WEBINAR TRANSCRIPT

TIME STUDIES GONE BAD
(AND HOW TO AVOID IT HAPPENING TO YOU)

JULY 11, 2024
HFMA WEBINAR

TIME : STUDY

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PARTICIPANTS

- **KISHAU ROGERS** CEO and Founder, Time Study Inc.
- **MICHAEL POLITO** Owner and Principal, Third Party Reimbursement Solutions LLC
- **DEREK GINOS** Senior Director of Transplant and Surgery, Intermountain Health
- **ASHLEY MEYERS** Client Services Specialist, HFMA

ON-DEMAND REPLAY

Visit the following link to watch the hour-long replay (HFMA membership required): https://learn.hfma.org/courses/time-studies-gone-bad-and-how-to-avoid-it-happening-to-you

NOTE TO READERS

The text has been edited for clarity.

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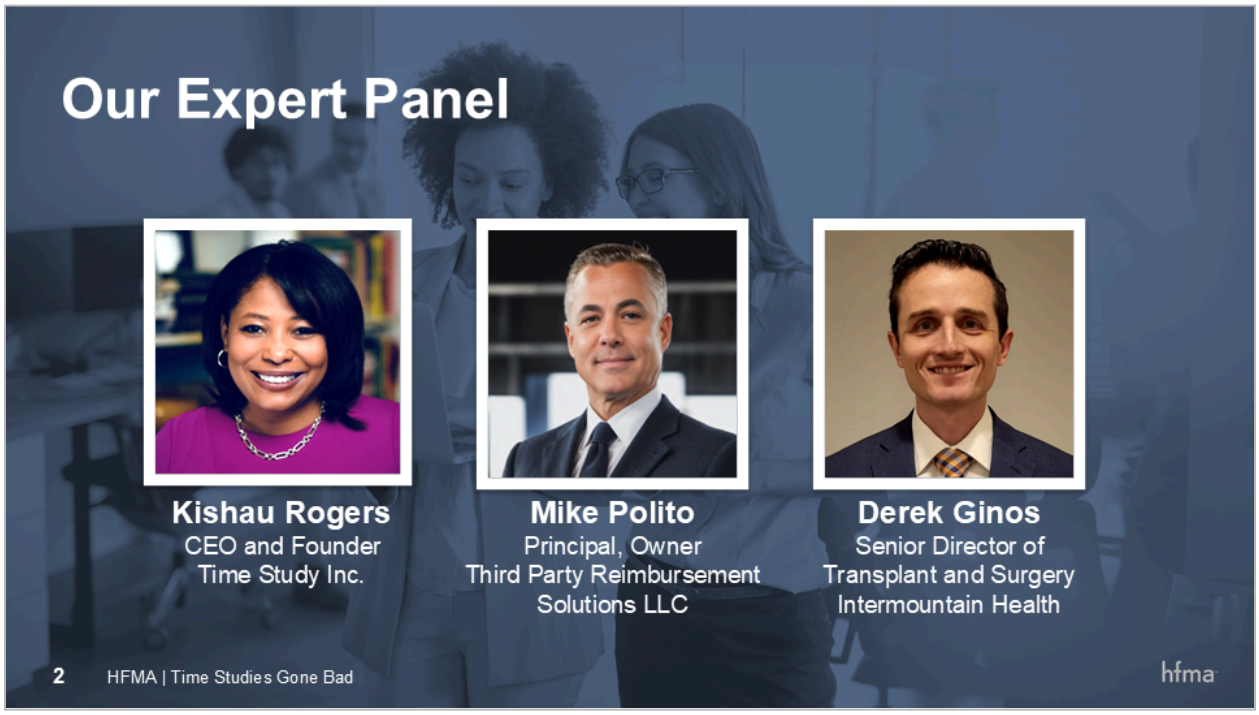


ASHLEY MEYERS: Welcome to today's webinar. This is Ashley Myers, HFMA's Client Services Specialist, and I will be moderating today's session. Now, it is my pleasure to welcome today's speakers.

- **Kishau Rogers** is the founder and CEO of Time Study and the first black woman in Virginia to raise millions in venture capital for her tech startup. With over 25 years of experience in technology and entrepreneurial leadership, her work has been featured in major publications such as the *Wall Street Journal* and *Forbes*. She advises several organizations committed to diversity, entrepreneurship, and STEM.
- **Mike Polito** is the Principal and Owner of Third Party Reimbursement Solutions, LLC, and a principal member of the Reimbursement Alliance Group LLC with over 30 years of experience in health care, focusing on revenue enhancement, operational change, and regulatory issues. Before founding TPR, he directed Medicare and Medicaid Cost Report preparations and analysis and has testified as an expert witness in federal fraud investigations.
- **Derek Ginos** is the Senior Director of Transplant and Surgery at Intermountain Health in Salt Lake City, Utah, and holds a Master's in Health Care Administration from the University of Pittsburgh. With 12 years of experience in the transplant community, he completed his Administrative Fellowship at Mayo Clinic and is a Fellow of the American College of Health Care Executives.

And with that, Kishau, I'll turn the presentation over to you.

KISHAU ROGERS: Thanks, everyone, for joining us today. Our agenda is to provide enlightening and insightful strategies for building a defensible time study program. I want to begin with an introduction to each panelist's experience with time studies. I'll start with my own, then we'll move to Mike and then Derek.

My first orientation to time studies was over 20 years ago. It was a manual system, and it was on paper. Back then, people were still faxing and inter-office mailing time studies for cost reporting. That was the first time I learned about time studies. As a systems person, my job was to figure out how to make the process more efficient.

I'd like you to know who your panelists are. Mike and Derek are our experts for today. So, let's start with Mike. I'd love to know your first experience with time studies, your perspective on time studies, and how that impacts your role.

MIKE POLITO: Thank you, Kishau, I appreciate that.

1993. There you go. That's a long time ago, I know. I was working for the fiscal intermediary at the time, and part of the audit programs of these hospitals focused on cost and cost allocation among physicians, as well as allocating those costs among the various components.

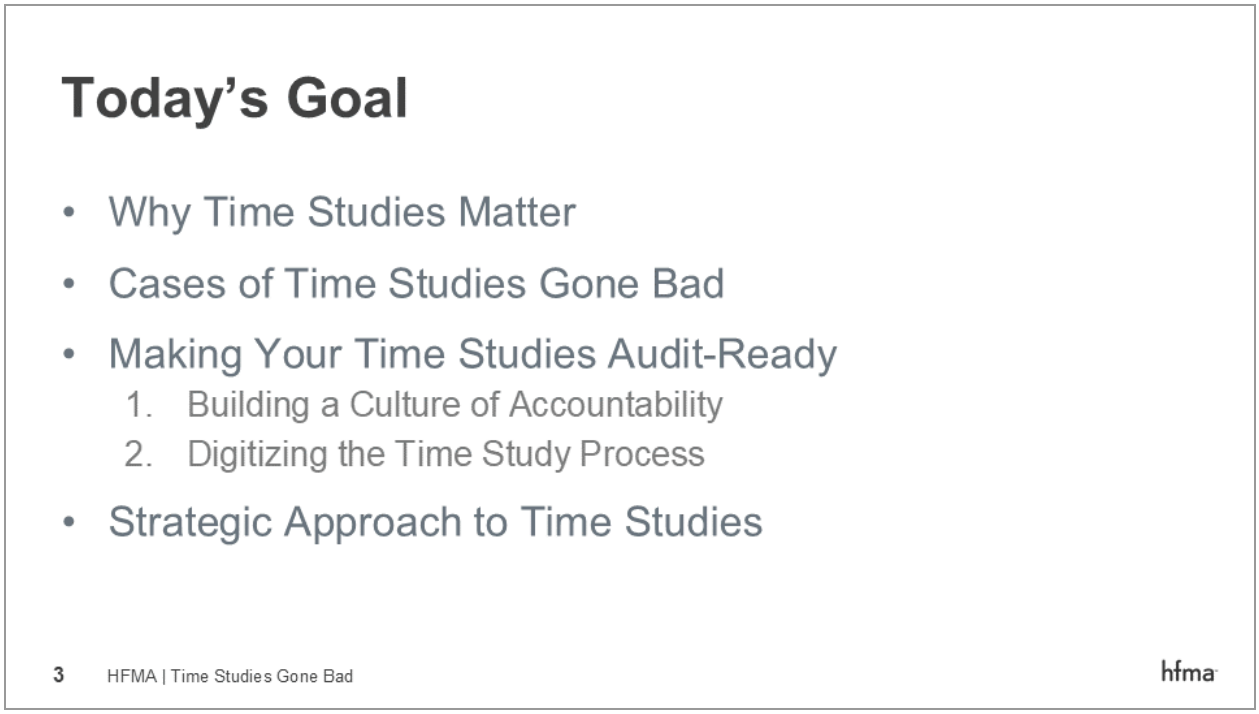
At the time, it was a very manual process. They were all paper, there were manual signatures and manual allocations, and Exhibit II of the CMS 339 Form was exclusively used as a summary. That's what we would audit and then try to tie it back to the completed time studies, which was always a very difficult and time-consuming process as part of the audit. That has evolved for me and my firm into a more automated system, so now we're looking at facilities in terms of time studies and their reasons for lacking them.

The transition from cost-based reimbursement for inpatient and outpatient care was a major change in the audit process. No longer was that cost for auditing allocations or time studies necessary. There was a lull, or a lack of time studies, that continued for a number of years and now has resurfaced over the last couple of years due to [Centers for Medicare and Medicaid, or CMS,] directives. Time studies are at the forefront again, and it will be an excellent presentation for you to listen to. I'm looking forward to it.

KISHAU ROGERS: What about you, Derek?

DEREK GINOS: Unfortunately, I don't go back to 1993 like Mike. I have been involved in several different transplant programs as an operator and as the one trying to convince everyone around them that this is important and needs to be done.

I had the chance to work with homegrown built systems that are electronic and automated, as well as down to paper and email. I have had a lot of experience helping people understand the “why” and working through some of the realities of having busy lives, and it's not always at the top of our minds, even though we may think it's important. Even within our organization, we've evolved over the last few years as we've refined and grown and figured out a few things. I am so glad to be a part of this panel.



KISHAU ROGERS: I'll provide a brief overview of today's agenda. We'll start with an orientation on why time studies matter and some rules and requirements around time studies.

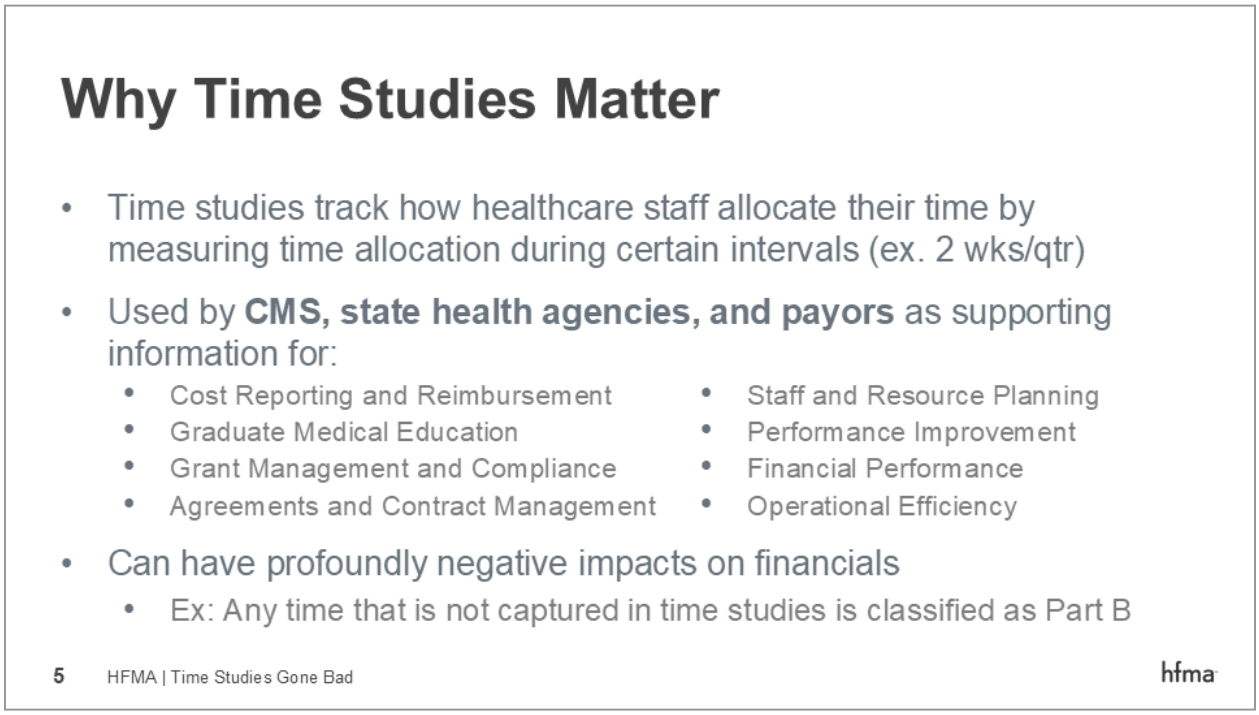
Then we'll share some stories – my favorite part! – of some experiences people have had about what can go wrong with a time study program.

Then we'll go into solutions because we don't want to leave you with war stories.

We'll share some solutions and things that work.

We'll end our session with you looking ahead to the future.

As a reminder, you will have polling questions throughout the session. There are four questions, and you'll have one minute to answer those questions.



KISHAU ROGERS: We'll go into why time studies matter. This is an important area, and this is a question that we get a lot at Time Study. Organizations generally contact us because some outside entity requires them to complete time studies, generally for cost reporting.

You provided an overview earlier, but what is your experience with the requirement, particularly from CMS and from the cost reporting standpoint? I'd love to get your expertise on impending or expected changes in those requirements. Your point about how things have evolved back to time studies is interesting.

MIKE POLITO: Now is probably a great time to ask, "What are the rules?" "What does CMS require in terms of time studies?" and the regulations in the Provider Reimbursement Manual.

It has yet to evolve over time. The problem is that the interpretation of that has been modified over time by the audits, which means that the hospitals continue to create time studies that may be less than the minimum requirements.

For example, those minimum requirements are to have an acceptable time study for a physician. The minimum accepted study time would be at least one week every month. So one week per month over 12 months means we need 12 time studies at a minimum. From there, each week must be a full work week. For example, we just had the July Fourth holiday. If there's a day off or a national holiday that you're not working, you cannot use that week in that time study for that month.

The weeks also must be equally dispersed. What does that mean? Well, we've got four weeks in a month. We have 12 months. So three of the 12 time studies have to be done for the first week., three have to be done in the second week of a month, three

have to be done in the third week, and three have to be done in the fourth. Three times four is 12, so that's 12 time studies.

Within those weekly time studies, you cannot have two months that use the same week in a row. For example, if you're using the first week in April, you cannot use that same first week in May. You would have to use a different week, an alternate week, and at the end of the year, there should be 12 time studies at a minimum, with each month being distributed proportionally to three time studies per week in each month.

Now, the time studies also have to be contemporaneous with the cost reporting for the fiscal year. This is a big issue in the industry when we're talking cost reports, wage index, and raw reimbursement. That means that those time studies are unique to the cost report period you're filing. So each time study must be made, handled, and compiled accurately to pass an annual audit. So, you cannot use a 2023 time study and make it applicable for 2024 or 2025. The time study in the cost report year has to be from the same period as your cost report.

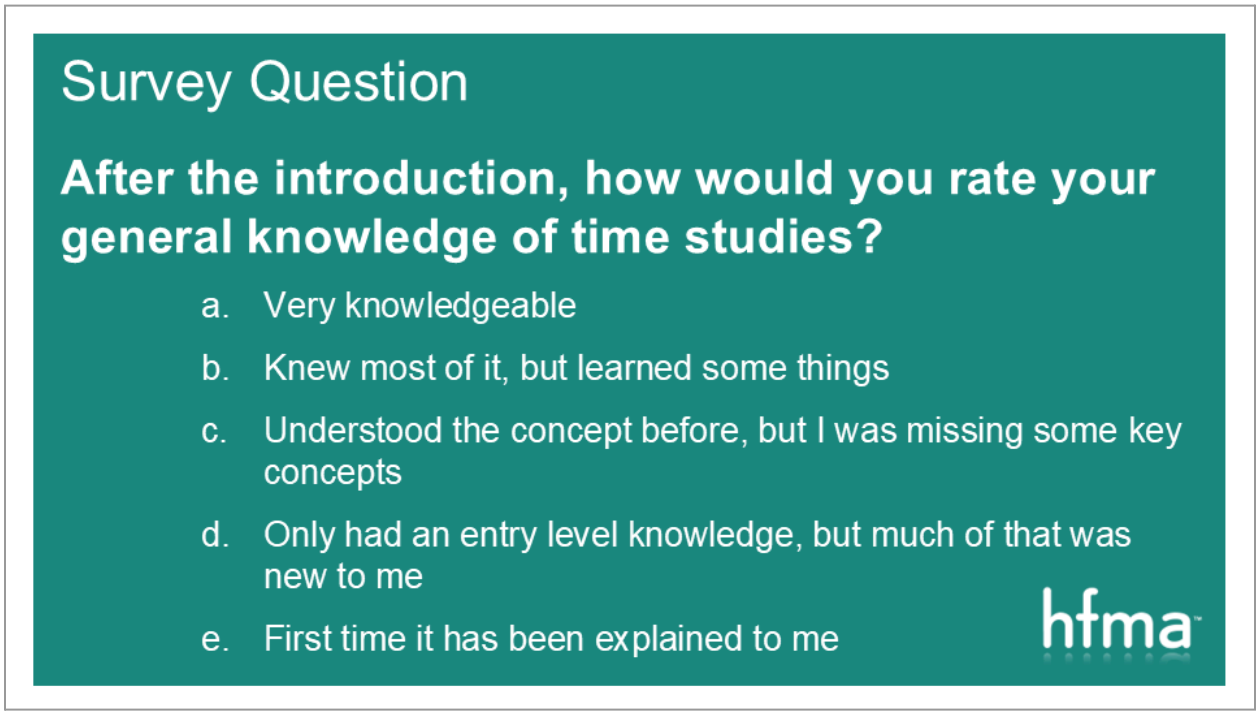
So that's an important factor to consider because that's what hospitals have been doing in my experience. They say, “Hey, we did a great job two months ago or two years ago, and it was audited in the past, so let's just use that in future years.” With the transition over the last couple of years, we can get into that later and as part of our case studies. With the relaxed interpretation of time studies in the reimbursement world over time, CMS said a few years ago, “Hey, what are we doing?” They approached the [Medicare Administrative Contractors,] or MACs, and said, we want you to go back to our minimum standards here and start auditing hospitals.

So you can imagine the shockwave through the providers that were not compliant with that because the auditors or the MACs in the past were accepting something “less than.” Now we're back in full swing with periodic time studies under Medicare regulations and being interpreted by the auditors.

KISHAU ROGERS: Quick question, either for you or for Derek. How do the MACs influence variability in requirements, or do they? Who determines one week per month versus two weeks per quarter for an organization, or is it related to the type of hospital that is collecting the time study? We've seen some variability in the cadence for time studies, including the use of optional weeks. Is that MAC-influenced or CMS-influenced, or maybe hospital leadership?

MIKE POLITO: I can respond to that. I believe it's hospital-specific. The MACs go down their audit program looking for time studies. They're trying to check their box, “Yes. I could see a time study,” and “Yes. It types to the detail.”

They're not interested in your selection of those. Suppose you're going to do sequential, first week-second week-third week, first week-second week-third week. They're not looking at it from that perspective. What they're really looking at is the volume. They want to see the minimums of 12 and 3 per each week within that month, within the month. So that's what they're looking for.



KISHAU ROGERS: We have our first polling question. After this introduction, everyone will know what a time study is, its impact, and its use. How would you rate your general knowledge of time studies, at the beginning of this session?

From "Very knowledgeable" to "I knew most of this, but I've heard some new things." Maybe you understood the concept but were missing some key concepts and entry-level knowledge, but much of that was new. Or is this the first time you've heard of any of this? Again, you have 60 seconds to input your answer, and thankfully, we get to see everyone's answers. That helps us as a panel to know how to structure our responses.

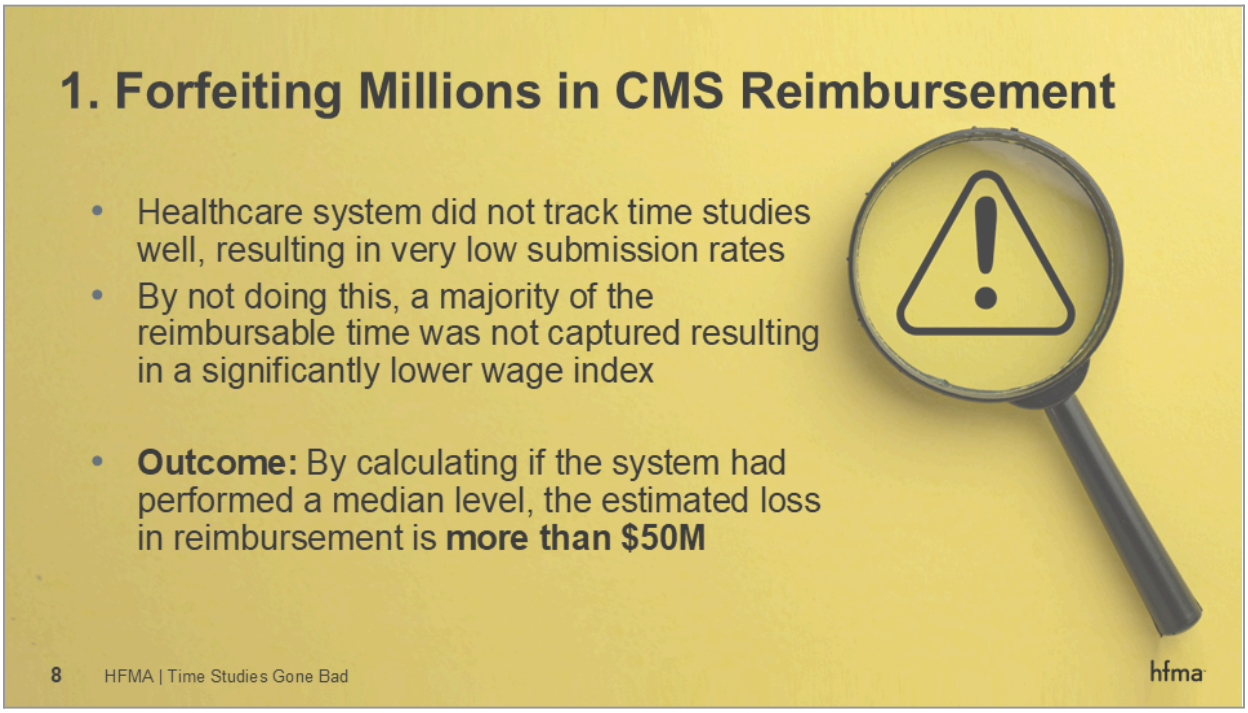
So, Derek, we talked earlier about our experiences with time studies. You've been in this space for a long time. Do you feel that you still don't know some things about time studies and are still learning something new or that it keeps changing? Or is it just a static process that's been the same over the years?

DEREK GINOS: Oh, no. In fact, I jotted down a couple of notes from listening to Mike here.

I think that anyone who's not learning isn't paying attention. So, definitely, there's always room to add and evolve. As you were asking about variation between one program and the next, that comes because as we learn more and understand our needs, then, of course, we want to make changes.

KISHAU ROGERS: So we have our results. I love quick results! It looks for 8% of you this is your first time, and about 24% are "very knowledgeable." So that's great.

KISHAU ROGERS: Let's move to our next section. So for our next section, we're going to talk about some stories. Some of them may be hypothetical. We may change some of the information to protect the innocent.



KISHAU ROGERS: Let's start with Mike. We started talking about reimbursement. Many of our clients collect time studies because they are required for cost reporting. Could you share some stories from your work about how the organization discovered its losses?

MIKE POLITO: Absolutely. Before I move on to that, one important factor when we're talking about cost reports and auditing is their various components. There are MACs across the country, and within those MACs, there are audit groups. When CMS comes down with an initiative, like, “Hey, we want you to look at time studies a little deeper.” The interpretation of that could get lost, not only at an individual MAC and among their own teams but across the country as well.

So you're going to see that time studies, and their acceptance could be different over time. When I'm saying the minimum requirements, that is when you want the gold seal; your auditor may accept something less. But if you want the gold seal, they are the minimum requirements, and that's what we would recommend so that you're always okay.

I do have a case study. For obvious reasons, I will call this hospital “Unfortunate Health System.” It's a six-hospital system, and this would be a great example of what we're talking about.

It has to do with the Medicare wage index. For those who don't know what the Medicare wage index is or how it works, this is when the federal government provides standardized rates for everybody across the country. They get adjusted based on the cost of labor in your specific market. The average hourly wage of your specific market and the hospitals in that area gets combined and compared against the rest of the country.

If you have an adjustment factor above 1.0, then your labor cost in your specific area is higher. So, the standardized rate that everybody starts with will be adjusted upward. So the higher this wage index factor, which is based on the average hourly wage of hospitals in that metro area, the greater your wage index. So we're always trying to ensure that hospitals' average hourly wage is optimized under the regulations.

So for this six-hospital system, their salary within their metropolitan area – for cost report purposes, it's called the "Core Based Statistical Area" (CBSA), which is a metropolitan area in most people's sense – is 75% of the total salary for the CBSA.

So if all of the salary in there gets adjusted for actions or items that come out of an audit related to this health system, there's 75% of that will be up or down depending on where it is. We call that a very, very heavily weighted health system or hospital within the CBSA, so every penny that average hourly wage moves makes a difference, and that's why we're talking about it right now.

> That's when the shock wave went through the hospital system. They said, 'Wait a second. We haven't met this minimum requirement for time studies in a long time.' ~ *Mike Polito*

This health system had typically used historical time studies. So they had older time studies that they kept rolling forward. The MAC accepted them, but that is not an excuse, nor does it allow you to keep doing time studies incorrectly going forward. When I say the MAC accepted them, then the auditors accepted them. There are so many line items within the wage index and within the cost report that they cannot possibly audit everyone.

They were not looking at physicians. They would essentially look at variance analysis between line items, and if you saw $100 million of "physician" in one year, the next year was $102 million, and the hours and the average were similar, it was a pass. They weren't auditing it because the allocations were the same, so the allocations came out the same every year, so there was no red flag.

How it usually works within Medicare is those audit adjustments or proposed audit packages from the local MACs that audit are sent to CMS. CMS does their quality review of what the MACs are doing. During that quality review a few years back, CMS said, "Wait a second. I see millions and millions of dollars of physician compensation being recorded here. I want to see the time studies. What are you doing to validate those?"

So the MACs were saying, "We didn't look at it this year," or "They had a time study from a couple of years ago." It doesn't excuse the fact that each year is unique, so it's not a defense to say that it was allowed in the prior year. It's not part of the regulation.

As a direct result of that, CMS said, "Alright, MACs, this audit, we want you to look at physician compensation time studies. I want you to pull everything." That's when

the shock wave went through the hospital system. They said, “Wait a second. We haven't met this minimum requirement for time studies in a long time. We didn't have to.” It's hard to get physicians on board to make that happen. There was no cost reimbursement as it used to be for your payments, but there is a lot of reimbursement at stake here.

Just one area, such as when Derek works with organ acquisition, which is a time study-based wage index, uncompensated care, and cost-to-charge ratio are other factors that these costs mean something.

After the reviews by CMS, that's where the initiative came in. Then that's where all hell broke loose, I guess you could say.

During those audits, the hospitals thought that they were free because they had passed the MAC audit. CMS came back to the MAC and said, “I want you to re-audit these physicians’ time right now.” When they did that, in this example here, they couldn't produce time studies that were applicable to the cost report period as one of the minimum requirements.

When we're thinking about the average hourly wage and wage index, physicians are compensated pretty well; it's $275/hour totaling $97,000,000 in physician compensation. The average hourly wage of the hospital overall is probably between $40-60/hour, so adding in nearly $100 million at $275/hour has a huge impact that increases that average hourly wage for the individual hospital, as well as for their complete metropolitan area (CBSA).

So zero – absolutely zero – was allowed. They had zero of the $97 million includable in their cost report for wage index, and

> So zero – absolutely zero – was allowed. They had zero of the $97 million includable in their cost report for wage index.... . ~ *Mike Polito*

their cost report for the cost-to-charge ratio, on one of the worksheets it's called “Physician Compensation” on Worksheet A-8-2. They zeroed it all out. The default is simple: No time studies means it is all categorized as Physician Part B.

There are three buckets:

- Physician Part A – I call that the good stuff. That's the allowable stuff, not hands-on patient care, including medical directors or a physician working on behalf of a hospital on an administrative level. They are allowable costs, and they are substantial.
- Physician Part B is hands-on patient care.
- Teaching Physicians.

So allocations among those categories are meaningful.

When in doubt, the worst scenario is that they make it all Physician Part B, hands-on patient care billing on a 1,500, which gets removed at 100%. So removing that 100% obviously decreases the hospital's average hourly wage. The hospital's average hourly wage goes down. The collective – remember, they’re 75% of the whole CBSA in terms of their weight and salaries – so

now the CBSA goes down, and the CBSA now is compared to the rest of the country, and their wage index value for that specific year tanks.

It's obviously millions and millions and millions of dollars of reduced reimbursement because of the lack of effective time studies that were auditable. Remember, for those who may not know, the wage index applies to your [inpatient prospective payment system, or] IPPS payments. A labor component gets adjusted for this, as well as for your outpatient [prospective payment system], or OPPS. So, there is a substantial reduction if it's inpatient and outpatient.

It could be anywhere between $30 million, $40 million, or $50 million of reduced reimbursement just by tweaking your wage index value by 0.02%. It's very, very volatile.

So that was the situation that happened there. Obviously, the reimbursement team's message to their CFO and board was not a good one. It was not a comfortable message to have to bring. They had to change operationally in what they were doing and how they were thinking. I'm happy to report that they have started to do things a little bit differently and are taking it seriously when it comes to their time studies.

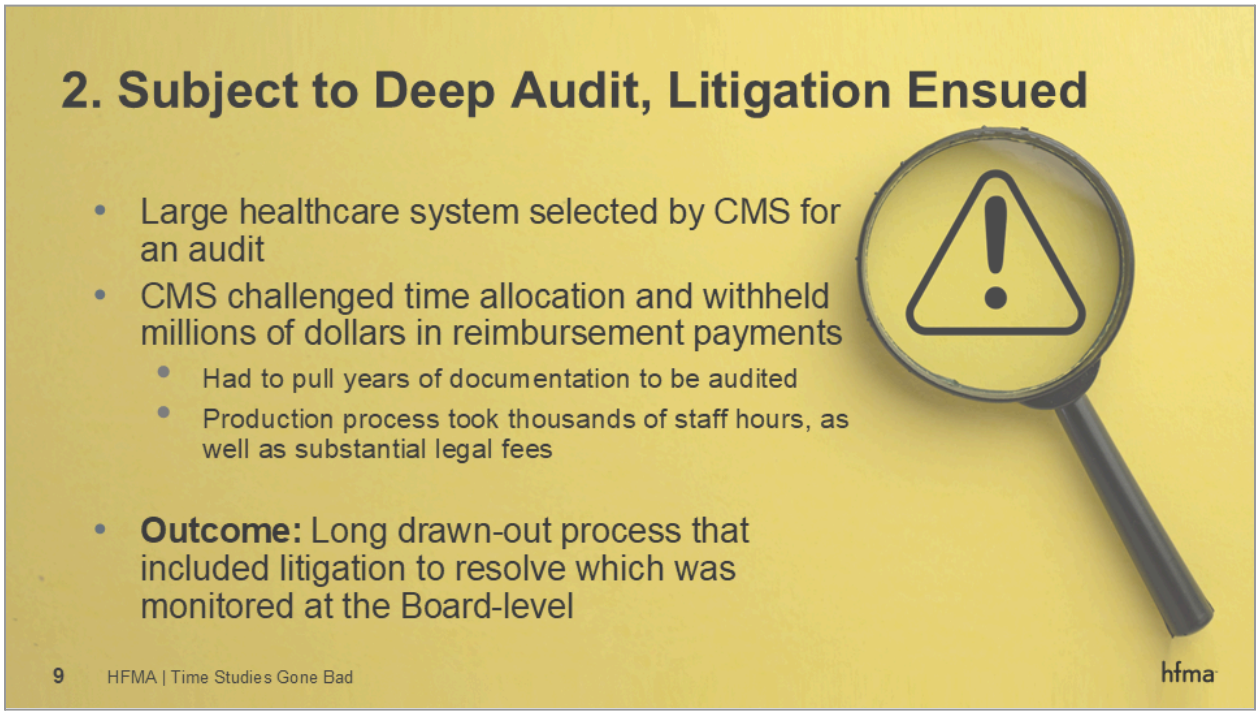
KISHAU ROGERS: So that is a great war story! I don't know how we come back from a $100 million loss.

DEREK GINOS: As I'm listening to Mike tell that story, one of the challenges that I know I've experienced, and I imagine other listeners have here as well, is that often it's not that you're entirely missing the boat. Instead, there may be opportunities that you need to appreciate fully. I've noticed that – especially coming specifically from a transplant perspective where there's a larger picture of what the Hospital Cost Report entails. Transplant is an important part, but it's not the only part.

When you go to meet with your financial analyst or whoever's preparing this information, they may have been doing this for decades. Sometimes there's a feeling that we've figured this out. To Mike's point, it has passed audits in the past. So why are you challenging me? Or why are you, who maybe don't fully understand this as well as I do, questioning our process?

That's part of what this is about: understanding and knowing what questions to ask, being open to looking at it differently than we have in the past, and looking for areas where we could optimize a little bit. That's one thing we have done, and where you asked about how we're learning and growing as we go, it's continuing to challenge and look at not just where we've been, but where we're heading.

KISHAU ROGERS: That's a great point.



KISHAU ROGERS: I want to move into audits because we've hit on it a few times. Again, many of our clients are collecting the time studies because they are required and want to maximize reimbursement as well. We've also seen an increased need to be more prepared for audits. I'd love to hear from both of you, and I'll start with you, Derek, about your experience of either participating in an audit or being blindsided by or unprepared for an audit.

DEREK GINOS: I am lucky that I have not been directly involved in audits in the organizations where I've worked. However, I have been requested to supply information for those audits from those who are being audited.

To your point, Kishau, it's amazing how you think you're doing the right thing until someone asks you to show your work. That's where it becomes a challenge. You know your intentions are good. You know what you're trying to gather. Then, when someone asks for evidence to prove something, why do you provide the information you did? It's hard.

I recall one case where we had to throw out data because it was incomplete. Because it was incomplete, we weren't able to include it. That's hard because that's actual information and time that should be counted, but we were not able to.

> [I]t's amazing how you think you're doing the right thing until someone asks you to show your work. ~ *Derek Ginos*

So when it comes to preparation, the other thing to remember, and I've noticed this myself, is that it is years in the making. Right? You're looking backward in time. The time to prepare for

an audit was two years ago, for what they want to look at now. That was the other realization: correcting it takes time because you are trying to address something in the past.

KISHAU ROGERS: That's a great point. For you, Mike, how bad can an audit get? Is it a quick request for information, or can it take a long time? Are there lawyers involved, and at what point does litigation come into play?

MIKE POLITO: So it goes back to the MAC, and it goes back to the audit team, and it goes back to the person within that audit team.

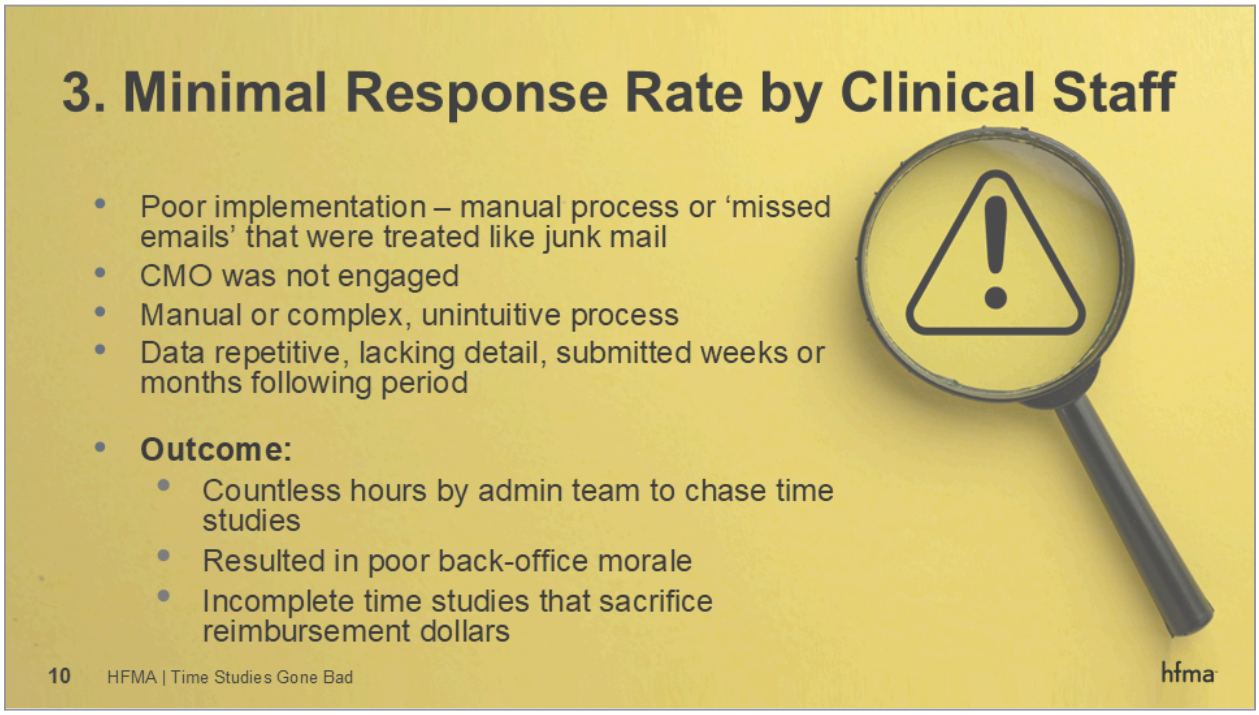
If you have a manager looking at it who's a little bit more savvy, they're going to dig deeper. If you have a first-year or a second-year, a lot of those are coming on-site. That's why a big portion of time studies is having them in such a way to know who's going to audit them. It is going to be less experienced in the group. It will mostly be that first-, second- or third-year associate doing all the grunt work.

If the time studies are in such a format that they can be easily read and understood so that the checkbox in the audit program can be made, it's always better. So the simpler the time study output can be, the better. Then let them pick a sample, and then you could dig deeper through the layers as you go through.

But to answer your question directly, I've had weeks of audit on time studies. I've had days. The easy part for an auditor is if you say you don't have time studies for the period, they just make it Part B, and they're happy to do it because that's it. They're done. It's over.

Now, if you do have some and you're trying to salvage some of the good, the allowable cost, and the Physician Part A costs, that's where it could take a little bit longer to get into the weeds.

Each situation is unique. Each hospital is unique. Each audit team is unique. So there's not a “one size fits all” when it comes to the audits around time studies. Unfortunately, there's a lot of gray and miscommunication between MACs and among MAC teams about what we are accepting or not.



KISHAU ROGERS: So I want to transition because we've hit on participation rates, more than once and low participation rates. Derek, I'd like you to paint a picture because you have so much experience with time studies across many organizations. Can you paint a picture of an organization with a meager participation rate? What does that look like from the physician's point of view, and, In your opinion, why is that the case?

DEREK GINOS: Again, I'll be coming from a transplant perspective because that's what I've worked for, but I'll describe an organization that I came into for a period of time.

There are two parts to it: there's the administrator participation, and then there's the actual people completing the surveys. From an administrative perspective, because we weren't using an automated system, it relied on an individual to remember to notify everyone that it was time for a survey and to collect information. So we were struggling with keeping track of:

- When was the last time we sent out the survey?
- Was it the first week? Was it the second week? Was it the third week?
- Remember to remind people in advance and follow up with them.

So even on the administrative side, it was already starting to fall apart.

Then once it came to the staff themselves, it was a manual process. Because it's manual, people fill out the best they can. But they only sometimes remember, or what they turn in may need to be completed.

I remember coming in and seeing this group and being handed a stack of papers

and told, “Well, this is the surveys for the last couple of months. I haven't had time to enter them yet, but we try to enter them as much as possible.” There's no way I'm going to do that. That's not going to work. We need to at least have some level of automation to this.

That's what we did. We took the survey, simplified it a little bit, standardized it using an Excel spreadsheet, and then used a REDCap survey to give us a way to reliably send that out. That's how we were able to evolve it.

I think that from a staff perspective, people are willing to participate, but at the same time, they have a lot that they're being asked to do – especially our clinical staff. When they're not participating, it's generally because we've created too much friction, and we need to look at where we can remove that friction for them.

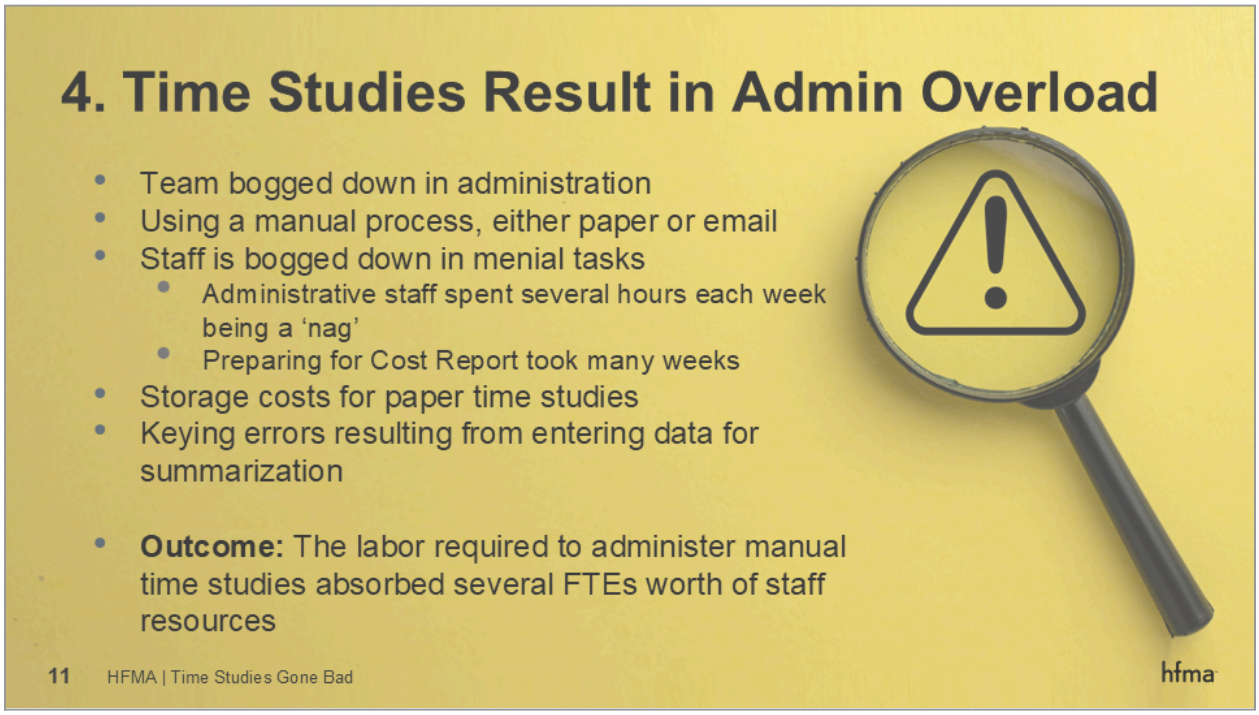
KISHAU ROGERS: I'm curious. Is there a baseline? How low can a participation rate get and still be acceptable for cost reporting? Like 10%, 5%, or does it not matter?

MIKE POLITO: Well, the listing must be by physician. So if a physician doesn't have a time study, it would be removed or reclassed to Part B fully. So there has to be a “by physician” listing. You don't just say, “Here's my total remuneration for physicians. Here's my total remuneration, not by department.” So, each of those physicians will have their summary allocation, which the MAC will audit. The MAC will pick a sample, so you don't know. You're not going to audit everyone, but you don't know which ones they're going to go with. So why not make them all correct?

DEREK GINOS: Mike, I'm curious about this question. So if I complete 11 out of 12 surveys, is that a problem?

MIKE POLITO: If one physician has 11 and the other has 12, that physician cost for the one with 11 would be removed under the minimum requirements. Then, it goes back to whether you have a friendly MAC. Do you have a MAC that has some compassion and empathy and will accept something less because they can? They can accept something less, and we see that all the time.

> When [clinical staff are] not participating, it's generally because we've created too much friction, and we need to look at where we can remove that friction for them. ~ *Derek Ginos*



KISHAU ROGERS: So you mentioned, Derek, the administrative costs, as well, on the participation rate. In your experience, do administrative teams have any control over some factors that lead to low participation rates, such as a time form with 30 activities or something that's causing friction with physicians?

DEREK GINOS: Yes, absolutely! It starts with education. If the teams don't understand why they're completing it and why this is important, then you're going to struggle with participation across the board, no matter what.

At my organization, the way that we do this is that anytime a new person starts, as part of their orientation, we go through a variety of expectations, and one of them is time study participation. We explain what it is, why we do it, and what the impact is. Then the hope is that it will stick with them.

We also talk about what you are gathering in the survey. I remember one organization that I worked with, their survey had over 30 individual line items. As a participant completing that survey, I'm trying to think about my day, and I'm trying to divide it into all these different activities. That becomes obnoxious if I can just be direct. Right?

Then, people must either fill it out completely, accurately, or at all. Really being disciplined to challenge yourself and say, "What is it that we really need to satisfy the requirements of CMS?" If we ask for additional information for internal purposes, that needs to be thought through carefully, and we need to be sure that that's the right way. Is there another source that you can use that doesn't require someone to manually review that with you?

Our organization keeps it very simple and only asks for the bare minimum. People are more willing and able to fill out the surveys by doing that.

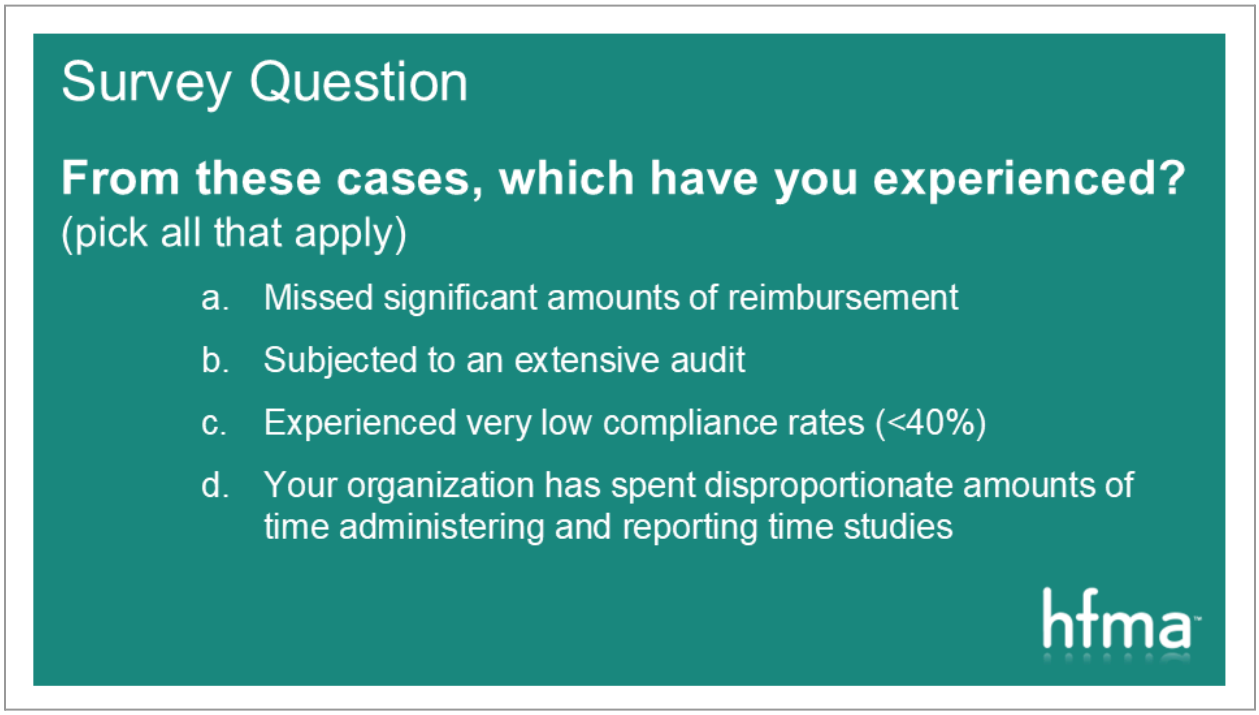
KISHAU ROGERS: Both of you can answer this. In 2024, so let's forget that we've been looking at this for 20 years or more, or since 1993, with you, Mike.

What is the most administratively intensive time study system that you've seen? Are we still seeing people on paper or spreadsheets? Is that a part of the cost leakage?

MIKE POLITO: I can say that, yes, there have been systems – both large and small – that have been transitioned to a more automated method, but they're still using paper. They're still using someone logging paper time studies into an Excel file, or I am using that as supporting documentation.

When you're touching it manually like that, there's a lot of room for errors, keying issues, and things like that. It is still prevalent out there, and we see it. I know that because we still have audit adjustments being proposed around these physicians, precisely because of the lack of effective time studies when we're doing our audits, and we're in the field right now,

Education is a big part of what we do, and what needs to be done at each hospital is just reminding people what the requirements are. Show me what you have. What do we need to do? Then, we'll create an actionable item to ensure they're capturing what they can to get as much reimbursement as possible.



KISHAU ROGERS: From what you've heard, could you check all that apply? What have you experienced in your work with time studies in your organization? The revenue leakage or reimbursement loss, extensive audits, very low participation rates, or administrative overhead managing and validating time studies.

I'm curious about the activities while they're filling out the poll. We mentioned a few cases, and we've seen cases where the time study has 30 activities, or is extensive, so much information is requested.

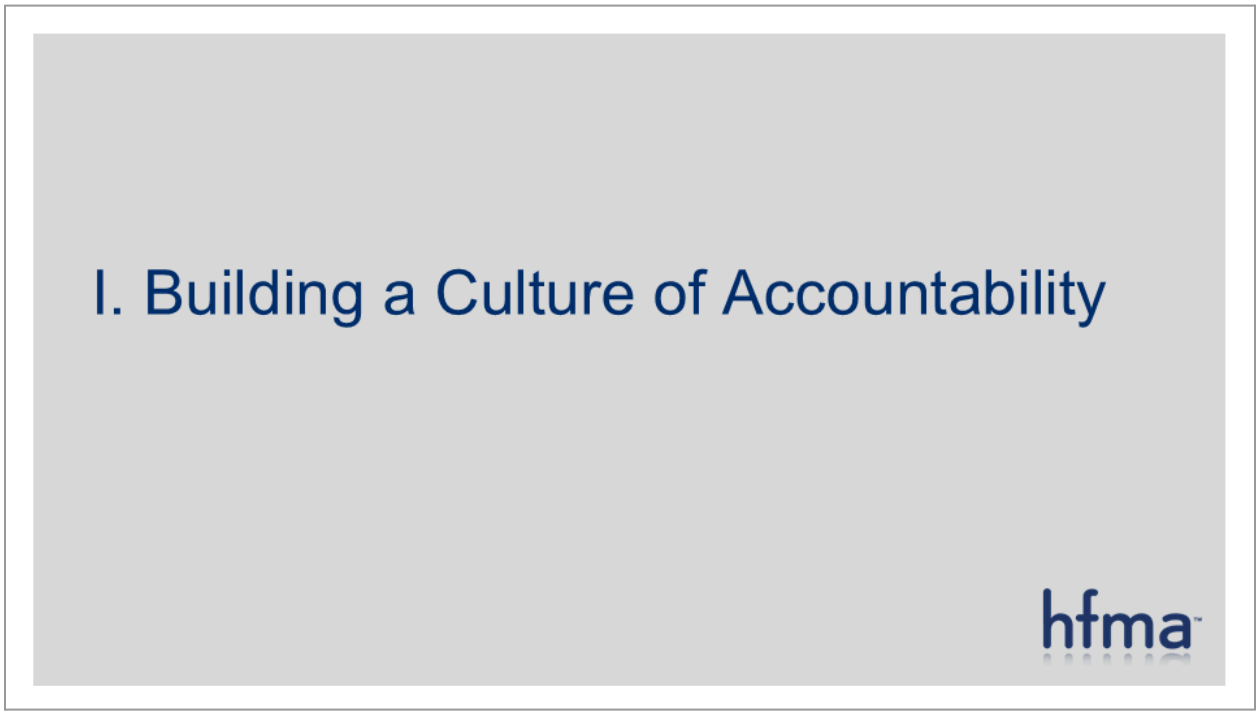
What do you think is triggering, either the MACs or the leadership, and having that many activities on the time study? Is that a cost reporting requirement, or is that for some other reason that's happening?

MIKE POLITO: No. From a cost report requirement, there's a CMS Form 339 Exhibit 2, which summarizes those three categories. So you can have all the details you want, but you will have to map each one of those categories to Physician Part A, Physician Part B, or Teaching.

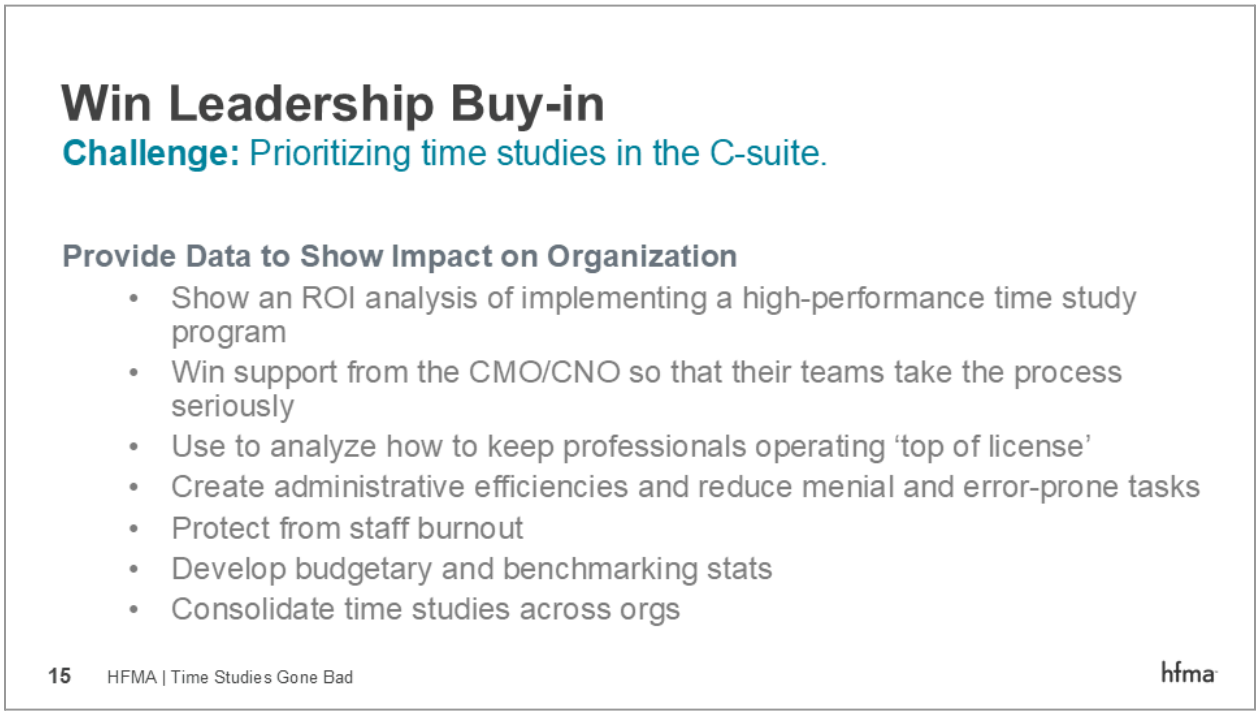
So that is what they want to see, and those allocations, you take the total cost for the physician and then just multiply it by each one of those allocations in those categories. That's the cost and where you split it or remove it from the cost report.

DEREK GINOS: I think it comes from operational. It's so tempting. You're already gathering the data, so let's just ask one more thing. The next thing you know, you've got a whole variety. In a perfect world, that's great. It does give you more information to act on as a leader, but it does come at a cost.

KISHAU ROGERS: So almost 60% of our listeners, have spent a lot of time managing time studies. That's the leading experience, pretty much all of them. Second place is low participation rates.



KISHAU ROGERS: Next, let's move to our solutions. We're going to talk about creating a culture of accountability, in terms of building a defensible time study program. I'll highlight some best practices, and then I'll ask our panel to indicate their experience, either their operations for collecting the studies or the impact from the financial end.



KISHAU ROGERS: Starting with leadership buy-in. We've noticed that when leaders understand the ROI and the impact of time studies, it leads to a successful program. I'm curious about you, Derek. In your experience, what strategies have been used to ensure leaders have bought into this process?

DEREK GINOS: As you said, it starts with education. What I've found helpful is starting by working with the people closest to it.

When I started at Intermountain Health, I first met with the finance team that was putting together the cost report each year. I just asked them to help educate me on what they're doing and why they're doing it and really understand the process before making any assumptions or trying to educate or raise awareness.

Then, have them as a partner to come with me so that when I'm talking to our senior leaders, it's not Derek telling on the guys over in the other office. It's Derek and Sarah and everyone together saying, "Look, we are partnering, and we see this as an important piece, and we need your help." Then, I will do the same thing with the Chief Medical Officer.

I appreciate that you called that out because we need the support of our physicians who need to complete this information. It is important to have that leader understand what we're trying to do and how it impacts us, not only from a financial perspective but also from a compliance perspective with CMS.

Communicate the "Why"

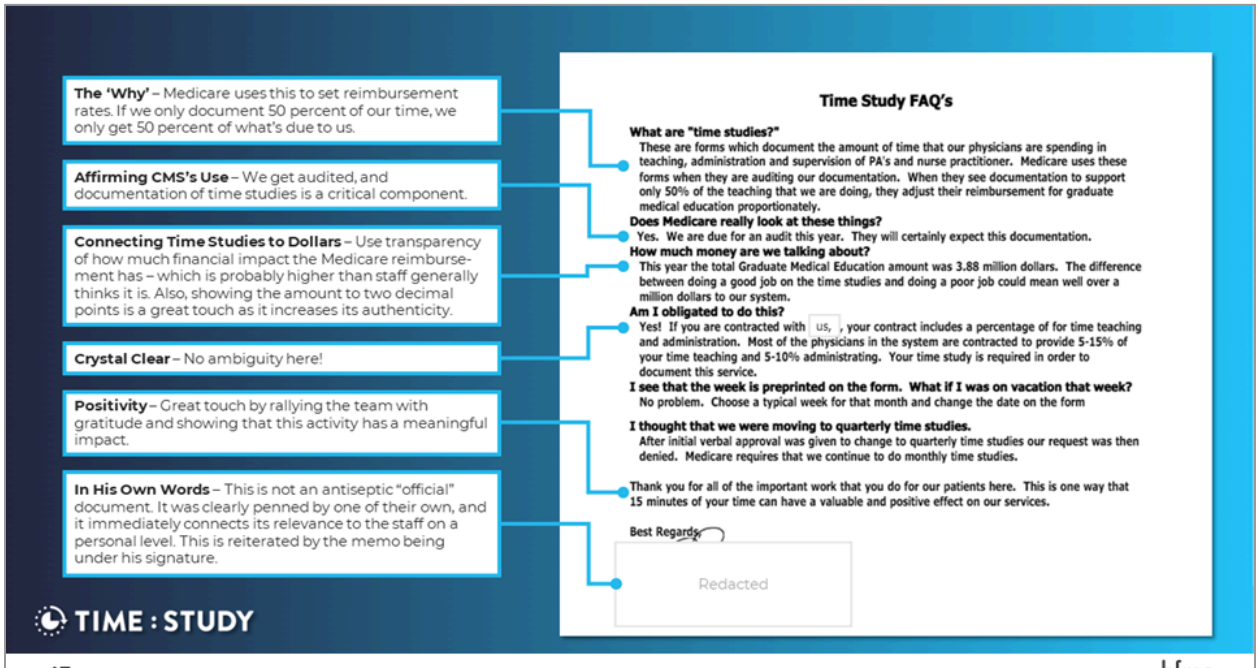
Challenge: Getting busy staff to prioritize completing time studies.

Show staff the importance of participating, including key data points

- Have it come from a leader, such as the CMO
- Incorporate it into onboarding training, but also send out regular reminders
- Describe the purpose of time studies, including who they are for and what it means to have their cooperation
- Share the actual financial impact on the organization
- Be crystal clear that participation is mandatory!

16 HFMA | Time Studies Gone Bad hfma

KISHAU ROGERS: Our next slide leads to something you mentioned: communicating the "why" to organizations. One of the things that we've noticed is it matters who sends the communication and when, but also how often they send the communication. Secondly, the way that it's communicated.



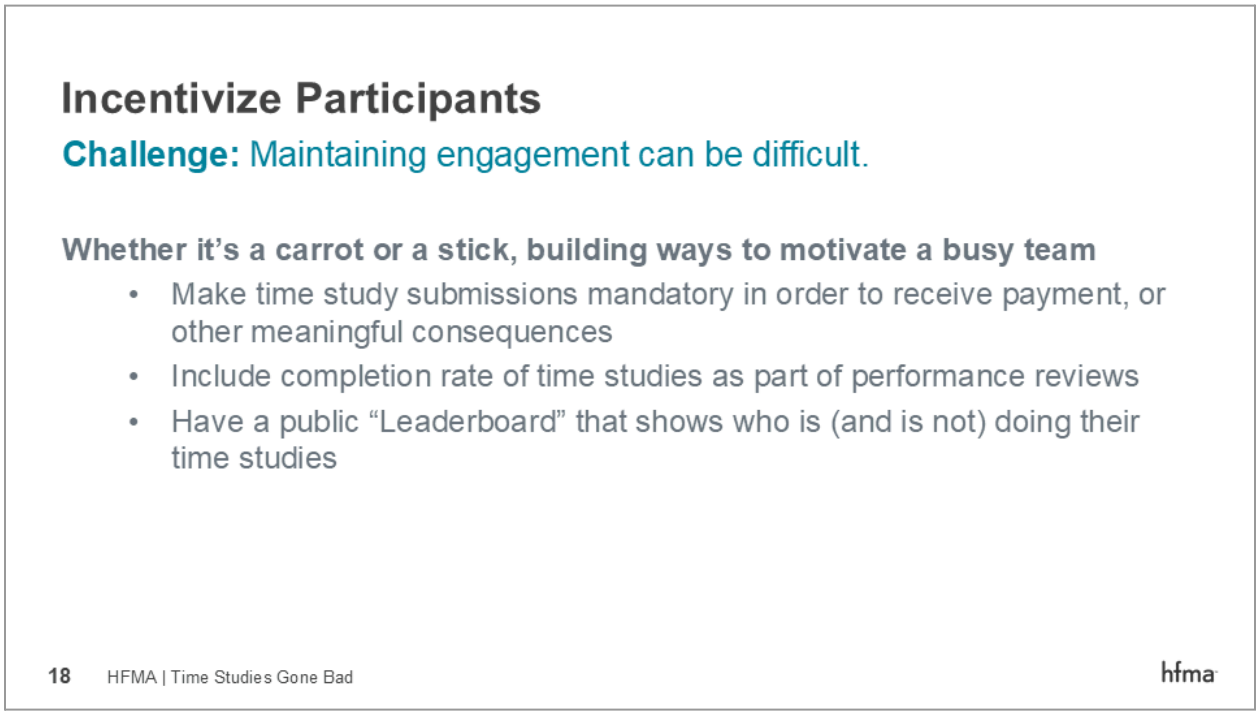
KISHAU ROGERS: This slide provides a "frequently asked question" document that one of our clients uses, which very effectively communicates why this is important across the company. This is an example of an FAQ that is available to anyone participating in a time study program.

In your experience, Derek, have these sorts of guidelines worked, or do you find that, you're still having to communicate, this information after practitioners are onboarded to the program?

DEREK GINOS: I think this is exactly what I'm talking about, right, of people understanding the "why" and understanding that this isn't just about us trying to track down their hours so that we can hold them accountable to fewer FTEs, or whatever other perceptions people might have. This is a requirement that we have to do in order to stay compliant.

We don't have it to this level of detail where we break out the millions of dollars, but I really like that. That's a nice addition and something that I want to take back to my team. So I appreciate that.

> People understanding the "why" and understanding that this isn't just about us trying to track down their hours...or whatever other perceptions people might have. This is a requirement that we have to do in order to stay compliant. ~ *Derek Ginos*



KISHAU ROGERS: Now I want to talk about incentives. I'll ask you this question, Mike. We've seen organizations try many different types of incentives. We've seen everything from shaming, such as posting who needs to comply, to withholding compensation if their time studies are not completed. We've seen some of them work and some of them be disasters.

How can an organization like yours arm your clients with the data they need to align the organization's financial incentive with the employees who are busy yet don't want another thing to complete? What type of data can they provide from a financial perspective?

MIKE POLITO: This is what we do at the C-suite level, especially with the CFO. We can provide modeling where we'll mimic where our client is at and show what it would mean for them if we successfully capture 50% of the physician salaries that are allowable.

The key, and where it has been successful with the clients that we work with, is monetizing or quantifying this as lost revenue. This is the revenue we *could* capture if we had something in place. Then, ultimately, it comes down to ROI, like everything else. There's also a compliance piece that if we can tie a dollar reimbursement piece to that, then that is what works the best.

We are giving the CFO the tools to discuss with other folks within the organization, like the physicians, to provide them with reasons about their "why" to do time studies. We all know that physicians do not like to do them. It's an administrative nightmare. So it's very difficult.

One of the successful things that I've seen is with compensation. I've had smaller

facilities where they can say, “No time studies, no check,” but that doesn't happen in most big systems. I think hospitals with physician-owned practices have more power, so they can do that.

I've seen incentives such as quarterly pizza parties, something monetary, a golfing event, or something they can provide to physicians who are compliant as best they can. So it varies.

DEREK GINOS: I've done a little bit of both. We have quite a few of our physicians that are contracted. In their situation, they need to log their time to get paid, so it is a mutually beneficial piece for them. For those that aren't in that type of compensation model, it's been similar to what Mike described. It's about explaining the “why” and its importance and then asking for their partnership.

Frankly, in some cases, even involving the CMO to sit down and say, “Listen, this is an expectation and one that we need your help with.” This is not unlike conversations we have about documentation or posting charges, or anything else that physicians are asked to do.

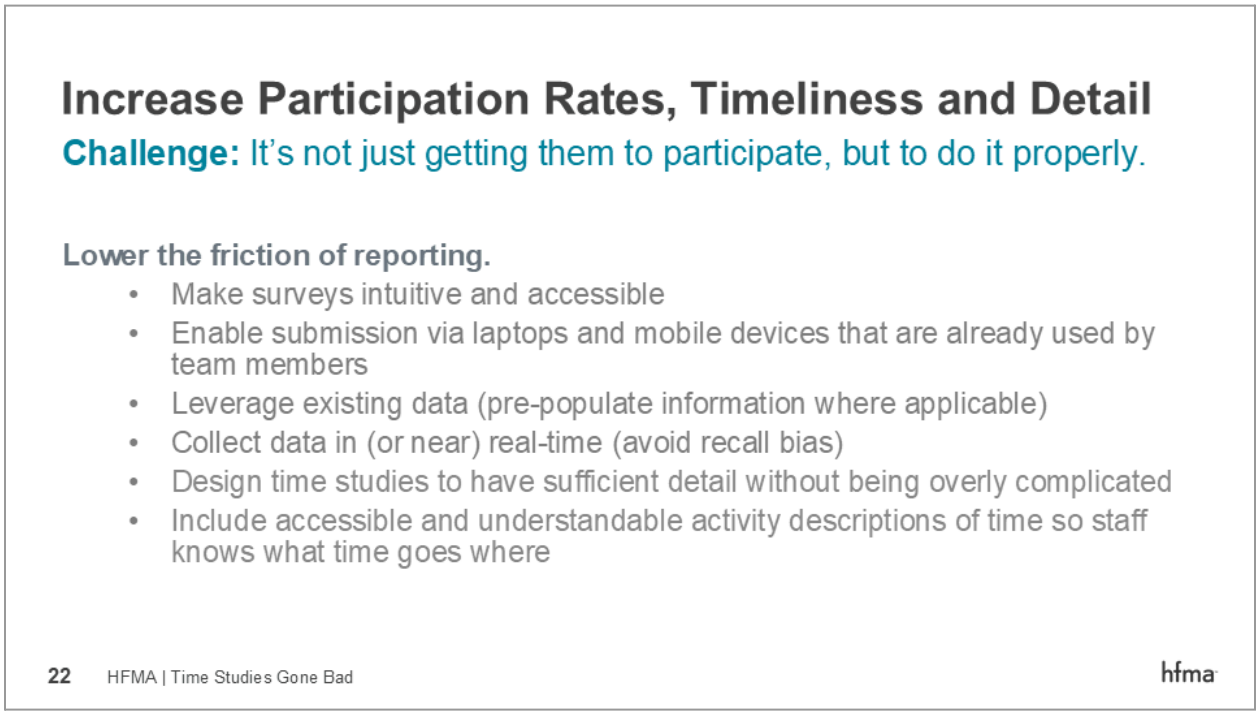
In the case of transplant, we're not only asking doctors but also nurses and other busy staff. In those cases, we do have it as an expectation, and this is where using a more automated system can help because we're able to run reports each month. When I see that somebody needs to complete the survey consistently, then that's my opportunity to do some education to ensure they understand that they're supposed to do it. Are they getting the notice? What questions do they have? Saying, “Let's do the next one together.” Then, if necessary, holding them accountable. That seems to work fairly well.

> [U]sing a more automated system can help because we're able to run reports each month. When I see that somebody needs to complete the survey consistently, then that's my opportunity to do some education to ensure they understand that they're supposed to do it. *~ Derek Ginos*

KISHAU ROGERS: That leads to our next section. We'll talk about automation, creating systems, and digitizing the process.

KISHAU ROGERS: We've talked about communicating with leadership, the CMO, the practitioners, physicians, transplant staff, nurses, and other staff. There's also IT buy-in and other members of the organization that could become an influence – or could prohibit – a successful time study program if they're not engaged early on.

This slide indicates the full breadth of things that need to be communicated and the different staff that you have to maintain compliance with, especially IT security. That's one that we see missed a lot.



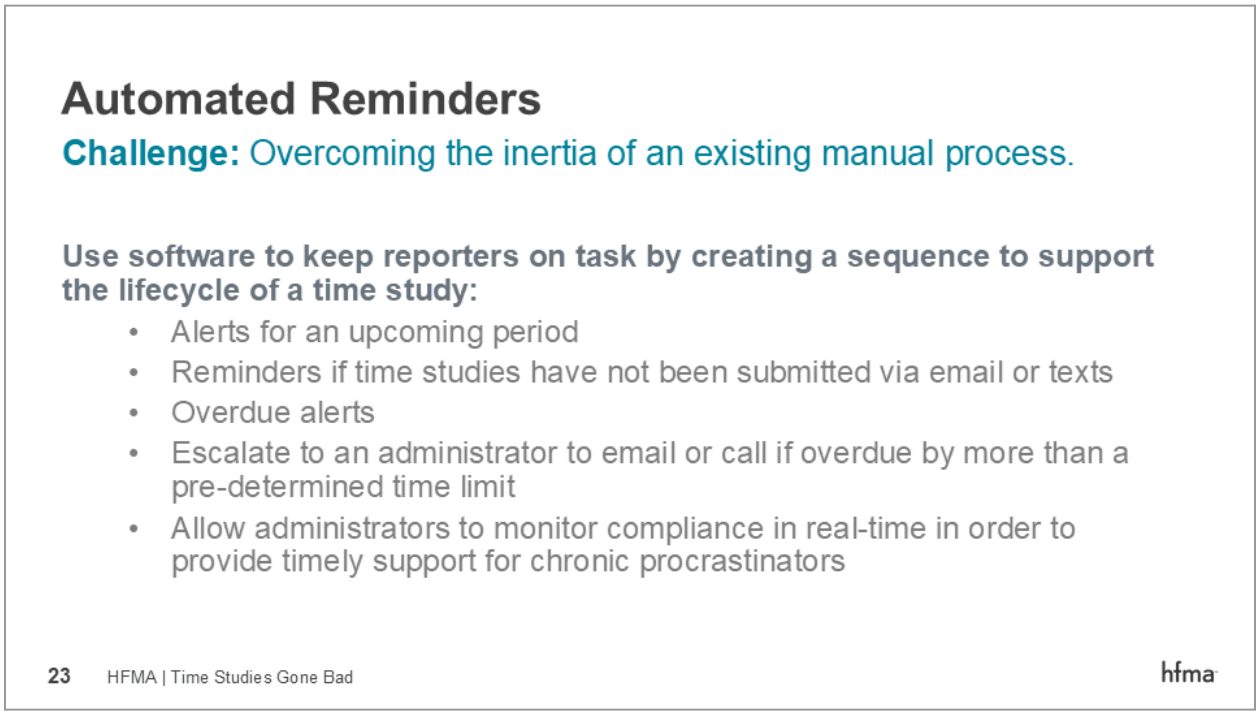
KISHAU ROGERS: We talked a bit about lowering the friction of reporting, and we hit on that earlier, making the time studies themselves more intuitive.

Mike, you mentioned the mapping of time to the three categories of reimbursement. We've seen time studies with only those three categories on it, and the practitioner basically translates what they're doing into those three categories.

Then we've seen studies with 30 activities, and the system translates them into one of those categories. Does one of those options work better than the other? I've seen the pros and cons of both.

MIKE POLITO: Obviously, with more categories, it always gets tricky when you define 30 categories among 150 or 200 physicians. Do they understand what those categories are? Do we understand the functionality of each of those so that it can ultimately be mapped to one of those areas? At the end of the day, the auditor will not care about the 30, but I can see the value of more information within an organization so that the team can grow smarter, quicker, and faster.

Strictly from a reimbursement perspective, mapping those into the three categories is all that is necessary to pass a cost report on it, as long as you can provide the details. You will need the support for those if they get selected, and that would be a great support.



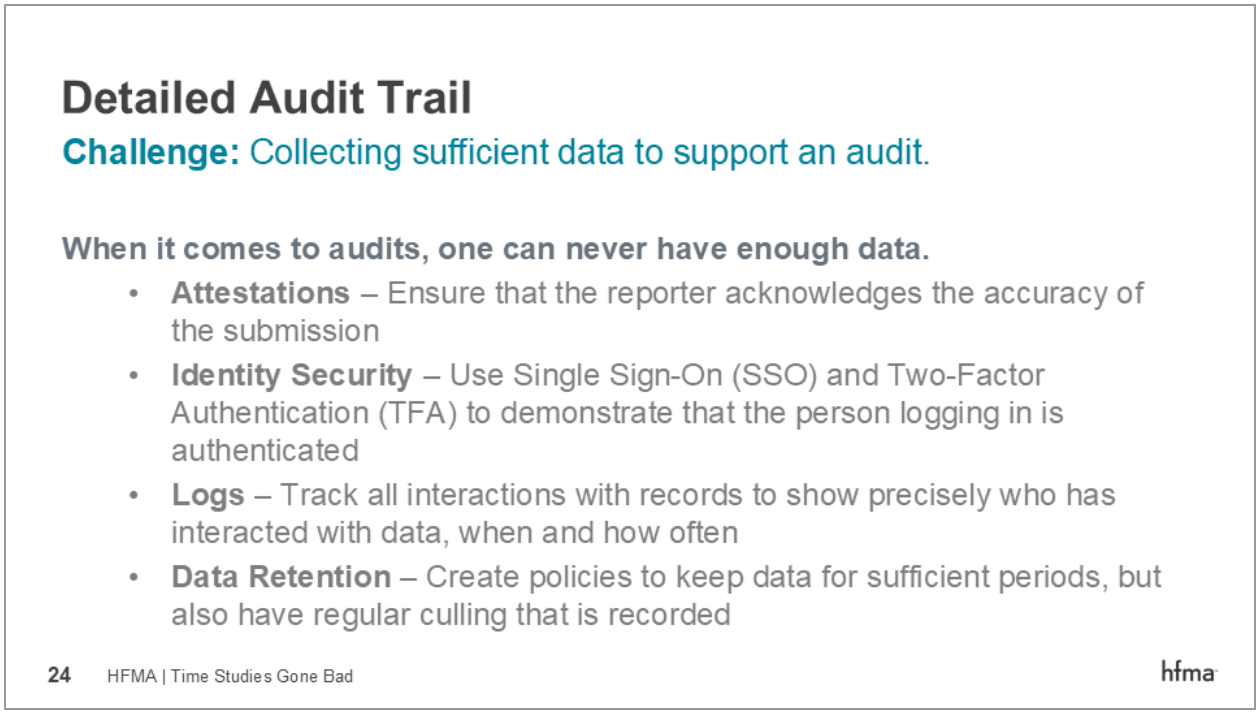
KISHAU ROGERS: I'm curious about automation. You mentioned that you've been using a manual system and you transitioned things from paper to spreadsheets. You've also used other products to collect time studies. In what ways has automation improved participation, reduced overhead, or improved the organization's financial standing?

DEREK GINOS: We went through all the phases. We went from paper to spreadsheets to slightly better spreadsheets, then on to a REDCap survey, and recently to an automated system. Each time you do it, you remove variability.

We have less inconsistency with sending out the surveys and following up. We have people filling them out the same way. Before, we had many more issues with how people recorded their time. Were they doing it in minutes, hours, seconds? So that's helped save time.

On the back end, it's been significant. I didn't fully appreciate that until we moved on to new systems that we were spending a fair amount of time each year reconciling the reports that we pulled together, adding it up, realizing that it didn't add up the way it should, and then trying to follow up and find out that they said that they worked 39 hours this week, but that you only worked one day. That doesn't make any sense! Then, trying to decide whether we can keep it or do we throw it out.

By removing those opportunities for variability, has allowed us to be able to be more efficient. Of course, that results in us being able to capture more accurate data, which then increases the bottom line on the other side too. As the guy who's had to administer the surveys, I spend a lot less time now thinking about it than I did a couple of years ago, for which I'm grateful.



KISHAU ROGERS: I wanted to talk next about collecting data that is defensible for auditing. This is beyond the activities and time spent on activities, but things like whether or not the practitioner completed their own time study or the distance between when they worked and when they reported it. Was it that month, that quarter, or was it at the end of the year? Other things like who approved and reviewed it.

I'd like to know from both of you, and I'll start with Mike, how important it is that you think these additional points of information are from a defensibility standpoint.

MIKE POLITO: From an audit perspective, the automation of the support is key to success. If an auditor can put his cursor on a number, on a Part A or Part B number, and then say, "Where does this come from?"

If it takes you back to the list of physicians, or whatever it may be in the mappings, and they could see that electronically, the audits go a lot smoother. It just has the perception of being more sophisticated and correct. So, there would be less audit work than the paper where manual actions and items are coming in. I definitely like the automation of time studies.

From an audit perspective, you get a first- or second-year associate to audit it. The MACs will have an audit work plan. Here's Step 1. Read the steps that I have taken and check them off. If it's not a step on that work plan, like some of the reconciliations you may be referring to, it wouldn't be that much of a compliance issue then.

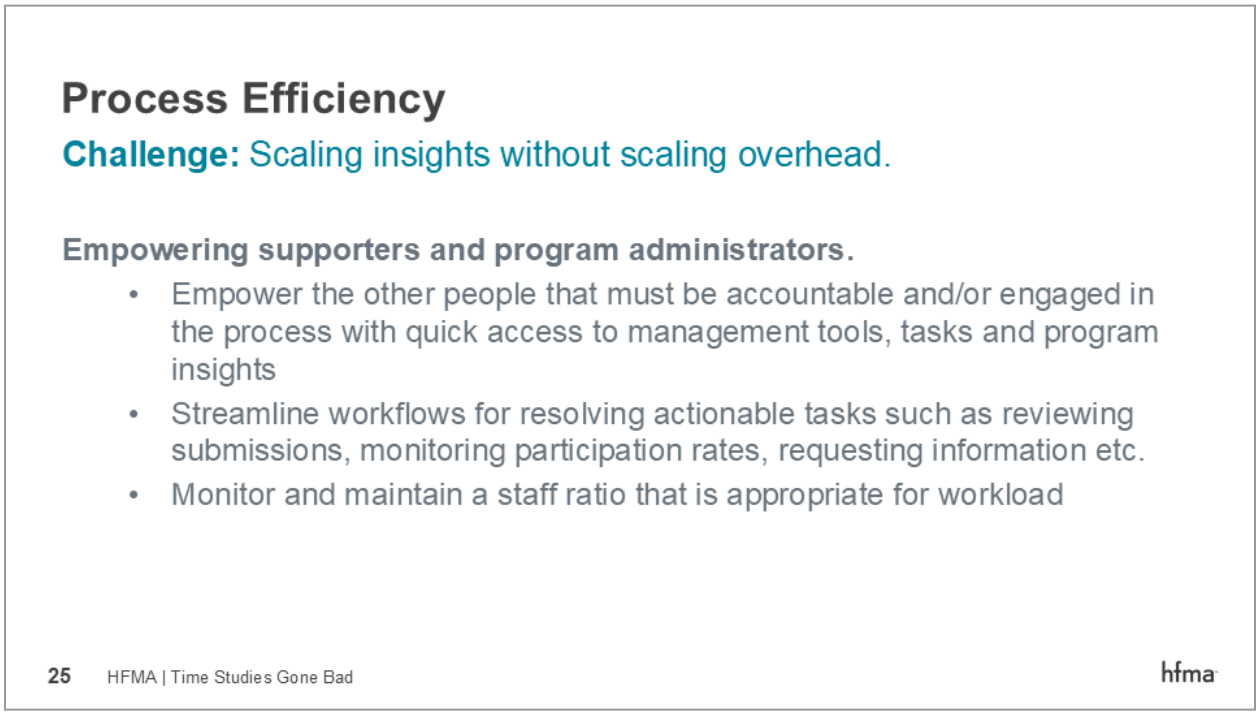
DEREK GINOS: I agree with what Mike just said there. This is not exactly related, but it's similar. We had an audit a few years ago with CMS, and I had this amazing analyst who had prepared the documents for the audit. She was the type of person who liked things organized.

We had binders with tabs, and everything was organized so that it was easy for the surveyor to find what they needed and move on so that they didn't bother getting overly fixated in certain areas. I think that's kind of the same thing. Is it necessary to have it in binders and tabs? No. But does it make it easier for you and for the surveyor? It does.

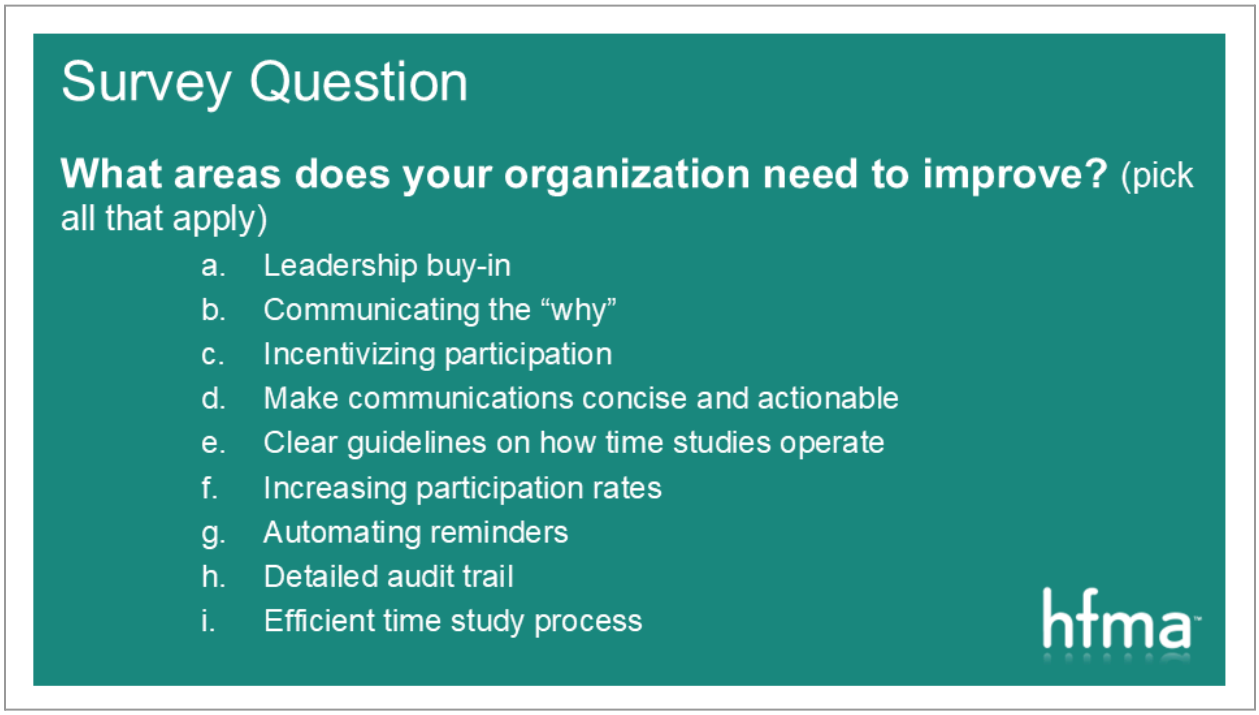
I think the same thing with this. The more structured you are, the more intentional you are about how you fill it out, who fills it out, and how soon they fill it out, then the easier it's going to be for you to be able to speak to that down the road when someone asks a question.

In our organization, we have all surveys done within, ideally, the same day that they're doing the activity, but certainly within the same week. We don't allow it to go months or quarters on, because we know that people just aren't able to be accurate at that point.

> [W]e have all surveys done within, ideally, the same day that they're doing the activity, but certainly within the same week. We don't allow it to go months or quarters on, because we know that people just aren't able to be accurate at that point. ~ *Derek Ginos*



KISHAU ROGERS: I only have one more question, and then I want to leave some time for our listeners to ask questions. We discussed process efficiency and automation, which allow you to scale your time study program. When health systems acquire new hospitals or have their new staff onboarded, we've seen that enable the staff to have an efficient onboarding process.

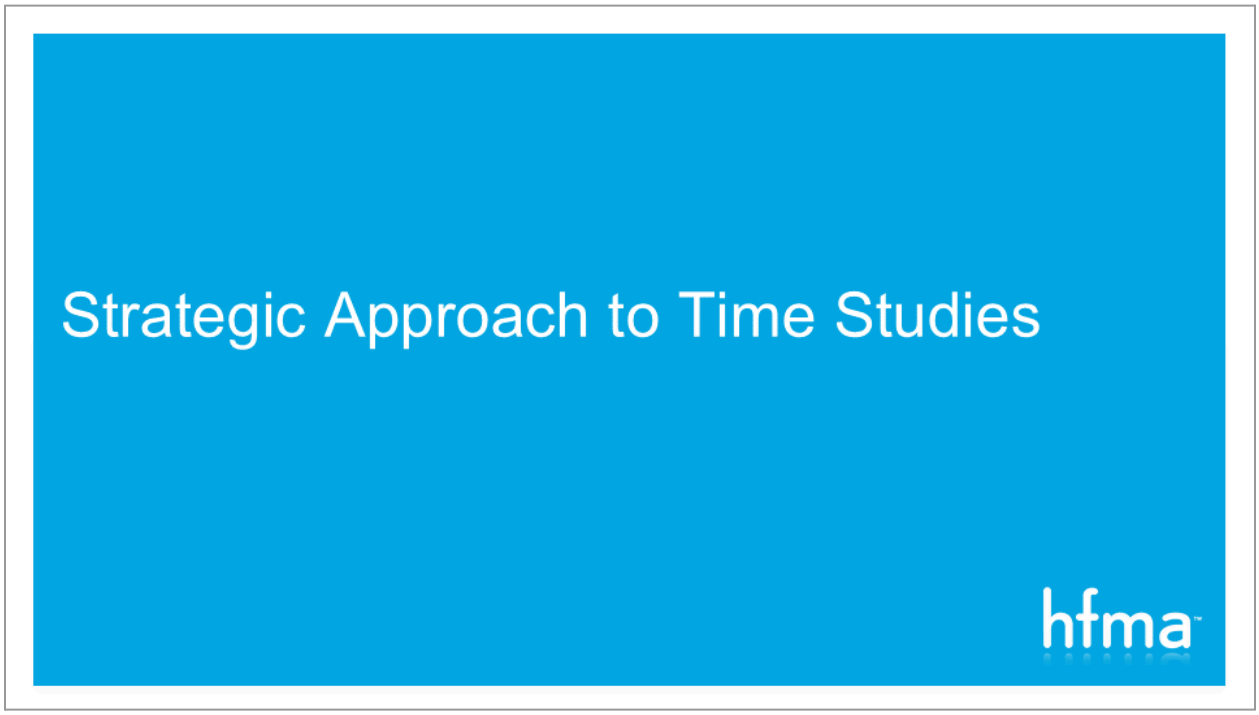


KISHAU ROGERS: So this is our next survey question. What areas does your organization need to improve in based on our conversation about digitizing the system? Also, leadership buy-in, communicating the "why," incentivizing participation, communicating concisely, and having clear guidelines on how the time study program works. Also, automating reminders and other alerts, having a detailed audit trail, and managing an efficient time study process. You can check all that apply. You probably have a few more seconds to respond.

My last question is going to be about looking ahead. We've talked a lot about the evolution of time studies, and in some ways, it has stayed the same since 1993.

There are no top answers here. People have evenly checked all that apply. I think the top answer is communicating the "why" enterprise-wide.

Thanks everyone for your responses.



KISHAU ROGERS: Let's move to our next section. We talked a bit about time studies over time and how they have evolved in some ways, but they haven't in other ways.

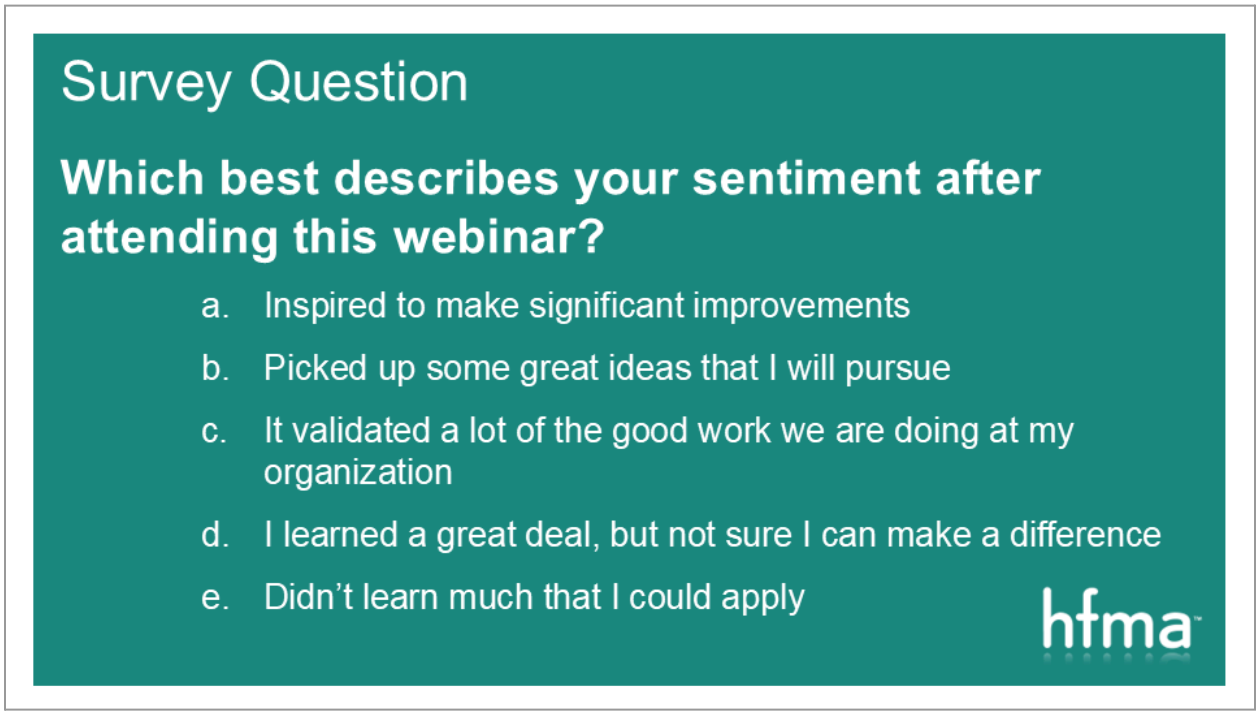
KISHAU ROGERS: What is the future, if any, of time studies, assuming that all organizations have an efficient, defensible time study program, what is an opportunity that you think can be leveraged?

MIKE POLITO: I think more auditable work papers would mean more reimbursement and ease of the audits. The automation of those time studies has certainly provided the beginning. There are still a lot of facilities and health systems out there that could benefit from this, both financially and from a compliance perspective, for that matter.

I do see with hospitals that the cost report software is electronic, so they submit it electronically now. There will be a process of getting used to completing it electronically, especially with the vast systems following the many mergers and acquisitions going on. The standalone systems are getting smaller and smaller. How do you get your hands around 80-, 90-, or a 100-hospital system in a compliant and effective way across all hospitals and across multiple states?

The only way to do that is through automation, including time study automation. As these health systems continue to grow, the need, the necessity, from both a reimbursement and compliance perspective, is certainly increasing.

DEREK GINOS: I agree with what Mike said there. We're getting increased pressure to make the most of our time, and our physicians are no exception to that. So anywhere we can make it easier, whether that'd be through automation or integration with our EMR or other sources, is key.

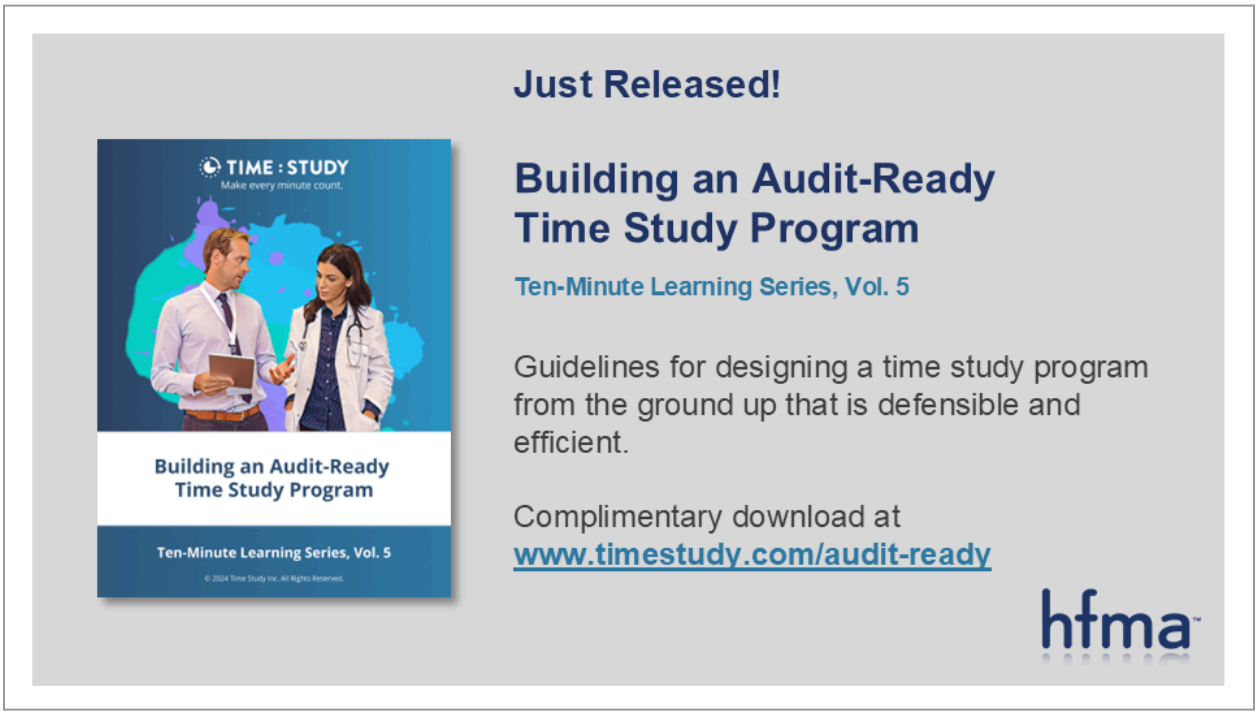


KISHAU ROGERS: Your last polling question, I promise. So, what best describes your sentiment after attending this webinar? Hopefully, you're inspired to make significant improvements. We will give you some good ideas for improving your time study program.

If this is validated, let us know that you're doing the right things at your organization. Also, let us know if you learned something but are still determining if you can act on it or make a difference. Finally, if you didn't learn anything, there's also a choice for you. You have less than 30 seconds to respond.

We have this presentation deck and a summary of some of the solutions and some of the points we've made during this particular session.

The top response is that you've picked up some great ideas that you will pursue. So we really appreciate that.



KISHAU ROGERS: This slide gives information on how to access a handout on building a defensible, audit-ready time study program. You can find it at timestudy.com/audit-ready. Feel free to download it. I will hand it back to Ashley.

ASHLEY MEYERS: Thank you so much, KIshau. With that, we have reached the conclusion of today's webinar. I would like to thank our speakers, KIshau, Mike, and Derek, for presenting and Time Study for sponsoring.

We hope you found the presentation informative. Thank you for your participation, and have a great day.

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