Today’s Agenda

- Discuss the current dynamics of providers in community health centers
- Discuss strategies for provider recruitment and retention
- Identify options for Medi-Cal rate setting
- Discuss pros and cons of rate setting options
The Virtuous Cycle

- Positive Cash Flow through Productivity & Payor Mix
- Investments in Infrastructure to Improve Quality & Efficiency
- Increased Coverage of Base Administrative Costs
- Working Capital to Fund Expansion
- More Sites, More Patients, More Revenue

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The Vicious Cycle

Negative Cash Flow through Low Provider & Staff Productivity

Lower Efficiency/ Inadequate Coverage of Fixed Costs

No Investments in Infrastructure to Improve Quality & Efficiency

High Turnover/ High Vacancy Rate

Inadequate Pay/ No Raises
Is It Possible To Move From the Vicious Cycle to the Virtuous Cycle?

Yes:
- From a Medi-Cal Change In Scope to get paid more for the same visits
- By adding a site with a higher Medi-Cal rate
- By improving provider productivity
- By getting new revenue sources of pay-for-performance dollars?
2015 Reality for CHCs

- Primary care providers are in short supply
- Provider salaries are rising faster than MEI
- The Medi-Cal private practice is rapidly becoming extinct. True private practice is also diminishing. Thus the proportion of providers in the recruitment pool who understand the relationship between their production and compensation is shrinking
- Full-time for a provider may mean less than 40 hours per week
- CHC employment is seen as an exit strategy for some Medi-Cal private practices
2015 Reality for CHCs

• Harder to recruit to rural areas

• Provider recruitment agencies seem to be more active than in the past. These organizations attract provider clients by promising large increases in salary and benefits (if using, best to define your parameters ahead of time).

• Demand for NPs & PAs from other providers is increasing rapidly. Demand for geriatrics is also increasing rapidly
2015 Reality for CHCs

• Hospitals are now the most active recruiters of providers (private practice used to be most active)

• One physician recruiting company reported that 73% of searches including incentive compensation based on production (mostly RVUs) and 39% had a quality component

• Many health centers have concluded that attempting to pay providers below market doesn’t work

• CHC hours and call (or lack thereof) may be a competitive advantage. Many providers also looking for less than full time (need to balance against operational issues)
2015 Reality for CHCs

• Some providers may be mission oriented, but generally compete against market

• Provider perception of average compensation may not be accurate, so the more data the better

• Need to weigh the cost of vacancies

• CHCs tend to have lower fringe benefit rates than health systems or County providers

• CHCs have developed expertise in ambulatory care that may make them more efficient than hospital and County clinics
2015 Reality for CHCs

• FQHCs are higher profile than ever. This may have removed some of the stigma of working at a CHC
• At many CHCs, the CEO doesn’t get along with the CMO
• Some CHCs have weak CMOs
• The virtuous/vicious cycle seems to be playing out amongst FQHCs, as the rich get richer
• The frontier of Medi-Cal expansion has closed
• EHR = higher costs & lower productivity
Actual Email From CHC CFOs

Sample hospital package in the Midwest
$216k base pegged to MGMA annual increases; $15k signing bonus; $38k annual corporate retirement plan first 2 yrs with $22k additional to a 401k thereafter; Full family medical, life and disability insurance paid; Guaranteed defined benefit retirement at 75% of salary.

Note from a CFO in the Midwest
“We are paying new graduating FM residents $180k right out of school. Base. Does not include sign on bonuses or benefits. Hospitals offering $200k plus $25k-$50k sign on bonuses. Brutal competition.”
# Impact Of Provider Vacancies

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Provider Vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider FTEs</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Visits/FTE</td>
<td>3,900</td>
<td>3,900</td>
</tr>
<tr>
<td>Total Visits</td>
<td>39,000</td>
<td>31,200</td>
</tr>
<tr>
<td>Net Revenue/Visit</td>
<td>$120.00</td>
<td>$120.00</td>
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<tr>
<td>Patient Service Revenue</td>
<td>$4,680,000</td>
<td>$3,744,000</td>
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<tr>
<td>Grant &amp; Other Revenue</td>
<td>$1,300,000</td>
<td>$1,300,000</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$5,980,000</td>
<td>$5,044,000</td>
</tr>
<tr>
<td>Provider Compensation</td>
<td>$1,750,000</td>
<td>$1,400,000</td>
</tr>
<tr>
<td>Variable Staff Compensation</td>
<td>$1,200,000</td>
<td>$960,000</td>
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<td>Fixed Staff Compensation</td>
<td>$1,600,000</td>
<td>$1,600,000</td>
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<tr>
<td>Total Compensation</td>
<td>$4,550,000</td>
<td>$3,960,000</td>
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<tr>
<td>Variable OTPS</td>
<td>$600,000</td>
<td>480,000</td>
</tr>
<tr>
<td>Fixed OTPS</td>
<td>$780,000</td>
<td>$780,000</td>
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<tr>
<td>Total OTPS</td>
<td>$1,380,000</td>
<td>$1,260,000</td>
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<td>Total Expense</td>
<td>$5,930,000</td>
<td>$5,220,000</td>
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<tr>
<td>Net Income</td>
<td>$50,000</td>
<td>$(176,000)</td>
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</table>
Changing the Provider Narrative

- CFOs want providers to do more visits. This frequently starts off the productivity discussion on the wrong foot.
- Providers typically feel:
  - An emphasis on visits per FTE is not consistent with good patient care
  - Specific changes could be made to improve patient flow/number of patients seen per day
  - Increasing patient access/number of patients is something providers generally respond to favorably
- CMO must act as part of management team, and develop solutions. The CFO needs to try to understand the CMO’s concerns about increasing production (which may require investment)
- CEO must exercise leadership in this area!
Many CHC providers believe that the center’s operations don’t function effectively. They may be right.

Providers may be open to the concept of fixing problems than of “working harder” (even though the fixing of problems may mean more work for them).

Double and triple booking to cover no-shows is very unpopular with providers.

Despite the fact that there’s always something to do, providers without patients during clinic hours is a waste of resources.
Capacity

- How many billable visits can we do:
  - Today?
  - On an average day?
  - In this facility per year as configured today?
  - With a new configuration?
Provider Capacity – Per Session

- Depends on session length
- Should be set on target average visits per day, not maximum per day
- Capacity may be a function of exam rooms
- Habits may be an important driver of performance. Therefore, it may be possible to only bill provider capacity (and eventually productivity) slowly
- Increases in provider productivity do not correlate with decreases in provider morale (it’s when providers feel they are presented with an impossible target)

If the daily visit target doesn’t correspond with reality, it needs to be changed!
Total Provider Capacity

- When should we/do we hire a new provider? Given how long it takes to recruit, should we build an inventory of excess provider FTEs?
- May result in only incremental costs, and help cover fixed costs
- Track other items that decrease provider capacity:
  - Provider absences (and what are the number of the visits done at a site when one provider isn’t there)
  - Vacation/CME/sick time/FMLA
  - Moving providers around sites
  - Vacancies
Utilizing Provider Capacity – Start of Day

- "The Lap"
- Time from patient entry to exam room (and ready for the provider) at the beginning of each session. Do we ask patients to come in early enough?
- What other tasks are we asking registration to do within the first 30 minutes of opening (e.g. calling up on no-shows)
- Culture – do our providers seek patients, or seek to avoid patients?
Appointment Slots Filled

- What percentage of slots are filled:
  - With an appointment
  - With a patient

- Health center should track number of walk-ins each day to answer the question “Can we count on walk-ins every day to fill empty slots”

- How late is late? When do we give away an appointment slot?

- For a single day, it may not matter how the slots were filled. Over the long term, this is a crucial question

Ultimately, it’s a question of whether or not your schedule is working
## Provider Consistency – How Many Different Providers Do We Need?

<table>
<thead>
<tr>
<th>Provider</th>
<th>Jan YTD Visits</th>
<th>Annualized</th>
<th>Less Specialty</th>
<th>Total Medical</th>
<th>FTEs needed @ 4000/FTE</th>
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<tbody>
<tr>
<td>Medical</td>
<td>40,853</td>
<td>61,280</td>
<td>1,728</td>
<td>59,552</td>
<td>14.9</td>
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<tr>
<td>Dental</td>
<td>6,632</td>
<td></td>
<td></td>
<td></td>
<td>4.0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>8,770</td>
<td></td>
<td></td>
<td>13,155</td>
<td>5.3</td>
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</table>

**TOTAL PROVIDER NEED** 24.2

This health center had 54 different individuals seeing patients during this year.
Provider Consistency

- Same provider, same exam rooms, same support staff
- Also same patients (patients not new to the health center, but new to the provider, take 5 – 8 minutes longer)
- Need to rethink use of part-time and locum providers
- Needed for continuity of care as driver of clinical quality and patient management

Provider compensation, and its relation to provider turnover, has a large impact on this consistency
Compensation Considerations

• In a CHC, need to consider administrative roles as well (CMO, Associate Medical Director)

• Determinations in differentials in provider compensation – experience? Performance (note that CMOs are notoriously poor at doing performance reviews)? Potential metrics for increase:
  ○ Productivity
  ○ Direct patient feedback
  ○ Peer review

• When primary care provider compensation is increasing at a high rate, keeping providers at market may necessitate giving proactive extra-normal raises
Staff Per Provider While Lowering Staff Cost Per Visit

- Physician $160,000 - $200,000
- Midlevel $85,000 - $110,000
- RN $65,000
- MA 1 $11/hr
- MA 2 $13/hr
- MA 3 $17/hr
- Care coordinator $20/hr
- Front desk $13/hr

The question may not be “what additional staff can we afford?” but rather “what incremental revenue could be generated by adding this staff?” (although this revenue is not guaranteed)
### Cost of New Patient vs. Established Visit

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<tr>
<td>Health Center Cost Per RVU</td>
<td>$60.00</td>
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<td>RVU for CPT Code</td>
<td>3.14</td>
<td>2.11</td>
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<td>Cost per Procedure</td>
<td>$188.40</td>
<td>$126.60</td>
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<tr>
<td>Addl Registration/Enrollment Effort</td>
<td>$60.00</td>
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<tr>
<td></td>
<td>(3 hrs @ $20/hr comp cost)</td>
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<tr>
<td>Total Cost Per Service</td>
<td>$248.40</td>
<td>$126.60</td>
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</table>

Patient retention & enrollment > outreach to new patients

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Does PCMH/APM Allow Us To Change the Provider Narrative?

• More team members taking away unnecessary work from providers may make them happier and less likely to leave

• Need to experiment first before committing to the more MA/increase productivity narrative

• APM may envision panel management – perhaps more palatable than visits (but potentially no less work)

• Who talks to the provider if their quality or patient satisfaction is bad?

• Flexibility on who a provider sees (a walk-in, another provider’s patient) increases productivity but diminishes continuity of care
## Compensation vs. Incentive Compensation

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<tr>
<th>Provider Name</th>
<th>Total Visits</th>
<th>Base Pay</th>
<th>Base Pay per Visit</th>
<th>Base Pay % of Total Pay</th>
<th>Float Pay</th>
<th>Inpatient Pay</th>
<th>Stipend</th>
<th>Incentive Pay</th>
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<th>Total Pay per Visit</th>
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<td>Jones, Bill</td>
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<td>888</td>
<td>169,756</td>
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<td>7,083</td>
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<td>Name, Tony</td>
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<td>149,814</td>
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<td>0.92</td>
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<td>1,730</td>
<td>7,692</td>
<td>625</td>
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<td>0</td>
<td>9,993</td>
<td>183,395</td>
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<td>0.85</td>
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<td>734</td>
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<td>Alvdama, Eduardo</td>
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<td>4,837</td>
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<td>7,233</td>
<td>143,445</td>
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<td>Tong,Qao</td>
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<td>0</td>
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<td>9,200</td>
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<td>34.69</td>
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<td>700</td>
<td>28,232</td>
<td>10,000</td>
<td>10,815</td>
<td>170,107</td>
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<td>48,738</td>
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<td>10,000</td>
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<td>0</td>
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<td>Yes, JT</td>
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<td>96,073</td>
<td>23.31</td>
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<td>0</td>
<td>0</td>
<td>3,785</td>
<td>103,686</td>
<td>25.15</td>
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<td><strong>Median</strong></td>
<td></td>
<td></td>
<td><strong>33.52</strong></td>
<td><strong>0.83</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>39.53</strong></td>
</tr>
</tbody>
</table>
Other Strategies

• Overhiring providers to prepare for vacancies
• Practice acquisition, provider brings panel to health center site
• Residency program
Considerations When Budgeting Providers

- Number of provider FTEs must match FTEs for visit calculation
- Provider level mix - physicians/midlevels
- Provider specialty mix - primary care, specialists, dentists, other provider types
- Contracted providers
- Vacancy factor
- Also need to budget for inpatient, after hours & incentive compensation payments
- Other staff should be budget based on staffing plan
PPS Rate Setting
PPS Rate Setting

- New sites – three comparable clinic vs. cost report
- Code 18/Form 3100
- Change In Scope
Why Is PPS Rate Setting Important?

- Medi-Cal accounts for the majority of visits, especially after the expansion
- Medi-Cal is typically our best payor (Medicare may now be equal or higher)
- The center only has one chance to get it right; it’s a costly hole to dig out of

Note before beginning: regardless of approach, rate setting package for a new site must be submitted within 90 days of the later of HRSA NOA for site and Community Clinic licensure date
Three Comparable Clinic

- Dimensions of comparability
  - Services (medical, dental, mental health, other FQHC billable)
  - Provider FTEs
  - Total site billable visits
  - In same county

- Must elect 3 comparable option on Form 3106 *Election Form*

- Services determined by Form 3106 *Summary Of Current Services Provided by Clinic*

- Provider FTEs and visits determined by Form 3106 *Summary of Healthcare Practitioners*
Considerations on Three Comparable Clinic

- Comparable must have a permanent rate, not an interim
- Sources for comparable rates
- Experience of other clinics
- One to three clinics may be rejected. There is an opportunity to resubmit (more than once)
- For unique clinics, can cross county lines
- If process is unsuccessful, can revert to cost report
Site Cost Report

- Form 3090
- Categories of cost:
  - Health care staff costs
  - Other health care costs
  - Overhead – facility costs
  - Overhead – administrative costs
  - Non-reimbursable costs
Home Office Cost Report

- Form 3089 home office
- Schedule 1A general information
- Schedule 1B sites
- Schedule 2A – health care costs and facility costs
- Schedule 2B – administrative and non-reimbursable
- Schedule 3 – adjustments to expenses
- Schedules 4A, B, C & D – Direct allocation of expenses
- Schedules 5A & B – allocation:
  - Health care cost: Medical staff salary
  - Facility: square footage
  - Administrative: accumulated cost
  - Non-reimbursable: accumulated cost
Thoughts on Preparing Cost Report

- Goal is to get rate to appropriately reflect cost
- If “Home Office” is co-located with a clinical site, first step is to separate expenses and square feet
- Using directly allocated Home Office expenses may be easier than trying to change allocation methodology on Schedules 5A & 5B
- Note that even if completing a cost report for only one clinic, still need to include all Home Office costs
- Some non-allowable costs may not overhead allocation commensurate with the cost
Thoughts on Preparing Cost Report

- “Incident to” from Medicare cost principles is basis for many discussions of allowable vs. non-allowable
- Health center must keep good workpapers, otherwise auditor’s decision will stand. This includes reclassification of fringe and other items
- Carve vacation, CME, and sick time out of provider FTE
- Remember offsets to costs (rent, interest income)
# Three Comparable Clinic vs. Cost Report

<table>
<thead>
<tr>
<th></th>
<th>Three Comp</th>
<th>Cost Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim Medicare Rate Available</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Requires Completion of Cost Report</td>
<td>Never</td>
<td>Twice</td>
</tr>
<tr>
<td>Interim Rate Available</td>
<td>Not needed</td>
<td>Yes at 80%</td>
</tr>
<tr>
<td>Requires Knowledge of Other FQHCs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Estimated Time To Get Full Rate*</td>
<td>45 days</td>
<td>5 years</td>
</tr>
<tr>
<td>DHCS Audit Methodology</td>
<td>Highly arbitrary</td>
<td>Somewhat arbitrary</td>
</tr>
<tr>
<td>Good for high-cost clinics</td>
<td>Probably not</td>
<td>Yes</td>
</tr>
<tr>
<td>Good for unique clinics</td>
<td>Maybe</td>
<td>Yes</td>
</tr>
<tr>
<td>Productivity standards apply**</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Appeal Process</td>
<td>Emailable</td>
<td>Administrative</td>
</tr>
<tr>
<td>Requires diligence with OSHPD completion</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

* Note additional time needed for Provider Enrollment to enter rate
** May be waived in certain circumstances
Form 3100

- Used to set Code 18 rate

- Cash flow implications of getting full rate:
  - Managed care + Code 18 above PPS rate: get full payment within two weeks of service
  - Managed care + Code 18 below PPS rate: get full payment in 3.5 years

- Your PPS rate is the constant. Managed care revenue is the variable. Thus if managed care revenue per visit is overstated, either because of payment or utilization, the Code 18 rate will be understated
Change In Scope

- From California Welfare & Institutions Code, a change means:
  - Addition of a service not included in the baseline rate
  - Deletion of a service
  - Change due to amended regulatory requirements or rules
  - Relocating or remodeling
  - Change in applicable technology
  - Increase in service intensity attributable to changes in types of patients served
  - Change in the provider mix
  - Capital expenditures
  - IME or GME payments
  - HRSA NOA

- 1.75% threshold

- Understand scope changing event. HRSA NOA always makes it easier
Change In Scope

- Have 150 days from end of fiscal year to submit
- Understand cost implications. Since Change In Scope application is optional, center should run analysis BEFORE submitting Change In Scope
- Requires regular cost report format (including Home Office cost report, if applicable), with an explanation
- Cost is based on ALL site costs, not just those associated with the change
- Get 80% of the difference between the cost report cost and your rate
- $100 + (($110 - $100) x 80%) = $108. $108 + (($120 - $108) x 80%) = $117.60 > $100 + (($120 - $100) x 80%) = $116.00, so it may be worth it to submit more frequent CIS