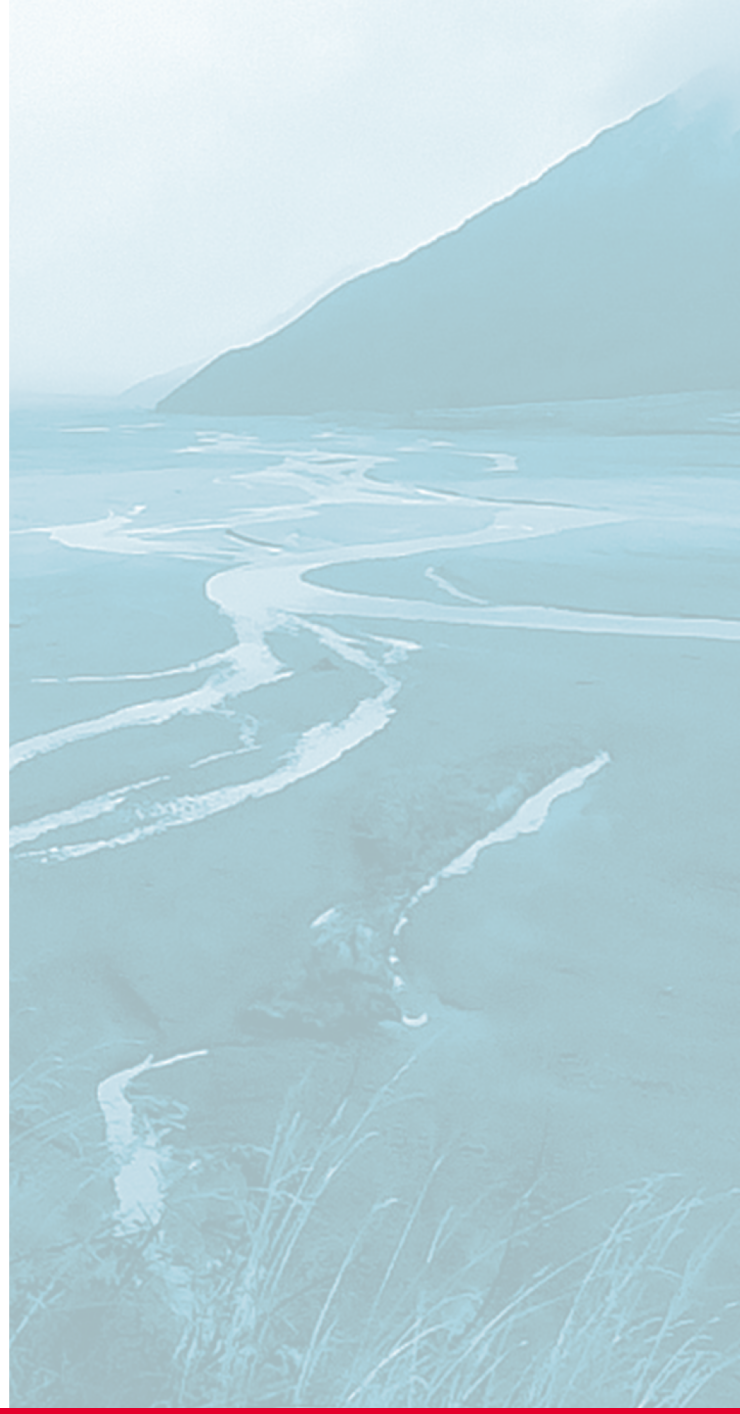
Understanding Your Costs in an Evolving Payment Environment

Session 1: Cost Allocation – Getting the Basics Right



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Session Titles and Descriptions

Session 1: Cost Allocation: Getting the Basics Right

Session 2: Preparing Internal Systems for Gathering Cost Data

Session 3: Cost Allocation Methodology for Value-Based Payment Systems

Session 4: Utilizing Cost Data to Drive Programmatic Change

We've Got Some Catching Up To Do…

The introduction of modern cost accounting in health care may prove to be the same type of breakthrough that it was in other industries decades ago.

Michael Porter, Harvard University

Source: What is Value in Health Care?; New England Journal of Medicine

But It Won't Be Easy

"As organized today, primary care is a mission impossible. Most primary care practices attempt to meet the disparate needs of heterogeneous patients with a single "one size fits all" organizational approach. This leads to frustration for both patients and the clinicians who attempt to serve them."

…and the back office charged with keeping track of it all…

Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs, Health Affairs, Porter, March 2013

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And some things never change:

Developing the capacity to accurately track, allocate, and compare costs across service lines is an essential tool in the successful management of a health center.

But HOW you do it will change

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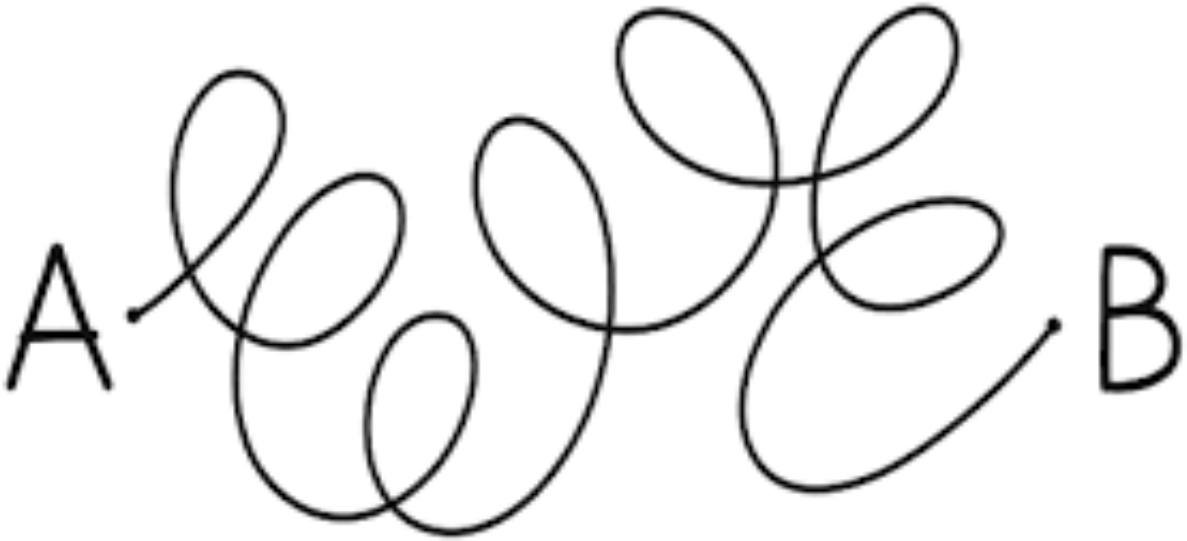
Getting From Here to There …

It's not a straight line between pay per visit and pay for outcomes!



Graphic from Veritus Group

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Current Approach

This Capital Link publication provides guidance on the pay per visit methodology.

Available at:
http://www.caplink.org/cost-per-visit

Originally published as a NACHC Information Bulletin entitled ***Cost Per Visit—Measuring Health Center Performance***, in December 2003 and updated by Capital Link in 2018; http://www.caplink.org/cost-per-visit

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Components of Cost Per Visit or Patient

All expenses at the organization can be classified into one of the following categories:

- Provider cost
- Direct Support cost
- Direct Enabling cost
- Overhead cost
- Ancillary and Other cost

Provider Cost

Provider costs are direct costs incurred by billable providers delivering services. Provider cost does not include items such as subscriptions, continuing medical education, or other non-personnel services.

EXAMPLE

Eastside Family Health Center

8.0 FTE physicians whose Total Salaries =	**$1,400,000**
Fringe benefit and payroll tax rate of 20% =	**$ 280,000**
Total provider cost =	**$1,680,000**

Medical providers generated **25,000** billable visits over the period.

Provider Cost Per Medical Visit at Eastside Family Health Center is **$67**

($1,680,000 divided by 25,000 visits)

If those 25,000 visits involved 7,700 Medical patients:

Provider Cost Per Medical Patient = $218

($1,680,000 divided by 7,700 patients)

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Provider Cost Per Visit/Patient

Four key factors that impact upon provider cost per visit are:

- Compensation
- Productivity
- Non-Clinical Activities
- Provider Staffing Mix

Sneak Peek: In a future presentation we discuss adding outcomes as an additional criteria.

Provider Cost Per Visit: Compensation

While the labor market generally determines compensation for providers in private practice, compensation for providers working in health centers has been below the market as a result of limited funding and other resource constraints.

	Health Center (50th percentile) (1)	Physicians in Private Practice (2)
Family Practice	$193,800 (3)	$231,000
Internal Medicine	$192,800	$243,000
Pediatrics	$175,500	$225,000
OB/GYN	$240,000	$303,000
Psychiatrist	$233,572	$260,000
Psychologist	$93,180	$107,460*

Sources:
(1) Health Center Salary and Benefits Report 2019-2020 NACHC
(2) Medscape Physician Compensation Report 2019 (*ZipRecuiter.com)
(3) Average of Family Physicians with and w/o OB Deliveries

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Provider Cost Per Visit/Patient: Compensation

In response to this challenging situation, many health centers have begun to implement **incentive-based provider compensation systems** that reward providers on a variety of measures designed to hold them accountable for aspects of service and production as determined by management/board. An incentive compensation plan can be based on one or more of the following criteria:

- **Productivity**
- **Patients/members satisfaction**
- **Quality**
- **Effectiveness at managing utilization**
- **Peer review**
- **Compliance with the health center's policies**

Provider Cost Per Visit/Patient: Non-billable Factors

When analyzing **provider cost per visit/patient,** it is necessary to also take into account the non-billable factors related to provider performance, including:

- **Length of standard workweek**
- **Number of clinic sessions**
- **Inpatient and on-call visits**
- **Clinical teams**
- **Travel time**
- **Documentation**
- **Continuing Medical Education (CME)**

Provider Cost Per Visit/Patient: Provider Staffing Mix

The mix of provider staff should be taken into account when analyzing provider cost per visit/patient. The chart below illustrates why this is important:

	Nurse Practitioner	Physician Assistant	Family Practice Physician	% Avg. APP to Physician
50th percentile Salary	$100,000	$101,100	$193,800	51.9%
Average Productivity	2,504	2,791	2,900	91.3%

Presumably this relationship holds between Psychiatrists and Psychiatric Nurse Practitioners (PNPs – avg. 2020 salary of $120,000), but the UDS does not provide productivity figures for PNPs.

Source: 2019-20 NACHC Salary Survey and 2018 UDS

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Provider Cost Per Visit: Productivity

Physician Type	Total Salary Cost	Total Visits	Visits /FTE	Cost per Visit
Family Practice (4 FTEs)	$700,000	12,300	3,075	$56.91
Internist (1.5 FTEs)	$262,500	4,450	2,967	$58.98
Pediatrician (2 FTEs)	$326,000	6,500	3,250	$50.15
OB/GYN (1 FTE)	$225,000	2,850	2,850	$78.94
Psychiatrist (1 FTE)	$230,000	2,100	2,100	$109.52
Psychologist (2 FTE)	$186,000	2,200	1,100	$84.55
Total	$1,929,500	30,400	15,342	$63.47

If Eastside Health Center can increase productivity by 15%, that would result in 34,960 visits. Assuming that salary costs remained the same, the total provider cost per visit would decrease to **$55.19** - generating an additional ~**$251,660** to be applied to incentives or other service costs.

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Direct Support Cost Per Visit/Patient

Direct Support costs are costs of non-provider staff or items that are directly involved in the delivery of healthcare services to patients.

These include:

- Nurses (RNs and LPNs), medical receptionists, medical assistants, and clinical managed care support
- Direct dental support (includes dental assistants and dental receptionists)
- Mental health support (includes mental health receptionists)
- Supplies

(Note that this is not an exhaustive list—some health centers may employ other support staff positions depending upon the major service lines offered.)

Direct Support Cost Per Visit/Patient

EXAMPLE

Eastside Family Health Center

3.0 FTE Dental Assistants whose Total Salaries =	**$105,000**
2.0 FTE Dental Technicians whose Total Salaries =	**$107,000**
Total combined salaries =	**$212,000**
Fringe benefit and payroll tax rate of 20% =	**$ 42,400**
Dental supplies =	**$200,000**
Total direct support cost =	**$454,400**

There were **7,500** dental visits over the period under analysis.

Direct Dental Support Cost per Visit at Eastside Family Health Center was **$61**
($454,400 divided by 7,500 visits).

If those 7,500 visits involved 3,000 Dental patients:
Direct Support Cost per Dental Patient = $152
($454,400 divided by 3,000 patients)

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Direct Support Staff Cost Per Visit/Patient

The major factors that impact the **Direct Support Staff Cost Per Visit/Patient** include:

- **Compensation**
- **Productivity**
- **Staffing Mix**
- **Ratio of Support Staff to Providers**

Direct Support Staff Cost Per Visit/Patient

Ratio of Support Staff to Providers

The average health center in 2018 (UDS) had:

- **1.75** FTE medical support staff (nurses, other medical personnel) per medical provider FTE;
    - **1.97** (2018) for health centers >=75th percentile for medical provider productivity.
    - **1.47** (2018) for health centers <=25th percentile for medical provider productivity
- **1.39** FTE dental support staff (Dental Assistants, Aides, Techs) per dental provider FTE
- **.27** FTE mental health support staff (Other Mental Health Staff) per mental health provider FTE

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Direct Enabling Cost Per Visit

Direct Enabling costs are those costs associated with social services or enabling services that are outside of the traditional definition of medical services. These services may include:

- **Case management**
- **Patient/community education**
- **Outreach programs**
- **Transportation**
- **Translation services**
- **Eligibility specialists**
- **Community health programs**
- **Child care programs, nutrition education, other SDOH outreach**
- **Other services outside the scope of the delivery of primary care services even if these services are considered medically necessary**

Across the general patient population, Enabling Cost Per Patient will vary as need/utilization varies. However if patients are grouped in care pathways, there may be more uniformity in utilization and an ability to document necessary costs to justify reimbursement.

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Overhead Cost Per Visit/Patient

Overhead costs include:

- Rent, interest, and depreciation expense (+ other facilities costs)
- Administrative and facility staff salaries and fringe benefits
- Malpractice insurance
- Office supplies, legal/accounting fees
- Other costs not already classified into a category

Overhead Cost Per Visit/Patient

Approximately 70%-75% of health center costs are personnel-related expenses. Of the remaining 25-30% of costs, approximately 5-10% are facility costs and another 2-5% are other fixed costs, which are difficult to reduce.

On average, **the percentage of total costs at a health center that are accounted for by administrative overhead is between 25% and 40%.** Cost reduction considerations include:

- **Improving Productivity**
- **Staffing**
- **Administrative Staff Compensation**
- **Facility Overhead**
- **Administrative Overhead**

Under a VBP system, the feasibility of reducing costs by manipulating these factors could change.

Ancillary and Other Costs Per Visit

Ancillary and Other costs are those costs associated with services that are outside of traditional primary or specialty care. It is important to note that with the growth, diversification and evolution of FQHC services some traditional ancillary services such as vision and pharmacy can now be considered to be their own direct service lines.

Typical Ancillary services include:

- **Radiology**
- **Laboratory**

Be sure to base your calculation on medical visits (as opposed to total visits) unless the center offers both medical radiology and dental radiology services then separating those costs and associated visits is appropriate.

Planned and necessary routine Ancillary costs might be integrated into a care pathway for a chronic care group under a Pay-for-Outcomes system.

Ancillary Care Cost Per Visit/Patient

Due to the wide variation throughout the country, there is no "standard" set of ancillary services offered at health centers

- **Range of Services Provided**
  - **On-Site vs. Off-Site**
  - **Availability of Services**
  - **Fixed and Variable Costs**
- **Utilization of Services**
- **Calculation of Costs**
- **Quality**

Sneak Peek – …but there could be, as part of an outcome-based set of procedures within a clinical pathway.

Ancillary Care
Cost Per Visit and Procedure

STEP ONE : Calculate Laboratory Direct Costs

Salaries and Wages	
3 Lab Technicians at $39,333	$118,000
1 Lab Supervisor at $67,000	67,000
Subtotal =	$185,000
Fringe Benefits (20%)	$37,000
Subtotal Personnel Costs	$222,000
Direct Supplies	$75,000
Total Laboratory Direct Costs=	$297,000

STEP TWO : Calculate Laboratory Overhead Allocation

Total Laboratory Direct Costs =	$297,000
Total HC Direct Costs =	$3,000,000
	= **9.9%**

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Ancillary Care
Cost Per Visit and Procedure

STEP THREE : Determine Laboratory Overhead Costs

Total Overhead Costs		$1,750,000
Laboratory Overhead Allocation	x	9.9%
Laboratory Overhead Costs	=	$173,250

STEP FOUR : Calculate Total Laboratory Costs

Laboratory Direct Costs =	$297,000
Laboratory Overhead Costs =	$173,250
Total Laboratory Costs =	$470,250

STEP FIVE : Calculate Laboratory Costs Per Visit and Laboratory Cost per Procedure

Total Laboratory Costs	$470,250
Total Health Center Visits =	**32,500**
Laboratory Cost per Visit =	**$14.47**
Total Laboratory Procedures =	**22,000**
Laboratory Cost per Procedure =	**$21.38**

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Summary of Components of Cost Per Visit/Patient

By analyzing the individual components of cost, it is possible to compare your center's cost-competitiveness to the average for all health centers on a per visit and per patient basis (from the 2018 UDS).

	Cost per Visit - 2018 UDS Average					Cost per Patient - 2018 UDS Average				
	Direct Cost / Visit	Enabling Services Cost/Visit	Overhead Cost / Visit	Lab & X-Ray Cost / Med. Visit	Total	Direct Cost / Patient	Enabling Services Cost / Patient	Overhead Cost / Patient	Lab & X-Ray Cost / Med. Patient	Total
Medical	$125.82	$17.57	$69.77	$5.91	$219.07	$407.18	$56.87	$225.78	$19.12	$708.95
Dental	$140.86		$68.22		$209.09	$363.44		$176.01		$539.45
Mental Health & Substance Abuse Cost	$134.15		$65.74		$199.89	$644.19		$315.71		$959.91
Vision Services	$115.50		$61.85		$177.35	$154.29		$82.63		$236.92
Pharmacy*	$11.45		$5.59		$17.04	$37.05		$18.09		$55.14
Pharmaceuticals*	$26.12				$26.12	$84.53				$84.53
Other Professional	$86.49		$42.37		$128.85	$256.74		$125.77		$382.52
Other Related & QI*	$7.00		$2.71		$9.71	$28.57		$11.06		$39.64

* based on Medical Visits/Patients only

** based on all Visits/Patients

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In a FFS world, more visits equals more revenue so productivity is a key

Revenue Model driver

BUT

In a typical capitated system, the FQHC is rewarded by not seeing the patient as often (but seeing more, different patients)

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In a pay for outcomes world, it will likely be up to the care team to determine the optimal number of visits to be able to demonstrate compliance with quality care / outcomes measures.*

*** This is the fundamental business model change that is coming and will be discussed in greater depth in the following presentations in this series.**

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Pitfalls, Barriers and Challenges

Why Sometimes We Get the Basics Wrong

- Need for a very detailed Chart of Accounts to capture all costs by site/dept./program
- Need to utilize EHR/Practice Mgmt. system to capture stats on denials and other adjustments that affect finances
- Need to make sure the HR system can sufficiently track hours/costs by site/dept./program.

But not all the reasons are about our systems:

– "Grants don't really cover our overhead, so we don't fully allocate our overhead costs to some funding sources."

– "This program is important to our patients so we keep offering it even though the funding has gone away."

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Conclusion: Looking Toward the Future

Fee for Service and capitation are still the dominant modalities for reimbursement of FQHCs and for that reason the methodologies and issues discussed in this presentation are still relevant for most centers.

However, many centers may already be participating in ACOs, shared savings and Pay-For-Performance programs that change the calculus.

Conclusion: Looking Toward the Future

Notwithstanding the complications of operating in this current hybrid payment environment, centers face an irreversible (we are told) transition to a system in which they will be paid based on producing **value/outcomes,** which will be defined by the payer and the patient.

(whose interests may not always align!)

Sneak Peak: What Will That Look Like?

Value

is defined as the

Health Outcomes Achieved / Dollar Spent

"In a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system. Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and

shifting focus from volume to value is a central challenge."

What Is Value in Health Care?, NEJM Michael E. Porter, Ph.D

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Sneak Peak:
What Will That Look Like?

"**Cost,** the equation's denominator, refers to the total costs of the **full cycle of care for the patient's medical condition**, not the cost of individual services.

To reduce cost, the best approach is often to spend more on some services to reduce the need for others."

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Coming Up….

Please join us for the next webinar in this series:

Preparing Internal Systems for Gathering Cost Data

February 18, 2020, 3:00 ET

We review how to set up your internal systems in a way that will allow you to accurately capture cost data in a meaningful/flexible way.

Thank you

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