



Mid-Atlantic Association of
Community Health Centers

Building the Financial Strategy Framework for Success

Unit economics, payer mix, staffing design, and productivity — and how together they drive how much mission a health center can afford.





SPEAKER BACKGROUND

Nora Hoban

Chief Executive Officer
Mid-Atlantic Association of
Community Health Centers



Front-line medic

Early career, six years of military service —the basics of care delivery continuing to inspire belief in high-functioning team-based care teams



20 years in federal service

CMS and GAO —inside how national health policy is built, funded, and held accountable



Senior Data and Strategic Analytics Executive

Executive leadership at Avalere Health & the Maryland Hospital Association with a front-row seat to global budgets, CMMI innovations, and value-based care implementation



CEO, MACHC

Leads the Primary Care Association and the Health Center Controlled Network supporting Maryland and Delaware FQHCs

Learning Objectives

- 1 Identify key provider productivity and financial performance indicators
- 2 Understand the finance leader's role in supporting value-based care transformation
- 3 Explore governance and accountability frameworks that drive performance improvement
- 4 Develop strategies for aligning productivity management with organizational goals

One number sits underneath every decision you make

THE BREAK-EVEN LINE

“Did the payment for this visit cover what it cost to deliver it?”

Every strategic question in a health center — hiring, hours, sites, service lines, contracts, grant reliance — eventually collapses into that one sentence. Cost per visit is how you answer it with evidence instead of instinct.

1 Rate & scope decisions

Documented cost is the foundation of a Medicaid change-in-scope request and of any credible rate conversation.

2 Service line viability

Medical, dental, and behavioral health have different cost curves and different rates. Only cost per visit shows which ones carry themselves.

3 Grant dependency

The gap between cost and collections is what 330 and other funding POTENTIALLY fills. Knowing the gap is knowing your exposure.

4 Board accountability

Fiduciary oversight requires a unit-economic view, not just a bottom line that moves for unexplained reasons.

Anatomy of the ratio

$$\text{Cost per visit} = \text{Total operating cost} \div \text{Total billable visits}$$

NUMERATOR — WHAT CENTERS SPEND

- ◆ Provider compensation and benefits
- ◆ Clinical support staff — MA, RN, BH, pharmacy, CHW
- ◆ Front office, revenue cycle, and administration
- ◆ Management, compliance, quality, and G&A
- ◆ Facilities, occupancy, IT and EHR, supplies, lab

DENOMINATOR — WHAT CENTERS PRODUCE

- ◆ Billable encounters
- ◆ Counted by service line, site, and provider
- ◆ Medical, dental, behavioral health counted separately
- ◆ Virtual and group visits treated by explicit rule
- ◆ Nurse-only and enabling services classified consistently

Define both halves once, in writing, and do not change the definition mid-year. Most "the cost per visit moved" conversations turn out to be counting-rule conversations.

Calculate it at three levels — and split fixed from variable

1 Agency-wide

The number the board and your funders see. Useful for trend and for grant narrative. Useless for management decisions on its own.

2 By service line

Medical, dental, behavioral health, vision. Costs and rates differ so much that a blended figure hides every problem worth solving.

3 By site and provider

Where the variation actually lives. Two clinics with the same model can differ 30% on cost per visit — and the reason is knowable.

Then split the numerator into fixed and variable

- ◆ Fixed: leases, most management and admin salaries, IT, minimum staffing to open a session
- ◆ Variable: supplies, lab, some clinical support hours, incremental provider sessions
- ◆ Typical FQHC cost structure is heavily fixed — often 70–80% of total operating cost

**Average cost tells you whether you are solvent.
Marginal cost tells you whether one more visit helps.**

How an FQHC actually gets paid — four different logics

MEDICAID

Encounter-based PPS

- ◆ Prospective per-visit rate rooted in audited cost
- ◆ Trended forward annually (Medicare Economic Index)
- ◆ Adjustable through change in scope of service

MEDICARE

FQHC PPS encounter

- ◆ National base encounter rate, geographically adjusted
- ◆ Beneficiary coinsurance applies to most visits
- ◆ Adjustment for new patients and preventive visits
- ◆ Generally below the Medicaid PPS rate for the same visit

COMMERCIAL

Fee-for-service by CPT

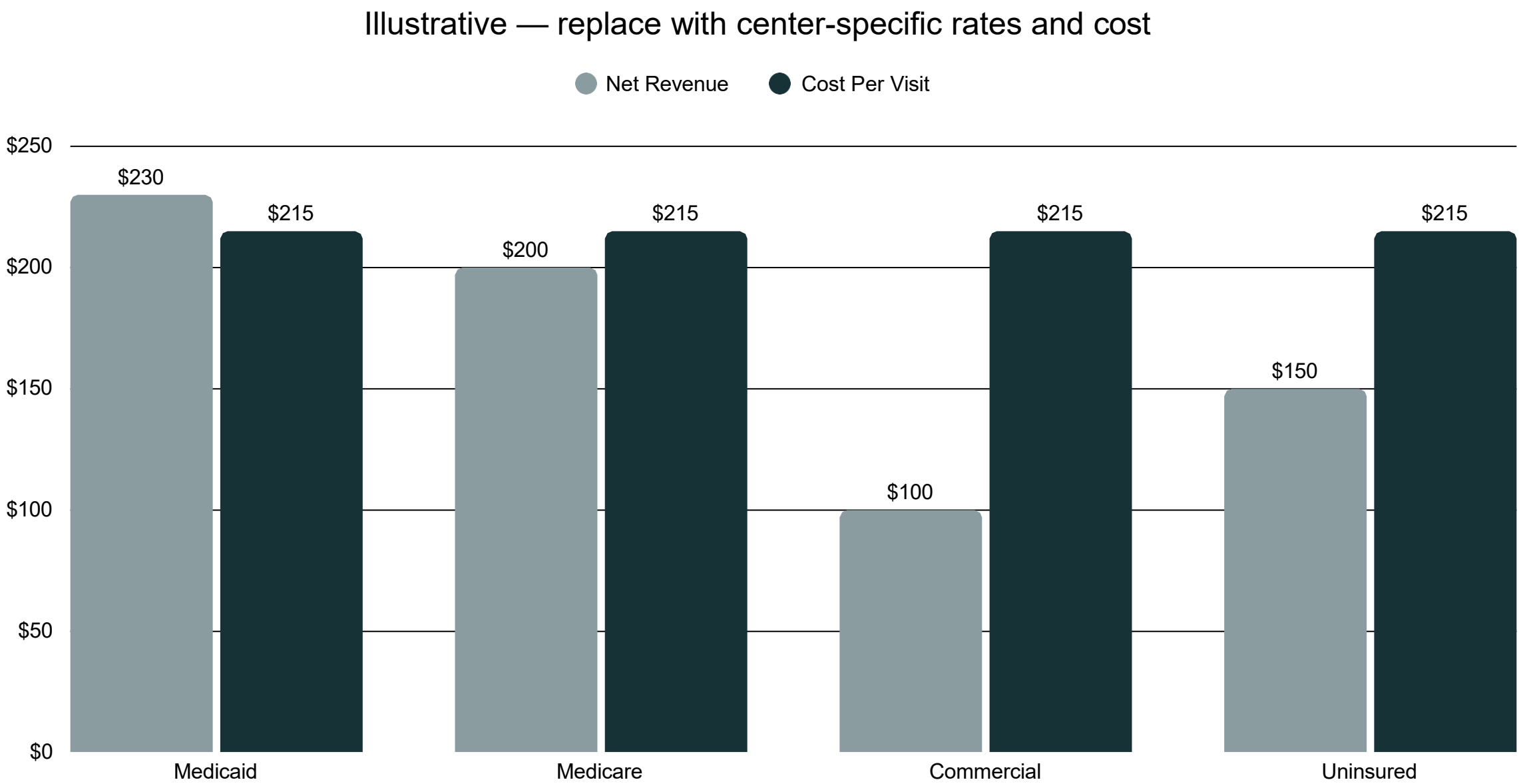
- ◆ No encounter-rate protection in most contracts
- ◆ Priced off a negotiated fee schedule, not your cost
- ◆ Frequently the lowest effective rate per visit
- ◆ Cost sharing adds collection risk and cost to collect

UNINSURED

Sliding fee scale

- ◆ Nominal or discounted charge; low realized collection
- ◆ Required program element, not an optional line
- ◆ Funded by Section 330, state/local, and philanthropy
- ◆ Volume here sets your true grant dependency

Net revenue per visit vs. cost per visit



WHAT THE PICTURE SAYS

Only one payer clears cost.
Medicaid PPS is the only line above the cost bar — and only because the rate was built from cost in the first place.

Commercial is not the premium payer.
For FQHCs the intuition from other provider types is backwards. Commercial fee schedules ignore your cost structure.

The gap is the grant and other funding.
Everything below the cost bar is subsidized by 330 funding, other grants, 340B margin, or reserves.

Illustrative figures for teaching purposes only.

Contribution margin per visit — the same visit, five outcomes

Payer	Net revenue / visit	Cost / visit	Margin / visit	So what
Medicaid PPS	\$230	\$215	+\$15	Protect the rate-keep eligible patients enrolled
Medicare FQHC PPS	\$200	\$215	-\$15	Near break-even; capture preventive and new-patient adjustments
Commercial FFS	\$100	\$215	-\$115	Renegotiate, or size the volume deliberately with eyes open
Sliding fee / self-pay	\$150	\$215	-\$65	Mission core — funded by grant; the volume must be planned, not discovered
Blended (illustrative mix)	\$190	\$215	-\$25	The gap grant funding must close, per visit, across the whole schedule

The same clinical visit — same provider, same room, same 20 minutes — swings in margin depending only on who is paying for it. **That is why cost per visit is only half the analysis. Payer mix is the other half.**

Illustrative figures. Net revenue should be net of denials, uncollected cost sharing, and bad debt.

Four decisions the comparison should drive

A

Cost above center Medicaid PPS?

Build the change-in-scope case. New services, added provider types, extended hours, and new sites can support a rate adjustment — but only with documented cost and scope evidence.

B

Commercial paying below cost?

Take it to the table with your cost data, and know your walk-away number. If you sign anyway, do it as a deliberate access decision with a volume cap in mind.

C

Sliding-fee volume growing?

Model it against available grant, 340B margin, and reserves. Uninsured access is the mission — but it has to be funded on purpose, not absorbed by surprise.

D

Which service lines carry costs?

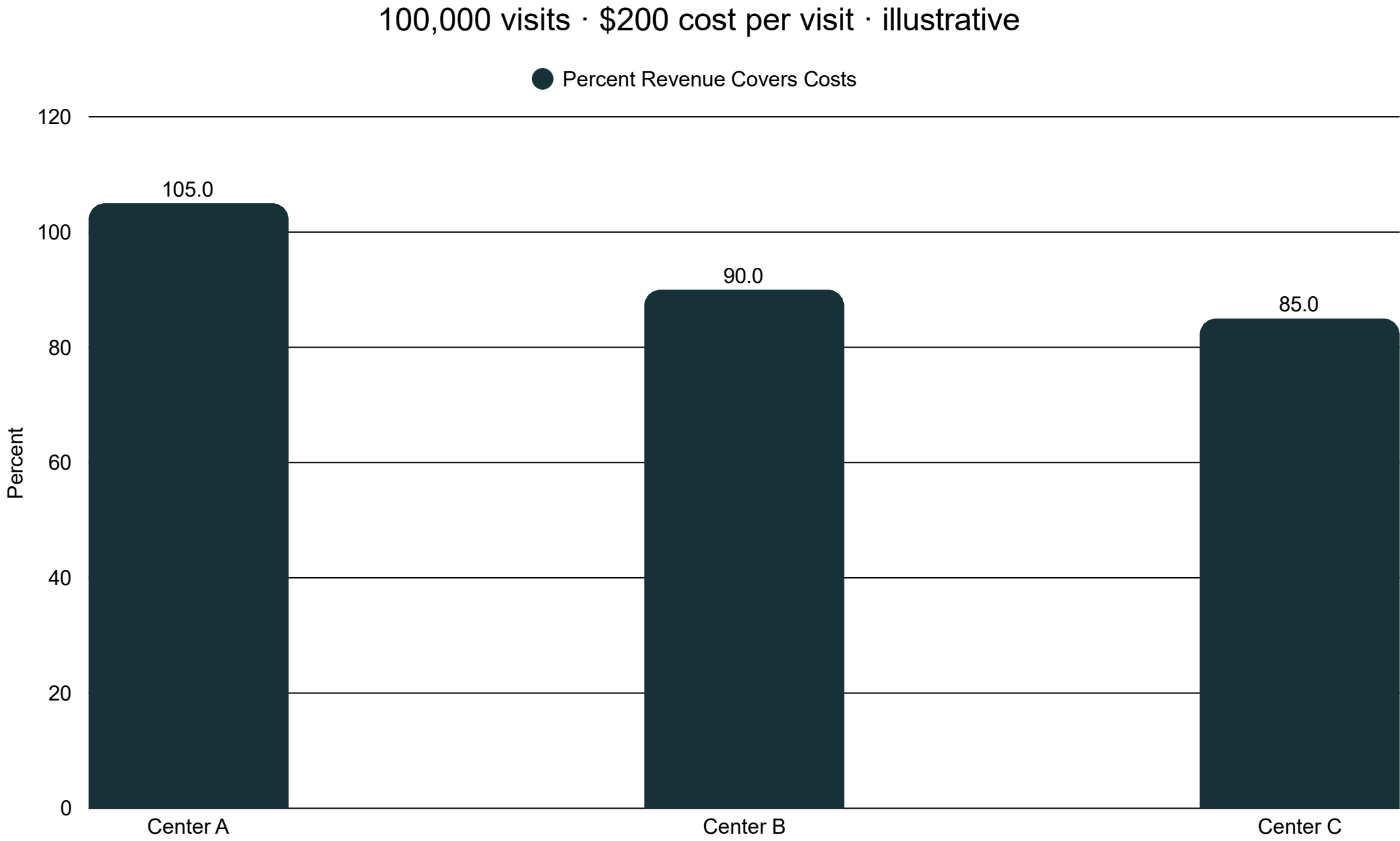
Compare cost and rate line by line. Dental and behavioral health often have separate rate structures and very different cost curves. Cross-subsidy is fine — unplanned cross-subsidy is not.

Payer Mix Determines the Financial Impact

Health centers can improve efficiency and manage cost per visit, but payer mix determines how far those improvements can go toward strengthening financial performance.



Identical operations, three payer mixes, three different organizations



Blended net revenue per visit

Center A Revenue Average \$210

Center B Revenue Average \$180

Center C Revenue Average \$170

Cost \$200 in all three

\$4M Revenue Difference

separates Center A from Center C — with the same clinicians, the same schedule, the same cost per visit, and the same patients treated.

Illustrative model. Assumes \$215 Medicaid, \$190 Medicare, \$150 commercial, \$30 sliding fee net revenue per visit.

Where to focus — highest leverage first

1

Coverage capture, not patient selection

Eligibility screening at every encounter, on-site application counselors, redetermination and churn outreach. Converting one uninsured patient to Medicaid is worth the Medicaid per visit amount with zero clinical change.

2

Get paid for what you already do

Wrap-around reconciliation, denial and rejection recovery, co-pays, deductibles, and secondary-insurance, billable-encounter capture across behavioral health and dental, care-management codes, 340B integrity, quality and value payments.

3

Rate integrity

Change-in-scope requests, annual MEI trending, PPS reconciliation, and verifying that every managed care plan is paying at or above your PPS floor.

4

Commercial contract discipline

Know your cost, know your walk-away number, and stop renewing evergreen contracts priced below it by default.

5

Then — and only then — growth

Add sites, hours, and service lines where the incremental margin is defensible. Growth into negative margin scales the problem.

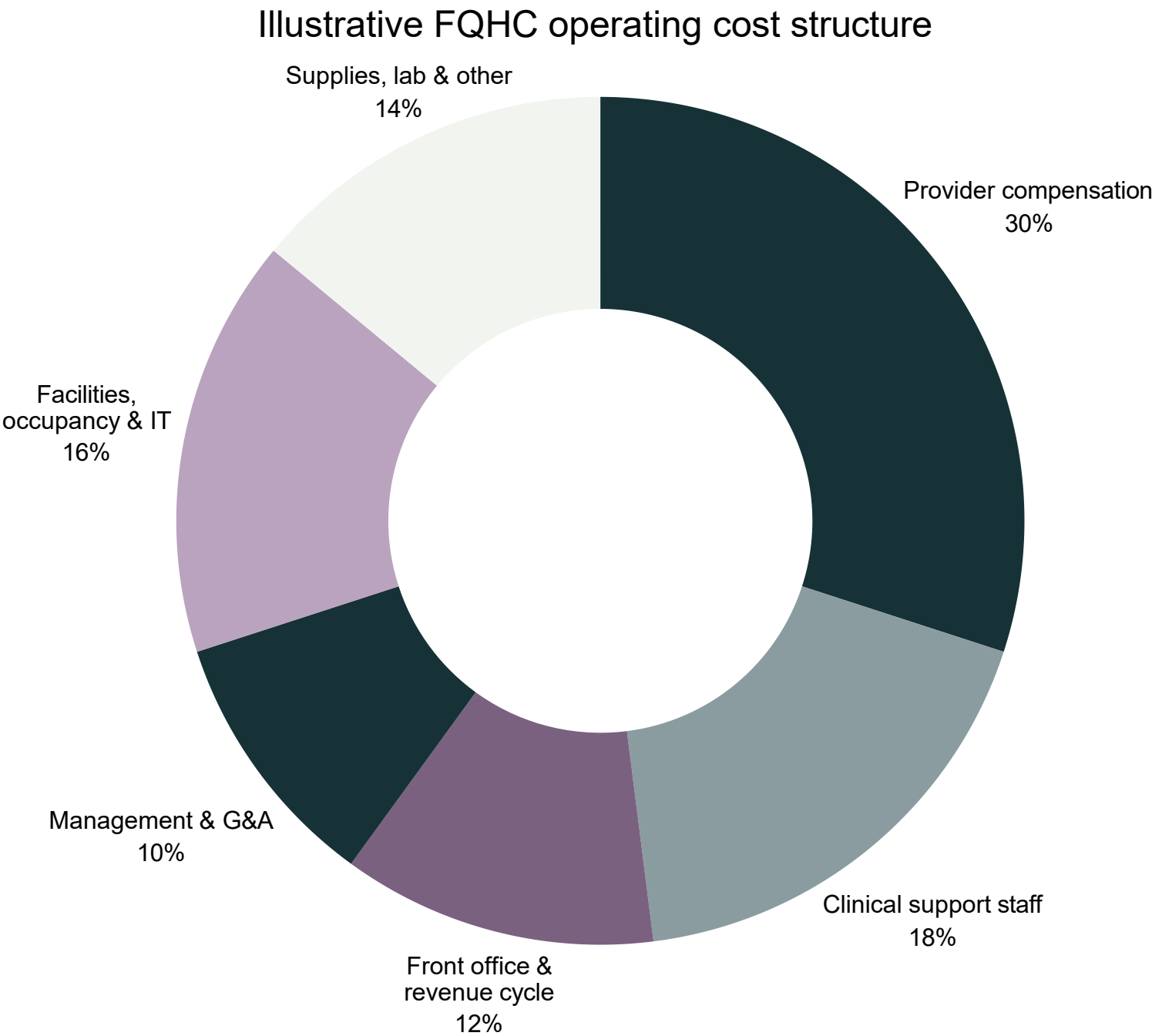
Guardrail: improving payer mix means covering more of the patients you already serve — never screening out the uninsured. Sliding-fee access is a Section 330 requirement and the reason the health center exists.

The Numerator: Staffing Is the Cost Structure

Roughly 65–75% of an FQHC's operating cost is people and benefits. Every meaningful lever on the numerator is a staffing design decision — not a supply contract.



Where the money actually goes



Illustrative allocation — replace with your audited cost report.

70 Percent

of operating cost is personnel and benefits. The staffing model is the cost structure — everything else is rounding.

Three questions that matter

- ◆ Who is doing each task, and is it the least expensive person who can do it well and legally?
- ◆ How many support staff surround each provider?
- ◆ How much is a center paying for turnover, vacancy, and agency coverage?

Provider mix — the encounter rate does not care who saw the patient

Under encounter-based PPS, a billable visit with a physician and a billable visit with an NP or PA generally generate the same payment — but not the same cost.

Provider type	Total cost of employment	Visits per year	Provider cost per visit	PPS payment per visit
Physician (MD / DO)	\$310,000	3,300	\$94	\$215
Nurse practitioner / PA	\$175,000	3,300	\$53	\$215
Difference per visit			\$41	<i>no change</i>

Design the mix, not just the headcount

- ✦ Physicians anchor complex panels, precept, and lead teams
- ✦ APPs carry appropriate acute, routine, and follow-up volume
- ✦ Match provider type to panel acuity, then set a target ratio

Guardrails

- ✦ State scope-of-practice, supervision, and collaboration rules
- ✦ Continuity, complexity, and quality outcomes must hold
- ✦ Preceptor and supervision time is real cost — budget for it

Design every role to the top of its license

Role	Top of License Examples
Physician / APP	Diagnosis, complex chronic management, care planning, procedures, team leadership
Registered nurse	Triage, nurse-only visits under protocol, chronic care management, complex coordination, patient teaching
Medical assistant	Rooming and vitals, standing orders, immunizations, screenings, care-gap closure, in-basket triage, referral prep
Clinical pharmacist	Collaborative practice agreements, medication reconciliation, diabetes and anticoagulation management
Community health worker	Outreach, social needs navigation, transportation, appointment confirmation and no-show recovery
Integrated BH clinician	Warm handoffs, brief interventions, screening follow-up, co-visits that generate their own billable encounter

Every task a clinician performs that someone else could legally and competently do is the most expensive minute in the building — and it consumes both halves of the ratio at once.

Six more levers that move the numerator

1 Turnover & vacancy

Replacing a provider can cost one to two times salary in recruitment, coverage, lost visits, and panel disruption. Retention is a cost strategy.

2 Agency & locums labor

The most expensive cost per visit in the building. Convert to permanent, restructure coverage, or fix the retention problem underneath it.

3 Span of control & admin ratio

Benchmark administrative FTE per provider FTE. Consolidate duplicated site-level functions before adding a layer.

4 Overtime & premium pay

Staff to actual demand curves by day and session rather than to historical habit or fixed templates.

5 FTCA coverage & 340B

Confirm deeming and gap-policy coverage to control malpractice cost; run 340B with airtight integrity so the margin is durable.

6 Revenue cycle efficiency

Cost per claim, first-pass yield, and days in A/R. Back-office rework is numerator waste that never touches a patient.

Three "savings" that raise your cost per visit



Understaffing support roles

Fewer or cheaper MAs looks like savings on the expense line. Then providers room their own patients, sessions run long, visits fall — and the ratio gets worse, not better.



Cutting care management and enabling services

Care coordination, outreach, transportation, and interpretation drive quality performance, UDS measures, no-show rates, and value-based revenue. Cutting them cuts the denominator and the rate.



Deferring EHR, IT, and training investment

Shows up later as denials, documentation drag, rework, unbilled encounters, and clinician time lost to workarounds — all of it invisible in the line item you protected.

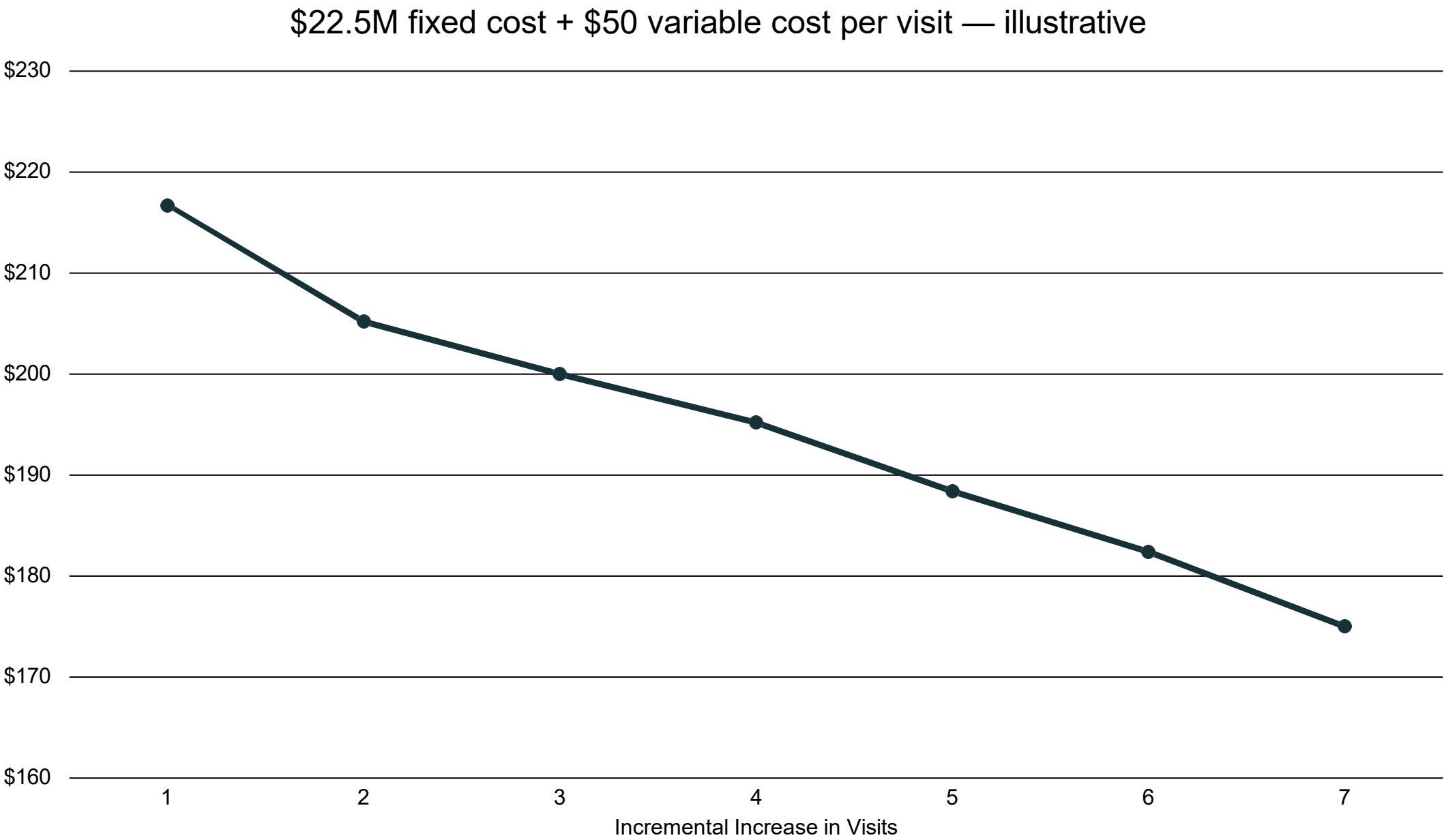
Cost per visit is a ratio, not a budget. Any cut that shrinks the denominator faster than it shrinks the numerator makes the number worse — while also reducing access. Test every proposed reduction against both halves before you approve it.

The Denominator: Visits Are the Faster Lever

Most of your cost is already committed for the year. Adding appropriate visits spreads that fixed cost across more encounters — and delivers more access at the same time.



Fixed-cost dilution: what one more visit per provider per day does



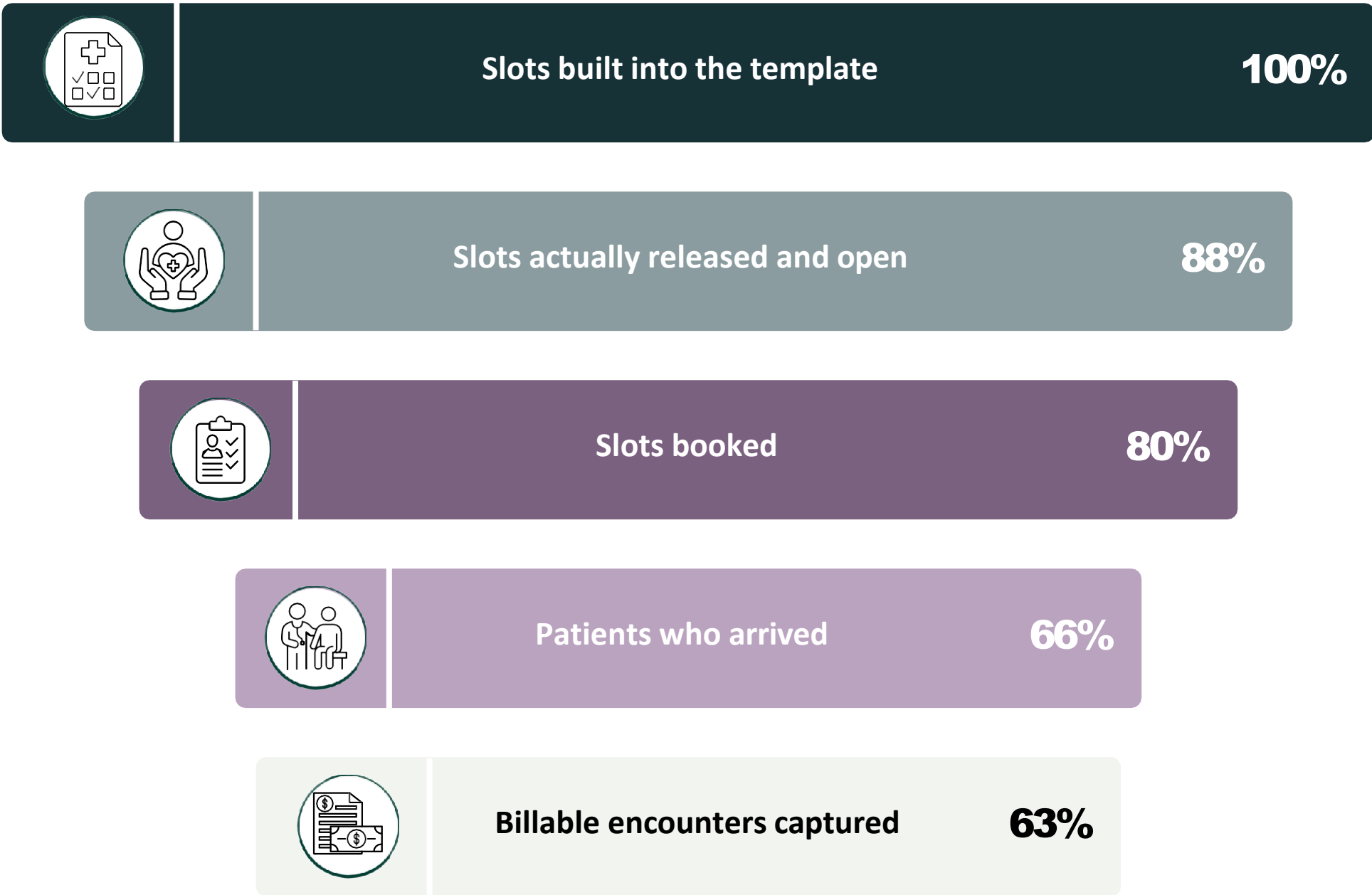
+1
visit per provider per day
60 providers × 210 clinic days = 12,600 additional encounters

-\$11.50
cost per visit (−5.3%)
\$216.70 falls to \$205.20 with no change to fixed cost

+\$1.5M
annual contribution
12,600 visits × (\$170 net revenue – \$50 variable cost)

Illustrative model. Marginal cost per visit assumed at 25% of total cost — calculate your own.

Where the visits are hiding



Measure Monthly

- ◆ Visits per provider per day, by provider and session
- ◆ Template fill rate and released-slot percentage
- ◆ No-show plus late-cancellation rate
- ◆ Third next available appointment
- ◆ Visit cycle time and room-turn time
- ◆ Session utilization and cancelled-session count
- ◆ Panel size versus modeled capacity
- ◆ Encounter capture rate — documented but unbilled visits

Most "we need more providers" conversations are actually template, no-show, and capture conversations.

37 points of capacity lost before a single new provider is hired.

Illustrative leakage rates — build this funnel from your own scheduling and billing data.

AI as clinician capacity — support to reduce PJ time

1 Ambient documentation

Drafts the note from the visit conversation. Returns clinician time — decide deliberately whether it goes to visits, to reclaiming after-hours work, or both.

2 In-basket and message drafting

Portal message volume is the invisible workload that pushes documentation into the evening. Drafted replies with clinician review cut that queue.

3 Pre-visit preparation

Summarizes history, surfaces care gaps, overdue orders, and last specialist notes before the patient is roomed.

4 Coding and capture support

Supports accurate level selection and flags documented-but-unbilled encounters. Protects both the denominator and the rate.

5 Referrals, prior auth, forms

Automates assembly and follow-up on the paperwork that consumes clinical and support staff hours.

6 No-show prediction and outreach

Targeted reminders, confirmation, self-scheduling, and waitlist backfill aimed at the largest single source of lost capacity.

Guardrails: clinician review of every output · documentation integrity and audit trail · business associate agreements and vendor security review · measure hours returned, not licenses purchased · decide in advance whether reclaimed time becomes visits, burnout relief, or both — and say so openly.

Support staff: raising the numerator to lower the ratio

THE BREAK-EVEN QUESTION

583

additional visits per year — about 2.8 per clinic day — is what one added medical assistant must unlock to pay for itself.

The math as an example

- ◆ Fully loaded MA cost: \$70,000
- ◆ Blended net revenue per visit: \$170
- ◆ Variable cost per added visit: \$50 → contribution of \$120
- ◆ Break-even: $\$70,000 \div \$120 = 583$ visits per year
- ◆ Above that, every added visit lowers cost per visit and adds margin

What support staff actually unlock

Medical assistants

Rooming and vitals, standing orders, care-gap closure at the visit, room turnover, documentation and order pre-work

RN triage line

Resolves what does not need a visit and routes what does to the right slot the first time

CHW / outreach staff

Confirmation calls, transportation, no-show recovery, and waitlist backfill

Referral & prior-auth team

Removes administrative work from clinical staff and closes referral loops that generate follow-up visits

A stacked, illustrative path from \$200 to \$174 cost per visit

Lever	Half of the ratio	Effect on cost per visit	Running total
Starting point	—	—	\$200.00
Provider mix rebalance (5 FTE)	Numerator	−\$4.00	\$196.00
Agency and locums reduction	Numerator	−\$3.00	\$193.00
Admin ratio and span of control	Numerator	−\$2.50	\$190.50
Turnover reduction	Numerator	−\$2.00	\$188.50
Added MA and team investment	Numerator	+\$3.50	\$192.00
AI tooling investment	Numerator	+\$1.50	\$193.50
+1 visit per provider per day	Denominator	−\$11.60	\$181.90
No-show rate 18% → 12%	Denominator	−\$5.50	\$176.40
Encounter capture improvement	Denominator	−\$2.50	\$173.90
Result		−\$26.10 (−13%)	\$173.90

Read the two colors

The denominator levers deliver \$19.60 of the \$26.10 — three quarters of the improvement — and they also add roughly 20,000 encounters of community access. The numerator levers matter, but they are slower and politically harder.

What \$174 changes

- ◆ Medicaid moves from thin to real contribution
- ◆ Medicare crosses from loss to positive
- ◆ Commercial loss per visit narrows sharply
- ◆ Each uninsured visit costs less to subsidize
- ◆ Grant dollars stretch across more patients

Illustrative and directional. Effects are not perfectly additive — model with real data with center-specific fixed/variable split.

The monthly dashboard — run all three columns together

COST

- ◆ Cost per visit: center, service line, site, provider
- ◆ Personnel as a share of total expense
- ◆ Administrative FTE per provider FTE
- ◆ Agency and locums spend
- ◆ Provider and staff turnover rate
- ◆ Fixed versus variable cost split

PAYER

- ◆ Payer mix percentage by visit and by revenue
- ◆ Net revenue per visit by payer
- ◆ Wrap-around collected versus expected
- ◆ Uninsured-to-coverage conversion rate
- ◆ Denial rate and first-pass yield
- ◆ Days in accounts receivable

PRODUCTIVITY & QUALITY

- ◆ Visits per provider per day
- ◆ Template fill rate and session utilization
- ◆ No-show plus late-cancellation rate
- ◆ Third next available appointment
- ◆ Encounter capture rate
- ◆ UDS clinical measures and patient experience

Never review productivity without quality. The fastest way to destroy a health center is to optimize visits per day in isolation. With primary care, higher visits typically correspond to high quality when care gaps are closed versus unengaged patients who remain untested.

A 90-day start



Measure

- Build cost per visit by service line, site, & provider
- Split the numerator into fixed and variable
- Pull net revenue per visit for every payer
- Document current payer mix by visit and by revenue
- Baseline template fill, no-show, and capture rates

Diagnose & Decide

- Compare cost against each payer's rate
- Identify negative-margin service lines and contracts
- Assess eligibility for a change-in-scope request
- Benchmark provider mix and support staff ratios
- Choose three denominator levers & set targets

Execute & Reassess

- Launch no-show reduction and coverage conversion work
- Pilot AI documentation with one team and measure hours
- Rebalance one clinic's template against real demand
- Stand up the monthly dashboard with named owners
- Take the baseline and targets to the board

Cost per visit is not merely a finance metric. It is the number that tells you how much mission you can afford.

Know the Number

Compare it to Every Payer

Work Both Halves

All dollar figures in this deck are illustrative. Use framework and approach with center-specific data.



Patient Access Tool

How the Tool Sizes Each Provider's Realistic Potential

TEAM-BASED CARE MODEL NEEDS TEAM-BASED CARE SOLUTIONS

WHAT IT TAKES IN

**Scheduled clinical hours**

Sessions and FTE per week

**Provider time**

Time provider spends face-to-face with patient

**Admin time**

Time needed to close notes

**No-show history**

Actual attendance patterns by provider



WHAT IT SHOWS YOU

**Realistic capacity range**

Sustainable visit volume per provider

**What levers are standing in the way**

No-shows, admin time, MAs per provider, lack of AI?

**Staffing & template tweaks**

Where added support unlocks capacity

**Individualized targets**

Fair, provider-specific productivity goals

▶ Up next: a live walkthrough of the tool