

# Welcome to the

# Rural Health Clinic Technical Assistance Webinar

## December 14, 2015

This webinar is brought to you by the National Association of Rural Health Clinics and is supported by cooperative agreement 1UG6RH28684 from the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA). It is intended to serve as a technical assistance resource based on the experience and expertise of independent consultants and guest speakers.

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# RHC Technical Assistance Call

## RHC Benchmarking

**December 14, 2015**

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HEALTH CARE PRACTICE



# Agenda

- A Changed Environment for RHC Management
- RHC Benchmarking Example 1
- RHC Benchmarking Example 2
- Summary
- Q & A



# A Changed Environment for RHC Management

# A Changed Environment for RHC Management

- Patient volume changes
  - *Increases related to Medicaid expansion*
  - *Decreases related to higher patient deductibles*
- Potential changes in payment policies and sources of payment
  - *Quality vs. quantity*
- Provider staffing changes
  - *Retirement, recruitment, and retention challenges*
  - *Changing compensation incentives*



# A Changed Environment for RHC Management

RHCs are frequently seeking answers to questions such as:

- *Do our RHC practitioners have capacity to see more patients?*
- *Are our costs higher or lower than other similar providers?*
- *Is our current reimbursement adequate to cover the cost of providing the care we deliver?*
- *What are the key cost drivers in our RHC, and how can we impact these costs?*



# A Changed Environment for RHC Management

Uncovering the answers to these questions can begin through a **benchmarking** process.

## Benchmarking

*From Wikipedia, the free encyclopedia*

- **Benchmarking** is the process of comparing one's business processes and performance metrics to industry bests or best practices from other companies. Dimensions typically measured are quality, time and cost.



# A Changed Environment for RHC Management

Fortunately for Rural Health Clinics, the Center for Medicare and Medicaid Services (CMS) makes available RHC cost report data from which **RHC Benchmarking** information can be obtained.

This information is available in bulk, and requires specific tools designed to extract and summarize the data for use by interested parties.

The National Association of Rural Health Clinics (NARHC) and Wipfli LLP have worked together to develop the **RHC Benchmark Report** ©.







# RHC Benchmarking Example 1

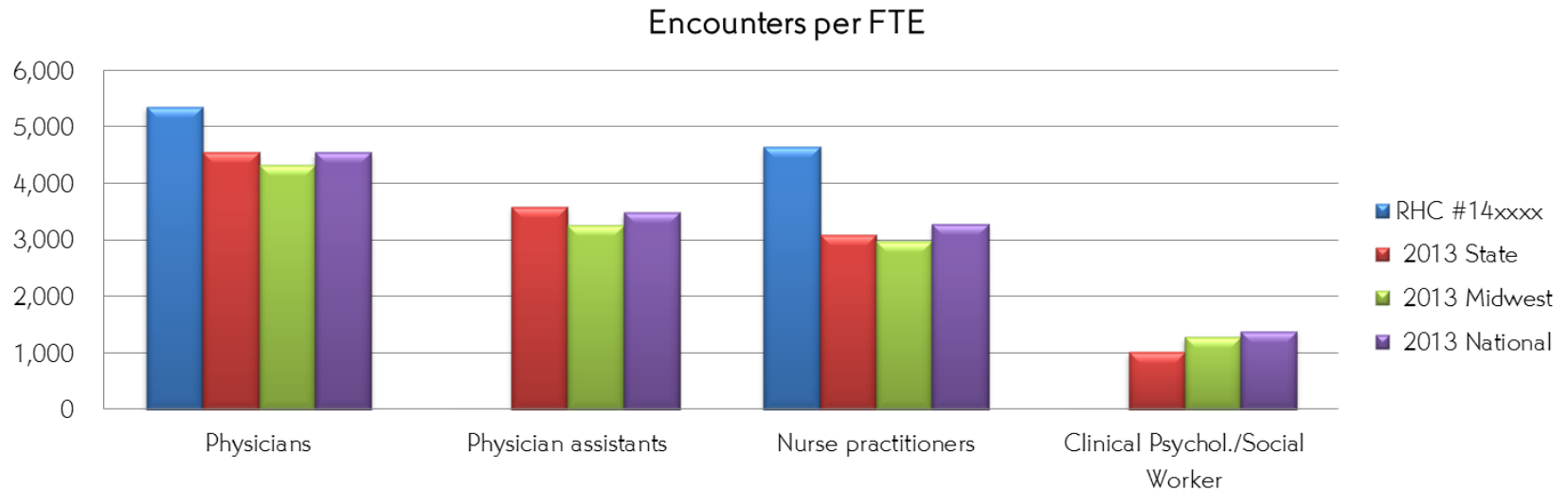
# Benchmarking Total Cost and Productivity

In Benchmarking Example 1, we have identified a moderate size RHC (just over 11,000 annual encounters) with a relatively low cost per encounter (< \$110).

What can we learn about this RHC based on a benchmark analysis?

# Benchmarking Provider Productivity

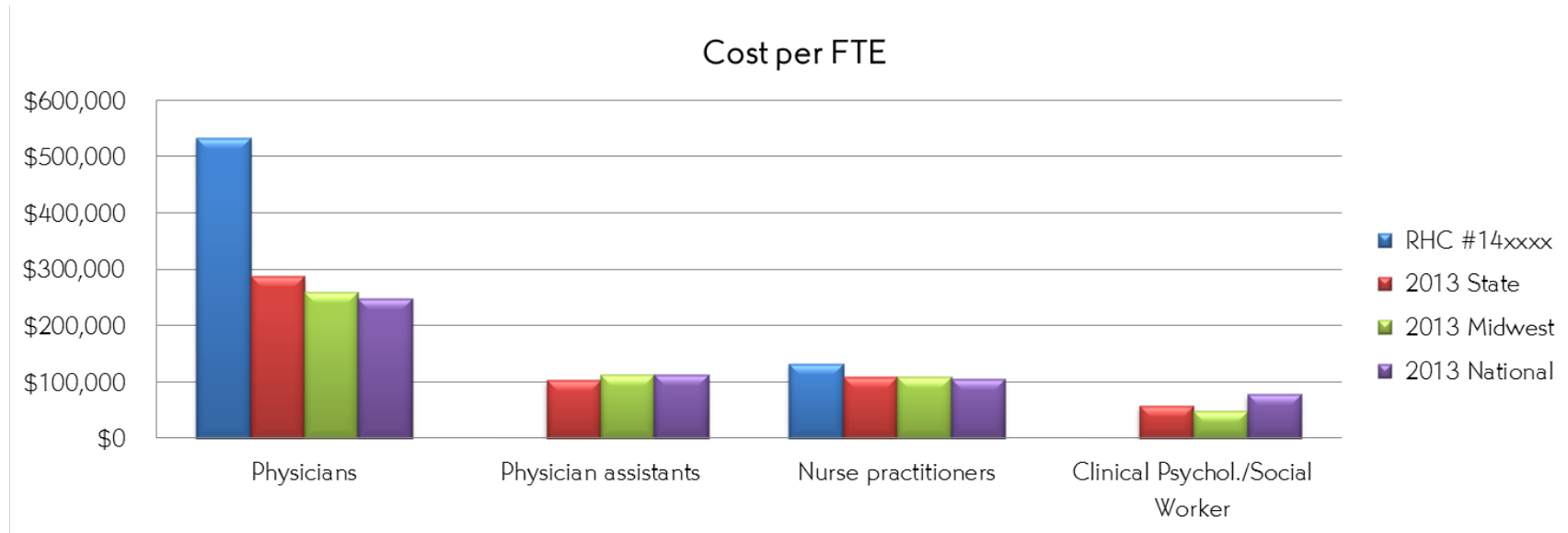
**Q1. Do our RHC practitioners have capacity to see more patients?**



**A1. Based on the data above, it appears that RHC practitioners have limited capacity to see more patients.**

# Benchmarking Provider Costs

**Q2. Are our (provider) costs higher or lower than other similar providers?**

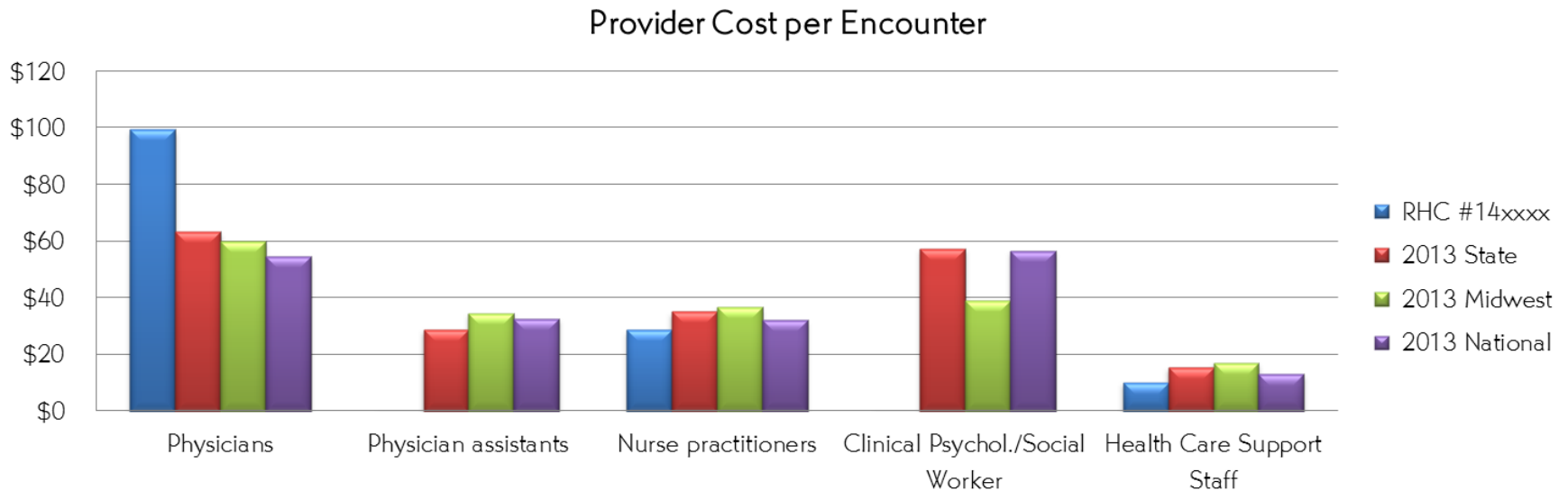


**A2. Based on the data above, it appears that costs (on a per FTE basis) are significantly higher than other similar providers.**

# Benchmarking Provider Costs

Costs per FTE provider are higher than average, and so is the actual physician cost per physician encounter.

(Note the NP and support staff cost per encounter is lower than average.)



# Benchmarking Physician Cost and Productivity

## Physicians Analysis

RHC Physician Cost Per FTE

533,213

Avg Physician Cost Per FTE

259,365

RHC Physician Encounters Per FTE

5,367

Avg Physician Encounters Per FTE

4,327

Provider Num...

Physician Cost vs Encounters Per FTE

148955 ✓
143811
143819
143821

City

ALTAMONT

ABBEVILLE

ABERDEEN

ABERNATHY

State

IL

AL

AR

AZ

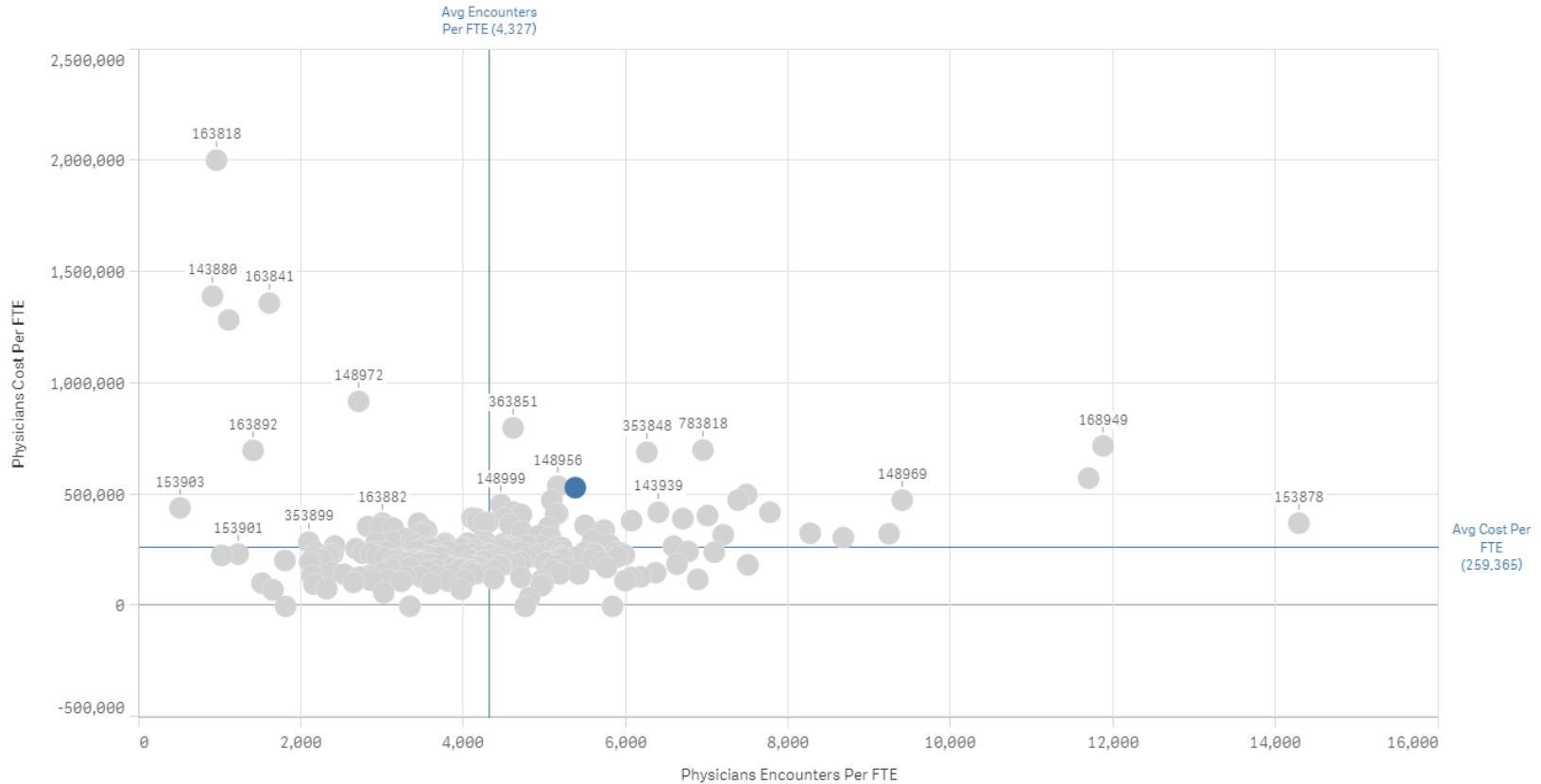
Region

Midwest ✓

Eastern

Southern

Western



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# Benchmarking Total Costs

While costs per FTE provider are higher than average, the cost per encounter (\$108) is actually lower than the state (\$132), regional (\$130), and national average (\$113).

	<u>RHC #14xxxx</u>	<u>2013 State</u>	<u>2013 Midwest</u>	<u>2013 National</u>
<b>RHC Cost per Encounter:</b>				
Total Health Care Staff	\$66	\$67	\$67	\$59
Total Direct Costs of Medical Svcs.	\$70	\$77	\$78	\$68
Facility Cost	\$3	\$9	\$10	\$10
Clinic Overhead	\$38	\$57	\$56	\$50
<b>Total Allowable Cost per Actual Enc.</b>	<b>\$108</b>	<b>\$132</b>	<b>\$130</b>	<b>\$113</b>
Total Allowable Cost per Adjusted Enc.	\$108	\$129	\$126	\$110

# Benchmarking Physician Costs and Productivity

## What did we learn so far?

- Provider productivity was higher than average (17% physician; 40% NP).
- Provider costs (salary and benefits) per FTE were significantly higher than average (200% physician; 26% NP).
- Total costs (on a per encounter basis) of \$108 were 5% below the national average.
- Health care support staff, facility, and overhead costs per encounter are all well (25% - 70%) below average.
- With a total cost per encounter of \$108 and the Medicare maximum payment rate of \$79 in 2013, this RHC was losing about \$29 on each Medicare encounter.





# Benchmarking Physician Costs and Productivity

## What more would we like to know?

- Does the RHC incentivize provider productivity, and if so, how?
- How does the RHC manage their support staff to achieve high productivity at a lower cost per encounter?
- How is the RHC able to achieve lower costs on their facility?
  - Is their plant and equipment outdated and in need of repairs and/or replacement?
- How is the RHC able to manage their practice overhead to achieve such low costs?
  - Do they outsource administrative services such as billing, accounting, management, etc.?

# RHC Benchmarking Example 2



# Benchmarking Total Cost and Productivity

In Benchmarking Example 2, we have identified a moderate size RHC (just over 12,000 annual encounters) with a relatively high cost per encounter ( $> \$160$ ).

Can we begin to identify the causes that contribute to the high cost, and develop strategies to move costs closer to the average data?

# Benchmarking Total Cost and Productivity

Total Allowable Cost Per Actual Encounter

RHC Total Allowable Cost Per Encounter

162.32

Avg Total Allowable Cost Per Encounter

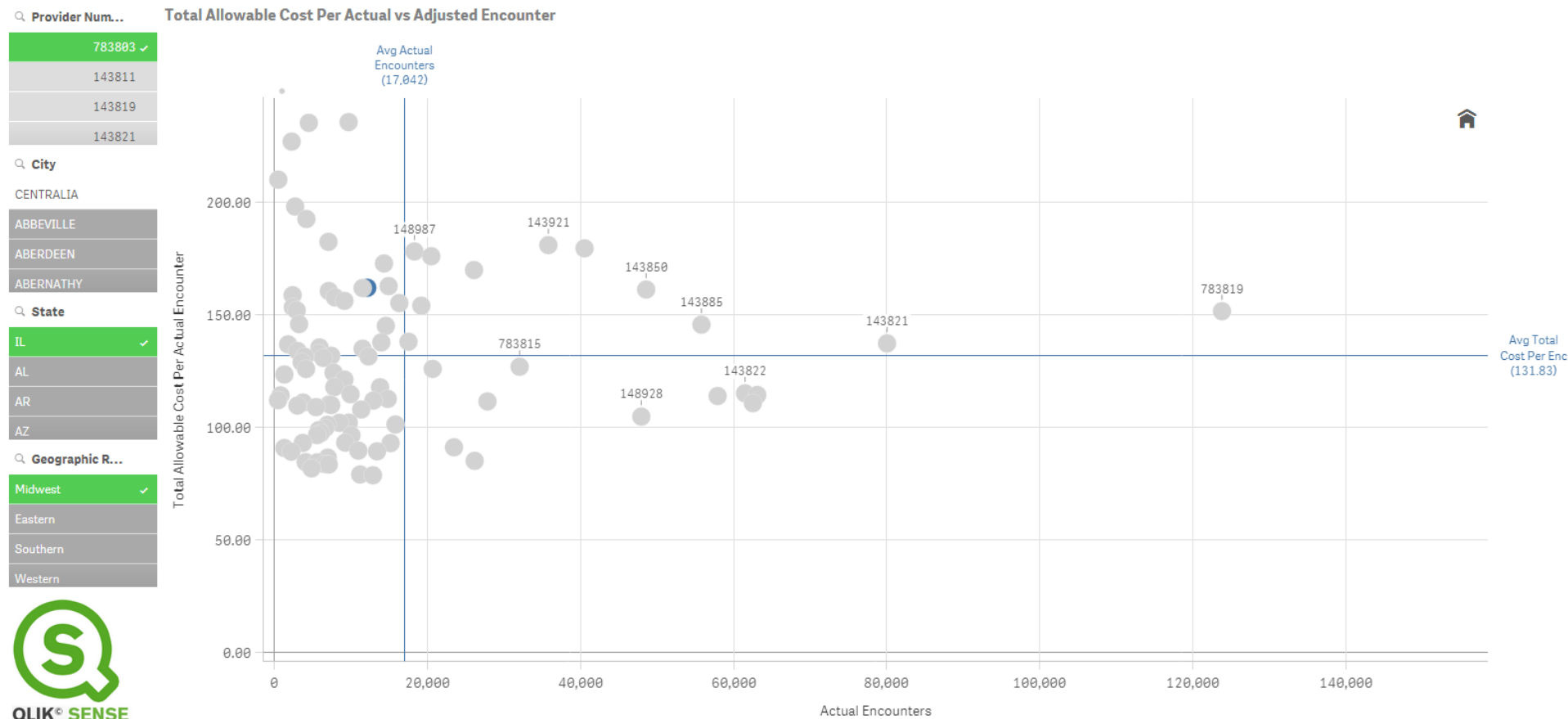
131.83

RHC Actual Encounters

12,008

Avg Actual Encounters

17,042



# Benchmarking Total Costs

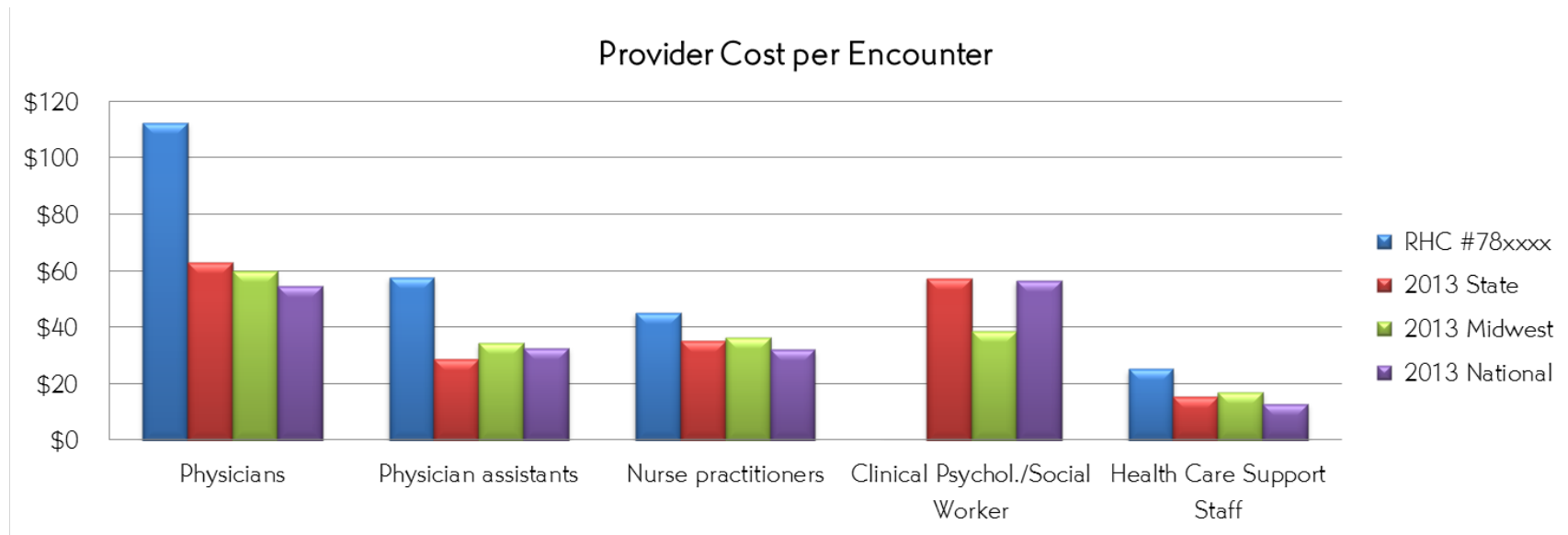
The cost per encounter (\$162) is substantially higher than the national average (\$113).

		Independent RHCs (Mean Data)		
	RHC #78xxxx	2013 State	2013 Midwest	2013 National
RHC Cost per Encounter:				
Total Health Care Staff	\$91	\$67	\$67	\$59
Total Direct Costs of Medical Svcs.	\$91	\$77	\$78	\$68
Facility Cost	\$16	\$9	\$10	\$10
Clinic Overhead	\$72	\$57	\$56	\$50
Total Allowable Cost per Actual Enc.	\$162	\$132	\$130	\$113
Total Allowable Cost per Adjusted Enc.	\$162	\$129	\$126	\$110

	Actual		Natl Avg		Variance	Var. %
Higher Direct Cost per Encounter	\$91	-	\$68	=	\$23	34%
Higher Facility Cost per Encounter	\$16	-	\$10	=	\$6	60%
Higher Overhead Cost per Encounter	\$72	-	\$50	=	\$22	44%

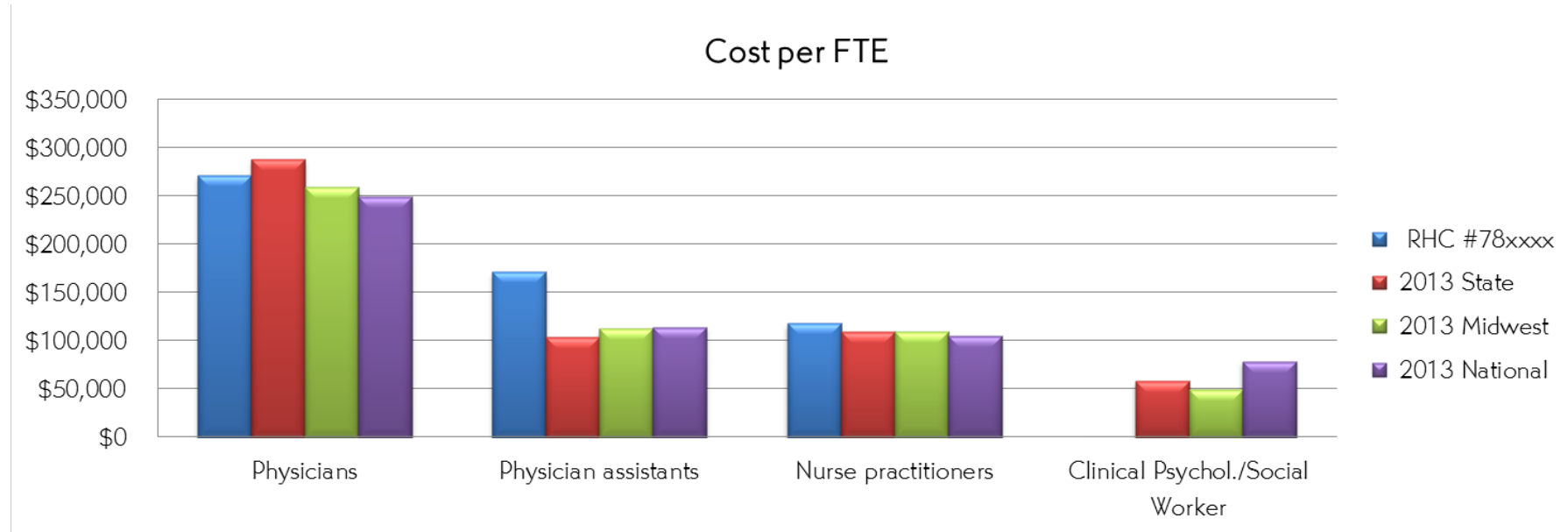
# Benchmarking Provider Costs

Costs per encounter are higher for physicians, PAs, NPs, and health care support staff.



Is this RHC paying more in salary and benefits (per FTE) or is the key issue lower-than-average production?

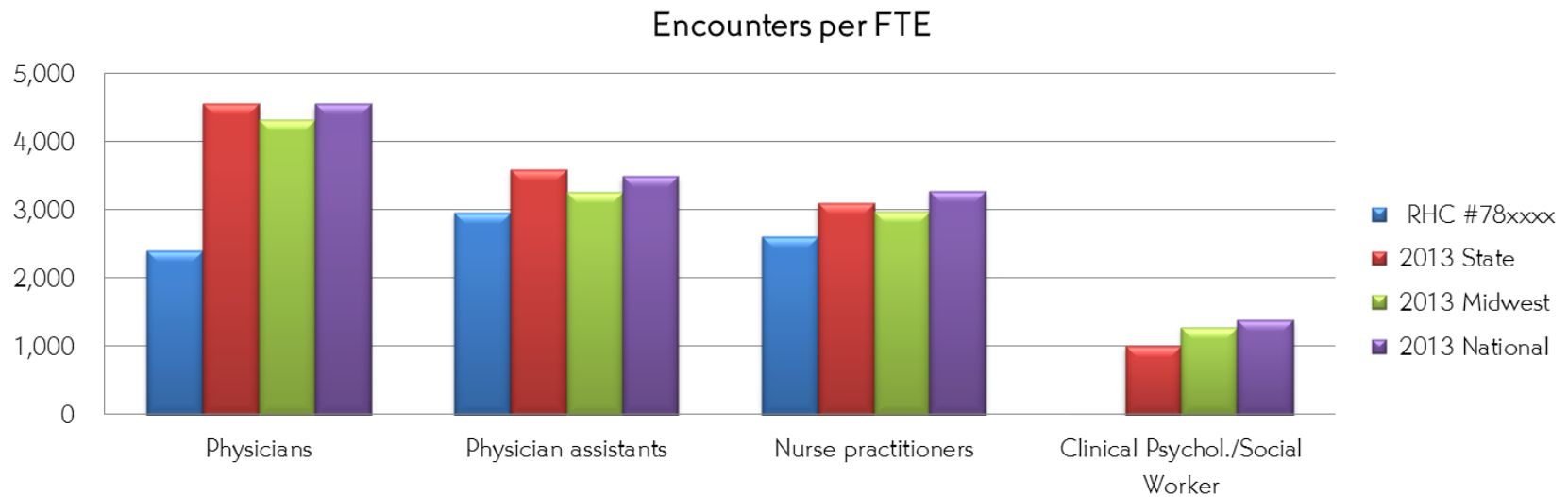
# Benchmarking Provider Costs



Based on the data above, it appears that costs (on a per FTE basis) are slightly higher (especially for PAs) than other similar providers.

# Benchmarking Provider Productivity

Based on the data below, it appears that low patient encounters may be the primary cause of the RHC's high cost per encounter.





# Benchmarking Physician Costs and Productivity

## What more would we like to know?

- Is it realistic to assume that this RHC could lower their average cost per encounter from \$162 to the national average of \$113 by increasing patient encounters alone?

<b>Total Allowable Costs</b>	<b>\$1,949,176</b>
<b>Actual Patient Encounters</b>	<b>12,008</b>
<b>Actual Cost Per Encounter</b>	<b>\$162</b>
<b>Total Allowable Costs</b>	<b>\$1,949,176</b>
<b>Target Cost Per Encounter</b>	<b>\$113</b>
<b>Target Patient Encounters</b>	<b>17,249</b>
<b>Encounter Increase to Achieve Target</b>	<b>5,241</b>
<b>FTE Providers</b>	<b>3</b>
<b>Increase to Achieve Target (per Provider)</b>	<b>1,747</b>
<b>Daily Increase to Achieve Target (230 days/yr.)</b>	<b>8</b>

# Benchmarking Physician Costs and Productivity

## What did we learn so far?

- Provider productivity was lower than average (52% physician; 16% PA; 21% NP).
- PA costs (salary and benefits) per FTE were significantly higher than average (50%).
- Total costs (on a per encounter basis) of \$162 were 43% above the national average.
- Low productivity appears to contribute heavily toward the high cost per encounter.
- To lower the cost per encounter from \$162 to \$113 through increases in patient encounters alone would require each provider to see 8 more patients per day (probably not realistic).





# Summary

# Summary

- While not providing all the answers, the benchmark information does help uncover potential opportunities for improvement.
- When performed on an ongoing basis, benchmarking can be used to measure continuous improvement in various areas.
- Do you know how your RHC costs and productivity compare to state, regional, and national averages?

**RHC Benchmark Report** © data is available as a National Association of Rural Health Clinics (NARHC) member benefit.

<http://narhc.org/member-portal/benchmarking/>



# Questions?

# Technical Assistance (TA) for Rural Health Clinics (RHCs)

- TA Listserv
  - To join the technical assistance listserv for RHCs, send an email to [admin@narhc.org](mailto:admin@narhc.org) and put “Listserve and/or TA Call Signup” in the subject Line.
- TA Webinars/Calls
  - To view past webinars go to:  
<http://www.hrsa.gov/ruralhealth/resources/conferencecall/index.html>

# Thank you!

# Contact Information

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