

RHC Financial Benchmarking

Rural Health Clinic Technical Assistance Series Call

December 14, 2015

1:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are on listen only mode. During the question and answer session, please press star followed by the 1. Today's call is being recorded. If you have any objections you may disconnect. I like to turn the meeting over to Bill Finerfrock. You may begin.

Bill Finerfrock: Thank you operator and I want to welcome all of our participants. As the operator said, my name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'll be the moderator for today's call and Webinar.

Today's topic is benchmarking for your rural health clinics. This particular series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy and it's done in conjunction with the National Association of Rural Health Clinics.

We're supported by a cooperative agreement, as you can see on your screen, through the Federal Office of Rural Health Policy, and that allows us to bring you these calls free of charge.

The purpose of this series is to provide RHC staff with valuable technical assistance and RHC specific information. Today's call and Webinar is the 68th in the series which began in late 2004.

And during that time, there have been over 17,000 combined participants on these bimonthly RHC national teleconferences and now Webinars. As you

know, there's no charge to participate in the series and we encourage you to refer others who might benefit from the information to sign up to receive announcements regarding dates, topics and speaker presentations.

They can go to <http://www.hrsa.gov/ruralhealth/policy/confcall/index.html>. During the Q&A period, we request that all callers please provide the name and city and state location as part of your question or you can type your questions into the online space available as part of the chat room.

In the future, you can email questions to info@narhc.org and put RHC TA question in the subject line. All questions and answers we will try to get answers to them and to the extent possible, post on the RHC TA listserv.

I want to thank our speakers today. We have Jeff Bramschreiber who is a CPA - Health Care Partner with Wipfli, as well as Vicki Mueller, who is also a CPA and she's a Health Care Director with Wipfli.

Wipfli has been working with the National Association of Rural Health Clinics for some time now on developing and making, to members of the Association, RHC benchmarking reports.

Jeff and Vicki are going to talk to us today about those reports, how to do benchmarking and why benchmarking is important. Jeff and Vicki, we look forward to your presentation. The time is yours.

Jeff Bramschreiber: Well, thank you Bill. This is Jeff Bramschreiber and I'm joined here by my colleague, Vicki Mueller. We thank you for this opportunity to present RHC benchmarking for the RHC technical assistance call.

Today we've got some unique information, we think anyway, to share with you a format that we certainly hope gets you to think differently about analyzing performance metrics within your rural health clinics.

We're going to start off the sessions by talking about some of the challenges faced by rural health clinics and how benchmarking can help identify potential opportunities for improvement within your rural health clinic.

We're going to walk through two different examples of how clinics can use the rural health clinic benchmark data to better understand their own strengths and weaknesses in their organization, as well as uncover areas that might require further study in order to achieve improved performance.

So let's get started. In my years working with rural health clinics, and it's been quite a few, I don't think there has ever been an environment quite as challenging as what it is today.

For anyone who's been involved in rural health clinic management over the last decade or so or even longer, I think most will agree that the healthcare industry in general, as well as, in particular, the rural of the environment has changed dramatically over the last several years.

The challenges of owning and operating a rural health clinic are much more difficult today than I think they've ever been before. And in particular, as we talked to rural health clinics and work with rural health clinics across the country, I think there are three particular areas where many clinics are challenged today.

The first is a demand for primary care services. And it's interesting because this particular issue is different depending on where a rural health clinic may be located.

Some rural health clinics are dealing with increases in patient volumes and that means that some of these organizations have had to cope with an overflow of provider schedules.

Limited resources, both in terms of their physical environment within their offices, as well as their human resource capacity of staff for further stretched by expanding Medicaid programs, for example, that allow access to healthcare providers by individuals who have not had an established relationship with the primary care provider previously.

These patients oftentimes have neglected health problems that require more time and resources to catch up on care that's going without attention for many years in some cases.

On the other hand, and some other areas of the country, we're seeing rural health clinics that are dealing with changes in health insurance coverage with higher deductibles and co-pays that actually discourage patients from receiving necessary healthcare services.

So in some cases, we're also talking with rural health clinics that are grappling with issues around how to provide cost-effective care in the face of declining patient volumes.

The second challenge area that we hear from rural health clinics is the reimbursement changes that have begun and will continue to evolve as payers are attempting to transition from a reimbursement method that was historically based on service volumes alone to reimbursement methods that now might include aspects of quality, of patient satisfaction as well as access to care.

And the shifting of reimbursement incentives by some payers and not others, along with the various reporting requirements and changes in the healthcare delivery model, for example, a patient centered medical home model, can certainly stretch already tight budgets.

And then the third issue that many rural health clinics are attempting to cope with centers around provider staffing. And many rural health clinics are dealing with an aging population, in particular, of their primary care physicians along with a limited supply of primary care physicians ready to take their place and practice in rural markets.

So these, and other factors, motivate rural health clinics to seek answers to some of these types of questions. For example, do our rural health clinic practitioners have capacity to see more patients?

Are our costs higher or lower than other similar providers? Is our current reimbursement system adequate to cover the cost of providing the care that we do deliver?

And finally, what are some of those key cost drivers in our own organization and how can we impact some of these costs? We believe that uncovering the answers to some of these questions should start with the process of benchmarking some of the key metrics that are available to rural health clinics. Vicki.

Vicki Mueller: Thank you, Jeff. We're very lucky being rural health clinics because the Centers for Medicare and Medicaid has actually made the cost report data available.

The unfortunate part in the data is that it is in bulk. It is not something that you can easily just download it to an Excel worksheet and try to work through.

What it is, as every cost report that is filed with CMS is out on the CMS Webpage, however it's not the regular CMS Webpage.

It's under the research specifics data and system. So you do have to go into a little bit different format getting into CMS to do that, to be able to find the data.

But all cost reports and every line that is on the cost report is in the data and you do need to be able to extract it. Now, here at Wipfli, we've been lucky because we worked with the National Association of Rural Health Clinics and their organization to develop the RHC benchmark report.

And we've been doing that for a number of years now. And we've been trying to figure out, you know, for the exemplary organizations and what organizations do need additional assistance?

So - as we're going through this, let's take a couple of looks at some examples, of some benchmarkings that are out there. And this is - once again, this is all data that is out in the public domain.

There's nothing hidden when it comes to doing your cost report with CMS. So for this first example, we have identified a moderate sized RHC. They have a little over 11,000 encounters for the physician and mid-level.

And they have a relatively low-cost per encounter. Actually their cost per encounter is less than \$110. So how can we use the benchmark report such as what we have to learn more about these rural health clinics?

First off, the first thing that a lot of people want to know is, do our practitioners have capacity to see more patients? If you ever asked the practitioners, they're always super busy and, you know, we don't really know.

So I'm looking at this, particular clinic, the physician alone is seeing almost 5400 patients in a year. And the nurse practitioner is seeing over 4600 patients per year.

So we take a look at that and we try to say, okay, where would we have capacity? Well, the physician has 5400 compared to the average for the region, and this is being an Illinois clinic, we took the Midwest region. The average is only 4300.

So the physician really does not have capacity to take on more patients and the same thing with the nurse practitioner in this practice. At 4600 patients, the average for the Midwest is not even 3000, a little less than 3000 patients per year.

So both of the physician and the mid-level are very high producing practitioners. So in this case, it would have to say they don't have capacity. They are very limited capacity.

The second question that often is asked is, are our provider's costs higher or lower than other similar providers? In this case, the physician, the cost for that (FTE) is over \$533,000 compared to the Midwest which is only \$259,000.

So this position is compensated well over the average and the nurse practitioner is also high \$134,000 is the cost per (FTE) for the nurse practitioner in this practice.

An average for a mid-level in the Midwest is \$109,000. Now, we also do have state data and national data included in here. We have taken the Midwest because we have found that that is normally how practices are - like to consider themselves.

Someone in Illinois doesn't really want to consider what are they doing in California? Whereas, if we take the Midwest, and when we're taking the different regions - the Midwest, the East, the West, the South, they're using the CMS definition for those areas.

So once again, in this particular situation, are the costs higher or lower than other similar providers? They're significantly higher in this particular practice.

Jeff Bramschreiber: Vicki just to clarify, in terms of cost, is that salaries? Is that benefits? Is that - what is that cost number that's illustrated here?

Vicki Mueller: The cost number that would be illustrated here with the salaries as well as benefits and any other direct costs, such as CPE and any - maybe - anything that that position purchases directly for their cost.

Jeff Bramschreiber: And, again, it's taken directly from the cost report so it's from that particular line on the cost report...

((Crosstalk))

Vicki Mueller: It's directly from that line on the cost report. So this - another indication here is you need to be very aware of what you're putting into the different lines on your cost report because if we are doing benchmarking, CMS is also using this data for going forward in setting rates. So it's very important that you are watching what goes on to that cost report and into the different lines.

Jeff Bramschreiber: Thank you.

Vicki Mueller: So the cost per FTE provider, as I said, are much higher than the average and the actual position cost per physician encounter. Now another thing that we

noted here is that the nurse practitioner and support staff that cost per encounter is lower than the average.

So in this case, the physician per encounter is \$99. Midwest, it's about \$60. So we're looking at \$39 per encounter more than what the average is in other rural health clinics within their particular region.

But the nurse practitioner is at \$29 and the average is \$37, so a savings of approximately \$8 per visit. And then we have other healthcare support staff at \$10, whereas the region is at \$17, so it's a savings of \$7.

This is something that when you put it into terms like this, it really points out, what is happening within this practice? The physician is high but the nurse practitioner and the healthcare support staff are low, and yet, they have high productivity.

The next thing that we are very lucky to have, we are using a new tool called click Qlik Sense. And with this tool, but we can load all of these cost reports, all of this information that is tons of data from CMS is loaded in and we can actually see a particular rural health clinic, and in this case, it's the one that we were just talking about, we can put it on to a scatter graph. And we can say, "Okay, where are they compared with everyone else?"

Jeff Bramschreiber: Yes, and in this particular graph we're showing, on the horizontal axis, is the number of encounters per FTE physician and on the Y, or the vertical axis, is the amount of compensation per FTE physician, our theory being that at higher levels of productivity, one would expect to see higher levels of compensation.

That in this case, in particular, you'll notice that the number of encounters per physician are to the right of the average, so higher than average productivity

or higher than average number of encounters, as well as the cost per full-time equivalent physician is also higher than average, similar to what we would expect.

But this is showing the relation to other particular rural health clinics within that region and how the data of all of those Midwest rural health clinics lineup in relation to compensation, cost and productivity.

Vicki Mueller: And as we said, for the cost per the FTEs are higher than average and because the cost per encounter is \$108, it is actually lower than the state average of \$132 or the region of \$130.

The national average is only \$113. So we actually have shown here, you know, what that total healthcare staff is compared with all of the other states, the Midwest, or the nation - the facility costs, the direct costs of medical services, as well as (unintelligible).

So this is the data that is available through these cost reports, and you know, through the downloads from CMS. We've been able to break it down into states and into the Midwest and the other regions across the nation, wherever your rural health clinic is located.

So what did we learn from this? You know, we've had some pretty pictures. We've had a nice scatter graph and - but what is that really telling us? It's telling us that our provider productivity was higher than average by 17% for the physician, 40% for the nurse practitioner.

So, again, the productivity is very high within this facility. Provider cost, being salary and benefits, as well as any other direct costs related to those providers, per FTE are significantly higher, 200% for the physician, 26% for the nurse practitioner.

Now, we do expect higher compensation, higher costs, for higher productivity, however, 17% higher (on a) physician, 200% on that cost. Total costs are 5% lower than the national average.

So they're at \$108 compared to that \$113. Healthcare support staff and overhead costs are also well below the average - 25% to 70% below the average.

With that total encounter cost of \$108 and the maximum payment for a freestanding rural health clinic of \$79 in 2013, the rural health clinic is still losing \$29 per encounter per Medicare encounter that they are seeing within their clinics.

So, what would we like to know? One of the questions that we would ask is, does this RHC incentivize provider productivity, and if so, how? That's something that we could do within our own clinics to be able to increase our productivity.

How does the RHC manage their support staff? I mean, you've got such high productivity on such a low-cost per encounter for support staff. What are they doing that we might be able to do within our clinic?

So how is this RHC able to manage their overhead, their (plant) and equipment? Is it possible that their building, their equipment, all of this is so outdated?

You know, is that the only clinic in the area that patients don't have a choice but to go to an outdated clinic that needs repair? We don't know that from the cost report, so these are questions we would like to ask.

And then how is this RHC managed? How do they manage that overhead? Are the outsourcing different services, you know, such as billing and accounting? Is that one of the ways that they're able to keep the cost down? And once again, those are not questions that can be answered through the cost report.

Jeff Bramschreiber: Right, but the cost report allows us an opportunity to identify those high performers, right, Vicki? And with the opportunity, once we know who they are, perhaps we can learn more from them directly.

Vicki Mueller: Exactly.

Jeff Bramschreiber: And be able to improve performance in other areas and these other situations.

This is Jeff and I'm going to go through, now, Vicki, the second example.

And in the second example, we use our scatter graph in order to identify, again, a moderately sized rural health clinic, just over 12,000 RHC encounters, only this one, rather than a low-cost, we identified one that has a relatively high cost on a per encounter basis.

And their cost per encounter was just over \$160. The question here is, can we begin to identify some of the causes that may contribute to the high cost and could we develop strategies to move costs closer to what we would consider to be the average data?

So we started with analysis, looking again, at that scatter graph, and trying to find relatively high costs with a moderately sized rural health clinic. And so we looked at cost per encounter, graphed that out, and while you can barely see the chosen rural health clinic because it's kind of sitting behind actually

another data point, we did identify one that has a relatively high cost and a moderately sized close to average number of encounters.

And as you can see at the top, the data summarized in that their cost per encounter was \$162.32. The average is in the data set here is \$131.83. I believe that is a state average that we're showing, the state of Illinois.

And the average - the number of encounters is about 12,000 encounters for this particular rural health clinic. So again we started - in this case, we're starting the opposite end. We're starting with costs and working our way up.

So we looked at, for example, their actual costs per encounter at \$162. That is substantially higher than the national average as well as the state and the regional average.

So their \$162 of cost is driven up by three items in particular. They have a higher direct cost per encounter. Their direct cost per encounter, or medical cost per encounter, were \$91 per visit. That is about \$23 higher than the national average, or 34% higher.

So we know that their direct costs related to their encounters are higher. They also have a higher facility cost per encounter. Their facility related costs are \$16 per encounter. Both the regional as well as the national average is \$10 per encounter.

So again, high cost per encounter per facility. That's about 60% higher than the national and the regional average. And they also have a higher overhead cost per encounter.

Their practice overhead is running \$72 per encounter. The regional average is \$56. The national averages \$50. So they're about 44% higher than the national average on an overhead cost basis.

So bringing that down a little bit further, we looked at the cost on a per encounter basis for their healthcare providers and their physicians - they happen to have physicians, PAs and nurse practitioners, as well as their healthcare support staff.

On a per encounter basis, you can see here on the graph, the physician costs per encounter were significantly higher than other comparative data would suggest.

The national state regional averages were somewhere between \$50 and \$60 per encounter. They were running about \$110 on a per-encounter basis for their physician staff.

Similarly, their PA -- physician assistant -- costs on a per encounter basis, they're running significantly higher than those averages as well. However, their nurse practitioner costs are higher than but not nearly as high as their PA or physician costs. And finally, their healthcare support staff costs are higher on a per encounter basis.

So the question, when we look at that cost on a per encounter basis, we're questioning whether or not the cost, the high cost is driven off of a higher than average cost per full-time equivalent provider or is it really because perhaps there's a relatively low productivity and that's what's driving up our costs.

So we first looked at cost on a per full-time equivalent basis. And, in fact, what we found is their physician costs were only slightly higher than the

national average and they were pretty much in line, just slightly higher, and the regional average per full-time equivalent basis.

So their costs of salaries and benefits for each full-time physician was about \$271,000. The Midwest region was about \$259,000. So relatively close - a little bit high, but not dramatically higher than the averages.

Their physician assistant costs, however, were significantly higher. Their costs on a per full-time equivalent basis were about \$171,000 in relation to about \$113,114 on a regional or national basis.

So both the physician and the PA costs on a per full-time equivalent basis were higher. The nurse practitioner costs for FTE were pretty much in line with the state and regional averages.

So if the cost per encounter is high and the cost per FTE is pretty much in line, we suspect that productivity has a lot to do with the issue on high cost per visit. And when we look at those productivity benchmarks and the metrics, we data shows that.

Physician encounters on a per full-time equivalent physician basis for this particular rural health clinic are about 2400 encounters per physician full-time equivalent, compared to benchmarks of around 4300 two 4500 visits per full-time equivalent positions.

So clearly there's a significant gap in productivity in the physicians as well as the PAs and the nurse practitioners. So in summary, what we found was in this particular rural health clinic, the high cost per encounter was driven in large part by the relatively low productivity which drives up the cost on a per encounter basis.

What more would we like to know? Well, the first question is, is it realistic to assume that this rural health clinic could lower their average cost per encounter from \$162 where they are today to the national average of \$113 simply by increasing patient encounters?

So we went through a calculation to say based on their allowable costs on a per encounter basis of \$162, what would their encounters need to be in order to bring that average cost per visit down to \$113, assuming all the costs remain the same and the only thing that changes is the number of encounters?

Well in order to get down to that \$113 per visit, they would have to increase their productivity from 12,000 visits up to over 17,000 visits per year. And on a per provider basis, they have three full-time equivalent providers that would mean that they would have to increase the number of encounters per provider by over 1700 encounters per year.

That averages out to about eight additional encounters per day that this clinic would have to achieve in order to bring costs down simply by changing the model based on number of encounters along.

It's highly unlikely that the clinic would be able to have each provider see an additional eight visits per day over the course of the year and bring their costs per encounter down in line with the national benchmark simply by increasing the number of visits alone.

So again, what did we learn? In this particular instance, provider productivity was lower than average. Physician provider productivity was 52% below average. The PA was 16% below, the nurse practitioner was 21% below.

The PA costs per FTEs were significantly higher than average, almost 50% higher. Our total costs of \$162 per encounter were 43% above the national average.

And low productivity appears to contribute heavily towards that high cost per encounter because their costs on a per FTE basis were not that much out of line that would - that a higher - that a more high productivity clinic couldn't overcome.

However, to lower the cost per encounter from \$162 to \$113 probably could not be achieved by increasing patient volumes alone because, in order to get the cost per encounter down from \$162 to \$113, each provider in that clinic would have to increase their number of patient visits by eight patients per day more than what they are currently seeing and that's probably not realistic to expect.

Vicki Mueller: So in summary, these benchmarks don't provide all of the answers. However, they do provide information that can help you to uncover potential opportunities for improvement within your clinics.

When performed on an ongoing basis, benchmarking can be used to measure continuous improvements in various areas. As we said, we have been doing these benchmark reports now in conjunction with the National Association of Rural Health Clinics for number of years.

And when you look at the benchmarks for - as a three-year average, you know, we actually will show 2012, 2013, 2014 side-by-side, you can actually see if you have made changes within your clinics.

And then the question is, do you know where your costs and your productivity is compared to your state or your region or the nation? That is one of the answers that the benchmark alone can answer.

The benchmark reports are done, as I said, in conjunction with the National Association of Rural Health Clinics. And they are free to members of the Association.

So as a member, you can go out to their website and when you have the website listed below here. It's <http://narhc.org/member-portal/benchmarking/>. One of the things they should know when requesting these benchmark reports, we do have two different databases going.

One is for the independent rural health clinics and the other is for provider-based rural health clinics which other rural health clinics that are part of a hospital with less than 50 beds.

Because if you were to compare an independent freestanding clinic to a clinic that has all of the overhead of a hospital, that would really skew the data. So we do have two different databases, and depending on what type of clinic you are, would determine the type of benchmarking report that we would supply.

Jeff Bramschreiber: Yes, and thanks, Vicki. And the benchmarking information that we're showing today, that's from the independent rural health clinic database.

Vicki Mueller: That is from...

Jeff Bramschreiber: So here we've not co-mingled the provider base and the independent. This is all independent that's shown today. But the same type of information is available through a provider-based rural health clinic (costs per) as well, correct?

Vicki Mueller: Correct. So yes it is. So for any hospital-based rule health clinics out there, this same type of data is available to you. So the current benchmark data that we do offer through (NARHC) is basically a report.

It's a one-page side by - three year side-by-side report of the health of your clinic compared with the state, the region and the nation. It does not include the scatter graph and maybe you'd like to speak a little more on that, Jeff.

Jeff Bramschreiber: Sure. If anyone is interested in seeing how their clinic compares using that scatter graph and the Qlik Sense tool, I would be happy to show that information as well.

For that, you could probably either contact either Vicki or myself and our contact information is at the end of this presentation. But again, that allows you - while the benchmark report compares your data to others and the average, the scatter graphs allow you to visually identify how your data aligns with either the state, the region or national clinics compared to your - to other (rural) clinics that are either independent or provider-based.

And it gives you a better indication of kind of where you sit and where your data sits in relation to those other individual providers or other individual clinics.

Vicki Mueller: And I would say also that that information gives you an opportunity to maybe find out what are those clinics doing that they are operating differently than what you are and possibly, you know, help you to learn what you can do.

Jeff Bramschreiber: Thanks. We're going to now take a break and address any questions from anyone in the audience. So I think there are two different ways of addressing questions, Bill.

Bill Finerfrock: Sure. Thanks, Jeff and thanks, Vicki. That was great. It was very helpful. I really do encourage folks to take a look at these reports. I think it really gives you some insight into the financial operations that sometimes folks don't take time to look at, and more importantly, gives you the ability to see how you compare to other RHCs in your state, your region and nationally.

Operator, if you would give the instructions for folks who want to ask the question by phone. And then once you're done, I'll review how to do that if they want to type in their questions.

Coordinator: Yes, so thank you. At this time, on the phone lines, to ask a question it is star followed by the 1. You will be prompted to record your name so you will need to unmute your line and record your name clearly as prompted. If you would need to withdraw your question, it will be star followed by the 2.

Bill Finerfrock: And then if you'd like to write your question as opposed to asking it verbally, just type it into the chat line. It should be on the left-hand side of your screen and we'll take the opportunity to answer those questions as well.

We'll read those online questions and get them included. So, if you want to take a minute and either start typing in your questions in the chat box or lining up in the verbal queue to get them over the phone, we'll take a second to give you a chance to do that. And it shows several people are typing, so. Okay, Jeff or Vicki, first question online from (Deborah Smith).

(Nathan): (Deborah Smith) asks what other areas benchmarks cover - and she specifically wants to know vaccine costs. Jeff or Vicki.

Jeff Bramschreiber: Yes, in particular, vaccine costs are part of the benchmark reports.

Essentially we're taking any data elements - all the data elements of the cost report trying to drive benchmarks from those.

So it's really based on productivity, individual productivity by provider. The cost information that you have seen previously as well as vaccine costs, both the flu and pneumococcal vaccine costs, and the percentage of Medicare business that are part of your total visits.

So you can determine whether your portion of Medicare patients subject to the cost report are higher or lower than other rural health clinics in, again, the region, the state and nationally.

Bill Finerfrock: Okay, great. Thank you. Operator, before we take the next online question, were there any folks lined up in the queue to ask a question over the phone?

Coordinator: I'm showing no questions on the phone lines at this time.

Bill Finerfrock: Okay, then we'll go back to answering the online questions.

(Nathan): So (Ellen Schomburg) asks, we are critical access hospital system in Missouri. They have four individual RHCs, however, when they file their cost report, all for clinics are dumped into one. Is there a way to break out each clinic to look at them more of an individual basis?

Vicki Mueller: Unfortunately at this time, there is not a way for breaking those out to view them individually. Because they are on the cost report in one clinic, we are only able to benchmark them as one. That's the unfortunate part in doing (that).

Jeff Bramschreiber: Yes, if you select or choose to consolidate your individual rural health clinics onto one cost report form, there's really no way to break that apart using the Medicare cost report data set.

I suppose you could re-create that individually if you were to essentially prepare a separate cost report file for each clinic and then to the benchmarking. But that would not be part of the standard benchmark report unfortunately.

Vicki Mueller: Right. Right. I mean, if someone did have all of the individual data and was requesting that, it can be done, but it's just that would not be part of the benchmarking report that we would do through NARHC.

(Nathan): Okay, thank you Jeff and Vicki. The next question was from (Christa). She wants to know the process for getting the benchmark comparative for our practice. I believe she's just asking about how to get the benchmark analysis. And we've posted that link once earlier in the chat but I think Bill will post it again.

Bill Finerfrock: Yes, if you scroll back up through the chat function, you'll see the phone number there for the national office and you can just call and they will verify that you're a member. The phone number for the national office is 866-306-1961.

It generally takes two to three weeks to get the report, although if there's a high volume, it may take a little bit longer. Or you can visit the website and go to the member portal there and click on benchmarking.

(Nathan): All right, so the next question is from (Elaine). She wants to know, does the Medicare deductible calculate into the cost for independent RHCs? So how does the deductible work on the cost data?

Jeff Bramschreiber: Well, the - I guess the short answer is, no, the coinsurance for the Medicare patients is based on 20% of the charge for that particular encounter. Here on the cost report data, we're looking at the cost as it pertains to the clinic itself and what are their costs, the costs that they incur to provide that service?

So the coinsurance is really the cost to the patient based on 20% of the charge. It's not necessarily - does not necessarily relate to the cost reported on the cost report or in the benchmarking.

((Crosstalk))

Vicki Mueller: Part of the reimbursement that the clinic would receive, because it would be - the (unintelligible) would be that deductible plus the 80%.

Bill Finerfrock: Operator, anybody on the phone line?

Coordinator: I'm showing no questions.

Bill Finerfrock: Okay, we'll keep going then.

(Nathan): The next question is from (Laura) who wants to know if the scatter report included in our presentation today is available for the benchmark comparative reports or is that a separate request. And Vicki or Jeff does the...

Jeff Bramschreiber: Yes, I can address that, (Nathan). That is a separate request. What I would suggest you do, since that scatter graph report is really best viewed in an interactive session, but I would suggest you do is request the benchmark report which comes with an interpretation.

We always offer to walk through the benchmark report with the clinic itself, and as part of that interpretation, we could also provide you with a scatter graph looking at different components of the cost report as it relates to your particular clinic.

So it is a separate report. It's not a standard set. It's also not in a report format that could easily be printed out. It's meant to be something that allows the user to interact with.

And we would be happy to do that as part of the evaluation or interpretation of your benchmark report. We would be happy to do an interactive session that - shows you your data on the scatter graph.

(Nathan): Okay, so I think this is a follow-up from (Elaine) who says the FI chart is - the clinic with 100% of the deductible. I'm not entirely sure what she's referring to there, Jeff and Vicki - the FI charges.

Jeff Bramschreiber: And, (Elaine), if you feel like - the chat function, if you want to call in with your question, and then if you want to go into a little bit more detail, operator, can you give the instructions for someone wants to ask a question verbally?

Coordinator: Yes. Again, to verbally ask a question, it is star followed by the 1. You will need to unmute your line so you can record your name so I can introduce you. Again, that's star followed by the 1.

Bill Finerfrock: (Elaine), if there's some confusion over your question or the point you're trying to make, it might be easier to call in with your question rather than trying to do it over the chat function.

Jeff Bramschreiber: Yes, I think maybe the confusion was we answered her first question based on the co-insurance and really she was asking about deductibles. But really again, I think the answer is similar, that the deductible, again, is the reimbursement that's going to be received by the patient because they haven't satisfied their deductible yet, and that's a different element of cost.

That's the cost of a part of the patient. We're looking at the cost - simply at the cost on the books of the rural health clinic in terms of what costs they incur to provide the services. So, happy to answer the question more clearly if she could call in.

(Nathan): Okay. And so the next question is from (Debbie). She wants to know where I can get a copy or a link for these slides.

Bill Finerfrock: And we will have them hosted on the NARHC website. You can go in and download them. You don't have to be a member. It's in a public section of the website. We'll send that link out hopefully either by the end of today or early tomorrow.

In addition, the Federal Office of Rural Health Policy will be making it available on their website as well, so you can go there and download it from their website.

We also have a recording of this call which will be posted on the Federal Office of Rural Health Policy website along with the transcript of the call. That generally takes a little while to get all of that to go through the clearance process, the review process and particularly the transcript.

So that will be a little bit longer to get up and posted. But if you want to go back and listen to this call, look at the slides, those will be available for

review hopefully within about ten days of today we'll have that all done enough and posted for you to go and download.

Coordinator: And we do have a question online if you'd like to go ahead and take that right now, on the phone line.

Bill Finerfrock: Yes.

Coordinator: Okay. (Elaine), your line is open.

(Elaine): Hi. I'm the one with the question about the patient to double. What we see in our clinic is that, if the patient in an independent RHC as the deductible, the fiscal intermediary takes that deductible directly out of our check and are never able to bill anyone for those monies.

If there is a secondary and the secondary pays their - they're only paying that qu- the fiscal intermediary has taken from us so that we have to put out, for each patient, that amount of services free of cost every year before we are paid one penny. So I'm not sure how that calculates into the benchmark for our cost report.

Jeff Bramschreiber: Well, it really wouldn't - other than - it wouldn't calculate in the cost other than the fact that that particular encounter is included in the cost amount that is shown on the cost report.

I think there may be - and I know that this happens frequently - when the Medicare intermediary offsets your reimbursement check based on the deductible amount.

And essentially what they should be doing is, you should be recovering the full cost of the deductible from the patient, correct? And they should be only

offsetting the difference between what your encounter rate is and the full amount that you've collected from the patient.

So, for example, if the patient had a \$150 deductible and you collected at \$150 from the patient and your encounter rate was \$80, theoretically, Medicare should only be pulling back or taking off that difference so that at the end of the day, you should still be reimbursed for that particular encounter \$80 rate, not the \$150 that you may have collected from the patient to satisfy their deductible.

((Crosstalk))

(Elaine): That is never - I am not seeing that on our ERAs. What happens is that the office, if it was \$150, and the deductible is still \$150, then the FI puts that \$150 in their pocket.

That if the secondary covers that deductible, then they pay \$150 so that the fiscal intermediary - the FI - has taken the \$150. The secondary has paid the \$150 but we don't get any of those monies.

Does that make sense to you? I mean, I'm having a hard time with (it) obviously. I've been at this for eight years and never, ever, an ERA, has that ever said that the deductible is the patient responsibility.

Vicki Mueller: Of that is not - I mean, it should always be a patient responsibility and if you're not able to collect that from the patient or, you know, say that they have - you know, they're not able to pay it or whatever, that would qualify them as a bad debt.

(Elaine): (Janet Litton), who is our RHC consultant, agrees that that is the way that it happens, that the FI takes the money and we have no recourse to bill for it.

Jeff Bramschreiber: But there's still a patient responsibility for that.

(Elaine): No, there is not.

Jeff Bramschreiber: But, (Elaine), maybe we could - if you want to follow up with either one of us afterwards, we'd certainly be willing to do that and look through an example and see if we can't...

(Elaine): I'd love to do that. Also how can I get a hold of you?

Jeff Bramschreiber: Okay. You've got our contact information at the end of this presentation and we be happy to...

(Elaine): Okay, wonderful. Wonderful. I'd love to do that. Thank you so much.

Jeff Bramschreiber: Okay, great. No problem.

Vicki Mueller: Thank you.

((Crosstalk))

Coordinator: Thank you, and as a...

Jeff Bramschreiber: I'm sorry, go ahead, operator.

Coordinator: As a reminder, if you have a question or comment, it is Star 1 and record your name.

(Nathan): All right, we would like to thank (Jennifer Foley) who points out, on the bottom right, for those of you who do not want to wait for the link, you can

download the slides right now if you double-click the line. That's RHC technical benchmark in the file share box.

So thank you, (Jennifer), for pointing that out. Next we have a question from (Trish Zoolander). Hopefully I said that right. Are we able to see the state and region data without signing up for the full report? So if she doesn't want an individual report, she just wants to see, I guess, or region and state. Is that available or?

Jeff Bramschreiber: Certainly. If she's a member of the National Association of Rural Health Clinics, we can certainly provider that comparative data without her clinic specific information if she chooses. That's fine.

Bill Finerfrock: Right. Okay, but if she - I mean, as Jeff pointed out, this information in a very raw form and is not - you can't individually download it is so there's a lot of work involved in trying to put this together.

So that's why it's been made a member benefit rather than just something that folks can do. So while I understand folks might want it, I hope folks can appreciate that is a lot of work that goes into trying to put this together and make it available to people.

Wipfli does it and does not charge the National Association of Rural Health Clinics. We make available through a cooperative agreement with the folks that Wipfli for very generous in doing this.

So I hope folks can just understand that's why it has to be that way. If someone else wants to do it and download it and make it available, that's certainly their right. The raw data is public data. It just takes a lot of work to manipulate and understand.

Jeff Bramschreiber: Thanks, Bill.

Bill Finerfrock: Operator, any questions on the phone lines?

Coordinator: I'm currently showing no questions or comments at this time.

Bill Finerfrock: Let me just double check and see if we're getting anything here. I'm not seeing any - okay, this one says we're a member but we have not had our first full year. I'm not sure why the whole message isn't...

Jeff Bramschreiber: That's a follow-up question to the previous one. So certainly, (Trish), or (Trish), if you're a member of the National Association of Rural Health Clinics, you can request your benchmark report even though you may not have any data there for your clinic in particular. We certainly would prepare you a report in that would give you the state, regional and national benchmarks as well. No problem.

Bill Finerfrock: I'm not seeing any additional questions come in. If there are none (at least) from the operator, I want to thank our speakers, Jeff Bramschreiber and Vicki Mueller, from Wipfli, for the presentation.

And I always find it very helpful and very educational and I always come away learning some things I had not known before. Again, I want to encourage you to encourage others who may be interested, to register for the RHC technical assistance series.

In addition, we welcome you to email us with your thoughts and suggestions for future call topics. You can send those suggestions to Info - that's I-N-F-O, at NARHC.org, and be sure to put RHC TA topic in the email subject line.

We anticipate scheduling the next rural health clinic technical assistance call for January and that will be on the new chronic care management benefit as well as the advanced care planning benefits that are going to become available on January 1.

We're arranging for people from CMS to go through the benefits, what the requirements are, what the expectations are for meeting that and we will announce the specific date and time of that hopefully very shortly. I think a lot of folks would be very interested in that particular topic.

Again, I want to thank Jeff and Vicki for their time today. Thank everyone who participated in the call and I look forward to talking with you next month during the next RHC TA call. Thanks everyone. Have a great day and have a happy holiday.

Coordinator: That concludes today's conference call. Thank you for your participation. You may disconnect at this time.

END