Lawler and others, was that hospitals were dealing with a surge of non-Covid patients as well, as people caught up on visits they might have skipped earlier in the pandemic. "Between November and mid-January, we really did stretch hospital capacity in the state," said Hansen of the Rural Nebraska Health Association. "I think it's difficult for the general public to understand just how unsustainable it was during that period. Nebraska was no different."

The Value of Rural

Rural healthcare should be an **incubator** of innovation and a laboratory for new ideas and care delivery models. It does not need to play second fiddle to urban healthcare because we can be more **agile**, impact our communities more quickly and collaborate in creative ways with like-minded partners.

COVID



On the one hand, the COVID pandemic was a generational tragedy and a reminder of how our systems' fragility. It also exposed and exacerbated the vulnerability of our healthcare system, especially as it relates to care givers and medical professionals – **especially nurses**.

On the other hand, the pandemic illuminated the importance and durability of rural providers and communities. It also revealed how rural healthcare can function as a high-quality **relief valve** and set of partners to deal with shocks in demand.

Either way, things have changed and we're unlikely to go back

Our Agenda

01

RHCs

Relevance and strategic importance

02

Nebraska

State and national performance benchmarks

03

Measures

Making sense of the Tower of Babel

04

Opportunities

RHCs and alternative payment models

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Rural Health Clinics

Relevance and Strategic Importance

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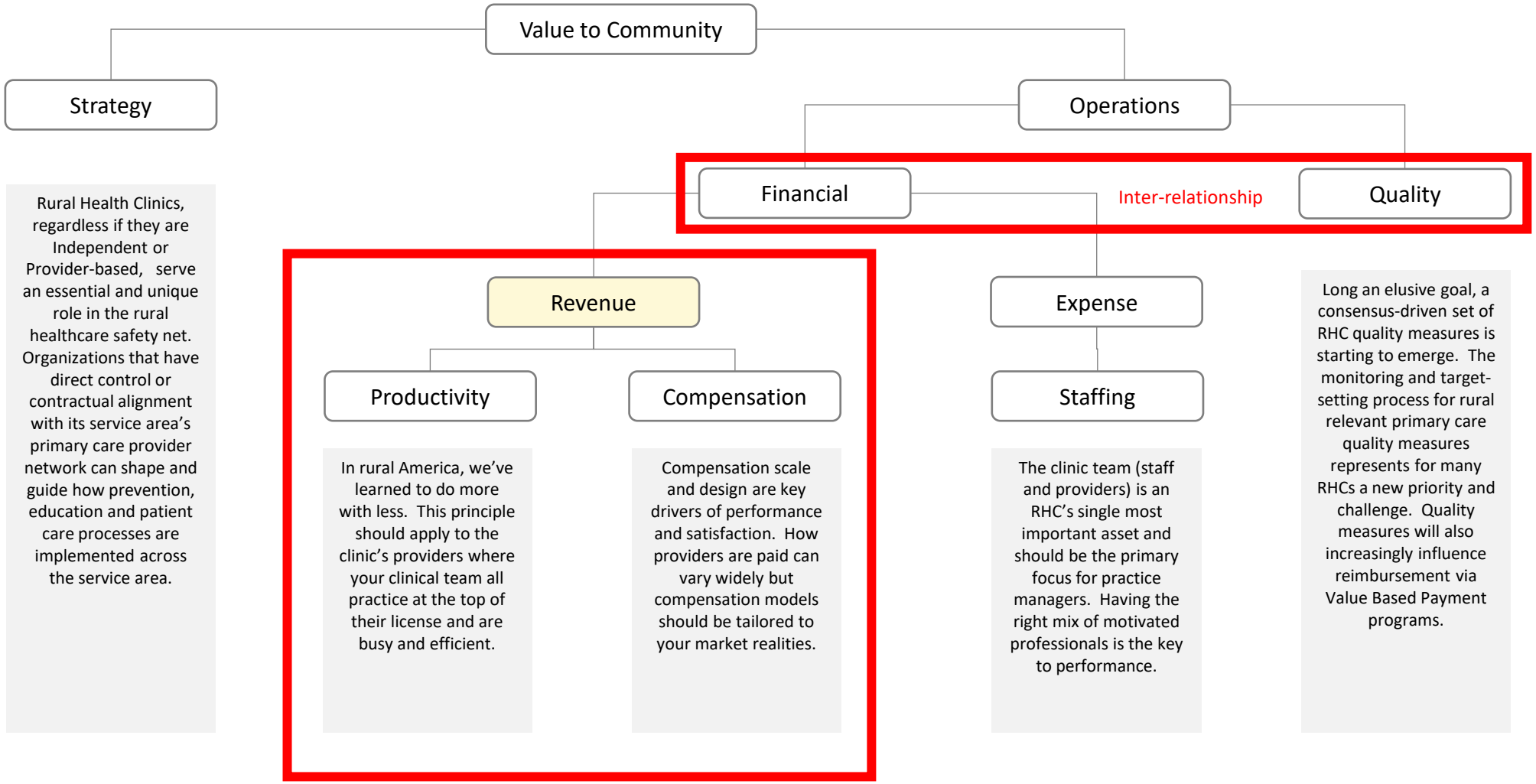
RHC Performance Model



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Consolidated Appropriations Act

Implications for Rural Health Clinics

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RHC Modernization Act

The Consolidated Appropriations Act, 2021 (CAA) changed the reimbursement methodology for Rural Health Clinics (RHC) starting on **April 1, 2021**

Provider-based RHCs no longer have uncapped rates and therefore have entered a new environment where fee for service-like realities demand more focused attention and sustained financial performance

126

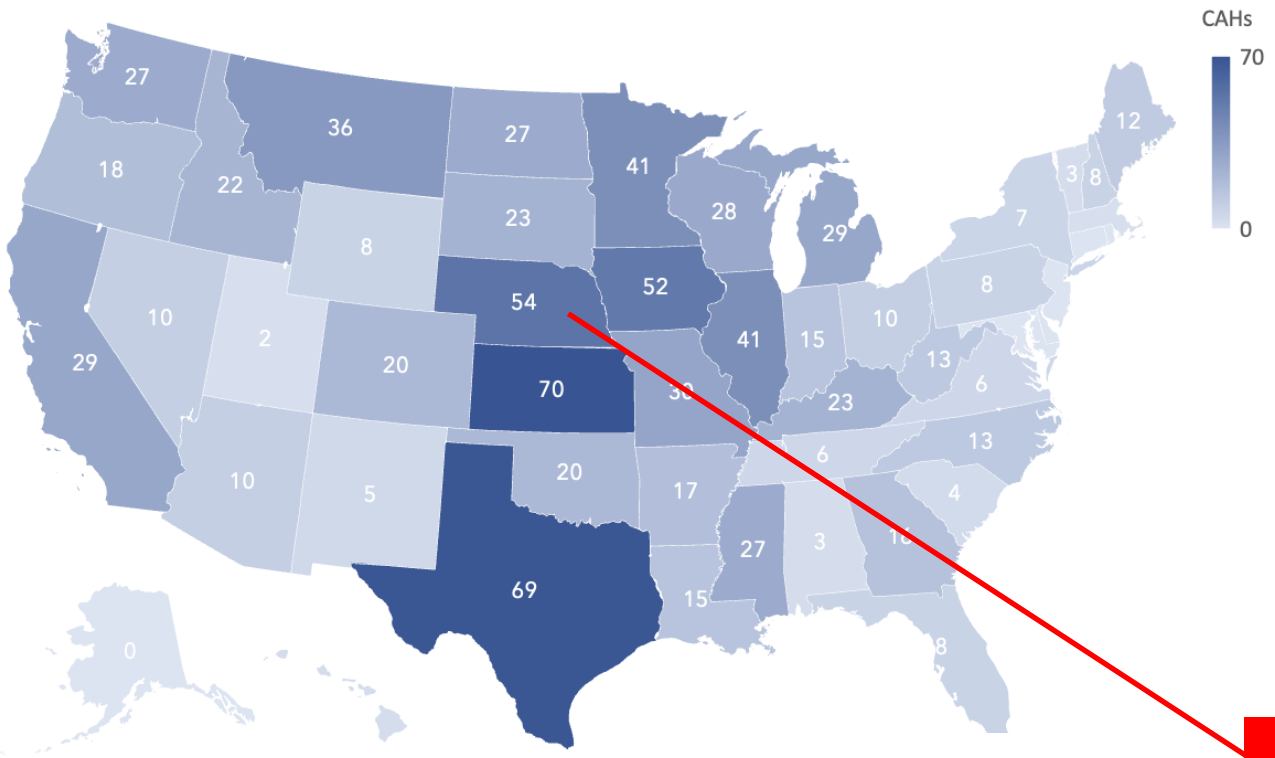
Nebraska Provider-based RHCs

Consolidated Appropriations Act

Holding all other factors constant, the reimbursement impact of the Modernization Act in Nebraska is projected to be a nearly **$24 million** loss for PB-RHCs and a statewide loss of over **$22 million** in 2028

CAHs with Provider-based RHCs by State

Map A: State Comparison of CAHs that Own Provider-based Rural Health Clinics (2019)



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.

Nebraska has 54 CAHs with Provider-based RHCs Representing 126 of 138 RHCs (91%)

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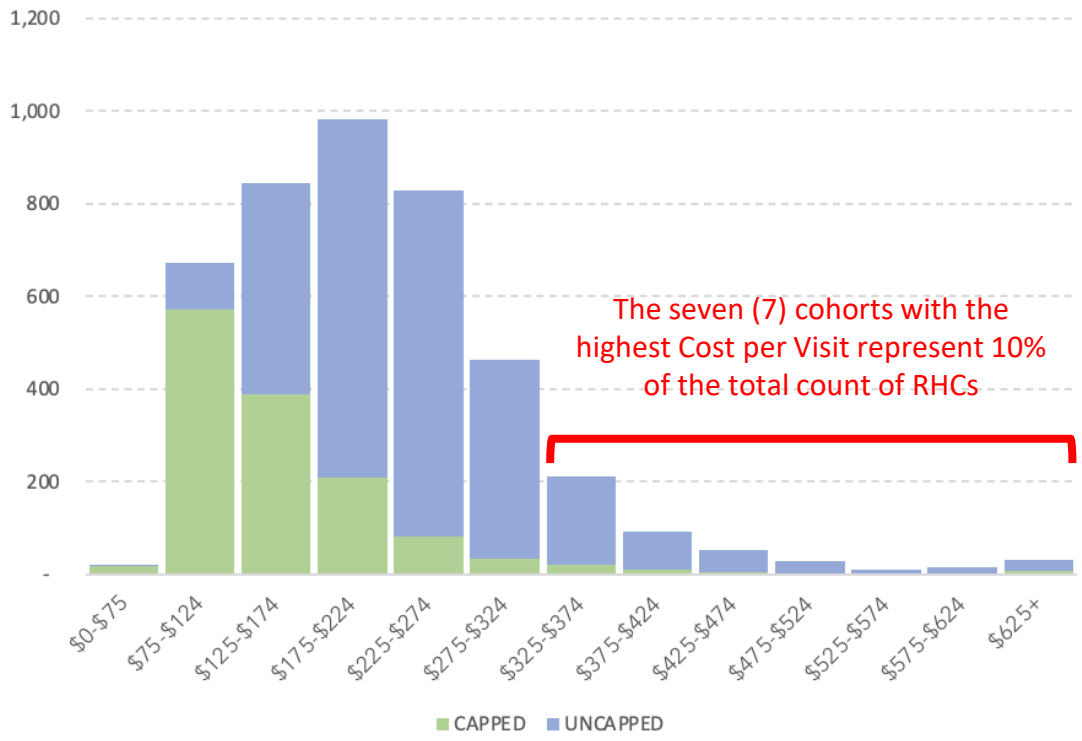
Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

RHC Cost Per Visit Rate Bands

Chart A: Distribution of Cost Per Visit Rate Bands for All RHCs (FY 2019)



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

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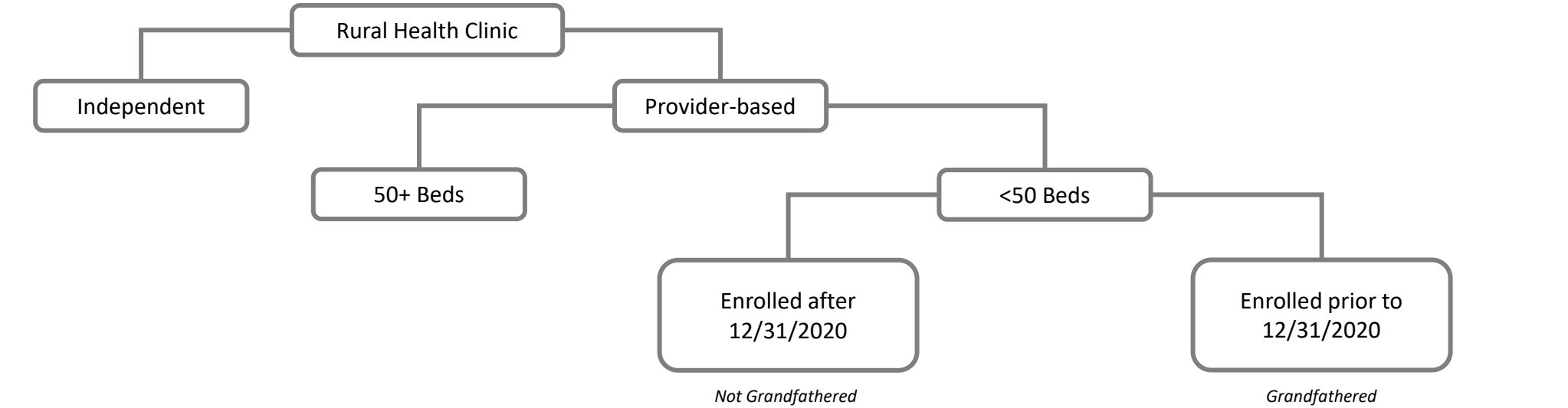
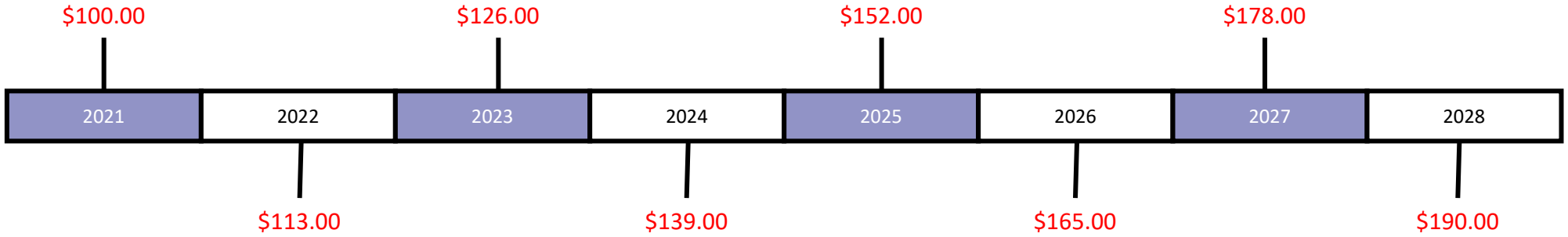
Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

RHC Payment Model



Independent RHCs – Reimbursement Trajectory



$190.00

Medicare per visit rate in 2028 for Independent RHCs

By the Numbers

The Consolidated Appropriations Act, 2021 (CAA) changed the reimbursement methodology for Rural Health Clinics (RHC) starting on **April 1, 2021**

Annualized cost increases for PB-RHCs (**9.6%**) and Independent RHCs (**8.3%**) far outpace the MEI of **2.1%**

3%

While the percentage of independent RHCs dropped **50%** since 2015, the percentage of PB-RHCs increased **3%**

9.6%

Provider-based

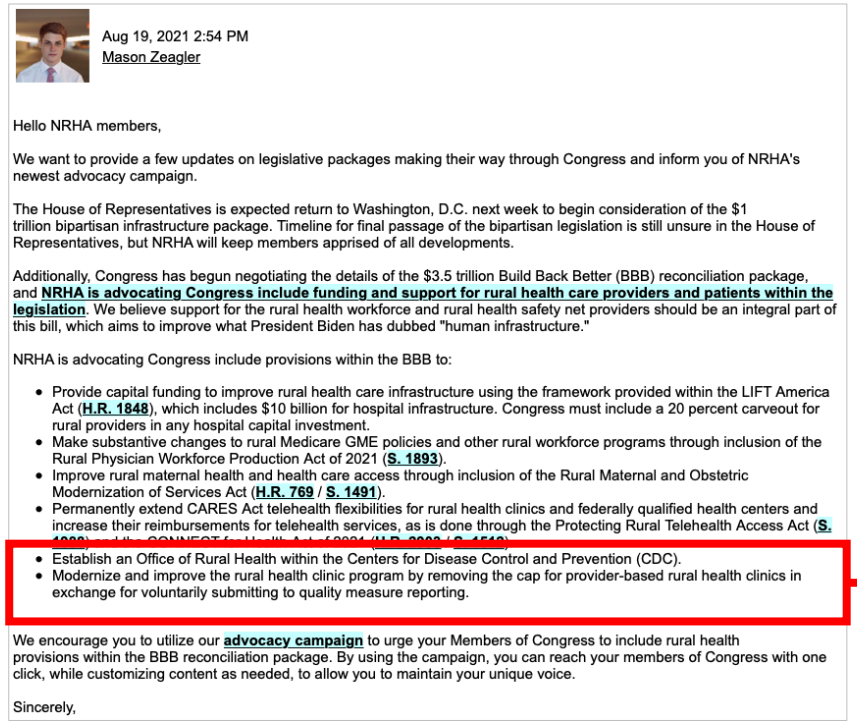
8.3%

Independent

$8.9M

Holding all other factors constant, the reimbursement impact of the Modernization Act in Nebraska is projected to be a nearly **$24 million** loss for PB-RHCs and a statewide loss of over **$22 million** in 2028

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 (H.R. [illegible] / S. 1512).
- 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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Nebraska

State and national performance benchmarks

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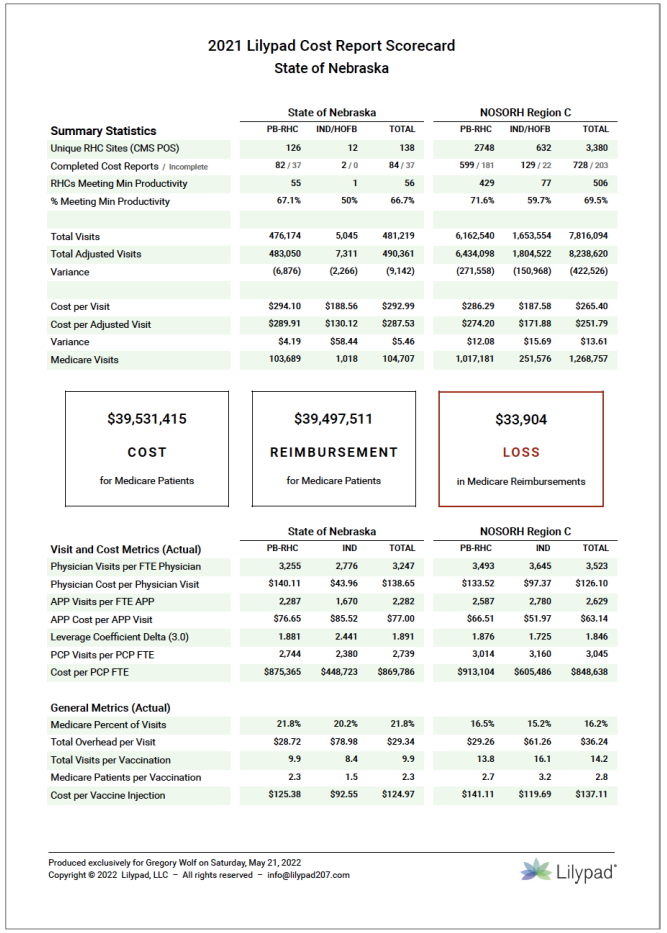
Nebraska RHC Scorecard



2021 Lilypad Cost Report Scorecard
State of Nebraska

Summary Statistics	State of Nebraska PB-RHC	State of Nebraska IND/HOFB	State of Nebraska TOTAL	NOSORH Region C PB-RHC	NOSORH Region C IND/HOFB	NOSORH Region C TOTAL
Unique RHC Sites (CMS POS)	126	12	138	2748	632	3,380
Completed Cost Reports / Incomplete	82 / 37	2 / 0	84 / 37	599 / 181	129 / 22	728 / 203
RHCs Meeting Min Productivity	55	1	56	429	77	506
% Meeting Min Productivity	67.1%	50%	66.7%	71.6%	59.7%	69.5%
Total Visits	476,174	5,045	481,219	6,162,540	1,653,554	7,816,094
Total Adjusted Visits	483,050	7,311	490,361	6,434,098	1,804,522	8,238,620
Variance	(6,876)	(2,266)	(9,142)	(271,558)	(150,968)	(422,526)
Cost per Visit	$294.10	$188.56	$292.99	$286.29	$187.58	$265.40
Cost per Adjusted Visit	$289.91	$130.12	$287.53	$274.20	$171.88	$251.79
Variance	$4.19	$58.44	$5.46	$12.08	$15.69	$13.61
Medicare Visits	103,689	1,018	104,707	1,017,181	251,576	1,268,757

$39,531,415	$39,497,511	$33,904
COST	REIMBURSEMENT	LOSS
for Medicare Patients	for Medicare Patients	in Medicare Reimbursements

Visit and Cost Metrics (Actual)	State of Nebraska PB-RHC	State of Nebraska IND	State of Nebraska TOTAL	NOSORH Region C PB-RHC	NOSORH Region C IND	NOSORH Region C TOTAL
Physician Visits per FTE Physician	3,255	2,776	3,247	3,493	3,645	3,523
Physician Cost per Physician Visit	$140.11	$43.96	$138.65	$133.52	$97.37	$126.10
APP Visits per FTE APP	2,287	1,670	2,282	2,587	2,780	2,629
APP Cost per APP Visit	$76.65	$85.52	$77.00	$66.51	$51.97	$63.14
Leverage Coefficient Delta (3.0)	1.881	2.441	1.891	1.876	1.725	1.846
PCP Visits per PCP FTE	2,744	2,380	2,739	3,014	3,160	3,045
Cost per PCP FTE	$875,365	$448,723	$869,786	$913,104	$605,486	$848,638
General Metrics (Actual)						
Medicare Percent of Visits	21.8%	20.2%	21.8%	16.5%	15.2%	16.2%
Total Overhead per Visit	$28.72	$78.98	$29.34	$29.26	$61.26	$36.24
Total Visits per Vaccination	9.9	8.4	9.9	13.8	16.1	14.2
Medicare Patients per Vaccination	2.3	1.5	2.3	2.7	3.2	2.8
Cost per Vaccine Injection	$125.38	$92.55	$124.97	$141.11	$119.69	$137.11

Produced exclusively for Gregory Wolf on Saturday, May 21, 2022
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	Total NE RHCs		Regional Benchmarks
	138		
	Provider-based	*Independent*	
Count of RHCs	126 91%	12	
Meeting Productivity	55%		68%
Cost per Visit	$294	$188	
Capped Rate Visits	1,018		
Physician Visits/FTE	3,255		3,493
APP Visits/FTE	2,287		2,587
Cost per PCP FTE	$875k		$913k

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Measures

Making sense of the Tower of Babel

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Why Quality Measurement is Important

- Research demonstrates that health care frequently fails to meet the current standards of quality care
- Errors, suboptimal management of disease, and overutilization/underutilization of services occur when evidence-based health care is not provided
- The consequences include higher mortality, increased morbidity, decreased quality of life, higher costs of care
- Low-quality care and inconsistencies in quality are linked to health care disparities
- Failure to measure quality suggest that the extent of these issues are not understood at the practice-level
- Quality measurement accelerates internal clinical improvement

Hierarchy of Quality Measures (QM)

- Structural measures
  - The foundation of QM - evaluates infrastructure/capacity of health care organizations to provide care (e.g., equipment, personnel, or policies)
  - Examples - % of providers using an electronic health record, % of diabetics tracked in a patient registry, staff to patient ratio
- Process measures
  - The building blocks of QM that focus on evidence-based steps that should be followed to provide good care
  - When executed well, increases the likelihood of a desired outcome
  - Examples – medication reconciliation, colorectal cancer screening, use of aspirin for patients presenting with ischemic vascular disease

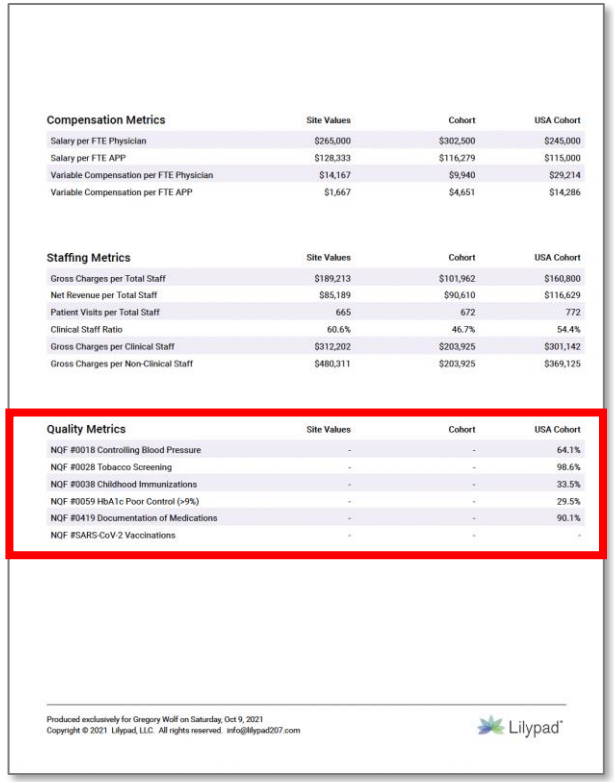
Hierarchy of Quality Measures (cont.)

- Outcome measures
  - Evaluate/assess the results of care on a patient's health, such as clinical events, recovery, or health status
  - Outcome measures are slots into which process blocks fit
  - Process and outcome measures go hand in hand as improving a process can result in an improved outcome
  - Examples: optimal asthma control, long-term complications of diabetes, controlling high blood pressure
- Composite measures
  - Combines individual measures to produce one result that gives a more complete picture of quality for a specific area or disease
  - Examples – comprehensive diabetes care, substance use screening and intervention, optimal vascular care

What to Measure?

- Choose measures that:
  - Are relevant to your RHC and the patients you serve
  - Address perceived or known gaps in care
  - Align with practice goals
  - Align with nationals/regional quality initiatives such as MIPS or Medicaid managed care quality reporting requirements
  - Actionable
- Focus on process and outcome measures
  - Evidence-based process measures linked to effective outcomes, are more useful for performance management in primary care
  - Outcome measures are the gold standard
  - For purposes of day-to-day quality measurement and management - focus on process and outcome measures

What quality measures should we track?



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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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.

Maine Rural Health Research Center

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.

Best Practice RHC Quality Measures

NQF 0018	Controlling Blood Pressure
NQF 0028	Preventive Care: Tobacco
NQF 0038	Childhood Immunization
NQF 0059	Diabetes: Hemoglobin A1c
NQF 0419	Current Medications

Opportunities

RHCs and alternative payment models

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Medicaid Value Based Reimbursement

Missouri Primary Care Health Home Initiative

- Department of Social Services
- Department of Mental Health
- Missouri Foundation for Health
- Missouri Primary Care Association
- Missouri Coalition of Community Mental Health Centers
- Missouri Hospital Association
- Missouri School Board Association

Better Outcomes with Cost Savings

$50.00 PMPM

Medicaid Managed Care

Not today and not tomorrow, but at some point could there be a new rural hospital VBP **partnership**?

Mission-Aligned Partners

You have a unique opportunity in Nebraska, and a great set of partners

Primary Care – R-QIN Network

HRSA Network Planning Grant

- Build an operational Network sustainable beyond the grant period
- Identify a core set of quality and cost performance indicators
- Explore a common reporting system
- Develop a list of evidence-based strategies
- Create a plan to share best practices across the Network and state.

Project Summary

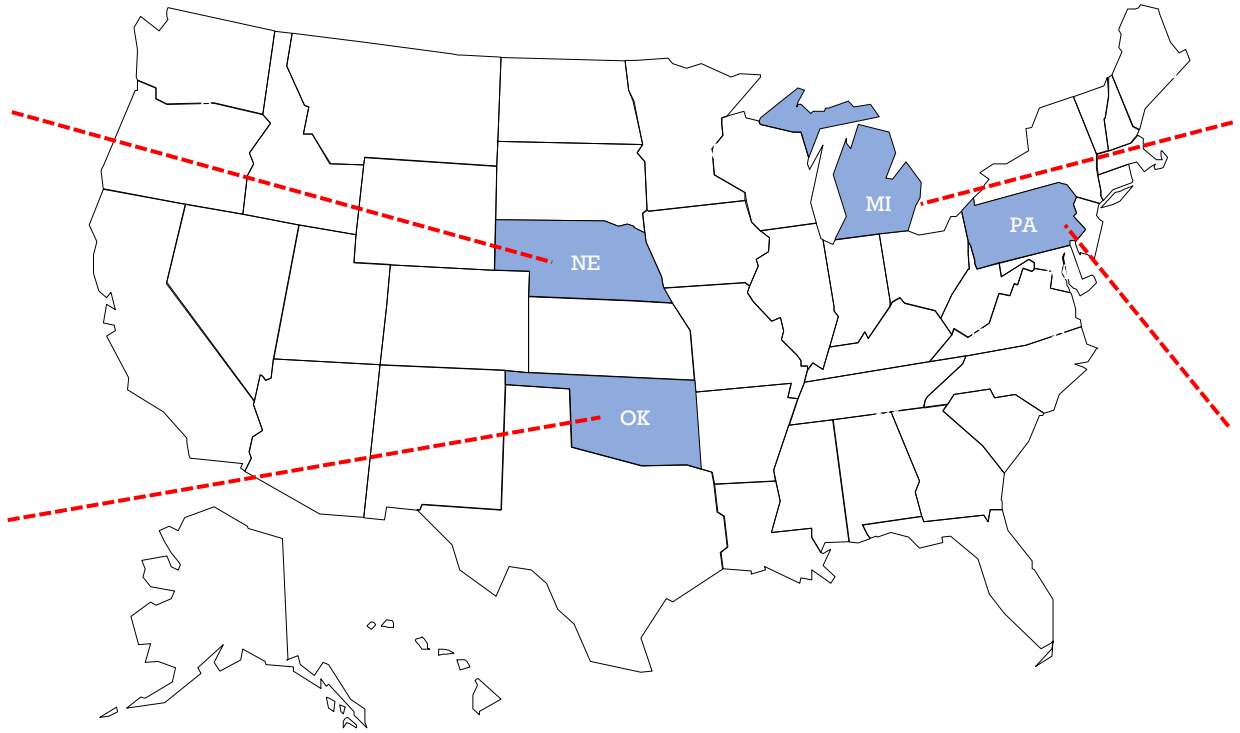
- Rural Hospital Flexibility (Flex) Program
- 12-month QI project starting September 2021
- Small group of volunteer Provider-Based RHCs
- Track a set of research-based quality measures (6)
- Select one measure for a targeted project/initiative
- Implement a Plan, Do, Study, Act (PDSA) initiative
- Analyze and document results by August 2022

Our goal is to improve the quality of care in your communities

Participating States

Nebraska
11 RHCs representing **9** Critical Access Hospitals

Oklahoma
10 RHCs representing **10** Critical Access Hospitals



Michigan
9 RHCs representing **9** Critical Access Hospitals

Pennsylvania
6 RHCs representing **4** Critical Access Hospitals

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Project Timeline

Q1 Key Milestones: Pilot RHCs selected; Practice Operations National Database (POND) and Learning and Knowledge Exchange (LAKE) onboarding completed

Q3 Key Milestones: Review initial findings from PDSA initiatives; Peer sharing of challenges and opportunities; Best practice spread

September 2021

August 2022

Q2 Key Milestones: Baseline data acquired and analyzed; PDSA methodologies in place at pilot RHCs; Focus area selected

Q4 Key Milestones: Project completion, including formal documentation of process, findings/results, recommendations and report submission to the Federal Office of Rural Health Policy (FORHP)

Practice Operations National Database (POND®)

RHC Reporting and Benchmarking System

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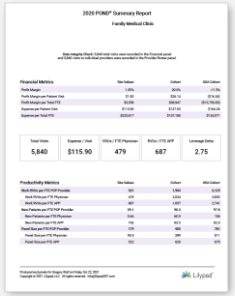
POND Reports



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.

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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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
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