SESSION 1: MANAGING APP SPEND, SUBSIDY TO PRACTICE PLANS, AND PRIMARY CARE NETWORK

CFO Forum

August 2, 2024

Agenda

- Managing APP spend
- Subsidy (Funds Flow) to Practice Plans
- Primary Care Network

Managing APP Spend

Response to ACGME Changes

- The Accreditation Council for Graduate Medication Education (ACGME) revised the required for Pediatric Residency Programs, effective July 2025.
- These changes will reduce the number of inpatient rotations required during residency training. To support this change, care models will need to be refined so that we can continue to deliver high quality, effective, efficient, and timely care to our patients.
- **As of July 2025, the residency program will no longer care for patients on 4 teams, resulting in the need to hire 19 more APP FTEs in FY25**.

APP Salary Model

- There are 2 tiers of the salary model for Advanced Practice Providers including Physician Assistants, Certified Registered Nurse Practitioners, Certified Nurse Midwives).
- All APPs are salary exempt employees and receive no hourly wages unless working in a per diem or moonlighting capacity which is a standard hourly rate/hour.
- The salary is based on years of experience as an APP and previous RN experience is not included in salary.
- There are 2 APP Leadership roles:
  - **APP Team Lead** - serves as a conduit between the Advanced Practice Nurse/Advanced Practice Provider Management Team and a defined group of Advanced Practice Providers (NP/CNM/CNS/Physician Assistants) for the purpose of facilitating communication, supporting on-boarding of team members, maintaining day to day operations and evaluating clinical practice with a particular focus on quality and performance improvement.
  - **APP Manager (Clinical or Non-Clinical)** - provides oversight of Advanced Practice Providers. The APP Manager will serve as a leader in the field ensuring the highest standards of clinical practice. He/She will support development and implementation of the role within the specific Division and in alignment with institutional values and goals.

Tier	Roles and Details
Tier 1	Primary Care Specialty Care (inpatient/consult and outpatient) • Roles do not include 24/7 accountability or coverage
Tier 2	Hospital Provider • Inpatient front line ordering clinicians who have 24/7 accountability for patients in the acute care environment and ED • 15% higher salary than tier 1 • Per Diem Hospital Provider employees are not eligible for the additional compensation beyond their hourly rate.
Leadership	APP Team Lead • Graded the same as their current role with a 5% differential based on span of control
Leadership	APP Manager (Clinical or Non-Clinical) • Manager grade salary with 5% increase over Hospital Provider tier based on years of experience

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Alternative APP Roles and Additional Compensation

- **APP Per Diem** – A non-exempt/hourly part-time employee with no regularly scheduled work hours (typically fewer than one 8-hour shift per week). The per diem APP is not eligible for APP incentive plan.
- **APP Flex Team** - Providing a flexible staffing model to the hospital to fill gaps in staffing due to LOA, FMLA, PPL, vacancy, etc. Hospital Provider APP must be a 0.5 FTE or greater. They will receive a 5% salary increase after the APP has had 1 year of Hospital Provider experience.
- **APP Moonlighting Program -** moonlighting to facilitate patient coverage for vacations, absences, and temporary vacancies within the unit and/or team. Hourly rate paid and rate varies by shift
- **Hospital Provider APP Back-Up Scheduling Pay Program** - coverage for areas whose vacancies are not supported by the APP Flex Team. If Hospital Provider is called in, the provider will receive moonlighting rate that is current at the time of shift. Compensation for APP is Standby pay.
- **APP Nocturnist Program -** Commitment is to work permanent nights for 6 months or 1-year, additional bonus paid bi-weekly.
- **APP Incentive Plan –** Objects are to improve recruiting, retention and engagement, increase agility with respect to evolving marketplace for APPs, enhance line of sight to enterprise, department, and division goals, and to have a tighter alignment between physicians and APPs.
    - APP Incentive Plan - Hospital Nursing, Care Network, Primary Care, Research
    - Advanced Practice Provider Incentive Plan – Physician Practices
    - Advanced Practice Clinician Incentive Plan (CNS) - Hospital Nursing

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Subsidy (Funds Flow) to Practice Plan

Overview of Subsidy (Funds Flow) Structure at CHOP

- Funds flow generally refers to financial support from the Hospital for the Physician Practices for various agreements
  - ***Division Program Support*** includes funding for Division based resources in support of agreements approved as part of a strategic plan, growth initiative, or to offset some key program losses
    - May include time limited funding tied to recruitment of a Physician leader
    - Also includes flat amount of funding for Administrative Support and Training for each practice plan
  - ***Direct Charge for Purchased Services*** from Divisions includes provider effort for non-revenue generating activities as requested by the Hospital. This includes Medical Directors to provider oversight of hospital services, leadership roles and advisory roles to name a few.
  - ***Other Hospital Purchased Clinical Services*** includes the P&L loss support for the services provided in support of the Hospitalist Services, Care Management for complex services or other clinical services. In these programs, the professional revenue for the clinical activity does not cover the cost of the services needed to run the hospital, requiring the additional funding from the Hospital.

Overview of Subsidy (Funds Flow) Structure at CHOP

- Funds flow agreements are reviewed annually during the budget process
  - Established Guiding Principles set the expectation for the annual process
  - Input is collected/updated starting in December, with a goal of reviewing output in March and April, aligned with timeline to finalize the annual budgets
  - Documentation is required for agreements/funding requests, purpose/role is documented, physician effort is validated, accountable leaders is identified, etc.

- There are some ‘shared services’ allocations that are outside of funds flow, where the Hospital passes expenses to the Practice Plans for centralized functions (ie, Accounts Payable, IT Revenue Cycle Support)

Guiding Principles for FY2025 Funds Flow Budget Collaboration

Align with CHOP Enterprise Strategic Plan	• Promote partnership based on a shared commitment to vision, mission and values • Comply with all regulations
Leader Alignment on funding agreements	• Division and Hospital Leaders have discussed and aligned on agreement, prior to entry into the data file or request form is submitted
Fair and Transparent	• Foster open dialogue and full disclosure of all relevant information • Rules based, transparent to all departments; consistent labeling/categories, funding rules and policies • Documentation/articulation of specific purpose of the funds, quantitative and qualitative performance expectations, as well as duration of support
Match Revenue And Expense	• Align where appropriate, expenses and revenues in all entities

Financial Stewardship	• Funding requests should be submitted with a “Financial Stewardship” mindset
	  • Leveraging centralized resources, technology, and philanthropy in lieu of increased or new support
	  • Demonstration of alternatives considered to remediate funding where appropriate

Adherence to Timelines	• Alignment between entities on the FY25 budget timeline
Funding Approval	• Approval for funding is not final until we have alignment from the Executive Team

Primary Care Network

Primary Care Physician Compensation Plan Overview

- FY 22 in collaboration with Sullivan Cotter, built new Primary Care Physician Compensation Model to reward physician productivity and incentivize productivity and quality metrics – launched in FY23

- Simplified the plan and ensured a transparent compensation model for all physicians
  - Standardized the definition of a clinical FTE
  - Established a framework for consistently modeling base salary, productivity incentive and performance incentive, adjusted all calculations for prorated Clinical FTE when appropriate
  - Standardized dollars earned for ‘leadership roles, protected time, and other non-clinical effort
  - Shifted about 20% of total compensation into base salary
  - Total Compensation is market competitive and reviewed annually to ensure alignment with Sullivan Cotter benchmark

- Transitioned from Excel based model to Sullivan Cotter Performance Suite software, enabling each physician individual line of sight into their own compensation data

Compensation Models for Suburban and City Teaching are separate and distinct

- **Suburban PC Site Model** has 5 tiers of base salary, determined by prior year productivity (Tier 1 at <P41 and Tier 5 at >P70 in Sullivan Cotter blended peer benchmark data)
  - Year of Experience based additive dollars of between $5K-$15K
  - Each tier sets productivity threshold required for next years base salary, as well as threshold for which additional per RVU incentives are earned (ie, $49.50 per RVU generated over threshold of 5,300 for a physician in Tier 2)
  - Performance incentive based on three metrics and have, in the past, included well visit rates, chart closure, patient screening
  - Additional Stipend allocated for all physicians for sites that include APPs in provider staffing model

- **City Teaching Site Model** has 4 tiers of base salary, based on years of experience
  - Six tier productivity incentive, with flat incentive amount per Tier
  - Performance incentive includes Value-Based, Teamwork and Teaching metric
  - Additional Stipend allocated across all physicians for sites that include APPs in provider staffing model

Market Survey Sources

Suburban vs City

Suburban physician market data is a blend of three survey sources as shown below.
The MGMA survey is included to account for the community-based medical practices

Surveys	Description	Data Effective Date
SullivanCotter: *2022 Physician Compensation and Productivity Survey Report*	Includes data from 790 health care organizations representing 285,635 physicians, PhDs, advanced practice clinicians, and medical group executives. Data effective as of January 1, 2022.	1/1/2022
SullivanCotter: *2022 Medical Group Compensation and Productivity Survey Report*	Includes data from 366 medical groups representing 173,286 providers. Data effective as of January 1, 2022.	1/1/2022
Medical Group Management Association (MGMA): *2022 Provider Compensation and Production Survey*[1]	Includes data from 6,929 medical practices representing 144,846 physicians and non-physician providers. Data effective as of January 1, 2022.	1/1/2022

City physician market data is a blend of three survey sources as shown below.
The AAMC survey is included to account for the teaching-based medical practices

Surveys	Description	Data Effective Date
SullivanCotter: *2022 Physician Compensation and Productivity Survey Report*	Includes data from 790 health care organizations representing 285,635 physicians, PhDs, advanced practice clinicians, and medical group executives. Data effective as of January 1, 2022.	1/1/2022
SullivanCotter: *2022 Medical Group Compensation and Productivity Survey Report*	Includes data from 366 medical groups representing 173,286 providers. Data effective as of January 1, 2022.	1/1/2022
Association of American Medical Colleges (AAMC): *Report on Medical School Faculty Salaries 2021-2022*[2]	Includes data from 153 of the 155 accredited medical schools in the U.S. representing 124,480 full-time faculty. Data reflect fiscal year 2021-2022.	6/30/2022

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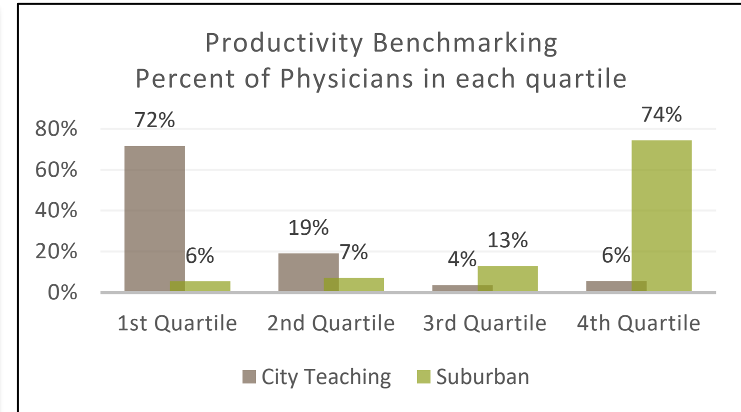
Primary Care Physician Productivity results FY24 (as of February)

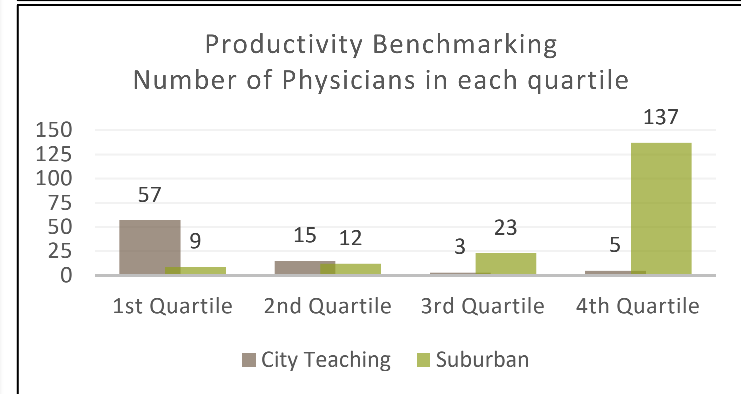
Suburban Physicians

- Year 3 physician comp plan based on productivity and VBC incentives
- Average wRVU Productivity is 108% of p75th benchmark
  - 74%, or 137 Physicians, are in the top quartile for productivity

City Teaching Physicians

- Aligned compensation plan but not based on productivity due to teaching and complexity of mission-based work
- As expected, 72%, or 57 physicians are in the first quartile





- Benchmarking data utilized: Sullivan Cotter Blended Surveys
- PPMT (Physician Performance Management Tool) has enabled every provider real time access to their own data in FY24
- FY24 mid-year – identified 25 physicians with productivity opportunity to meet or exceed budgeted Tier – resulted in YTD an additional 1400 visits with changes in work- flow

CHA BIG 5 REVENUE CYCLE

Session 2: Revenue Cycle

August 1, 2024

CHA Big 5 Revenue Cycle

Session 2

- Overall Denials
- Audits
- Level of Care
- Challenges w/Medicaid redetermination process
- Out-of-State Medicaid
- Increase of self-pay following PHE (Public Health emergency)
- Gene & Cell Therapy
- Revenue Cycle Transformation Program

Hospital Denial Performance

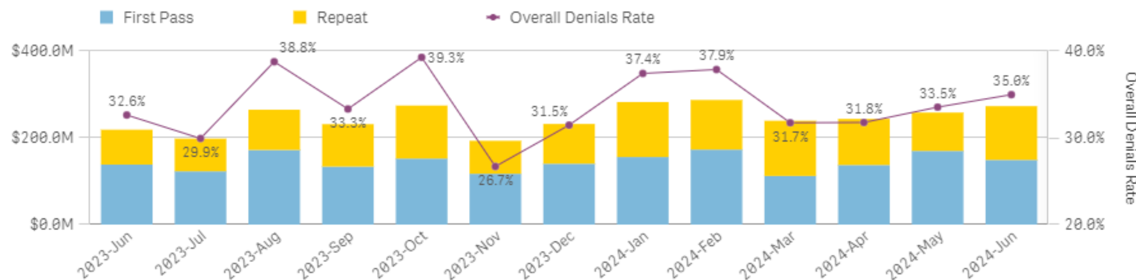
Overall Denials as a % of Gross Revenue

Hospital Performance Summary

Denials as a % of Gross Revenue	Performance	Target	Variance
Current Month (Jun '24)	35.0%	25.0%	*+10.0%*
Prior Month (May '24)	33.5%	25.0%	*+8.5%*
FY24TD (Jul '23 – Jun '24)	**33.9%**	**25.0%**	***+8.9%***
Baseline (FY23)	**35.8%**		

Overall Denials as % of Gross Revenue

(First-pass and repeat)



Calculation Notes

- Denials as a % of Gross Revenue: Denied gross dollars/ Average monthly gross revenue (rolling prior 3-months)

Denial exclusions:

- Repeat denials, Secondaries, Contractual, Duplicates, Informational, Patient Responsibility, Readmission, Reversals. Blue payer requests for itemized bills (CARC 252), identified custodial rate cases, and remit code N784.

Hospital Denial Performance

Overall Denials as a Percentage of Gross Revenue

Targeted denial segments	Current Month (Jun '24)		Prior Month (May '24)
Additional Information Needed/Billing Errors	10.0%	▼	12.3%
Inpatient Authorization	6.4%	▲	5.3%
Insurance Eligibility	1.2%	▼	2.2%
Coordination of Benefits	1.3%	▼	2.0%
Timely Filing	3.8%	▲	2.6%
Outpatient Authorization	1.5%	▼	2.0%
Outpatient Non-Covered	0.7%	▼	0.8%
Coding *(goal under review)*	1.9%	▲	0.8%
Total Denials	**$272.3M**		**$258.2M**
Denial Rate:	**35.0%**		**33.5%**

Targeted denial segments	FY2024 (Jul '23 – Jun '24)		FY2023 (Jul '22 – Jun '23)
Additional Information Needed/Billing Errors	12.1%	▼	13.7%
Inpatient Authorization	4.6%	▼	4.9%
Insurance Eligibility	3.1%	▲	2.7%
Coordination of Benefits	2.3%	▼	2.9%
Timely Filing	2.3%	▼	3.0%
Outpatient Authorization	1.8%	▲	1.6%
Outpatient Non-Covered	0.8%	▲	0.7%
Coding *(goal under review)*	0.7%	▼	0.9%
Total Denials	$ N/A		N/A
Denial Rate:	**33.9%**		**35.8%**

- Working to greatly reduce Eligibility/Coordination of Benefits through Automated Filing Order implementation
- Receiving high levels of denials for non-covered on Interim Billing
- Partnering with Data Scient Team to identify opportunities to improve Additional Info denials
- Initiating an orders/referrals project and implementing DNB checks to catch late change orders requiring authorization to reduce overall Authorizations/medical necessity/noncovered denials
- Enhancing to Simple Visit Coding and additional upfront coding edits to reduce Coding Denials. Implementing 3M360 software will greatly help this as well as noncovered/medical necessity

Hospital Denial Performance

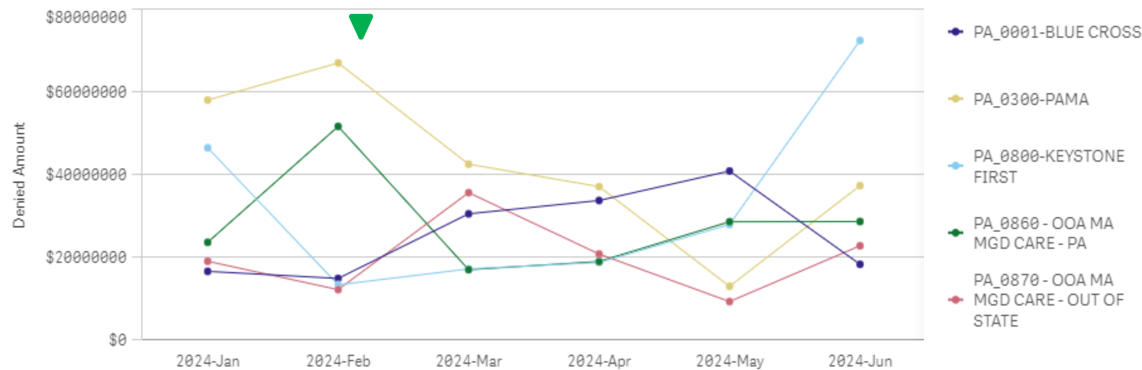
Top Denied Payer Trends

Payer Performance Summary

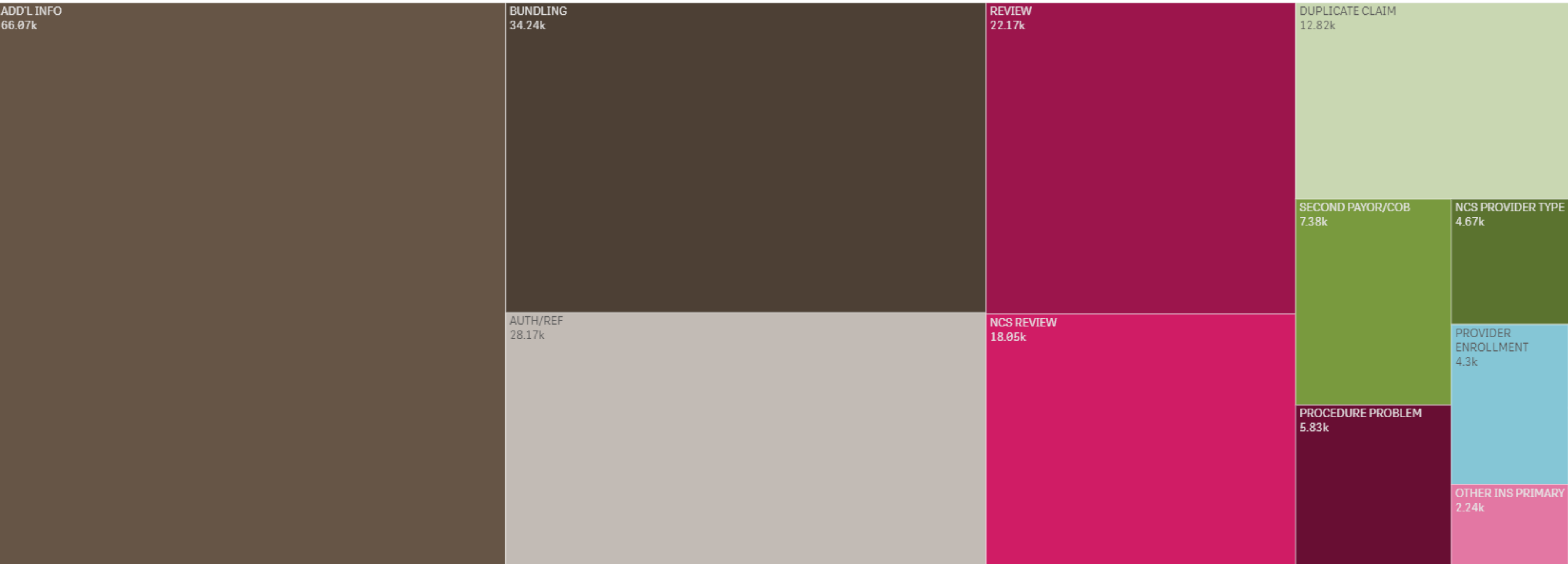
Top denied payers	Current Month (Jun '24)	Prior Month (May '24)
Keystone First	**$72.5M**	$28.0M
PAMA	**$37.4M**	$13.0M
OOA MA Mgd Care – PA	**$28.7M**	$28.6M
OOA MA Mgd Care – Out of State	**$22.8M**	$9.3M
Blue Cross	**$18.3M**	$40.9M

Top Denied Payers Trend

(Overall denials, 6-month trend)



CHOPPA Denials Bucket Heat Map



Descriptions

- ADD'L INFO: Generally related to medical record or provider enrollment information requests.
- BUNDLING: Services billed together or similar services on same day within same tax ID but different specialty group.
- REVIEW: Additional information requests based on appeals or investigation submitted by AR teams.
- AUTH/REF: Authorization or referral requirements not met. Combination of inpatient and hospital.

CHOPPA Denial Trends

3-Month Denied Rates

3 Month Paid Rate	3 Month Denied Rate	3 Month No Resp Rate	3 Month Pat Resp Rate	3 Month Write Off Rate	3 Month Not Sent Rate	Transactions
74.5%	6.7%	9.1%	3.5%	2.6%	3.6%	6.05M

Denial Trend | % of Transactions Trend

3 Month Denied Rate: 0.0% – 15.0%; Avg (6.7%)

May 2021 – Mar 2024 (SERVICE_DATE.YearMonth, Rev Loc Grp)

Rev Loc Grp: CHCA, CSA, RACH, CAA

Key:

- CHCA - Children's Health Care Associates
- CSA - Children’s Surgical Associates
- RACH - Radiology Associates of Children's Hospital
- CAA - Childrens Anesthesiology Associates

Audits

Organizational Structure

- Itemized bill and medical record requests are handled by Patient Financial Services
- Revenue Integrity Auditors (2) review and respond to the audits
- CHOP is implementing the RAC module available in Epic during FY2025

DRG Audits

- Totaled 85 for FY2024
- Handled by Health Information Management Team
- Bulk of volume: 52 from Medreview, 20 from Health Partners

Charge Review Audits

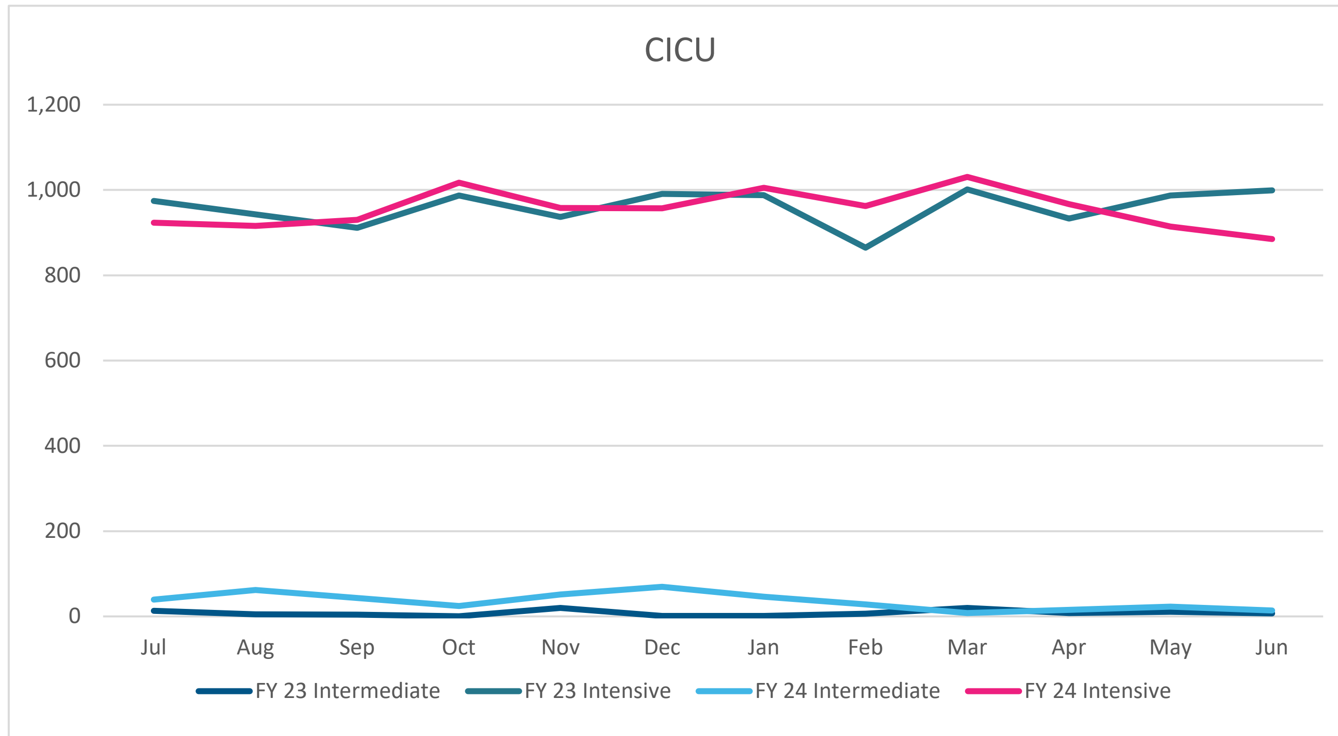
Total of 213 charge review audits in FY2024

Independence Blue Cross made up 50% of the volume

- Effective 1/1/2019, BCBSA requires prepayment claims review for out of area members, on inpatient claims that are reimbursed by percent of charge methodology.
  - The thresholds of the claims that qualify for the prepay review have been updated over the years:
    - Effective 1/1/2019, reimbursement ≥ $250k
    - Effective 1/1/2020, reimbursement ≥ $200k
    - Effective 1/1/2021, reimbursement ≥ $100k
- IBC requests itemized bills as opposed to medical records to perform the audit.
- Disallowed charges are based on revenue code.
- **Cigna and United** (Commercial and Medicaid) audits are increasing
- United uses outsourced company Medreview (postpayment): 50 audits in FY24
- Cigna sends audits via fax and is the most difficult to come to agreement
- Audit Trends:
  - Nitric Oxide, labs, respiratory and supply charges the Payor wants included in the Room and Board

Level of Care Trends

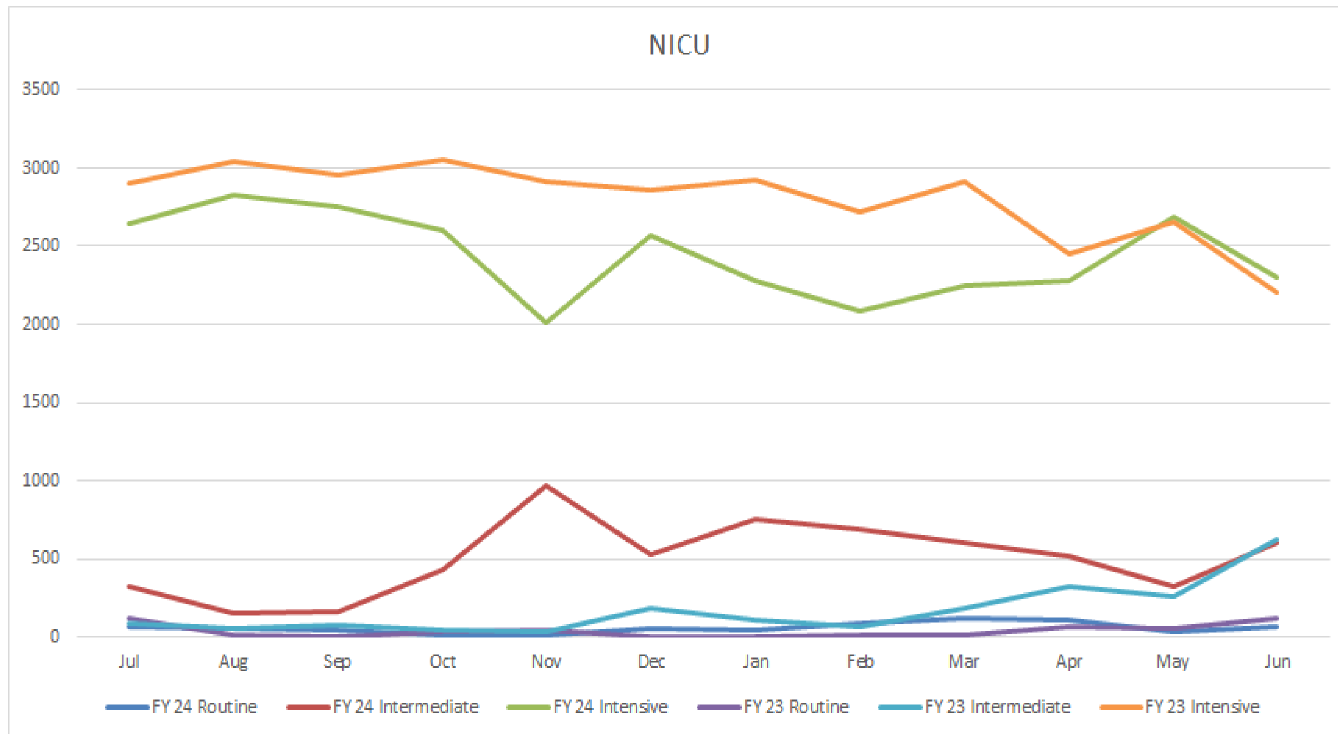
FY24 – FY 23 CICU Accommodation Code Comparaison



- Attributed to InterQual Criteria Changes
- Increasingly more difficult to meet Intensive Level of Care
- FY 24 Accommodation Code Volume Changes
  - 326 more Intermediate Days or 339%⬆

Level of Care Trends

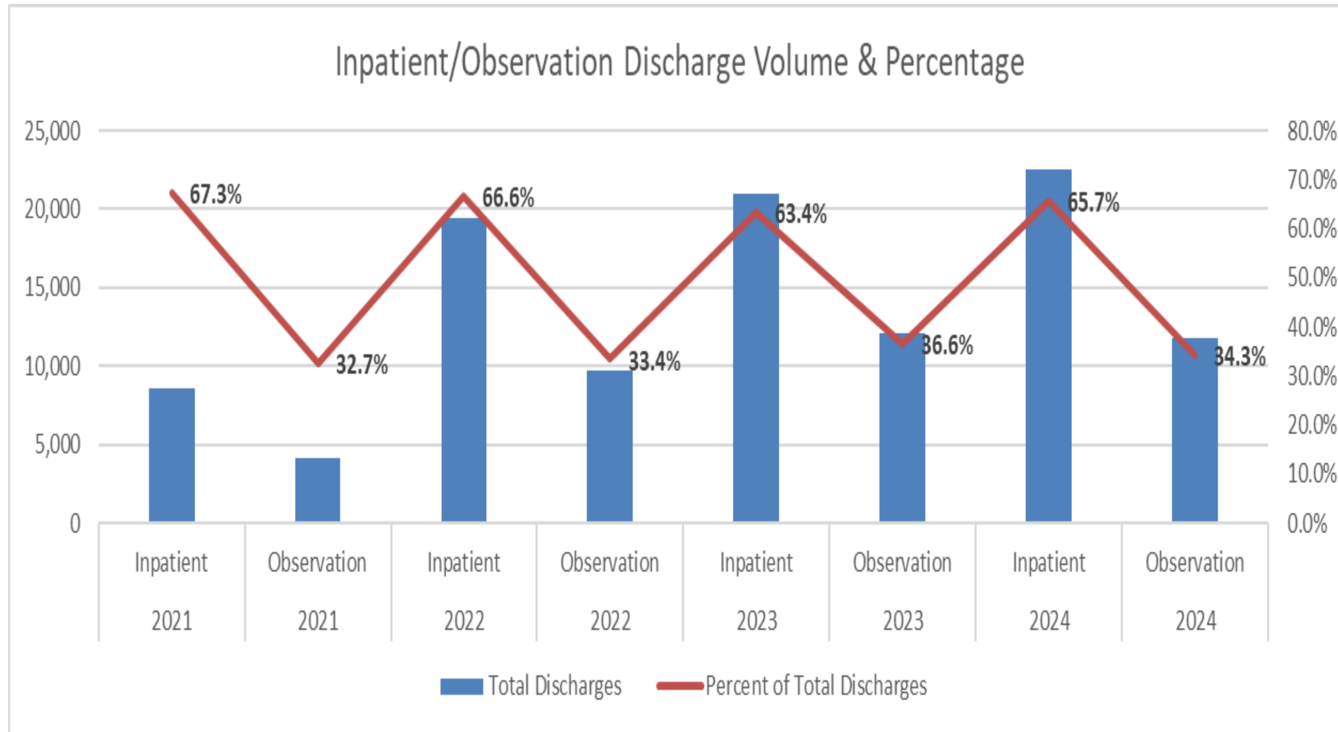
FY24 – FY 23 NICU Accommodation Code Comparison



- Attributed to InterQual Criteria Changes
- Increasingly more difficult to meet Intensive Level of Care
- FY 24 Accommodation Code Volume Changes
  - 212 more Routine Days or 44% ⬆
  - 4,007 more Intermediate Days or 197% ⬆
  - 4,344 less Intensive Days or 13% ⬇

Level of Care Trends

Inpatient/Observation Discharge Volume By Fiscal Year



- FY 24 Observation Volume Changes
  - Observation Discharge Volume 6% ⬇

Challenges w/ Medicaid Redetermination Process

CHOP's Key Challenges

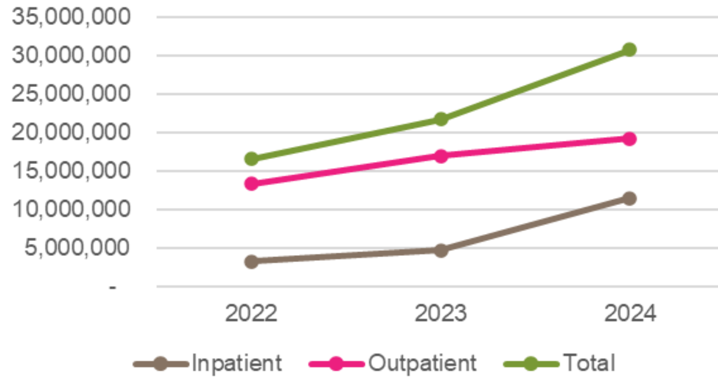
- Historically reimbursement has been for HB, and PB would process separately and differently, increasingly PB enrollment impacts HB reimbursement.
- Hospital and physician enrollment shifted from an AR process to a requirement for obtaining authorization or negotiating rates.
- Payors do not allow CHOP to approve services deemed available in-state or to seek retroauthorization for services. Payor authorization requirements have increased the work for referring physicians.
- Determining medical necessity is not solely based on clinical requirements. Payors increasingly consider the necessity to seek out-of-network care.
- CHOP is losing negotiation leverage for rates post-service coupled with a decrease in negotiated rates, which are shifting to in-state Fee For Service rates.

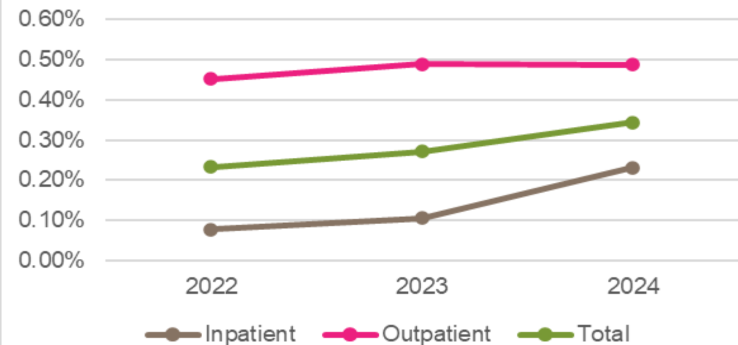
Out-of-State Medicaid

Primary Challenges

- Provider Enrollment
- Credentialing

Increase of self-pay following PHE (Public Health emergency)





Self Pay Gross Revenue as a $ - YoY			
	2022	2023	2024
Inpatient	3,259,451	4,723,841	11,480,253
Outpatient	13,323,091	16,957,241	19,245,622
Total	16,582,543	21,681,082	30,725,875

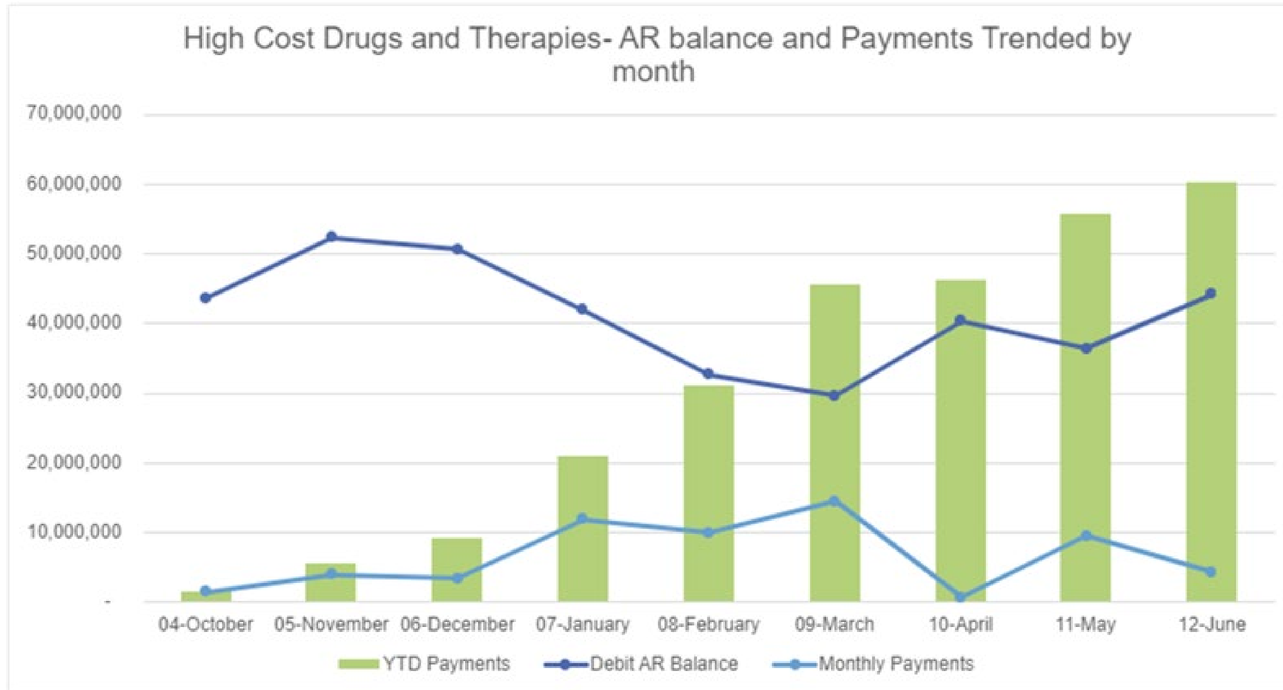
Self Pay as a $ change from PY		
	2023	2024
Inpatient	1,464,390	6,756,412
Outpatient	3,634,150	2,288,381
Total	5,098,539	9,044,793

Self Pay Gross Revenue as a % of total - YOY			
	2022	2023	2024
Inpatient	0.08%	0.10%	0.23%
Outpatient	0.45%	0.49%	0.49%
Total	0.23%	0.27%	0.34%

Self Pay as a % of total gross revenue change from PY		
	2023	2024
Inpatient	0.03%	0.13%
Outpatient	0.04%	0.00%
Total	0.04%	0.07%

Gene & Cell Therapies

FY24 AR Trends – June 2024



- AR continues to out pace total monthly payments on therapies.
- Ideally, we want them to intersect in the middle, but the payers are not always certain how to pay the claims correctly the first time.
- We are forming cross-functional teams to examine and improve the process new claim submissions to ensure first pass clean claims.

Gene & Cell Therapies

Payer/Payment Methodology

- CHOP continues using "Buy and Bill" for our cell & gene therapies.
  - We are concerned about chain of control if we "white bag".
- CHOP has been successful negotiating longer payment terms with the pharmaceutical suppliers specifically related to these products (e.g., Net 90 – 120 days). The challenge CHOP is currently experiencing the payments from the insurance companies are well past the 90-120 timeframe.
- We are contracted for these therapies for all our commercial plans and have narrowed our margin in some cases to enter narrow network plan designs.
- Medicaid contracting has been more challenging in terms of payment methodologies and out of state reimbursement provides significantly lower margins
- We also tell patients to advocate to their employer if authorization is challenging.

Revenue Cycle Transformation

Program Results

Adjusted Net Revenue Impact

2023	2024
$35.6M	$73.0M

- ***Revenue Cycle Transformation***: A multi-year journey to address key internal and external challenges facing revenue cycle operations, currently in Phase III: Continuous Process Improvement.
- The adjusted net revenue impact demonstrates the improvement in revenue cycle performance over the baseline year, which included many challenges such as an industry-wide cybersecurity attack.

Revenue Cycle Transformation

Preliminary Assessment

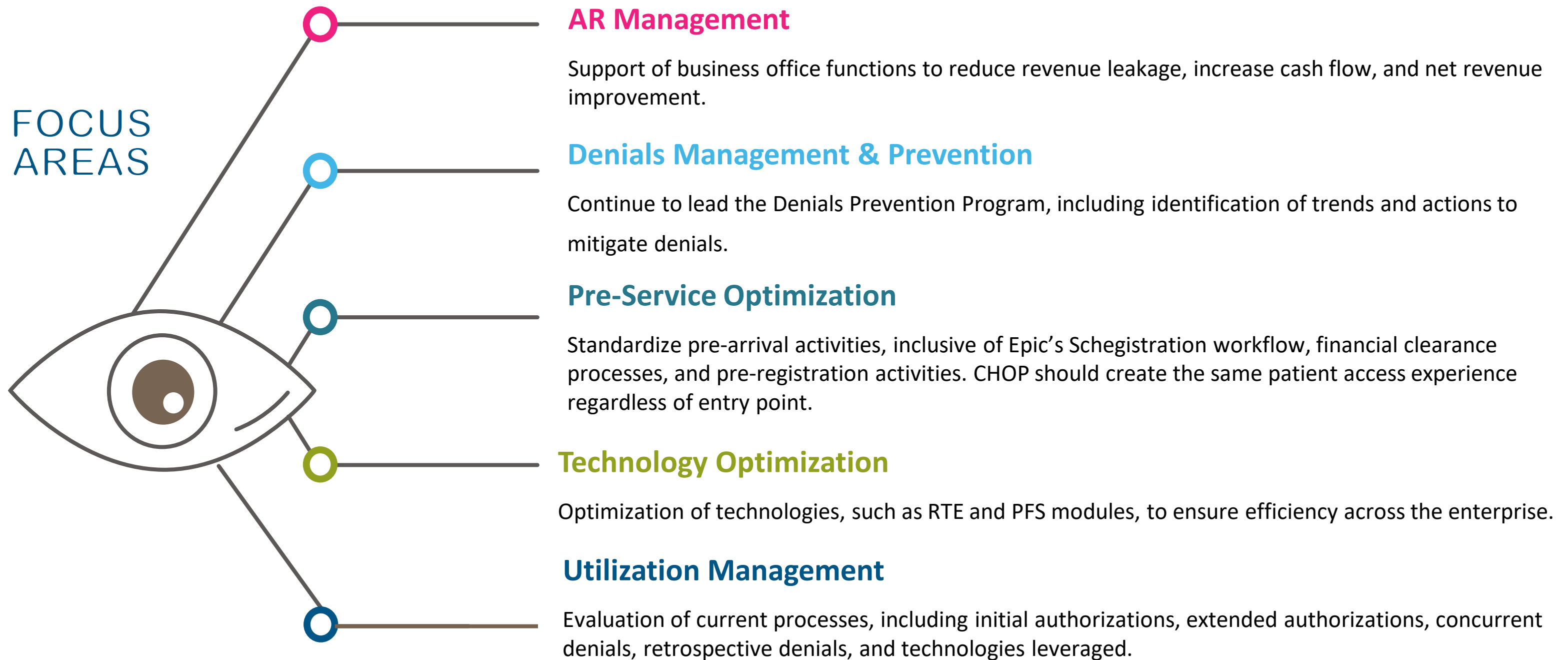
CHOP’s Key Challenges

- CHOP was not performing as a cohesive Revenue Cycle team; it performed in silos with limited transparency into results/performance.
- Gross A/R days were 92 days higher than industry leading practice (Hospital).
- Clinical departments and Revenue Integrity were reacting to finance findings instead of proactively mitigating revenue leakage.
- CHOP’s Avoidable Write-Off Rate as a % of Net Patient Service Revenue was 3.1% higher than industry leading practice (HB).
- Point of Service Collections as a % of Net Patient Service Revenue was 0.1%, which is 10x lower than the leading practice benchmark of >1.0%.

Proposed Solutions

- Optimize workflows, technology, and account prioritization strategies across the Patient Financial Services Department.
- Improve CHOPs ability to provide actionable information to the right stakeholders at the right time, in order to turn revenue cycle data into insight and action.
- Expand Revenue Integrity’s scope to influence revenue generating departments to ensure revenue is captured timely and completely.
- Focus on denial prevention efforts and engage additional stakeholders to materially influence performance.
- Enhance point of service and post service family collection efforts through optimized technology platforms.

Revenue Cycle Transformation
FY24 Workstreams



- To capture full financial opportunity and continue to mature CHOP's revenue cycle, leadership recognized the Program needed to elevate further. Several of the Workstreams from FY23 were expanded upon or maintained for FY24, while additional focus areas were established to optimize critical revenue generating areas of the revenue cycle, increasing staff efficiency, and upskilling management and staff.
- Therefore, launched 5 more workstreams to continue elevating Rev Cycle performance into FY24

Revenue Cycle Transformation

FY24 Results Metrics

35% Increase in 4 Week Rolling Average of Claims Billed	**15%** Decrease in Average Initial Denied Patient Days	**1,800** Visit Types Mapped to Enable Co-Pay Collections
25% Improvement in Independent Review Organization (IRO) recoupments	**1.0%** Adjusted Collection Rate Improvement FY24 YTD (Jul 23 – May 24)	**19,500** Hours of Labor Saved per Year from Registration Work queue Standardization
10% Improvement in Rolling 91 Day Average Cash per Day	**16%** Improvement in Registrations without Warnings Bypassed	**33%** Decrease in Average Days on Collection Work queues

- The success of the Revenue Cycle Transformation Program in FY24 cascaded across the CHOP enterprise.
- We saw a 1.0% adjusted collection rate. All the successes here feed into that number and are based on all the numbers you've heard throughout the previous discussions

Revenue Cycle Transformation

Phase 3: Continuous Process Improvement (FY25 Plan)

Operational Workstreams

- Pre-Service Optimization (Scheduling & Registration)
- Financial Clearance
- Middle Revenue Cycle Management ((Rev Integrity, Coding, HIM Ops, & CDI)
- Utilization Management
- Denial Prevention
- AR Management & Clinical Trials

Support Workstreams

- Technology Optimization & Automation
- Revenue Cycle Human Resources
- Revenue Cycle Analytics
- Education & Quality

Program Management

- Project Management
- Change Management
- Communications Management

Expanding scope, reorganizing, and collaborating with key partners to more effectively prioritize and support revenue cycle operations improvement.

CHOPPA Faculty Compensation Overview

Total faculty compensation (base, incentive and administrative supplements) per individual faculty member is reviewed on an annual basis by an external consultant and approved by the Compensation Committee of the Board

Total compensation is compared to national benchmarks by degree, specialty and rank

- AAMC – All Medical Schools, Northeast Medical Schools and Private Medical Schools
- AAAP – For pediatric subspecialities only
- SCORCH – For radiology
- Sullivan Cotter Associates

Complement of base and incentive may vary by department but all departments use a common template to calculate the incentive portion of compensation using the following:

- Department funding threshold
- Enterprise safety goal
- Division/department metrics
- Individual metrics

Division/department and individual metrics and their relative weightings are determined by each department, within approved ranges

- Division/department metrics include financial and quality measures
- Individual metrics include clinical performance/productivity, quality, citizenship, academic and leadership (if applicable) measures

Productivity Measures

- Clinical productivity standards vary by specialty to align with appropriate measures (surgical cases, outpatient encounters, new patient visits, RVUs etc)
- Productivity measures used vary in complexity from volume measures to individual provider P&Ls.
- Clinical productivity targets are adjusted to account for research, academic and leadership effort of an individual provider
- Expectations for departments where staff cover shifts are based on clinical service coverage (clinical days, sessions, shifts and on call assignments)
- All departments monitor performance monthly (use of billing reports, dashboards, scorecards)

Challenges of Productivity Benchmarking

- RVUs for many procedures which are calculated based on adult practice (Medicare) do not accurately reflect the more intensive work effort and care requirements of pediatrics

- Some unique services in pediatrics do not have comparable codes assigned in the adult world

- RVUs reported on surveys on a full CFTE basis can be unreliable and inconsistent across academic practices due to multiple confounding factors:
  - Proportion of clinical/nonclinical time
  - Unreimbursed clinical administrative work related to patient care (care coordination, documentation)
  - Leadership roles
  - On call coverage/hazard hours
  - Increasing use of telehealth

- Survey data is insufficient to addresses the differing size and complexity of each institution's care model that may include APPs and/or trainees

- The organization's growth and geographic spread may lead to staffing inefficiencies outside of the practitioner's control

- No standard definition of hours per work week across institutions

- Comparisons of productivity by individual provider are inappropriate in "service based" specialties where the practitioner does not control demand. (e.g., Anesthesiology, Critical Care, Radiology, Pathology, etc.) In those specialties, productivity is measured on a group basis

HOT TOPICS IN GOVERNMENT AFFAIRS

July 2024

CHOP Structure and Process

Structure

- Government Affairs (led by AVP) reports up to SVP of External Affairs.
- Two years ago, created Director position with matrix reporting to Finance.
- Among the reasons for closer ties between Finance and Government Affairs:
  - Increasing engagement with state Medicaid and CMS on reimbursement issues
  - Increasing political fallout from contracting negotiations
    - Legislators publicly engaging on contract issues
  - Increasing implications for revenue from hot topics in the government sphere

Structure

Direct Reports are only included for relevant teams to minimize complexity of the chart.

EVP and Chief Financial Officer

VP Budget and Business Planning

Manager, Reimbursement

Financial Data Analyst

Financial Data Analyst

Financial Data Analyst

Financial Data Analyst

VP, Reimbursement Strategy

Director, Contracting

Contracting Specialist, Managed Care

Senior Manager, Payor Relations

Payor Relations Specialist

SVP, External Affairs

AVP Government Affairs and Advocacy

Director, Reimbursement Policy & Strategy

Assoc. Director, Advocacy and Policy (state and local lead)

Assoc. Director, Federal Affairs and Operations

Hot Topics

A partial list of complex issues, familiar to many children's hospitals:

1. Threats to **340B** savings
2. Uncertainty regarding federal approach to aspects of **provider tax** (supplemental Medicaid) programs
3. Criticism of hospital **charity care and community benefits** (including questions about nonprofit status) by media and some lawmakers
4. Politicization of **gender affirming care** services

Responses to Hot Topics: 340B

Federal & State Context:

- There is ongoing interest from Congress in making changes to the program, some of which could harm children's hospitals.
- CHOP has had to respond to state-level threats, with a 2023 effort to eliminate 340B savings on cell and gene therapy in Pennsylvania.

Our Approach

- Links among Finance, Pharmacy and Government Affairs to rapidly assess impact of proposed changes at federal or state level
- Development of strategy and responses is also collaborative, engaging all three teams.

Responses to Hot Topics: Provider Tax

Federal & State Context:

- Pennsylvania has had a provider assessment that support both state and hospital efforts since 2010.
- Philadelphia City Council recently reauthorized an assessment specific to city hospitals, including children's hospitals (CHOP and St. Christopher's) for the first time.

Our Approach

- Close work linking Government Affairs and Finance in estimating impact of these assessments and lobbying for authorization and appropriation
- Government Affairs convenes as necessary to trouble shoot implementation issues

Responses to Hot Topics: Charity Care and Community Benefit

Overall Context:

- Increasing media and lawmaker criticism of funds dedicated to charity care and community benefit issue, with the underlying point that hospitals may not deserve nonprofit status.
- This is present across all jurisdictions in varying manners.

Our Approach

- Internal “Tiger Team” created to review CHOP charity care and community benefits reporting and practices. Goal is a response that gets ahead of predicted concerns by illustrating commitment to both financial assistance to patients in need and investment in the Philadelphia community.

Responses to Hot Topics: Gender Affirming Care

Federal:

- Congressional inquiry last year and continuing politicization of this care require close attention by CHOP leadership and Government Affairs in partnership with clinical leaders.

Our Approach

- Top leadership engagement in and support for the program
- Multidisciplinary emergency preparedness team (including legal, finance, public relations, security as well as government affairs) routinely meets to review federal, state and local landscape
- Team has developed contingency plans for election season and beyond.

LABOR MANAGEMENT

August 2, 2024

Labor Management - Benchmarking

- CHOP has historically utilized CHA PROSPECT benchmark data for Hospital departments
  - During FY 2024, the Peer group for benchmarking comparison purposes was expanded to 10 Children's Hospitals. The Peer Group was determined based on total operating revenue > $1.5B
- No established benchmark data has been utilized for staff within the Practice Plans (Medical Group), Research Institute, and Foundation
- During the FY 2025 operating budget process, labor standards were established for each Hospital department (non-Nursing) beyond the default labor standard of "adjusted patient days". Worked Hours per unit of service was calculated for the FY 2025 operating budget, including 3-year historical data for comparison to the FY 2025 operating budget submission

Labor Management – Benchmarking Cont'd

- Recently started preliminary work to establish an Enterprise Labor Efficiency Steering Committee
  - This Committee will support the PERFORM pillar within the Financial Stewardship Program (discussed at yesterday's session)
  - The Committee will work with operational leaders to establish a benchmark for Practice Plans, Research Institute, and Foundation
  - Continue to advance the PROSPECT benchmark data for Hospital departments. This will include further refinement of labor standards, improve data submission process, and gain an understanding of best practices from Peer Group.

Labor Management – Position Control

- CHOP established an Enterprise Position Requisition Review Committee in February 2024.
- The Committee has members from Human Resources, Hospital Operations, Research Institute, and Practice Plans (Medical Group)
- The Committee does not review requisitions related to Physicians, Advanced Practice Providers, Trainees, and Temporary staff

Labor Management – Position Control Cont'd

- The following criteria were established for review of requisitions:
  - Weekly Requisition Report – how many roles does leader already have frozen.
  - Funding – identify if role will be subsidized by funding outside operations.
  - VP Staffing Report – consider if role is hard to fill or has high turnover.
  - Strategic Initiative – identify relationship to or critical dependency for time-sensitive strategic initiative.

  Established criteria to be utilized during FY 2025

  - *Productivity (as and when relevant, reliable data exists).*
  - *Budget, determine if position was budgeted and if unit/cost center is favorable or unfavorable to budget predictions.*

Labor Management – Pay Practices/Special Pay Programs

- TBD

MARGIN IMPROVEMENT (IMPROVEMENT INITIATIVES AND CAPITAL SPENDING PLANS)

August 1, 2024

Margin Improvement Initiatives – FY24 Financial Contingency Plans

- During FY 2024, CHOP's operating margin was unfavorable to budget. FY 2024 operating margin projection reflected only 50% achievement of annual budgeted operating margin
- Finance Team developed financial contingency targets for each business segment (i.e., Hospital, Practice Plans, Research Institute, and Foundation). Targets totaled $45.2M, with contingency plans submitted for $46.5M
  - Contingency plans included not recruiting for 270 open positions, reduction in purchased services spend, and reduction in discretionary expenses such as travel and food services
- Total achieved by the end of FY 2024 was $21.0M. This offset other financial headwinds for CHOP to achieved the projected operating margin

Margin Improvement Initiatives – Financial Stewardship Program

Background

- CHOP established a Financial Stewardship program in FY 2017. This program represents a holistic approach to financial management with four areas of focus:
  - Lead – Advance the financial acumen of our leadership team
  - Perform – Promote a regular cadence of reviewing financial performance
  - Grow – Develop a standard process for evaluating capital investments, including investments in new clinical programs
  - Improve – Identify and implement opportunities to improve our financial performance by ensuring we are being appropriately reimbursed for the services we provide; increasing the efficiency of our workforce and utilization of our assets; and finding ways to better manage our costs

Financial Stewardship Program – FY25 targets

- CHOP has set a target of $100M for FY 2025
- The FY 2025 budget includes $50M of margin improvement
- Non-labor initiatives are classified into the following categories:
  - Revenue enhancement projects (~$26M) focused on net patient revenue improvement through Revenue Cycle improvement initiatives, growth in specialty pharmacy, and increase in unrestricted contributions from the Foundation
  - Non-labor expense projects (~$9M) related to supplies and purchased services

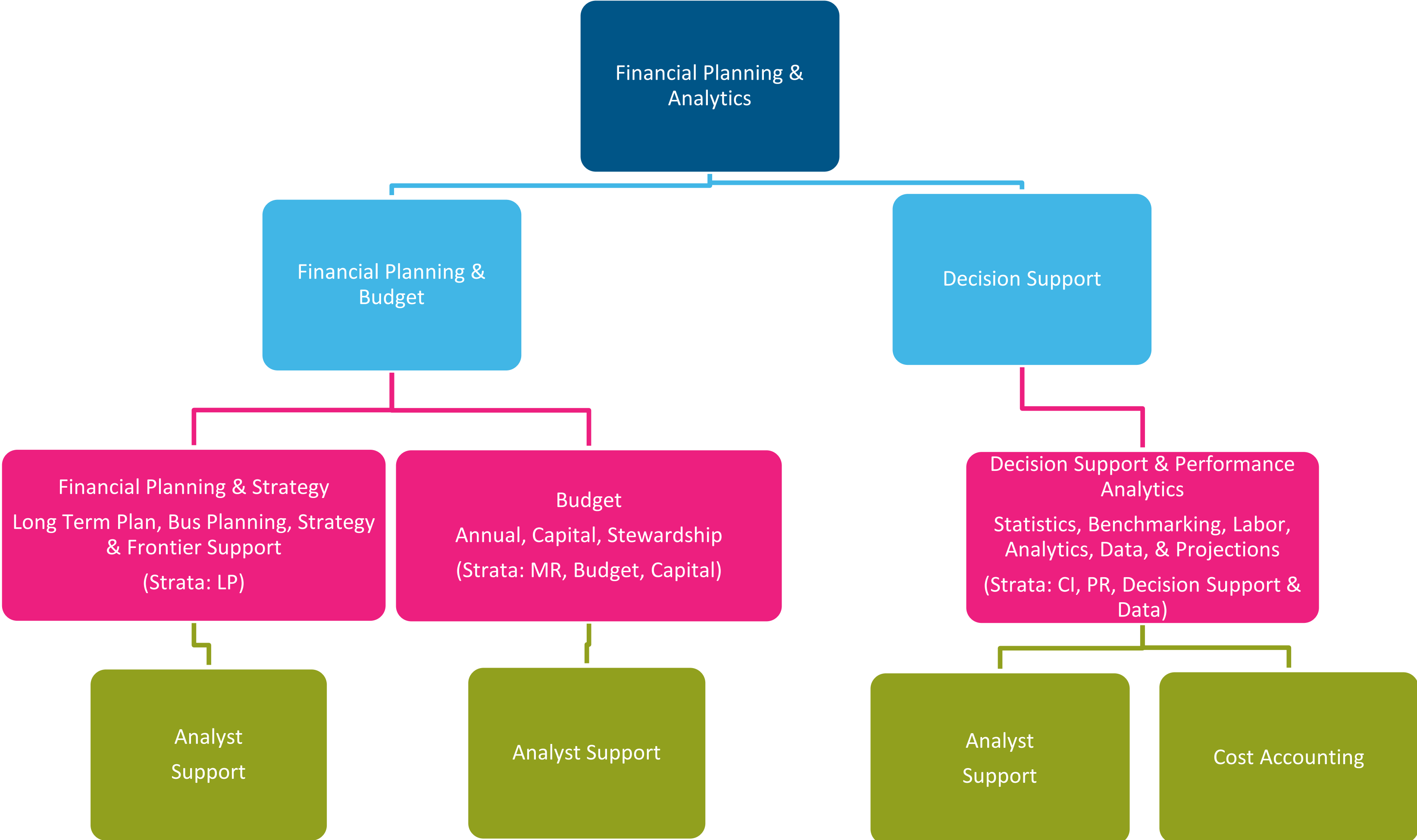
Capital Spending Plans

- On an annual basis CHOP updates a 10-year Long-Term Plan (LTP)
- The most recent Board approved LTP included ~$5.0B in capital investment
  - Major capital investments include a new research building (The Morgan Center for Research and Innovation – opening in 2025) and a new Patient Tower (scheduled opening in 2028).
  - Includes continued capital investment in information technology, existing infrastructure, new strategic initiatives, and medical equipment.
- 10-year capital spend plan will be funded by operating cash flow margin and debt

Debt Issuance, Financing Plans, and Liquidity Planning

- Current debt portfolio at $1.7B
- Targeting additional debt issuance in October 2024 to support capital investments
- Ongoing liquidity planning as part of overall "Plan of Finance". Liquidity options are being developed to support strain on operating cash flow due to timing of capital projects with significant cash outflow over next 5 years

Financial Planning Org structure at CHOP



CHOP PAY PRACTICES AND SPECIAL PROGRAMS

July 18, 2024

Pay Codes

Holidays

- Non-exempt are paid 1.5 hours when working on a holiday
- Non-exempt working OT and Holiday will only get 1.5 times pay (two pays will not be combined)
- CHOP has paid holidays, so if an employee works on a holiday, time is added to the Holiday Bank of hours

Overtime

- Shift differential is added to the regular rate for the purposes of calculating time and one-half
- Training time, Conference time, actual hours worked during call-backs of on-call or stand-by pay, and Worker's Compensation time are considered hours worked for the purposes of determining overtime.
- Paid personal leave (SPPL/UPPL), statutory holidays, military leave, jury duty, bereavement, and other short-term leaves are not considered part of the workweek for determining overtime.
- Overtime is paid only for hours worked in excess of 40 in the workweek. For example, employees who are regularly scheduled to work 37.5 hours per week are paid straight time for hours worked between 37.5 and 40.

Pay Codes continued

Critical Shift Program

- The Critical Shift Pay program has been developed to accommodate gaps in staffing as a result of, but not limited to, increased vacancy rates and high patient volume. Activation of the Critical Shift Pay program may vary based on needs of each business unit.
- Rates vary depending on day, evening, or weekend shifts.
- Employees may sign up for critical shifts in weeks that also have approved PPL or other types of paid time off (Ex. Bereavement, Holidays) however Critical Shift Time and PPL/other paid time off will not be paid on the same day.
- ~10,400 hours attributed for one quarter

Shift Differential

- Non-union, non-exempt employees who are scheduled to work at least shift zones within a workweek are eligible to receive shift differential pay for actual time worked.
- Shift differential is not payable on Short Term Disability (STD) hours or other paid administrative time (ex. SPPL, UPPL, Holiday, Bereavement, Jury Duty, Conference, Workers Compensation time).
- Rates vary across Weekday Evening, Weekday Nights, Weekend Day, Weekend Evening, and Weekend Nights and by job roles.
- A person is required to work a minimum of 4 hours within a zone, excluding meal breaks.
- ~1.5M hours attributed for one quarter

Pay Codes continued

On-Call Pay

- On-call schedules have a start and stop time.
- For non-exempt employees only, on-call pay stops and regular pay begins when the employee returns to work.
- When on-call and required to travel back to work outside normally scheduled hours, the employee will be paid the greater of the actual time worked or a guaranteed minimum of four (4) hours not to exceed the schedule of hours on-call.
- Call-backs that occur within 45 minutes of the employees scheduled start are not eligible to receive the 4-hour minimum guarantee.
- There is a base rate, but some departments have an exception to pay a higher rate.

Other Pay Programs

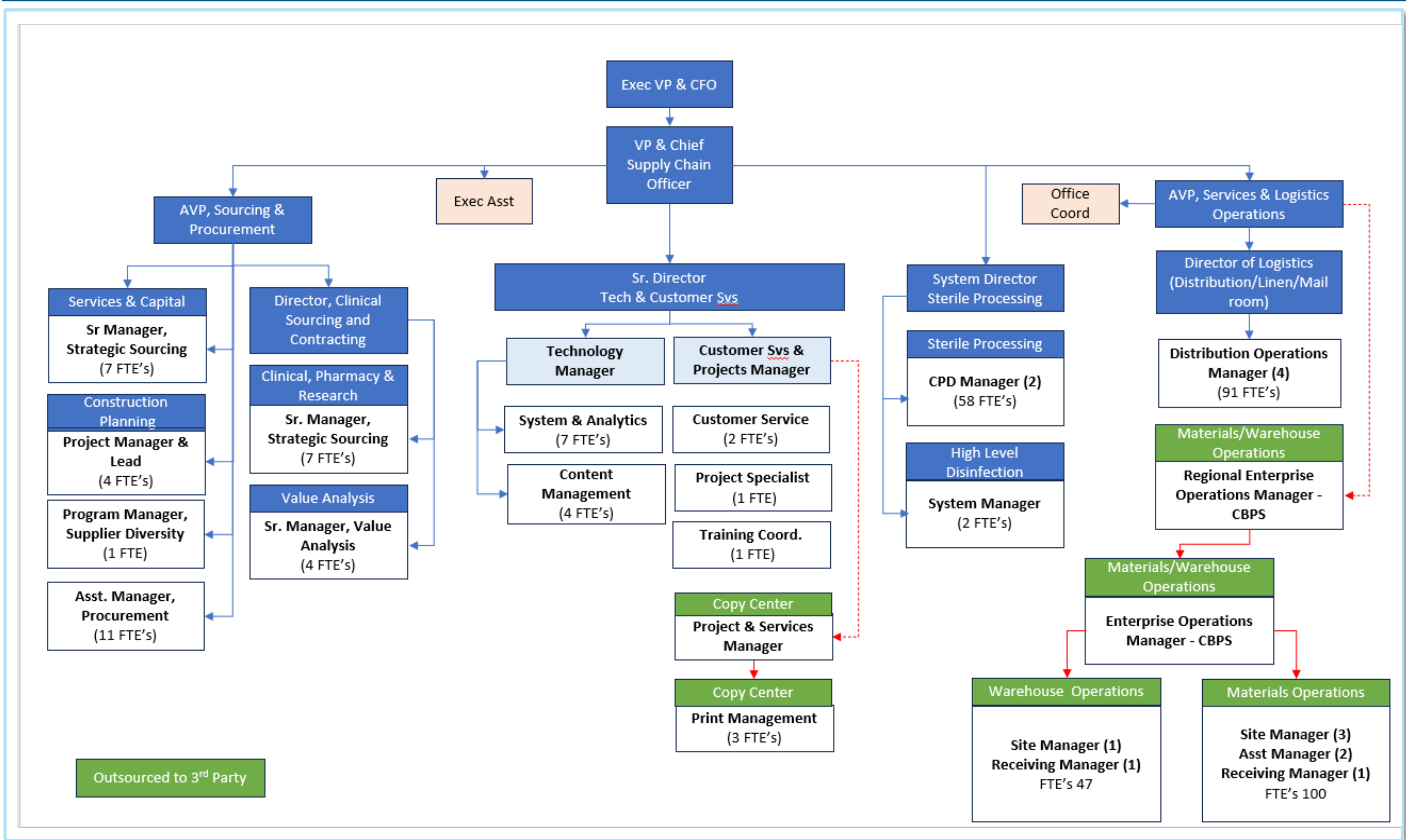
- Several departments have access to a program that allows for payments of bonuses if an exempt or non-exempt person takes on additional shifts. Rates vary depending on the role.
- Limited departments have access to pay non-exempt employees an hourly premium in addition to other pays. This premium will include calculations based on holiday and overtime rates. (~33,700 hours attributed for one quarter).
- Limited departments have access to a weekend incentive program to cover hard to fill shifts. Rates vary by department and role. (~700 hours for one quarter).
- CHOP also offers moonlighting pay and peak incentive pay to certain roles.

Discussion / Questions

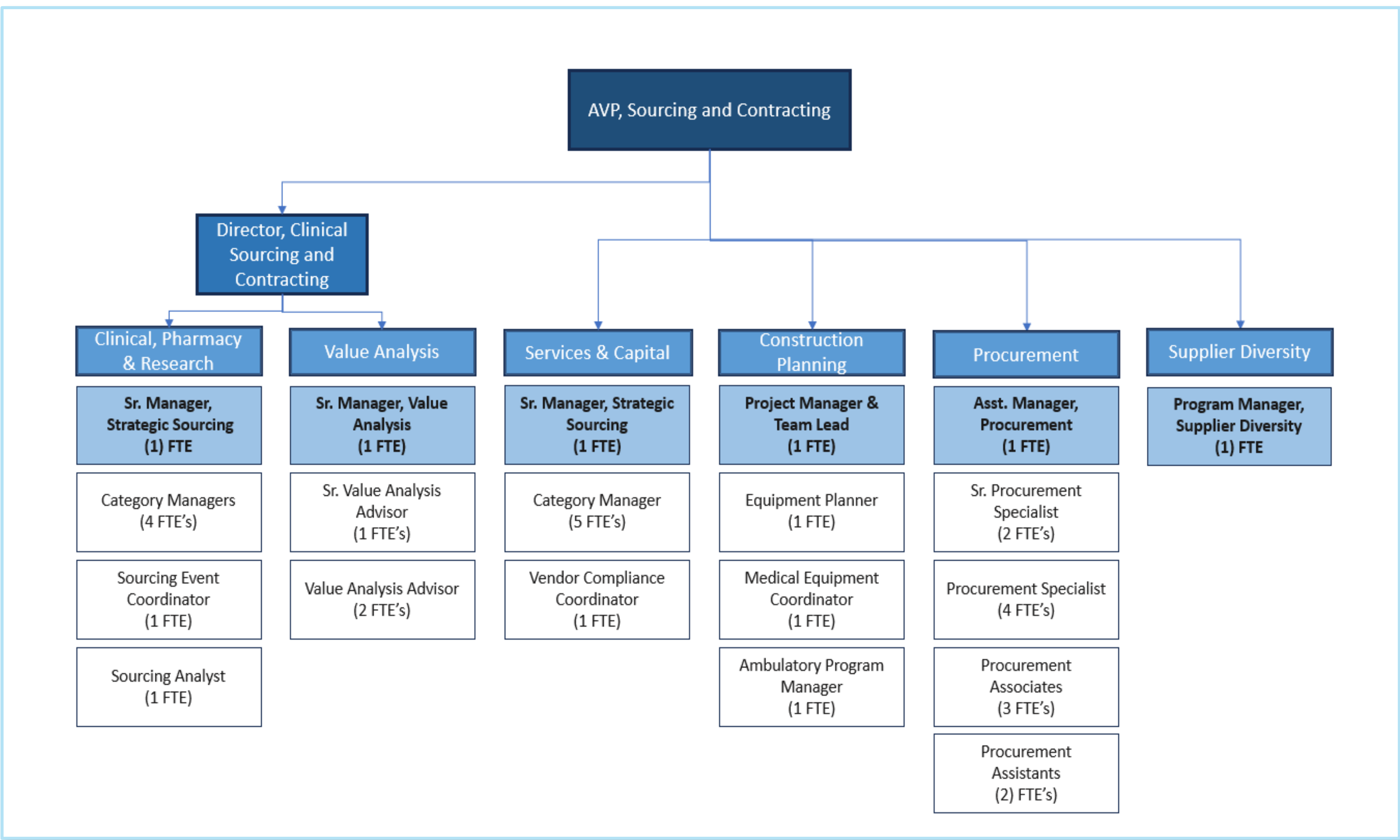
SUPPLY CHAIN CONTRACTING & MARGIN IMPROVEMENT

August 1, 2024

Supply Chain Management



Sourcing and Contracting



SCOPS Data for Procurement/Sourcing

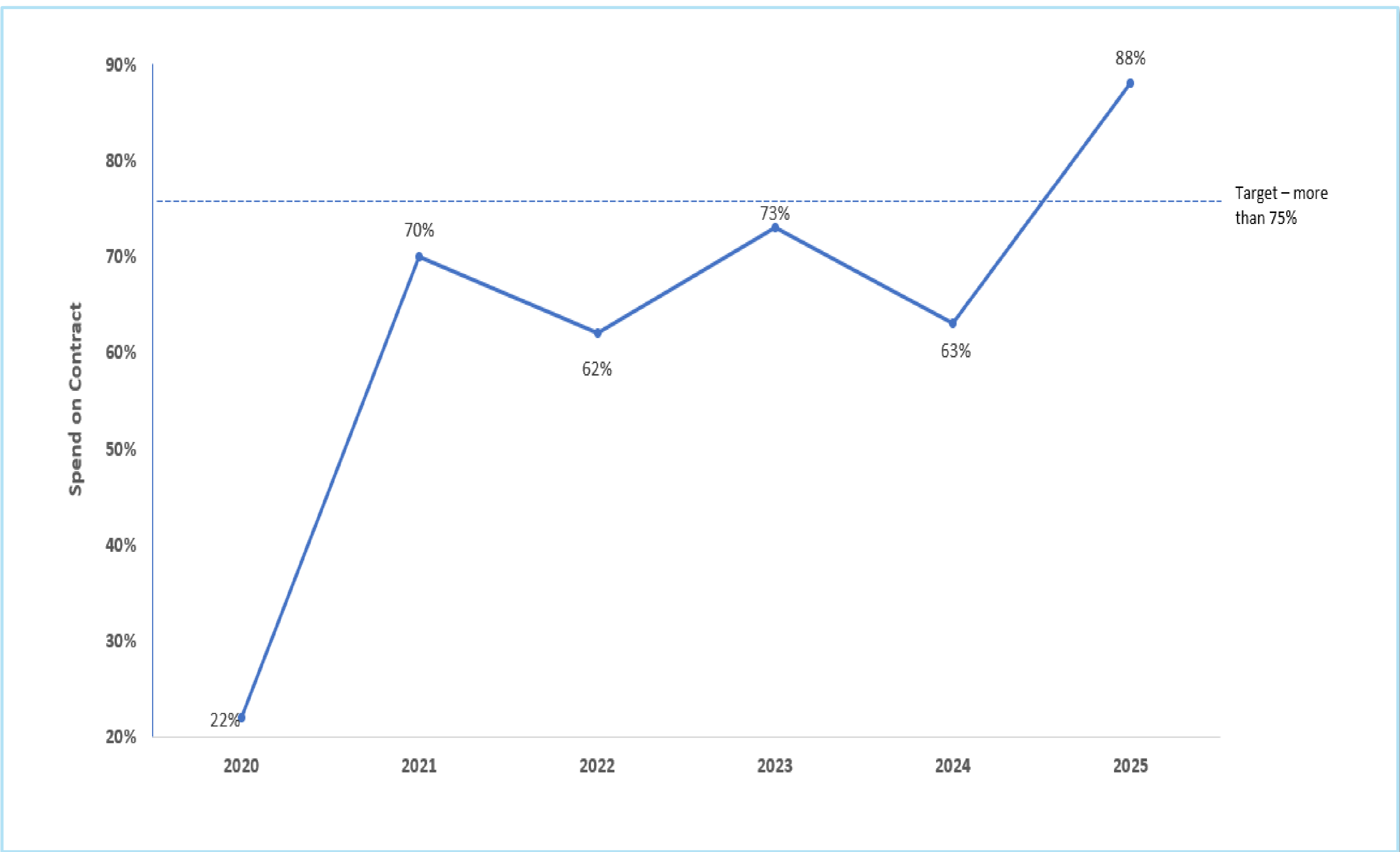
FTE Analysis (all dollars are in 000s)				
	Phila	Hosp A	Hosp B	Hosp C
Procurement	11	19.3	34	13
Sourcing	23	9.3	10	9
Purchasing Analytics		1.0	0.5	1
Total FTEs	34	28.7	44.5	22
Annual PO Dollars	$ 1,078,600	$ 1,032,744	$ 775,918	$ 208,874
Local Contracts	2064	348	840	896
Vizient Contracts	678	594	456	
Total Contracts	2742	942	1296	896
Contracts/FTE	80.6	32.9	29.1	40.7
PO Dollars/FTE	$ 31,724	$ 36,022	$ 17,436	$ 9,494

Spend Under Contract	$ 651,191	$ 185,700		
Percent of Spend Up Contract	83%	18%		

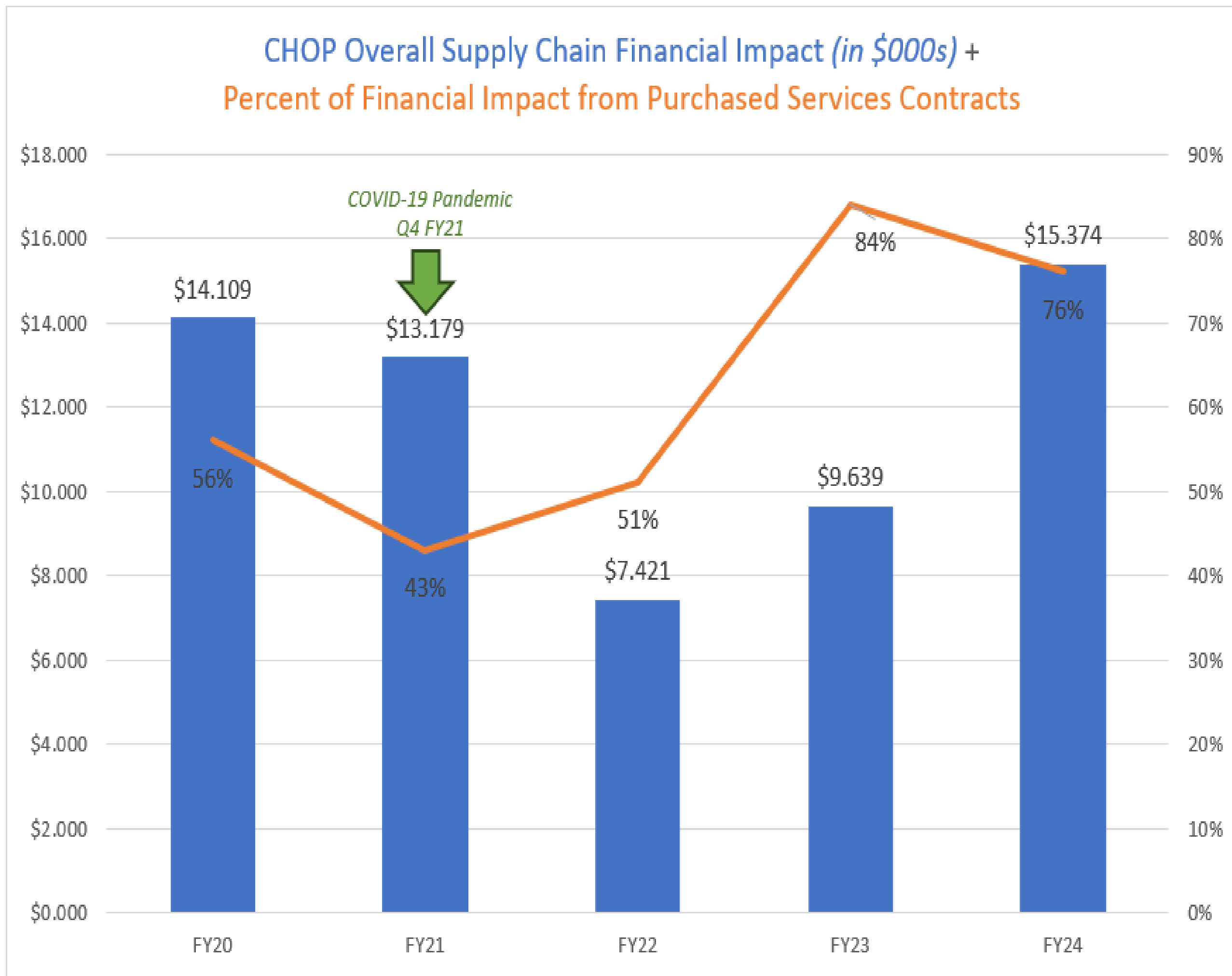
Scope of Service				
Contracts Managed	PHL	Hosp A	Hosp B	Hosp C
Biomedical Engineering	Yes	Yes	Yes	Yes
Blood Procurement	Yes	No	No	No
Capital Purchasing	Yes	Yes	Yes	Yes
Services (EVS)	Yes	Yes	No	Yes
IS/IT	Yes	Yes	No	Yes
Laundry	Yes	Yes	Yes	N/A
Linen	Yes	Yes	Yes	Yes
Mail Room	Yes	Yes	Yes	Yes
Pharmaceuticals	Yes	No	No	No
Print Shop	Yes	Yes	Yes	Yes
Purchased Services	Yes	Yes	Yes	Yes
Research	Yes	Yes	Yes	No
Facilities	Yes			

See Notes section for explanation.

Percent of Spend on Contract Pricing



Supply Chain Financial Stewardship: Purchased Service Focus



- "**No Purchase Order = No Pay"** policy drives PO spend; eProcurement solution allows for PO to contract match prior to PO issuance
- **Strict controls on distribution of employee credit cards** with annual audit on credi t card spend
- **Purchased Services/Non-Clinical savings** have consistently represent the **majority of Supply Chain-driven savings** over the past five years
- **Purchased services contracts centrally managed in Supply Chain** with designate d team in place for 10+ years
- All **Marketing and Consulting agreements** are competitively bid via RFP by Supply Chain to ensure fair market pricing.

Projects in FY25

- RFP issued in May for Purchased Services Assessment; currently in final vendor selection process
  - Planning for work to start in September
  - Objectives:
    - Assess current spend and identify opportunities for expense reduction
    - Assess current work processes for the contracting team and recommend best practices
    - Provide education to department leaders on managing service suppliers
- Finalizing vendor selection process for implementation of Contract Lifecycle Management (CLM) solution
- Evaluating Vizient tools to increase automation for routine tasks