RHC Benchmarking

Wednesday, 11/9/2022 2:00 PM • 1:15:12 total length

SPEAKERS

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MODERATORS

Nathan Baugh, Executive Director @NARHC

Nathan Baugh 00:00

You? All right, good afternoon, folks. Thank you for joining us today. My name is Nathan bomb, the Executive Director of the National Association of rural health clinics. Today's webinar is a little different if you follow a lot of our webinar series, that we call it technical assistance webinar series that is sponsored by HERSA. And I go through a bit of a disclaimer at the onset that this is, you know, sponsored by the government, etc. This webinar is very much not sponsored by the government. It's not, we're not calling it technical assistance. Instead, we're gonna be covering the benchmark reports and the benchmarking tool, which is bit of an NCIC benefit with a partnership that we have with Wipfli. And so the nature of this is a little different, the format and on everything else is going to largely remain the same. You still can get CEU credits for certified rural health clinics, professional course, at the end, but you have to take the survey. So when the survey pops up, at the end, if you complete the survey, you'll get a CEU code for attending today's webinar. And we have disabled the chat for the presentation. But if you have questions, you can use the q&a tool. And I know that Nathan and Eric, have some time for questions at the end. With that, I'm going to turn it over to Eric Prosser and David Smith. Eric Prosser is a senior manager with Wipfli. And Nathan Smith is a manager with Wipfli. And I'm going to turn it over to them so they can cover what the benchmarking report is and how to get one and how to read it and how to utilize it, Nathan.

Nate Smith 02:45

Thanks, Nathan. My name is Nathan Smith. I also go by Nate. We don't so don't get confused with the Nathan. Well, I

Nathan Baugh 02:53

go by Nate to do manual. Yeah, okay.

Nate Smith 02:56

Yeah, same here.

Nathan Baugh 03:00

But sorry, yeah, we can go by Nate for you for purposes of today.

Nate Smith 03:05

Sounds good. So Nate Smith, here I am in white Sam in Washington. I am a manager out of the spoken office for Wipfli. I work on these RHC benchmark reports. Along with Eric, some of you may have received some of the reports from in an email or maybe had a console with this. Eric is the technical guru expert. On the cost reporting side, I have more of an operational background. So I look at these a little bit differently and maybe similar to a lot of you on the call today. But I have a background in managing primary care clinics. I was an administrator for an independent RHC for a little over eight years. So I'm looking forward to going through these reports with you and kind of sharing how they can be helpful.

Erik Prosser 04:03

Good afternoon, my name is Eric crosser. I'm Miss mentioned the senior manager also with with Lee. I am located in Spokane, Washington. I have worked for with Lee for 20 plus years. My background has always been healthcare. I work with a lot of critical access hospitals, rural hospitals throughout the United States as well as a lot of those facilities have provider based rural health clinics. I also within the firm in Canada leadership on a lot of our benchmarking measures that we do within healthcare. So that's been my primary role is basically making sure that the benchmark continues forward. It's an initiative I go don't know exactly how many years back, but I would say probably a growth approaching 10 years or so that we started the real health rural health clinic benchmark with snark. And it's been something that we have been working with them in a partnership for the PERT for that period of time. So maybe to give a little more additional background in the benchmark. This data is 100% relies upon the Medicare cost reports in which the clinic's file that would be either a independent or provider based. So that data gets published by CMS, it is referred to as HC Chris data. And that data is made available to the public. The nuance, though, is it comes through in a format that is not very user friendly, and requires quite a bit of mapping, in order to actually kind of get the necessary value out of the data. So that's where Wipfli kind of has come in to manage that data, be able to extract the data from the different report types, and then take the relative data that drives the benchmark measures that we're going to go through from here today. So if you want to go to the second slide, we'll just kind of just show the agenda real quick. So, you know, there's three main topics that we're going to cover, you know, the importance of benchmarking, you know, the data source, the data source, as in the cost report side, not what I was explaining as far as how we build the benchmarks, some overview examples, and then we'll, I think we'll have quite a bit of time for discussion. So please take note of any questions that you may have along the way for the end. Was go ahead and go to the next slide here. So, Nathan, maybe you want to talk a little bit about our current promotion of the benchmark through dark?

Nate Smith 07:19

Sure, so we get a lot of these requests, you can, I think, go to the website and just put in your information, your CCN number, or numbers, and we look it up in our database. And you're able to compare your RHC or our ACS to state, other Archie's in your state region, or the nation. So a lot of times, we're able to kind of find things that are outliers. And you might want to look a little bit further into, if you see something that's off, maybe there's a reporting error, or maybe it's an area of opportunity for operational improvement. And then a lot of times, it's good, just to, well, it's always good to know what your cost per visit is, and track that and obviously optimize it to your advantage.

Nathan Baugh 08:21

And he has to weigh in on this as well. So just to be clear, I think this slide basically covers it. But this is something that if you're a member of any RHC, you can get for free. If you're not a member of any IHC, you can actually still go through us and we can I think there's a charge to it, I want to say I don't want to say what the amount is I don't I don't think it's too much. But if you're a member, it's free. If you're not a member, you can still request one, it would just cost a bit of money. But that is the partnership that we have with Wipfli. And if you go to that link, or just go to nic.org, you should be able to pretty easily navigate to the website to start this process and get a get a benchmark specifically for your clinic. And we anticipate potentially having a flood of requests coming out of this webinar. But we'll I know Nathan and Eric are going to be trying to turn those around as fast as we can. And then next month or so. So

Nate Smith 09:28

of course in some of you may have just sent a bunch out last week. So we might have some folks on the call today that have some questions and then obviously at one more point before we move on, you have the option to kind of go over this with us as a benefit of being an art member so you get a free half hour console to talk with Eric and I and we can go over your clinics data together alright, so we kind of already touched on this Eric did did You want to add anything here?

Erik Prosser 10:02

No. But just just to get understanding here is is that we're limited to the data that comes out of the reports. So if you request a benchmark, and you see an abnormality right off the bat that you disagree with, it's likely due back to the source data and how a form was completed. That in the end drives that variance or difference in the record, a prime example is, we have a provider FTE, yes, but physician FTE, but maybe there's no physician cost. Why is there a mismatch? Well, the cost component probably got entered on on a different line. And it's a simple fix on the cost report side. But it just, that's just the way the data is going to show up on the benchmark side.

Nate Smith 11:02

So here's where we can kind of give an overview and then talk about what the arrows mean, do you want to provide that? Eric? Are

Erik Prosser 11:09

you? Sure. You know, ultimately, this is just our disclosure that comes along with our benchmark. It's kind of the instructions regarding how to interpret some of the data. The the main takeaway here though, is our benchmark looks at your facilities, results compared to the region. And based upon a plus or minus 20% variance, indicate gives us one to three indications that you're, if it's green, you're doing better than your region. If it's yellow, that means you are trending within your region. And if it's red, that means you're performing below your region. So I think this next side, Nathan can probably give you a little Nathan, won't you take this slide?

Nate Smith 12:10

Okay. As an independent RHC example, I thought we could just maybe we can talk through together, Eric go through the different category, categories and indicators on the left hand side, as you see, each report gets three years of data. Sometimes we get requests from new RH C's, and obviously, we're not able to provide all the historical data. And we'll just put whatever populates on here and just hide the rest. But it's broken out. As you can see on the left, and I hope this is somewhat visible, the snapshot, it might be a little smaller, blurry, we'll have some cleaner shots, as we move along in the presentation. So we've got encounters per FTE, broken out by provider type, cost per encounter, also broken out by provider type, cost per FTE, and then clinic cost per encounter. And then you've got your total encounters that Medicare encounters and injection costs down at the bottom. And then you can see the green and yellow and red arrows that Eric just told you about. And those are drawing off of comparing the RHC value to the middle column, that the mean of the region, which this is an example from the Midwest clinic in Michigan. One thing to add on that

Erik Prosser 13:44

area. Yeah, one thing also to point out, is, this is always historic data. And therefore, you know, we're always going to be trending about a year behind this example. The most recent data is through 2020. So also take that into know that it's that this information comes out about a year after you file or your urine closes. So

Nate Smith 14:18

there is a bit of a lag time we do we can take some we can take the if there's a caution port, you know, sometimes on a console, I'll take the 2021 one if it's available in hickories, but just hasn't updated this report yet. And you can kind of take some of the numbers from it for a more updated comparison too. But yeah, the this report is about a year behind and we'll have the next update later this year, early next year, I think, is that right

Erik Prosser 14:47

that the full update to the benchmark, the DAT data becomes available in January. So it'll be I would say beginning of February when the next version of the bench more work with updated information will be available. Great.

Nate Smith 15:05

So here I have zoomed in on the kind of this top category here, this top left one encounters per FTE by provider type. And as you can see this one, the productivity for the physicians is well below the mean, they have a mid level staffing ratio, so they have more mid levels than they do physicians is what that 77% means, which is higher than state region, ordination. Anything you wanted to, I was going to show kind of the, we don't need to analyze this data too much. I've put it up here, because on this next slide, I wanted you to see kind of where this, this is. This is an Excel, when we run the report, and it pulls the FTE. You can kind of see the math behind this. So this clinic reported 1421 actual encounters by MD type. So I had a one FTE that equals 1652. So you can just kind of see the math behind this. And I wanted everybody to see that, as part of our process before these reports go out. See here, we tie it back to the cost report here from this worksheet. And you can see that these numbers match up. And so before we send the report out, we want to make sure that there aren't any variances. And this is just a screenshot that we have from our tracker.

Erik Prosser 17:04

If you want to bet back up to either one of those slides, dates, and something else here to take into account is we have some numbers across the top of the state, region and nation. And that's telling us the number of clinics that we're looking at good point. Yep. So we've got 23. In Michigan, you know, the Midwest is 144. And Nathan, each of this is a independent, it is Yep. So we have 952 independent, our ACS represented within the benchmark. Something else just to note is, you know, when you're looking at the Assura comparisons, you kind of have to realize, too, that this is just your clinics data, compared to, you know, these averages. So obviously, one thing that really kind of pops out is, you know, the physician productivity of 1652 is quite a bit less than any three of the metrics. But, you know, each each clinic is their own clinic. You there's a lot of there's a lot of things that kind of play into why that number might be the way that it is. And that's kind of the objective of the entity. The overall objective of this benchmark is to kind of point those type of things out so that you can either agree with or question why we're seeing so some of these things.

Nate Smith 18:32

Yeah, I've got a slide later on where we can kind of where I've got some questions, we can kind of get into this, this example in particular, all right. Before we got to that point, I thought we'd go through these other categories, though, just so they can get a zoomed in view of it might not be as easy to see with all that data on the slide, that here's the cost per encounter, and cost per FTE indicators. And this one, you know, we've got a takeaway here that there's favorable provider costs, but they've got lower visit numbers. This is the one from up here. So you know, as you can see, they're not they're not productive. The physician assistants are trending towards the mean, physicians are well below. But but they're not. They're not expensive. They're not spending a lot per provider type on cost. So and then this last, this slide will cover the remaining kind of categories where you you're looking at clinic costs. Also, you know, something really important here, obviously is the cost per visit of 138 97. And that ties to this other worksheet here that's pulled from the cost report. Another one of the measures that we reconcile before getting the report out to you guys. And this one was kind of I brought, I use this as an

example, because now we'll kind of get into, like, why is this information helpful? And kind of what can we do with it? So with as an independent RHC,

Nathan Baugh 20:28

then they Yeah, sorry to interrupt, we have actually a question. Okay. Can you go through the difference between cost per encounter versus clinic cost per encounter?

Nate Smith 20:47

Eric, that might be one, you could answer better than I? Are you talking about the actual versus adjusted here?

Nathan Baugh 20:56

I think that's what Alleyn means.

21:01

The actual versus adjustment

Nathan Baugh 21:02

adjusted? Yes,

Erik Prosser 21:04

yeah, I think the difference is, if a productivity adjustment comes into play,

Nate Smith 21:10

I've got a slide with a good example about how that impacts revenue here later on in the presentation. Okay. So maybe we can it, maybe that slide will kind of answer and provide a visual. Okay, what it means reimbursement wise on the Medicare side of things, great. So, with being an independent RHC, eventually, you know, this, that rate is from 2020. But you can see the current rates 126, or 113, I mean, but here in a couple of years, they're going to cap themselves. So I think it's really beneficial to know kind of, you're not going to see that full Medicare rate increase benefit, if your cost per visit is lower than that 190 and 2028. So just something to like, that's a useful thing to know. So yeah, here's the example. This is from that first slide, where we had low productivity on the physician side of things, the provider type. And so something that we can kind of dive further into maybe on a call after a console or during the console, we can talk about them from a high level view. But here's some of the questions that we would maybe ask if there's any care delivery impediments. Or if the, if the doctors have supervision duties, or executive leadership responsibilities, then they might not be as productive. Or, as Eric alluded to earlier, it could just be an inaccuracy on their reporting, and working with their cost report preparer. So those are good things to identify and correct moving forward. Anything you want to add there, Eric?

Erik Prosser 23:19

No, I think that pretty well covers it.

Nate Smith 23:25

So this is just okay. Here's the example that I was talking about. So I'm not sure who asked you a q&a. I don't have that pulled up, Eileen, I think is what you said Nathan. But here's a differential of the actual cost per encounter and the adjusted cost per encounter, and it's so how it impacts reimbursement. So since that's a $45 difference of their actual versus the adjusted, if you multiply that times 1100 95 Medicare visits, then that equals about a $54,000 loss in cost based reimbursement.

Nathan Baugh 24:14

So just to clarify, if you meet your productivity standard, there would be no difference.

Nate Smith 24:20

Correct. You can see they did that back in 2018. Here,

Nathan Baugh 24:24

okay. Yeah. So that that was a year they met their productivity standard, then they started missing their productivity. And that's why there's a difference between their actual cost per encounter and then what gets adjusted because of the productivity standard.

Nate Smith 24:38

Exactly. Perfect. So another takeaway that I wanted to highlight on this slide. When we this is so this is an example of a clinic that we worked with, on an operational assessment, and during that process, we request data And we, we noticed that on their charge master for office visits, they were well below what their all inclusive rate was. And the they were under the assumption that they always get their all inclusive rate regardless of what build. But they weren't taken into account that 20% of the money that you get is based off that gross charge. So Medicare pays you 80% of your Ayar. That's true. But if your charge isn't high enough, then you're gonna be missing out on being made whole on your cost based reimbursement. Does that make sense?

Nathan Baugh 25:48

Yeah, it makes sense to me. Of course. It's 78.4%. Okay. Er, because of the Medicare sequester, which is a whole different topic. But yeah, but your point, I get what you're saying? Yeah.

Erik Prosser 26:02

Yeah. So if your idea is that you're going to keep your charge low to benefit your patient, for $100 charge for an office visit, knowing that that would keep their coinsurance at 20, you know, the copay

$20. In the end, you're actually making up that difference out of your own reimbursement. So just always something to keep in mind operates.

Nate Smith 26:28

And that's what they were doing. They had a low charge just to try to be competitive, and not have it too high. But yeah, it does impact folks with Medicare that don't have a supplemental or secondary insurance, which will pick up that additional charge. But if you don't have that, then that would be a higher expense that the patients will notice for sure. All right, let's see what we have next. So this is a just an example of a provider based RHC report. It's pretty much the same thing. For some reason total encounters are up here at the top instead of down here with the Medicare encounters like they are an independent report. But other than that, I think it's pretty much the same. Right, Eric?

Erik Prosser 27:15

Yeah, it's a very similar benchmark. Overall, I did see we just had a question pop up to about how often should the cost per encounter be reviewed during the fiscal year, and I think maybe this might as well address that right now. It's a topic. My perspective, from a cost report and reimbursement perspective, is year end is probably the most best time if there's going to be a settlement, it's based upon that cost per encounter. So any sort of improvement or changes that need to occur, would have the best benefit at that time, things have somewhat changed with, with the provider based rural health clinic, if you if you have a grandfathered rate, you're that means you're you have a rate based upon your file 2020 costs report, or I believe your first full year cost record. That was a partial year. And so you do have somewhat of a limitation or cap on that cost per visit, too. But ultimately, if you were trying to measure or review your cost per visit throughout the year, essentially what you're doing is some sort of, you know, mini costs report or something along those lines to actually be able to get back into that number because for provider based rural health clinic, that's, you know, it's multiple factors that go into it. But the main one that you're having to at least estimate is the overhead of the hospital operation, that that gets allocated to the provider based clinic. And then from the provider based clinic cost level, you know, productivity standards changes, changes in FTE changes and visits, they can all impact that. Sure. It's definitely doable, but throughout the year, but really, in my opinion, is that is that year end number that makes all the difference as far as what you're actually going to get paid or settled on for the full year. I know Nathan, do you have any other thoughts or opinion on that?

Nate Smith 29:34

Now? I think you covered it there. Okay. Let's see what we have next. provider based in the Midwest. I probably pulled this example because there was a lot of read here. So during a console, if we were to have one requested you know, that would be an area here we're looking at clinic cost per encounter. someone else to keep in mind is we're looking at 2019 to 2020. And obviously, 2020 is a weird year with the pandemic. And so things are going to be out of out of whack. So for context, you have to keep that in mind. But still, when you see that your total healthcare costs are, you know, double of what the region is, then that would be something to look into further on why your costs are so much higher, that might be another area to improve on if we dug a little deeper, and those are things that we like to work with clients on. So another point here is the high costs per FTE on the physician side of things.

964 Compared to 381, is a pretty high difference. It looks like historically that they've been trending, you know, with the mean, but maybe that was just a unique thing to COVID, likely. So. However, it's it's worth noting, and then you can see what they're they've got a really high rate of $665, which is one of the higher ones I've seen before. And more than doubled from the previous year. So the way I like to look at these things, or think about them from an operator standpoint, is they're indicators and signals, they don't necessarily tell you everything that you do need to know, but it can potentially flag things, like I said, to look further into. Do you want to talk about any of these other arrows that we're seeing here, Eric, and how they impact each other?

Erik Prosser 31:45

Sure. I mean, you know, first off, like, this is just telling us, you know, half the story in terms of what we're seeing. A lot of times, it's that console that we have with the client that really tells the other half that story. One thing though, that I mean, I will just kind of point to which Nathan, you kind of already pointed to a little bit is this really high cost per visit and 2021 thing that I just interesting to me with when I look at this example, is my first thought would be, you know, this is a provider base rural health clinic. So did they get a productivity waiver? In 2020, which yielded in a really high cost per visit. But in 2019, the allowable, actual and adjusted are one of the same, which tells me there was not a productive adjustment in the prior year. So yeah, something really does jump out to me in terms of something happened in that cost per visit. You know, the other half is to find out if that was, you know, correct or incorrect. Your what was the driving force for that? Is it a cost factor? Was there a correction in cost, or maybe it had to do with visits, maybe maybe the visit count was was previously different, or maybe because it was the pandemic, the costs remain really high and the visits dropped quite a bit. You know, you don't really know that until you have that discussion.

Nate Smith 33:23

That's a reasonable assumption that the volume just decreased a lot and the costs stayed the same or even increase. So you can see the impact here. Let's move on to the next one. And then if we have questions, we were hoping to kind of get some engagement, I've got the q&a pulled up so we can address those as they come up. I think for the most part, I might just have a lot of examples here. This is a cleaner, one zoomed in, that we could look at. Oh, yeah. And I pulled this one, I'm sure because you know why? And this was the case, not just in 2020, because I remember this example and looking at it was the same and 18 and 19 further cost per FTE on the physician side of things. Eric, when you see something like this, what does it kind of, you know, what questions are asked like, at this is a provider based or cost may be carved out and allocated to the to the home office? Or how does that kind of factor in here when you see 27,000 Compared to 381?

Erik Prosser 34:33

Yeah, good question. I think that it would fundamentally go first back to is this a reporting issue that has historically been reported incorrectly? But more importantly, is this like a cost based issue because that just sounds to me like there could potentially be something incorrect somewhere in the data. were similar in the preparation of that that piece in the cost report to where you're not getting credit for the full physician cost, right?

Nathan Baugh 35:10

Because this, this is showing, essentially that a physician was making $27,000 a year.

Erik Prosser 35:16

Yeah, because this Yeah, this is this is an annual or like an FTD per FTE, you know, equivalent amount. So, even if they only worked a handful of hours, on a daily basis, it's just telling us that it was on an incredibly low rate. Yeah,

Nathan Baugh 35:33

I do have a theory, though. This could be that the NP or PA, here is really the primary provider, and that physician is just really serving as like a medical director or physician supervisor, and perhaps, is kind of doing it providing services, just add that RHC very occasionally, and really not charging the RHC, much to, you know, be the medical director kind of, I don't know, almost out of a charitable thought or out of the goodness of their own heart. Would that be an explanation? That very well could be in

Nate Smith 36:17

chat examples like that, where there's just a high non physician practitioner utilization with oversight by by the physician

Nathan Baugh 36:26

and the physician doesn't want to, you know, charge the NP, their NP partner essentially, like a really high rate, and that that would,

Nate Smith 36:36

and sometimes that's what you find out and then you can be like, Well, okay, well, we did our due diligence, we know that that's not a reporting error. We know things are being that's just kind of how our unique situation this Yeah, the dynamics at play in that unique market. So Exactly.

Nathan Baugh 36:54

Awesome. So if you guys want I usually I find it works well, if if I kind of prep the questions, and I can start peppering you guys with the questions as they come in. And we can do that, or if you have a few more slides to go through. Before we get into that full q&a.

Nate Smith 37:13

I think mostly, I've just got examples here, you know, so we can start with questions. I've just pulled some other cost report, or some benchmark reports with some outliers. Okay, great. Eric, are you comfortable with Sure?

Erik Prosser 37:29

Your questions? All

Nathan Baugh 37:30

right. So first question is from gray pulls in. He wants to know, does it make sense to wait and request to RHC report until our cost report is filed? And he notes that his is due at the end of the month? I guess I could just ask that more generally. Obviously, the cost report is going to be like more up to date information. So is it useful to be looking at a benchmarking reports, even though it's a year, so older, right around when you're filing the cost report?

Erik Prosser 38:01

Yeah, I think if you have not requested one for the most available report, it's not going to tell you if you're you know, there's issues with your current filing of a cost report. But you're definitely going to, you know, get some sort of insight in terms of how you're trending over the past three years. And if something jumps out to you than my relative to your current filing, then I would want to know ahead of time. So yeah, I would, I would think that the best time to request one of these would be in the first six months of the calendar year. Because that's when the most available information is going to be out there. And then, you know, if anything, then again, it just kind of depends on how that lines up with with your fiscal year. Awesome.

Nathan Baugh 38:56

Next question is from Laura fierce, who asks, Where would we find usual reasonable and customary charges? Would that be something that's on the cost report or? Well,

Erik Prosser 39:11

I think what they're, my interpretation of that is what Medicare determines the coinsurance to be calculated off of. So basically, what that equals is what your charge is for that service. So if I'm interpreting the question correctly, I think that's that's what you're

Nathan Baugh 39:36

right, which is, which maybe you could explain is a little different than fee schedule.

Erik Prosser 39:41

Yeah, it's different from fee schedule like which this is a completely different scenario. But if you had a service done in a hospital that was paid prospectively, from the IPP, s opp S system, your coinsurance is based is based upon 20% of the ill Loud Medicare amount. So if the charge was $300, but Medicare pays $100, you would pay 20 on that 100 as the 20% coinsurance component. So when you apply that same idea to a provider or a rural health clinic, it's that customary charge, which is what you're charging for that service. And that's why it's really important than to know that your your charges are

somewhat in line with with your cost per visit, or your ar, ar, so to speak, because that's the only way you're gonna get made hold the coinsurance piece. And then, of course, the only concern then is is, is that your charge is never going to kind of price you out of your own market. So that earlier example, you know, the cost a cost per visit at 695, you're probably not going to be able to charge that. That level of rate for an office visit. Right. And that's a pretty high one. Yeah.

Nathan Baugh 41:03

Do you want to go back to one of the cost report pages? Yeah, there you go. Just so people can look at it? Whether Yeah, question core. Awesome. So next question is from Jennifer. It's more of a comment from our earlier conversation. She says wouldn't the variance be likely because so much telehealth was used during the pandemic but Medicare doesn't allow telehealth visits to be counted as visits? And then perhaps you could expand upon how telehealth how you guys would anticipate telehealth impacting these numbers?

Erik Prosser 41:36

Yeah, so ideally, the way you would treat telehealth starting within the 2020 year is and this is actually one of the things I think that we want to build into the benchmark within our next you know, annual update is is an indicator for the telehealth because, ideally, what you should be dealing with with telehealth is, in this most specific to a provider based rural health clinic is on the M one schedule there is a specific line for telehealth cost. So, ideally, you are on similar level being able to track it in and identify telehealth related expense. Because that cost is entered on that line of a cost report excludes the cost from the allowable cost per visit calculation, because it knows that it was not paid on a cost basis. And then on the visit side, you would exclude and not include any telehealth related visits and your total visit count. Normally, the cost per visit for telehealth is far less than your Ayar average. So it's always beneficial to do it that way. And from this current benchmark, I mean, telehealth could be playing a role. I mean, if the cost report was filed, especially initially in 2020, it's very likely that you could have included the cost in allowable and the business and total because you were not tracking that we're not aware of that. That is not the correct way to handle it. And we've actually worked with quite a few clinics going to go back just to correct that, that that component of file report. So does that answer the question? I think yeah, yeah, I

Nathan Baugh 43:34

think so. Next question is from Jennifer Newby. She says I'm curious. If there are benchmarks for the percentage of physician hours that our agencies have available for visits versus non patient facing time, I wonder if we are too generous in our work time versus patient work time?

Erik Prosser 43:58

Yeah. So I think this goes back to how are you counting your ft

Nate Smith 44:04

FTE? You know, exactly.

Erik Prosser 44:07

You know, there's there's probably two approaches we most commonly see as well, our clinics are open these hours that in, in the doctor, you know, the providers take an hour lunch, so it's it's those hours times these days equals these total hours divided by 2080. And that's how we get you an FTE. But what we more likely like to see is something more based upon something much more granular on here's when the providers are actually available to see patients. You know, one of the best examples I could probably give is, yeah, our clinic hours are you know, till 508 till five, but the providers stopped seeing patients after 330. So, that last hour and a half is really dedicated to Uh, other duties. So, instead of treating though, you know, the full clinic hours open to just the hours specific to, you know, seeing patients you came up with with a lower number of FTE ultimately.

Nate Smith 45:17

So you understand 4200 for the productivity standard, as a physician, you would see three quarters of that as your benchmark, right.

Nathan Baugh 45:25

So yeah, but I think the question was like, what is the standard? I presume you can't get that data? So that example that you just gave, if that was prototypical or not, is there any data anywhere that supports like the average physician? Is there you are seeing patients 32 out of 40 hours a week or something like that?

Erik Prosser 45:49

Yeah, that that would be nice. But I don't think that there's any way to actually track that because in theory, we're, you know, the focal point is on the hours available to see see patients in the total clinic hours would be an unknown.

Nathan Baugh 46:07

Yeah. So unfortunately, there's not a good percentage benchmark to point two,

Erik Prosser 46:13

I guess. Yeah. I guess the only thing you could do? Maybe this would be something, you know, some thought for a future development is you could always say, Well, here's the, you know, the adjusted FTE. And compare that to the notion that, you know, the most the clinic could be open would be, you know, 40 hours or because. But even then, it's you're, you're still kind of kind of probably somewhat be coming up with a smoothed over type number. In the end. I mean, if it's done on a clinic basis, it's tough to accumulate that data to tell for

Nathan Baugh 46:56

sure. Next, next question is from Michelle Rodriguez. She said, I've thought providers need to see 40 220 100 per year. So I don't know if you guys want to handle that. Yeah, that's correct.

Nate Smith 47:13

One, Oh, yeah. If you're one FTE physician, then that's 42. And if you're a nurse practitioner, then it's 21. But if you're a half FTE, then it'd be half of those numbers.

Nathan Baugh 47:24

But if you don't see that many visits per year, it's not like you're out of Medicare or something,

Nate Smith 47:32

you just get deemed a little bit on, you're missing out on some of that reimbursement on that example, where I had there was the $45 differential on their actual costs. Exactly.

Nathan Baugh 47:44

Yeah. So actually, if you look nationwide, right here on the screen, the nationwide average for physicians per FTE is, well, it was 3900. But in 2020, was only 3400. So the on average, physicians did not meet their 4200 per visits per year. Yep. But if you look at the NPS, pas on the screen, this is top right, if you're looking at the screen, on average, your MPs or your pas see, well, more than 2100 encounters per year. So we're meeting our productivity standard as a whole as an RHC program, largely by that over performance from the PAs and NPS.

Erik Prosser 48:34

Correct. So,

Nathan Baugh 48:37

thank you for that. Michelle. Next question is from Susan Campbell. She's she's just noting that maybe one of the reasons that there was some weird numbers, there was a there was COVID cost was maybe pulled from one hospital department to another. I don't know if you guys want to comment on that, if you've seen some weird costs get shifted around somehow, because of COVID.

Erik Prosser 49:05

Um, I mean, what I've seen overall is an overall increase in cost. By a specific area, that's largely lab cost, you know, was much higher, how that contributes down to the clinic level. The only thought that really comes to my mind is that you had a lot of lab costs directly assigned to that clinic. But if it's being billed for as outpatient service to the hospital, then that cost probably should have been pulled out of the clinic and put back to the hospital. So, you know, send the other pandemic related, you

know, increase in costs. Sure. You see that across the board, in all areas, probably equally, you know, the additional pay and things like that, but you know, It's a factor. But it's tough to tell to what, what magnitude, especially if you're talking about a very noticeable increase, the more likely culprit in terms of a cost per visit site is always the change in visits more so than the change in cost.

Nathan Baugh 50:21

Next question is, again, this might be, it's good to know what you can get from the cost report, but then also what you can't get from the cost report. So Laura asks, How do I know if our charges are enough? And what is the average charge of a 9213? Is that is that information that is going to be market sign here? Yeah,

Erik Prosser 50:43

yeah, it's markets is market specific. But pricing information is now public. For a lot of hospitals. If you're talking about a hospital provider based service, you could very easily go out and pull some pricing data, the shoppable services tool that most hospitals have available out there, type in ng one, three, and you get a pretty good idea on what what the charges are.

Nate Smith 51:11

And those are engagements that Eric and I work on together. Well, where are we we look at what hospitals are charging, and compare that to competitors and get their rates optimized based on their allowables. By by health plans.

Nathan Baugh 51:28

And I don't know if this has been if a lot of insurance plans are doing just yet. But the similar tab, the hospitals are supposed to post their negotiated rates, I believe that insurance plans are supposed to be posting their negotiated rates with medical groups with with outpatient. Is that have you guys seen that data yet? Have you guys found that? Or is it one of those ones where they're required to but they're just not doing it and paying to find

Erik Prosser 52:00

maybe a mix? I haven't personally utilize that data yet. I know, it's was a new requirement that's out there? And I haven't my capacity is always on the provider side. So finding out what plants are doing would only be kind of second hand information. Got it?

Nathan Baugh 52:22

Yeah. But it might be a way to get that negotiated rate for you know, for non hospital.

Erik Prosser 52:29

So yes, definitely.

Nathan Baugh 52:33

Next question is more technical question. If you've requested or if you've already requested a benchmarking report, when should you expect to receive it? Generally, the the turnaround time varies, but what generally what is that?

Erik Prosser 52:50

I think it really varies depending upon the quantity of requests that we're getting.

Nate Smith 52:57

We just had a lot come through. And then some requests have several RH C's within them. If sometimes when we put in the CCN number, it's not clean, and it takes a little bit of touch to get it ready to send out. So the ones that are straightforward, we can get out in a week or two. Usually, sometimes it takes maybe a few weeks to get some out that require a little bit more attention.

Erik Prosser 53:28

So yeah, I mean, the turnaround time just varies. But I'd say one, one week to three weeks would be the

Nathan Baugh 53:35

Yeah. Okay, great. And Ken asks, on this slide that we have up here, can you guys dive in on the pneumococcal injection line? It looks like nationwide, we went from 280 to 295 to 329. In terms of the cost per pneumococcal injection, any but this clinic specifically looked like they had a jump there any ideas? What's going on there?

Erik Prosser 54:03

You know, I'll give you a couple of comments. Nathan, feel free to jump in. A lot of times when you see a green arrow on a cost item, you know, the first notion is something positive. But in this case, it looks to me like they might not have been tracking their true costs correctly. Because it's green because she it if it's correct, it's costing you less than your comparison. But, you know, saying that the trend of pneumococcal all in cost has been around $300. And you've been doing it? Well, I mean, it's it started at you know, 92 and then dropped to 74. And then started to get one word range at 259 probably tells me that there was some sort of tracking issue. Yeah, i or i Yeah, I think that's all was what it would have to

Nathan Baugh 55:00

be. Yeah, that's no, I agree. I mean, because all this is pneumococcal and flu is, of course, outside of the cost per visiting counter calculation. Right, you get, essentially a lump sum payment out. Yeah. Right. So you know it doing it for so last, I would agree it could be a tracking error that maybe got corrected in this last year.

Erik Prosser 55:30

I don't know offhand what the going rate for Prevnar is, but I know it's more than $76.

Nathan Baugh 55:38

Yeah, yeah. And, of course, the COVID vaccines are in this category, as well. And there's been a lot of shifting on that in more recent years, right. So we, for a minute there, both Medicare and Medicare Advantage was going to be I think, for 2020 and 2021. They were paid in a similar fashion to flu and pneumo. And then for the current year, Medicare Advantage went back to being paid by the Medicare Advantage plans. And now we just do traditional Medicare COVID vaccine costs in a similar fashion here, so I would anticipate that might be something that we would want to look at going for 21. Especially what the COVID putting a COVID line on here. Yeah. I think that the cost reports breakout, the COVID relative to fluid pneumo, right?

Erik Prosser 56:37

Yeah, it's a separate category now.

Nathan Baugh 56:39

Yeah. Hey, I we're coming up on the hour mark, I don't want to hold you guys if you have to run. But normally, we do go over if you guys are okay with that and get through maybe 15 more minutes of questions as long as they're rolling in. Unless you guys have a hard stop.

Erik Prosser 56:58

I personally have a hard stop. But Nathan, could you stay on?

Nate Smith 57:01

I can stay on a little bit, although I don't have the cost reporting expertise, but I'm happy to stay on and do my best.

Erik Prosser 57:08

Sure. I do have a hard stop. I mean, I can stay on for a few more minutes.

Nathan Baugh 57:13

Okay, Eric, you drop when you have to. And okay. You know, again, we thank you for for hopping on. But what let's just get right into questions, try to get as many done as we can. And then just if you have to leave, you have to leave. That's fine. Next question is from Katherine Brown, is cms looking at lowering the 4200 visits per FTE due to EMRs? Decreasing the providers productivity? I've been getting this question. I'll take this one. I've been getting this question more, more and more recently. It's not imminent that CMS is looking to lower that the 4200 visits per FTE. It's something that I'm going to

start talking with CMS about. And in fact, this benchmarking data is going to be very useful in that conversation. Because mean, clearly, the nationwide average is trending the other way, right? And it's pretty strong data to use to show CMS like, hey, maybe that 4200 is not realistic anymore. So

Nate Smith 58:23

why is there such a difference in a physician and a nurse practitioner productivity standard?

Nathan Baugh 58:31

That is a really good question. I don't know why they created the productivity standard numbers the way they did. I know that having a low NPPA productivity standard is certainly very helpful in terms of meeting your overall RHC. Productivity standard. But I just don't

Nate Smith 58:52

I mean, there's a difference to me. From a practical standpoint, just though

Nathan Baugh 58:57

it doesn't make it doesn't make a lot of sense, if you think of it in our modern conception of PAs and NPS. But I think it maybe historically, it was just like, well, pas and NPS don't do as much as physicians, it's it. I don't think it has a lot of logic. And this is none of the productivity standards, by the way, are built into the statute. So this is all something that CMS created, not Congress, Congress really just said per visit and less a lot of the details up to CMS. So and, and it's been 40 220 100 for a long time, maybe since the beginning of the program. So that's why I don't have the context on why those numbers were picked. So but it is definitely something we're looking at right now. Of course, we're still in the Ph. D. And basically productivity waivers are being given And for anyone who's asking for them, so little less relevant at the exact moment, but when we get to after the PHP, that productivity is going to matter a lot more. All right, let me get to one more and then maybe Eric can answer that one. And then we'll, we'll say goodbye. Marcus says, Just say you have to nurse practitioners, should it be 2100 between the two of them, or 2100 per

Erik Prosser 1:00:27

it's 2100 per FTE. So if there's two of them, and they each work half an FTE total one FTE there requirements 2100. They both work, you know, one FTE and, you know, it's 2100 Each, right? It's just the accumulative FTE multiplied by that right. factor.

Nathan Baugh 1:00:52

So if you have two that are half FTE is, then basically that's just one FTE and it would be 2100 between the two of them.

Nate Smith 1:01:00

Yeah. Here we go. Here's a slide on the productivity. So you can see that this example they were, like 1100 ish below.

Nathan Baugh 1:01:12

Can you point out where you're looking? Okay, so

Nate Smith 1:01:14

right here with the 61, that you compare the greater of column two or column four? Uh huh. And so here's what their actual visits were. But here's what they needed to meet,

Nathan Baugh 1:01:27

they needed to do 7000.

Erik Prosser 1:01:29

Yeah, it's the 1.71 times 2100, which equals the productive requirement of 3591. So for that provider type, they're far over because they had 40 710 visits, but then it's the physician requirement that is always tough to meet, because, yeah, realistically, a physician is not going to see four patients an hour, which is what that equals to. But if a mid level can easily see two patients, if not three patients an hour and that's why right? They balance each other out. You know, my only input on why is that productivity standard, so high. The only logic to my mind, if you want to apply logic to it is is just to encourage mid levels to see the majority of your visits otherwise, you're gonna be penalized?

Nathan Baugh 1:02:17

Yeah. No, I mean, it. It was He said, It was honestly before my time. And so I don't know if there was a discussion about picking those numbers, but I know that there's been more discussion recently about that 4200 figure being unrealistic. So, Eric, do you have any time for maybe one more, or I'll take one more, then we'll do one more to go. Okay. Next question is from Janet. She says, changes in e&m to MDM. And time based has dramatically impacted visit volumes increased nine to one fours versus threes and consideration being given by CMS as clinicians are required to meet new criteria. I don't know if you have any comments on that it was kind of fun talking about I really

Erik Prosser 1:03:07

don't have any further insight. As far as the the acuity last type level of the type of visit increasing in the consideration for more time. Right now, I think it just is what it is that you have to meet. Yeah.

Nathan Baugh 1:03:25

Yeah. Okay. Well, Eric, thank you so much. Don't want to hold you up. But appreciate you. You know, running through this helped us and I, and I anticipate that you will be getting a fair amount of benchmarking requests coming. So

Erik Prosser 1:03:41

definitely, we're getting prepared. I really appreciate the opportunity to in eighth and awesome. Definitely look forward to continue our relationship going forward.

Nathan Baugh 1:03:50

All right. Thank you, Eric. Thanks, Eric. All right. Bye. Right. So Nate and I, the two Nathan's will continue to take some questions, have some conversation here? Rochelle says, do your clients typically share these benchmark reports with the providers? Is that something you advise doing?

Nate Smith 1:04:11

That's a That's a good question. It varies this not across the board one way or the other. We encourage it, we like to see models of physician administrator kind of a cohort working together in a management structure. So and transparency is good. It's sometimes challenging when I've done it to keep focus on what there's a lot of data there. So there are challenges and how it's presented. That's that's something that we would be happy to facilitate with clients to if they were interested in it. Yeah. But yeah, we welcome and then on the console side of things if you wanted to have somebody join in, the more Are the merrier. It's nice to have a discussion instead of just, you know, a couple of people, it's nice to share this information internally.

Nathan Baugh 1:05:07

You don't want to, you don't want to make like, throw people under the bus or make them feel uncomfortable by kind of revealing who is the reason we're not getting our productivity standard or whatever. And yeah,

Nate Smith 1:05:19

I mean, it's divided up by provider type, but it doesn't have individuals on there or anything. So

Nathan Baugh 1:05:24

sure, sure, yeah. But if there's only one physician, yeah,

Nate Smith 1:05:29

yes. Yeah. Then you can kind of draw conclusions from the data based on dynamics locally, but yeah, of course. Yeah. All right.

Nathan Baugh 1:05:39

Next question is from Marcus, will the benchmark show trends of overusing or not using enough nine to one ones through nine, nine to one for codes? Or will this be tracked on another report?

Nate Smith 1:05:55

Wait, don't I mean, we we work with clients a lot. So if there were things indicated on the report, we wanted to dig deeper into, then we do coding distribution service for clients to make sure you know that they are billing appropriately and not leaving maybe some, like level fours on the table where, you know, or they've got a high distribution of level twos, you know, that would be something you'd want to look at. But this report does not contain that information. Right.

Erik Prosser 1:06:27

Right. Exactly. Okay. I

Nathan Baugh 1:06:31

think we've clarified a couple of these already. Robin asked a good question. Actually, Robin Nelson, chiropractors are allowed, aren't allowed service in the RHC. Now, what productivity standards apply to them?

Nate Smith 1:06:47

I'm not I'm not sure. I can't speak to that.

Nathan Baugh 1:06:54

Yeah, so that would be I'm pretty sure there's a limited Medicare coverage of chiropractor services. I don't think that I think that that would be an allowable cost. But I don't think that they would be considered a, an RHC encounter. So like, while you say they're an allowed service, yes, you can have a chiropractor in there, and you can count them on the cost report.

Nate Smith 1:07:27

So you can count the costs, but then you don't have visits. But that would be advantageous to your rate, it would make it go up with a lower denominator higher,

Nathan Baugh 1:07:35

it would later unless you're at the cap, or unless you have an upper payment limit, that's preventing you so it's, I put it in the same category as like physical therapists, like you can have PTs and OTs working out of your rec, they're going to add cost, but not generate RHC encounters for Medicare. So that may be okay, if you have room to run with your cost per visit relative to your clinics cap. But if you're at the cap or above the cap already, then it's essentially you're not getting reimbursed for it. So so that might

Nate Smith 1:08:18

show. So go ahead example we had where there was a clinic that's going to be kept on, you know, an independent or a new provider based and then they're going off the increases of 13 bucks a year, you know, $140 $130 ish rate, you're going to be kept soon. So maybe that's an area where you want to look into adding that type of provider which would add additional cost into your cost per visit calculation.

Nathan Baugh 1:08:46

Yes, yes. But they wouldn't have productivity standards, definitely on that side of things. But on this slide, you'll notice that RNs LPNs, RNs can't normally generate an RHC encounter. But psychologists and clinical social workers very explicitly can generate RHC encounters and they have no productivity standards. So good point, Nathan. I don't know if you've seen I don't know if you have an example of someone that has a clinical psychologist or CSW on on one of this, either the independent one

Nate Smith 1:09:30

you know, I'm not sure.

Nathan Baugh 1:09:32

It's, well, here, we can look at the nationwide

Nate Smith 1:09:35

nurse. Here's an example that's got some data for psychologist social worker.

Nathan Baugh 1:09:40

Yeah. So again, so this is actually there, there is no productivity standard applies here. So essentially having CSW or psychologist should, it doesn't increase your productivity standard requirements as a clinic, and you can count those as in Counter, so it should help you overall meet your our ACS productivity standard. You know, so you know whether or not that is worth, it might still depend on the cost of employing a psychologist or clinical social worker relative to how many more encounters you're getting. But you can see here that we, you've aggregated it on this report, does it aggregate that on the cost report? And that's why psychologists and social worker on the same line, anything,

Nate Smith 1:10:39

it must and there's Yeah, it maps from, you know, it's gonna map from this, this this right here. And that's all in the background of how the reports built. But yeah, I think you're spot on there.

Nathan Baugh 1:10:52

Okay. Yeah. So they, but essentially, they don't have productivity standards. Yeah, it's from this one. To that what you're saying?

Nate Smith 1:11:01

Yeah, but flip to the wrong

Erik Prosser 1:11:02

one. Okay. Yeah.

Nathan Baugh 1:11:05

So yeah, having behavioral health services helps you meet your productivity standard. Now, that might change. If CMS takes a reformed look at what productivity standards are, they might come up with a number for psychologists and social workers. And there's even movement on the Medicare side to have LPCs licensed professional counselors and Marriage and Family Therapists covered by Medicare and in the RHC setting. So CMS may take a new crack at this, especially if we ask them, and maybe they'll lower physicians, but then maybe they'll create a productivity standard for these other provider types. So it's a little bit one of those things where you kind of want to be careful and take Yeah, yeah. Be careful what you ask for, because, oh, yeah, you're right, we should take a look at those products. So right now, the physician is certainly, quote unquote, unfair, that the PA and P and behavioral health rules are a bit attractive, I wouldn't say are certified nurse midwife. Rules are attractive. So it's like you can make it work awkwardly? Yes. Under the current circumstances, but

Nate Smith 1:12:17

hopefully behavioral mental health integration will be something that's incentivized continue to be

Nathan Baugh 1:12:23

sure. Yeah, forward. Yeah. Yeah. I totally agree with that. So I know, I'm kind of talking here, folks. If you have any last questions, go ahead and get them in the chat box now. But I think we've kind of got to the end of our q&a. We still have 140 people online with us. So thank you, to those of you for sticking around through the full FAQ. Nate, any last thoughts? To close it?

Nate Smith 1:12:53

I don't think so. It's been awesome. Going through some of these examples with you guys. Here's kind of I did want to maybe show kind of some other things that kind of areas of focus, me and Eric, kind of things that we projects we work on. So if there's any kind of provider based or HCS out there that have a 340 b program, or if anybody was interested in maybe an operational assessment based on some of these slides that we we showed you today, there's been some areas for clinics to improve on. And we've had some success doing that. So just a couple of things to mention. Before we jump off, thanks for moderating.

Nathan Baugh 1:13:41

Of course, thank you guys for hosting and, and be patient as we get I'm sure a whole round of benchmarking requests. And we encourage you guys to submit them though, so don't don't be afraid of that. Yeah, we're ready for him. We know it's here. Yeah. And, and we can get you your Kleenex specific report, back out to you. And if

Nate Smith 1:14:04

anybody's out there that I just sent him to, if you want to request just reply back to the email, and we can I mean a console, then we can follow up with you on that Eric, and I can get together and talk through some of this.

Nathan Baugh 1:14:17
Excellent. Well, thank you, Nate. We're gonna go ahead and close it here. Just so quick reminder, for those of you that are CRH GPS, as you exit out, you got to take the survey. And then when you get that completed survey, you will get the CEU code for the webinar. So with that, just stay on the lookout for our we don't have another webinar scheduled right now, but I do think we're gonna plan on doing something before the end of the year. On the technical assistance side of things, the more the government sponsored side of things, so just be on the lookout for an email from us and hope you guys all have a nice Thanksgiving. Thank you. Thank you