Kentucky Rural Health Clinic Summit – July 2023

The State of Rural Healthcare and Looking Forward

PERSPECTIVE

CHANGES EVERYTHING.

WIPFLI

Overview of today's discussion points

State of Rural Health Care report

The state of rural healthcare
Research report data for 2023

Nearly one in five Americans live in rural areas and rely on clinics and critical access hospitals for lifesaving medical services.

Wipfli surveyed more than 100 rural healthcare organizations to get a pulse on their financial health. Our inaugural state of rural healthcare report covers some of their top financial challenges and strategic responses.

Wipfli surveyed 110 rural healthcare organizations across 25 states to learn how they're coping. We learned that bad news exists — but so does hope and optimism. The majority of the rural providers we surveyed are in good financial health and confident about the future.

110

rural healthcare organizations surveyed

across **25** states

Strategic priorities for rural healthcare organizations

To maintain financial health, rural healthcare organizations are addressing four strategic priorities:

1. Talent
2. Patient experience
3. Financial performance
4. Digital transformation

Priority No. 1

Manage talent in a record -tight labor market

Has your organization experienced a workforce shortage similar to the rest of the nation?

The industry has seen an influx of hospital executives with little or no healthcare administration experience. Is this true for your organization?

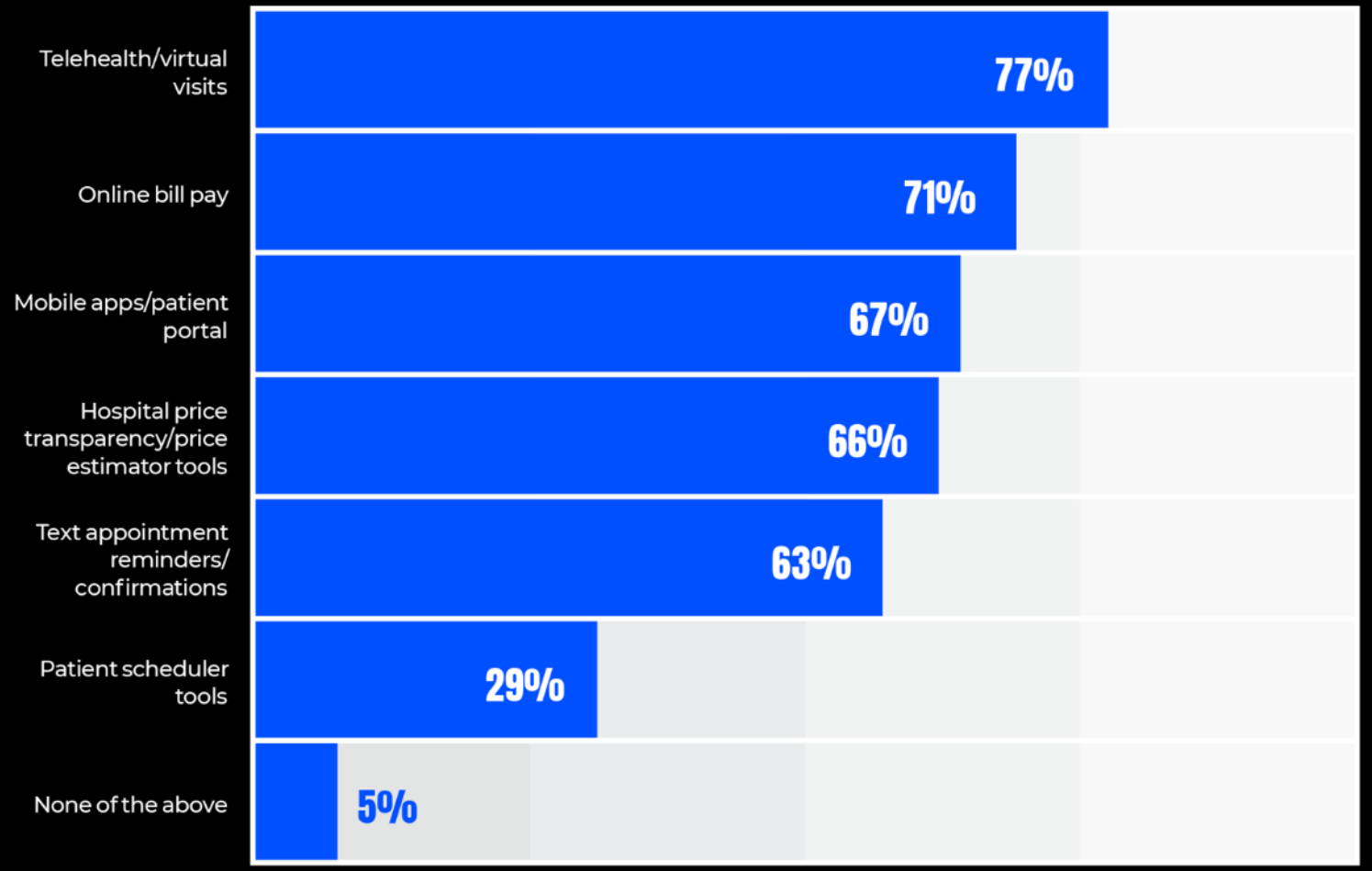
The top five ways rural healthcare organizations are addressing the labor shortage:

1. Increasing wages
2. Recruiting candidates more proactively
3. Using technology
   (e.g., automated phone systems and apps)
4. Using traveling/temporary nonclinical staff
5. Developing medical education and residency programs

Priority No. 2

Improve the patient experience

Which of the following tools have you developed/implemented to improve the consumer/patient experience?

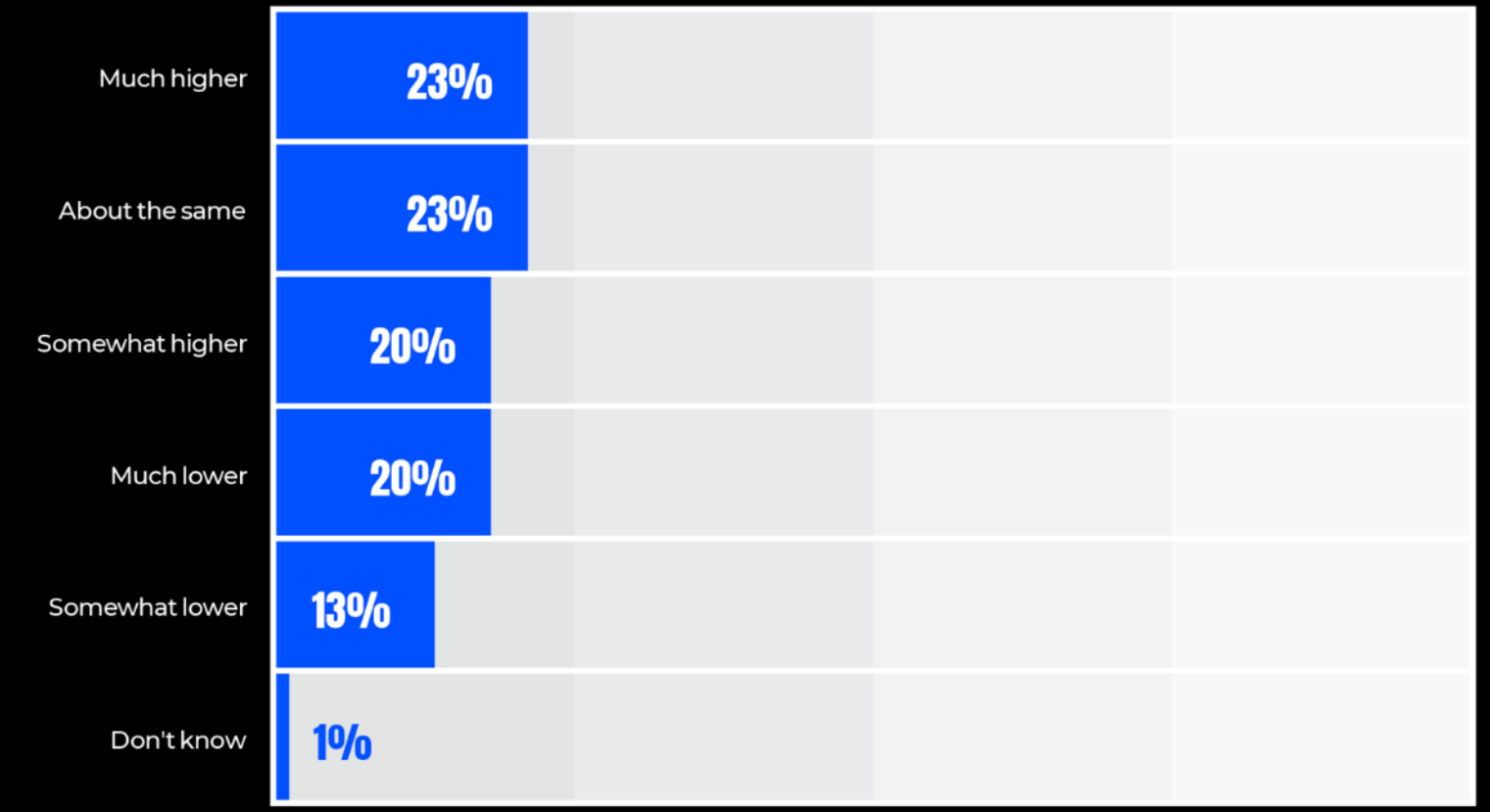


(Respondents were allowed to choose multiple responses.)

Priority No. 3

Strengthen financial performance

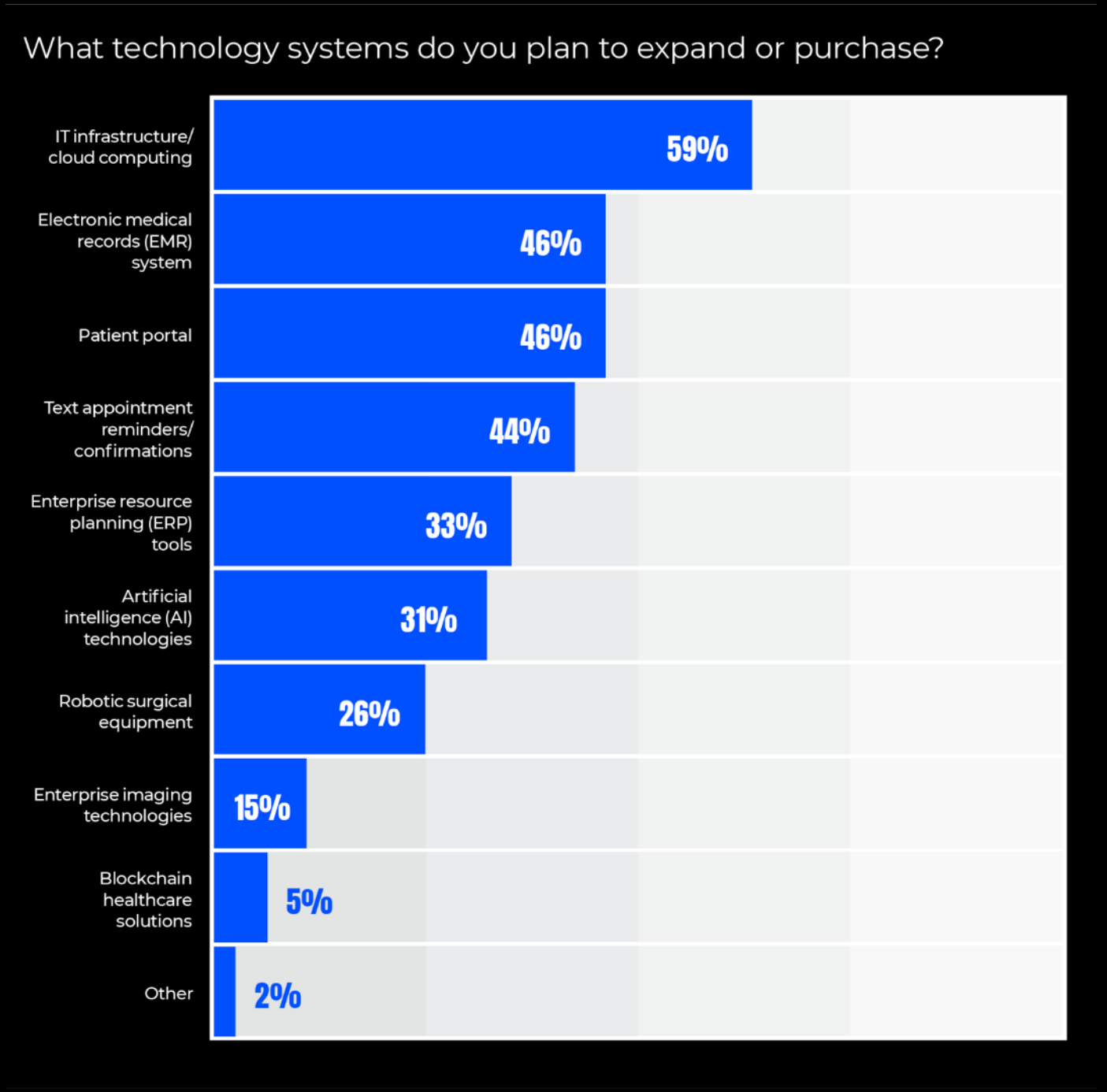
Which statement best describes your organization's level of financial stability as compared to five years ago?



(Respondents were allowed to choose multiple responses.)

Priority No. 4

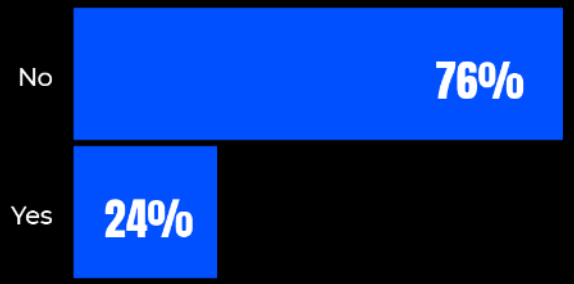
Pursue digital tools and experiences



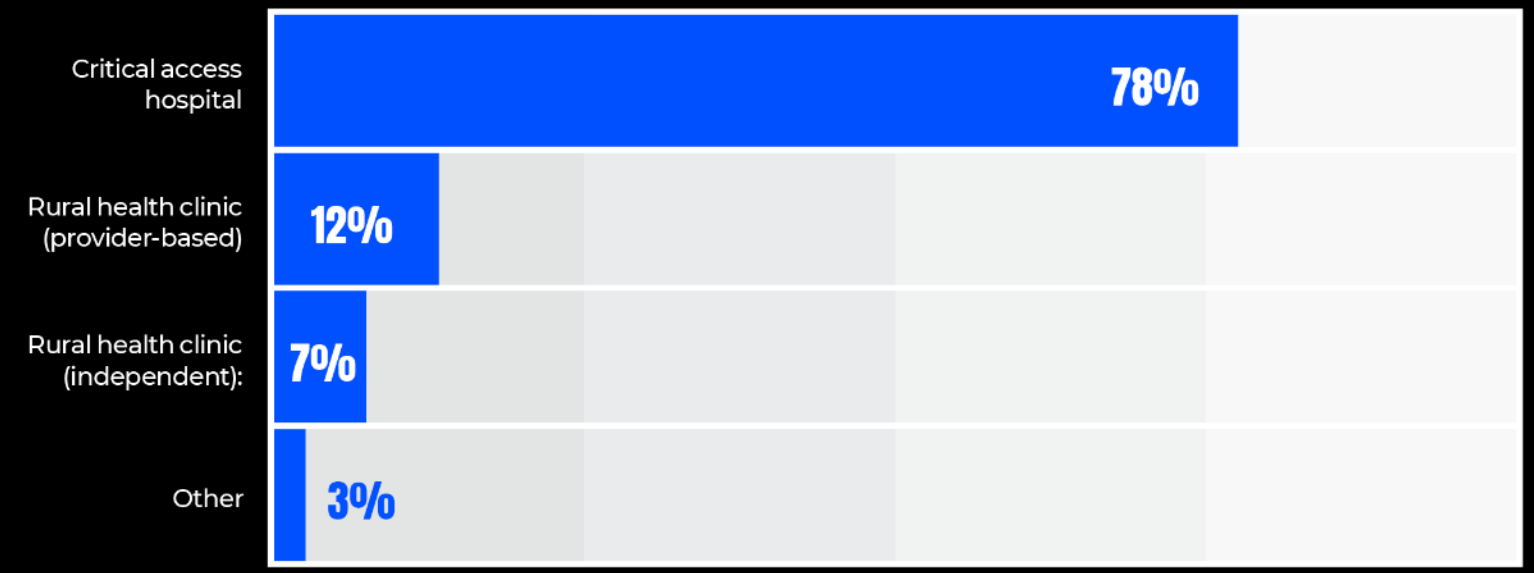
Appendix: The raw data

- Wipfli received survey responses from 110 healthcare leaders in 25 states.
- The survey was emailed out and answers were collected in mid -October through November of 2022. All responses were confidential and anonymous.
- Percentages may not equal 100% due to rounding.

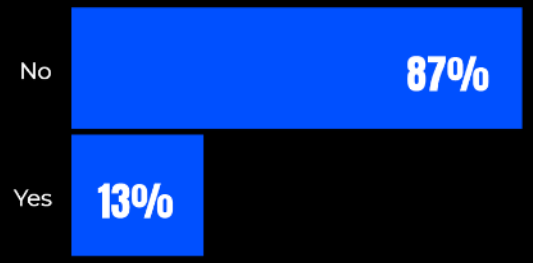
Do you have an affiliation with a larger health system?



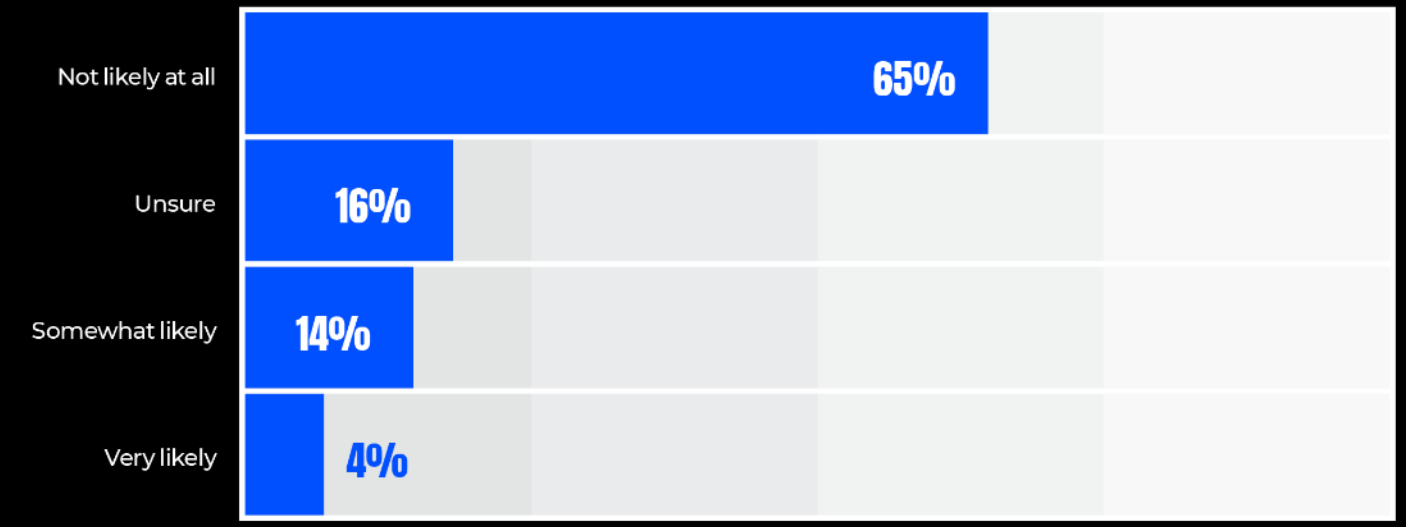
Which of the following best describes your organization?



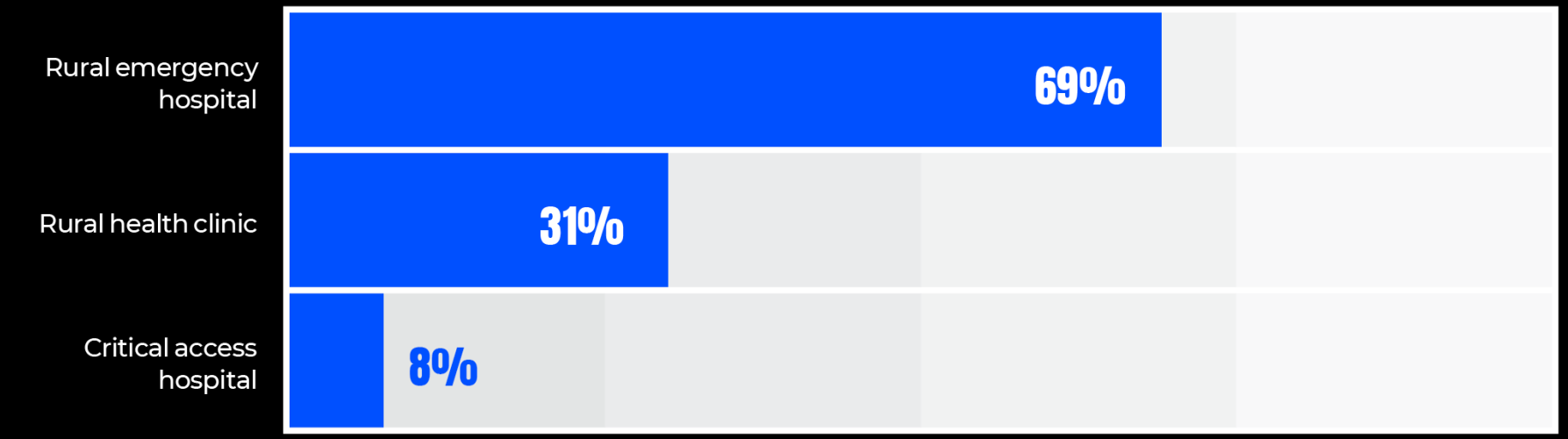
There are a number of different care designations emerging that could potentially improve your financial stability. Are you considering a different model of payment (e.g., rural emergency hospital, conversion to critical access hospital status or rural health clinic?)



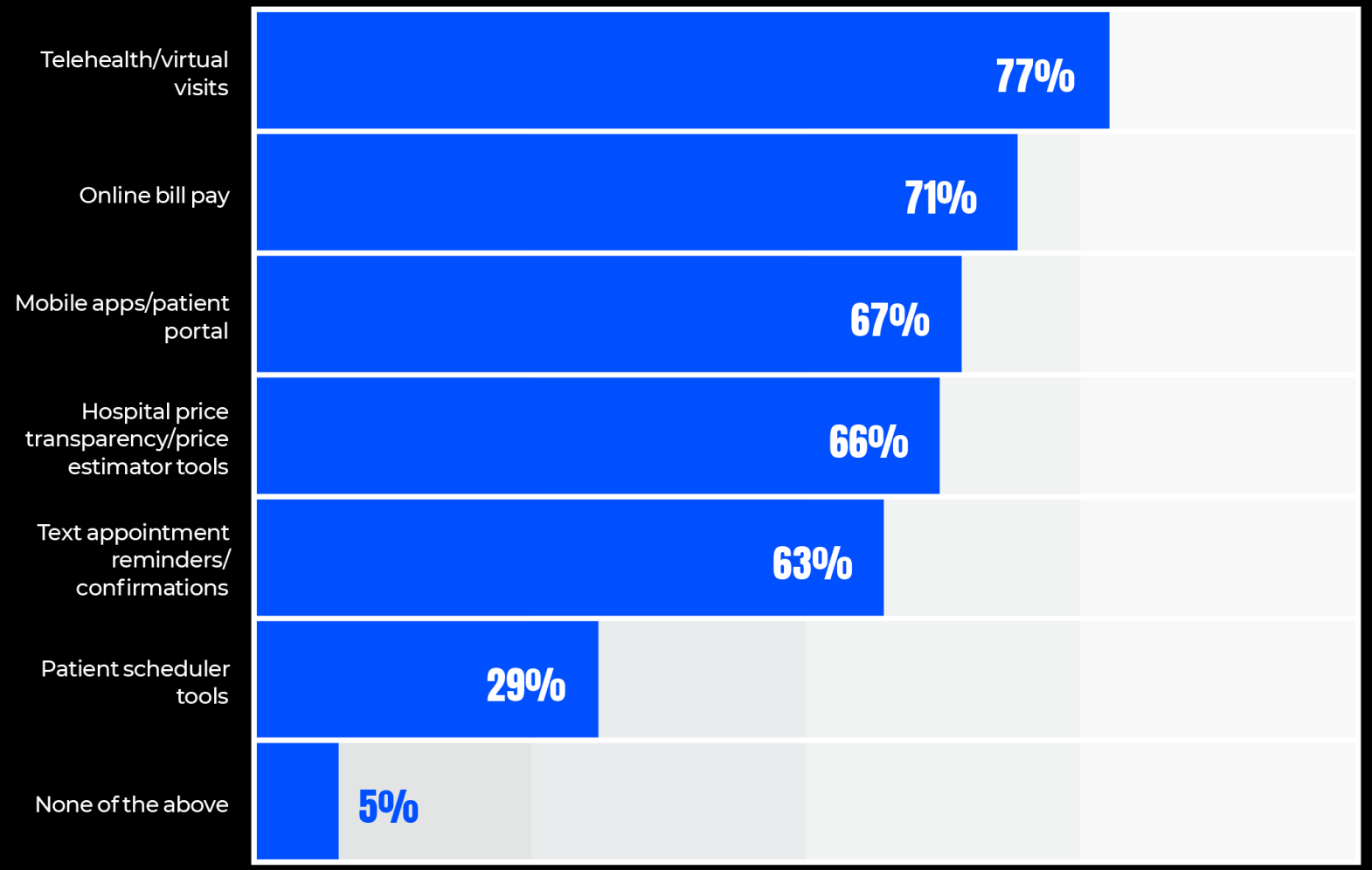
In the next two to five years, how likely is your organization to consider merging or consolidating with another healthcare organization?



Which model are you most interested in or considering?

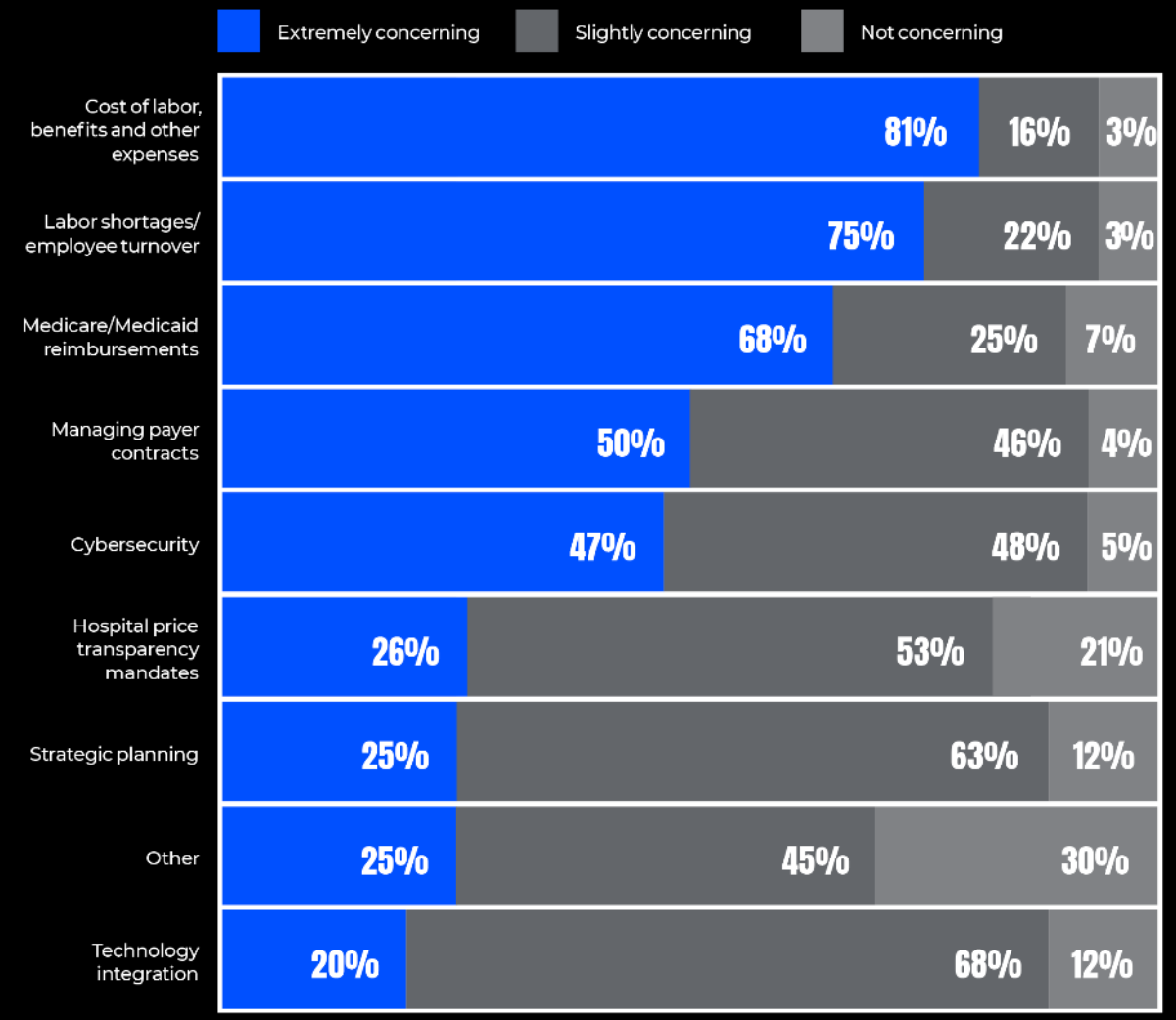


Which of the following tools have you developed/implemented to improve the consumer/patient experience?



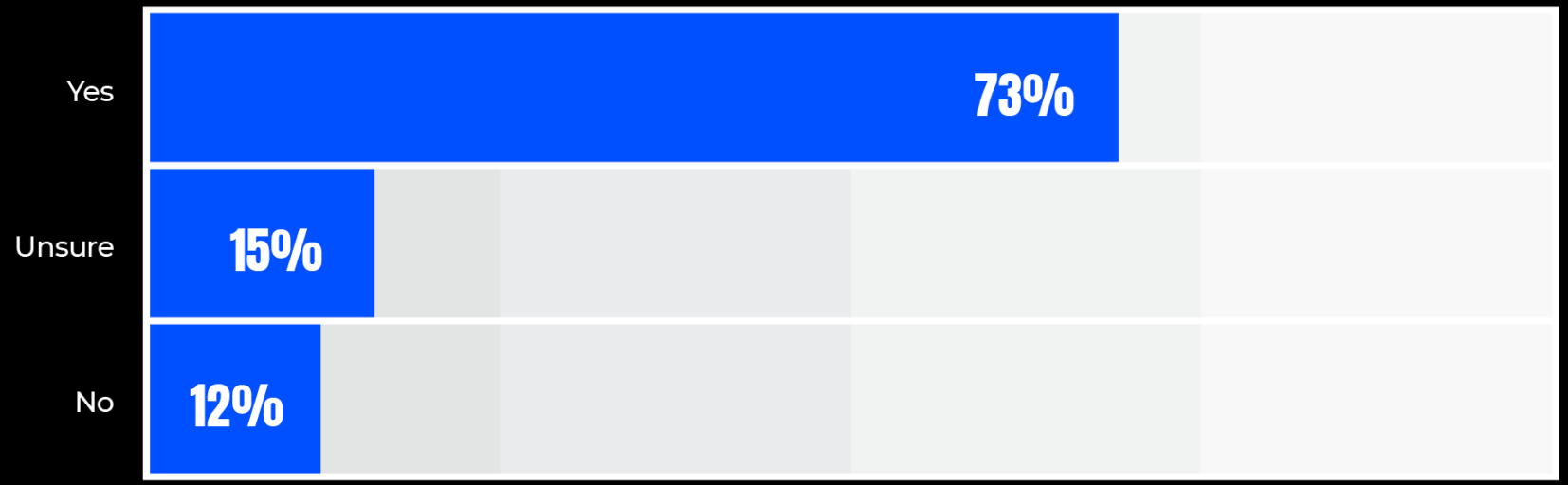
(Respondents were allowed to choose multiple responses.)

Please rate your level of concern for each of the following using a scale of 1–7 with 1 being "not concerning at all" and 7 being "extremely concerning."

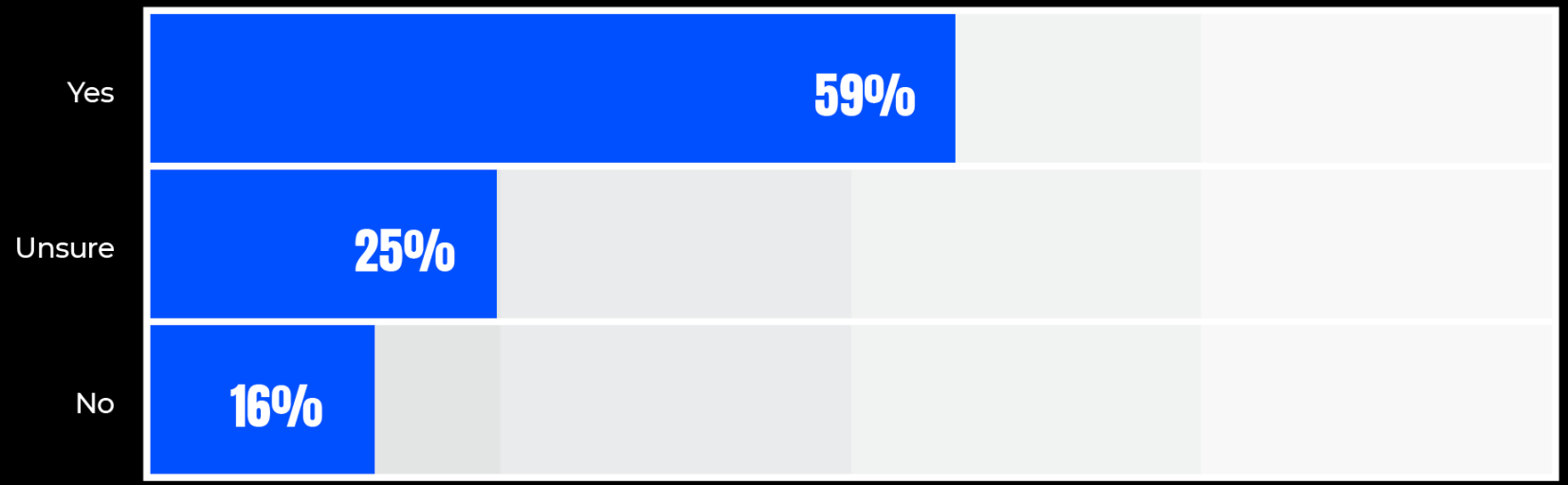


(Other responses included, infrastructure, provider issues and finances.)

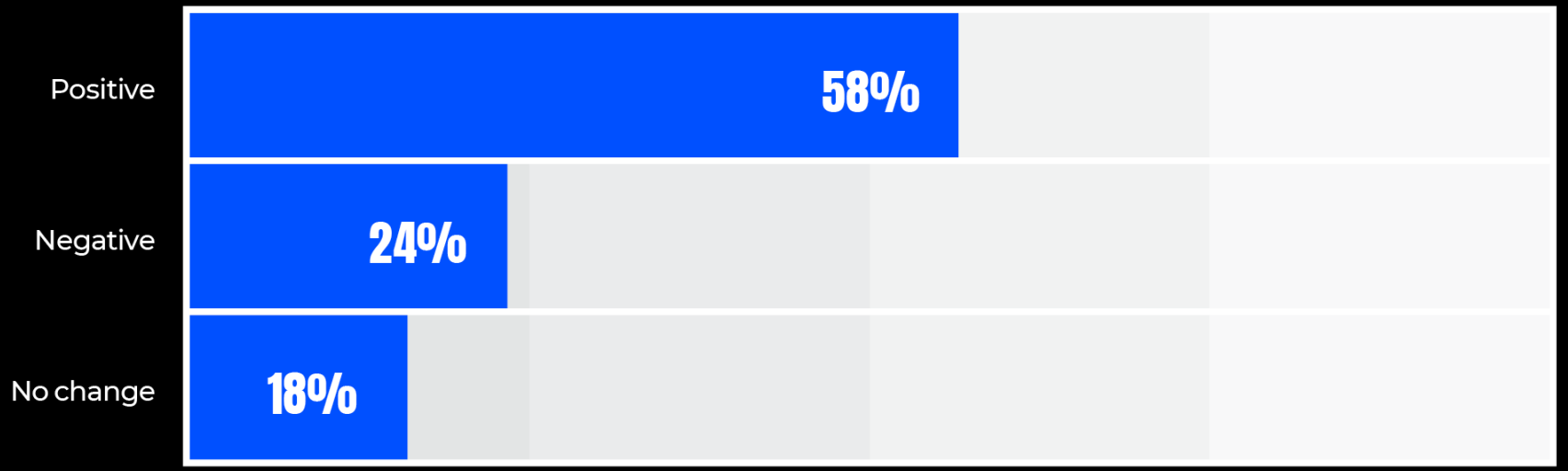
In the next two to five years, does your organization have plans to expand/invest in building new facilities or renovations?



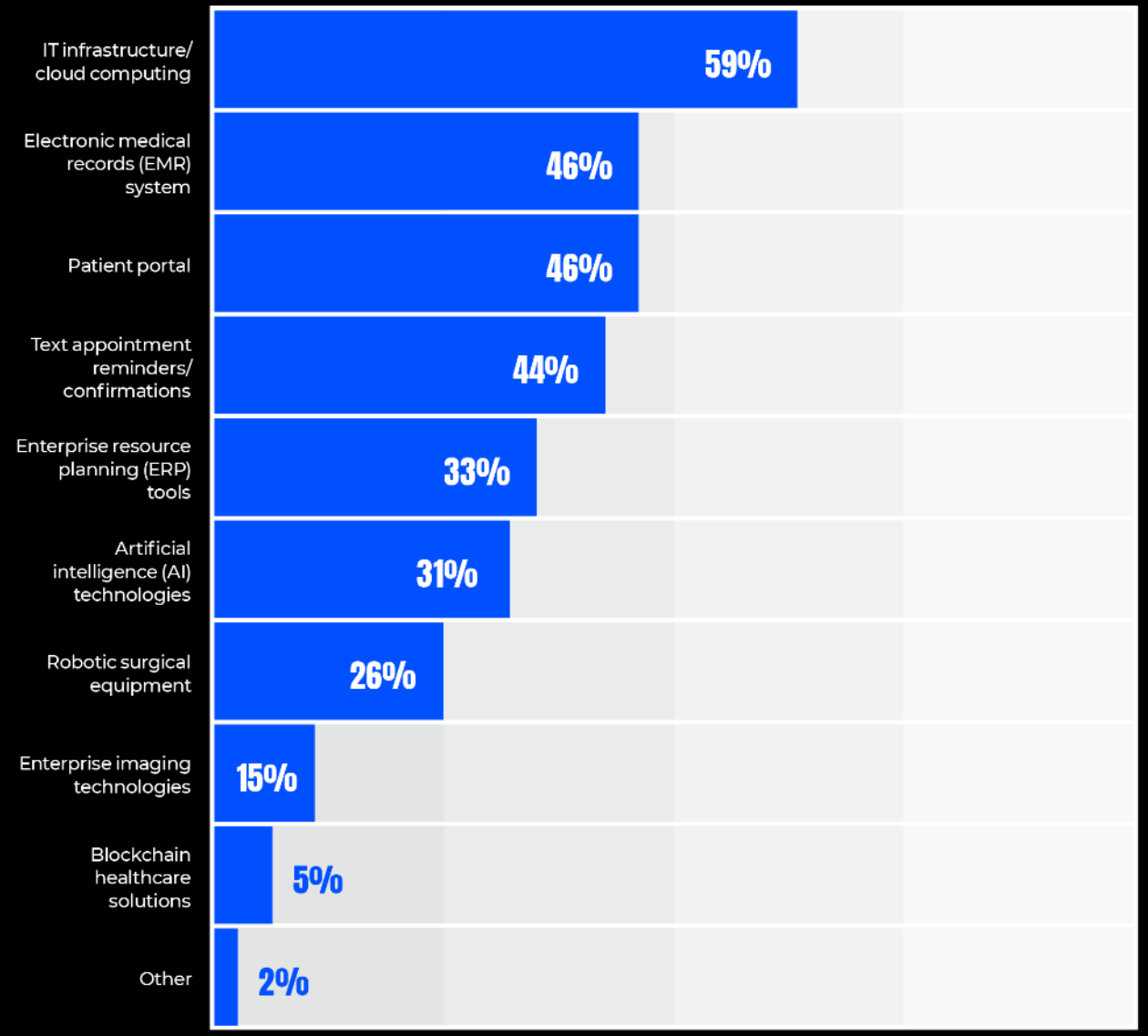
In the next two to five years, does your organization have plans to expand/invest in new technology platforms?



In terms of net revenue, which best describes the growth in your forecasted revenues over the next three years?



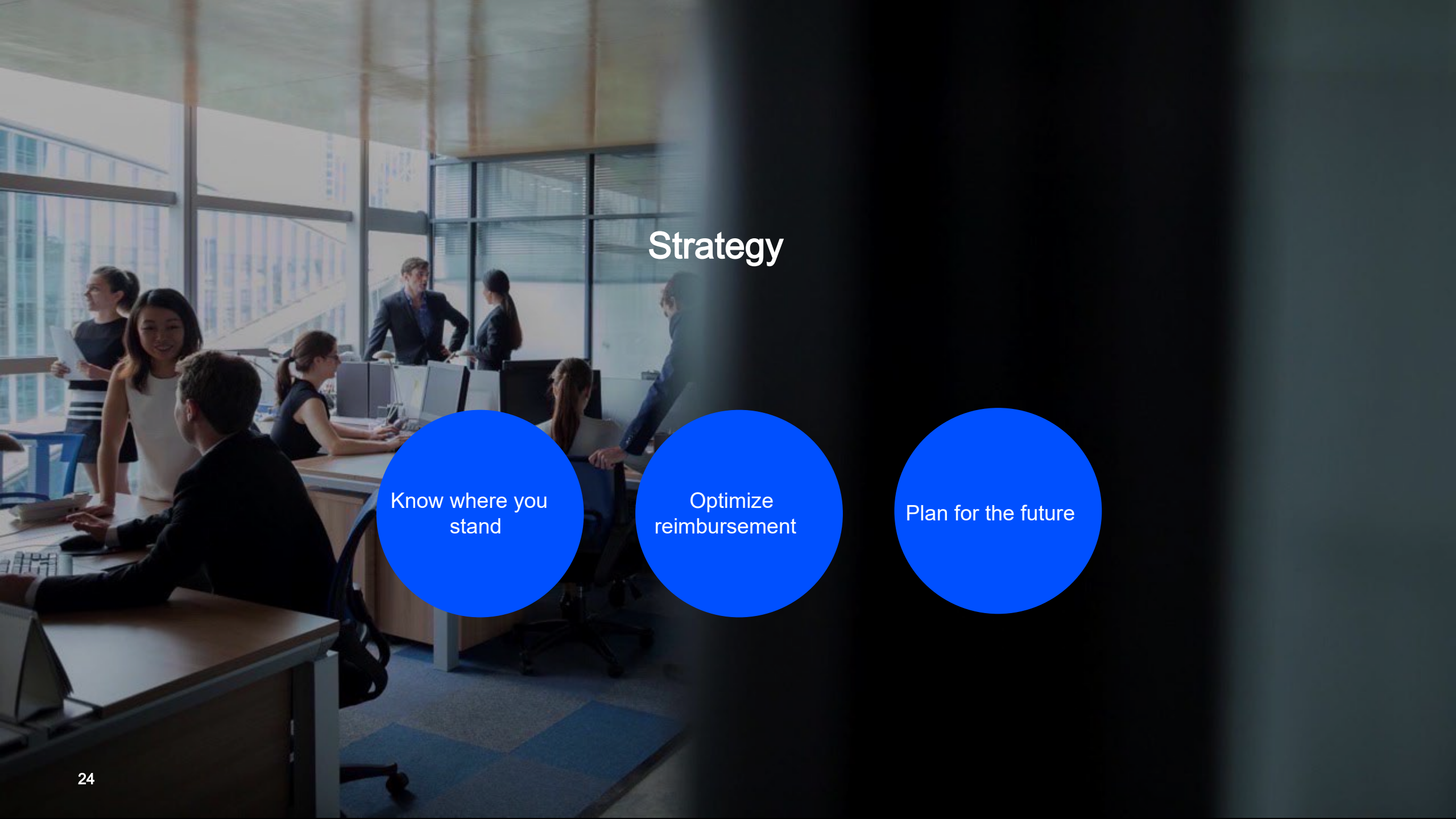
What technology systems do you plan to expand or purchase?



(Respondents were allowed to choose multiple responses.)

02

Strategic responses



Strategy

Know where you stand

Optimize reimbursement

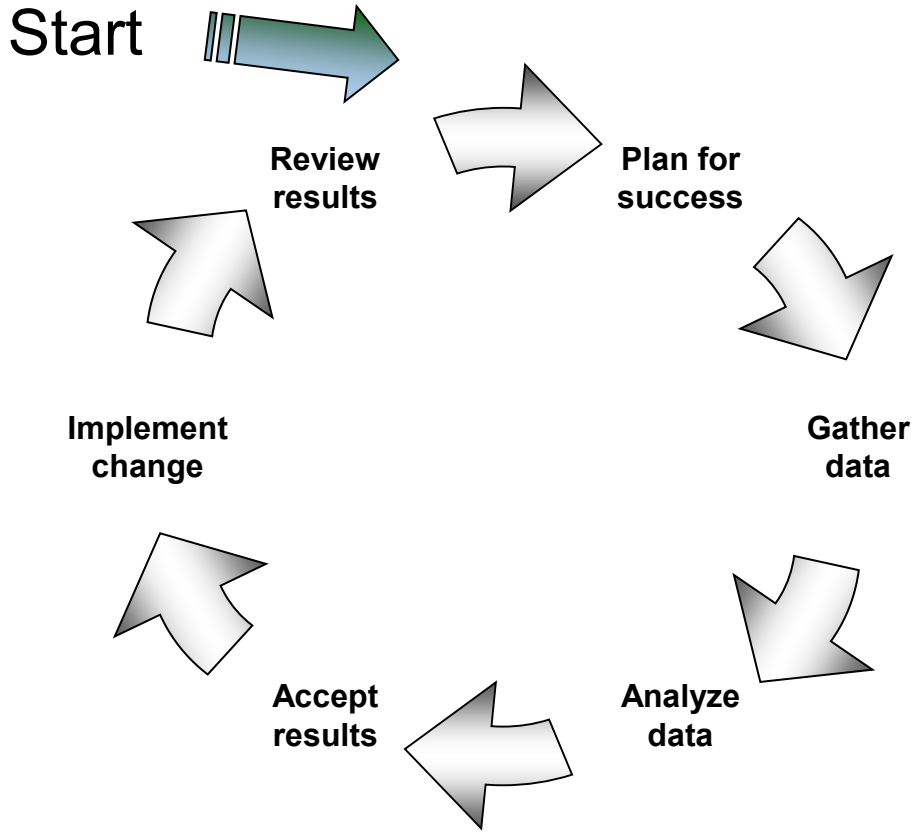
Plan for the future

“Benchmarking is the continuous process of measuring products, services, and practices against the toughest competitors or those companies recognized as industry leaders.”

- D.T. Kearns, Xerox Corporation

Principles of benchmarking

Key approach to benchmarking initiatives



Benchmarking helps us to drive the definition of:

- Targets - When have we achieved our goals?
- Alarms - When do we need to alert the organization to take action?

Wipfli/NARHC Rural Health Clinic Benchmark Report

Category/Indicator	12/31/2018 RHC Values	12/31/2018 Mean WA	12/31/2018 Mean Western	12/31/2018 Mean Nation	12/31/2019 RHC Values	12/31/2019 Mean WA	12/31/2019 Mean Western	12/31/2019 Mean Nation	12/31/2020 RHC Values	12/31/2020 Mean WA	12/31/2020 Mean Western	12/31/2020 Mean Nation
Number of Facilities	1	77	461	2,361	1	80	460	2,468	1	75	481	2,610
Encounters per FTE:												
Physicians	4,062	3,707	4,020	3,976	4,252	3,454	3,821	3,901	3,475	2,916	3,367	3,472
Physician Assistants	2,335	3,205	3,483	3,188	1,792	3,398	3,539	3,147	1,243	2,578	2,936	2,747
Nurse Practitioners	0	2,909	3,106	2,865	2,509	2,513	3,032	2,876	1,914	2,338	2,698	2,604
Clinical Psychologist/Social Worker	1,174	1,500	1,630	1,498	1,058	1,300	1,549	1,499	734	1,062	1,502	1,276
Total Encounters	15,719	1,103,592	5,639,341	25,258,132	16,269	1,181,644	5,953,776	27,179,505	13,014	712,184	5,034,987	25,365,033
Midlevel Staffing Ratio	27%	47%	54%	55%	29%	49%	54%	56%	31%	50%	55%	57%
Midlevel Visit Ratio	18%	42%	45%	46%	16%	44%	46%	48%	15%	46%	47%	48%
Cost per Encounter:												
Physician	128.93	121.98	117.16	100.70	135.87	129.90	126.06	106.66	178.42	162.13	144.13	118.82
Physician Assistant	136.17	75.65	56.55	50.35	194.18	76.08	52.40	52.27	299.11	104.32	66.97	61.74
Nurse Practitioners	0.00	37.97	60.55	49.08	83.84	41.26	62.94	50.39	268.49	69.45	68.80	57.03
Clinical Psychologist/Social Worker	112.26	25.65	41.37	41.89	116.10	37.72	42.22	35.42	191.96	107.96	70.30	45.88
Total Health Care Staff Cost	44.98	34.89	36.90	28.47	49.01	39.84	38.10	29.45	86.01	48.38	44.86	33.93
Cost per FTE:												
Physician	523,720	431,088	400,033	353,962	577,746	424,386	440,036	379,073	620,081	434,770	431,047	374,521
Physician Assistant	318,026	242,482	196,983	160,513	347,979	258,539	185,465	164,467	371,683	268,927	196,629	169,598
Nurse Practitioner	0	110,447	188,086	140,591	210,322	103,708	190,874	144,893	513,964	162,370	185,660	148,515
Clinical Psychologist/Social Worker	131,810	38,486	67,460	62,760	122,832	49,033	65,410	53,085	140,899	114,698	105,574	58,528
Total Healthcare Staff Costs per Provider FTE	173,304	123,603	149,905	101,996	187,613	132,508	147,659	103,654	255,550	133,338	152,359	106,538
Clinic Cost per Encounter:												
Total Health Care Staff	174.81	123.97	108.43	96.18	188.17	132.20	117.69	101.58	281.10	168.02	134.14	114.66
Total Direct Costs of Medical Services	181.46	137.70	140.47	119.80	191.57	148.36	146.53	123.78	288.69	190.56	169.20	138.80
Clinic Overhead	15.52	33.38	24.18	24.69	15.94	32.60	26.26	26.60	22.76	37.62	30.74	30.63
Parent Provider Overhead Allocated	90.61	74.78	96.79	81.06	92.45	81.13	99.30	83.63	136.31	137.63	122.94	96.63
Allowable Overhead (Clinic and Parent)	106.13	108.05	119.74	104.83	108.39	113.24	123.31	109.18	156.92	170.93	147.82	124.39
Allowable Overhead Ratio (Clinic and Parent)	100%	100%	99%	99%	100%	100%	98%	99%	99%	98%	96%	98%
Total Allowable Cost per Actual Encounter	287.59	245.75	259.58	223.78	299.96	260.81	269.68	232.15	445.61	359.85	316.79	262.48
Total Allowable Cost per Adjusted Encounter	284.83	231.68	248.80	213.77	298.94	241.95	254.33	221.30	444.99	332.74	300.67	252.83
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(8.07)	(4.27)	(5.66)	(6.21)	(6.48)	(4.11)	(5.66)	(6.77)	(10.87)	(8.29)	(6.99)	(8.21)
Rate per Adjusted Encounter	276.76	227.41	243.14	207.56	292.46	237.84	248.67	214.53	434.12	324.45	293.68	244.62
Total Medicare Encounters	5,718	312,883	1,396,321	6,362,621	5,552	335,391	1,499,683	6,730,574	4,598	199,901	1,233,603	5,907,972
Medicare Percent of Visits	36%	28%	25%	25%	34%	28%	25%	25%	35%	28%	25%	23%
Injection Cost:												
Cost per Pneumococcal Injection	409.54	300.86	298.73	280.61	260.83	289.85	299.05	295.95	160.67	298.58	310.18	329.20
Cost per Influenza Injection	48.14	81.67	92.14	79.87	57.59	80.19	91.03	85.69	62.03	87.03	97.72	140.66

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NARHC
NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

“Put the squeeze on Medicare reimbursement.”

- Michael R. Bell

Reimbursement optimization

Rural Health Clinics

Despite the changes in Medicare payments for RHCs, newly certified RHCs are still proving to be a viable option for organizations. In addition, there are some options to consider for both grandfathered and newly-certified RHCs.

Rural Emergency Hospital

Rural Emergency Hospitals (REH) are a new provider type established by the Consolidated Appropriations Act, 2021 to address the concern over closures of rural hospitals, effective 1/1/2023.

Commercial Payor Contracting

Often, one of the most overlooked areas for increased net revenue opportunities relates to commercial contracts. Understand the major payors, contract terms, and if it's time to ask for more.

Rural Emergency Hospitals

Rural Emergency Hospitals overview

- To be eligible for REH status, hospitals must have 50 or fewer beds and either be in a rural area or have an active rural reclassification
- REHs are required to provide 24 -hour emergency services, laboratory services, diagnostic radiological services, pharmacy or drug store area, and discharge planning by qualified professional
- REHs can also provide other outpatient services such as behavior health, radiology, and outpatient rehab. An REH may also establish a separate, distinct part unit licensed as a Skilled Nursing Facility
- REHs must meet Critical Access Hospitals CoPs for Emergency Services
- Cannot have per -patient averages exceed 24 hours (individual patient stays can exceed 24 hours)
- Can provide observation care and additional medical outpatient services
- All covered outpatient services provided by REHs will receive an additional 5% increase in payment of the standard OPPS rate that would be paid (none of this additional 5% would be charged to beneficiary coinsurance)
- In addition to the 5% increase, REHs will also receive an additional monthly facility payment from Medicare. This facility payment will increase annually by the market basket percentage which is established by CMS. The current established facility payment for 2023 will be $272,866 per month
- A hospital that converted to an REH is able to convert back to their previous provider type *as long as the conditions of participation are met.*

Rural Emergency Hospitals drawbacks

- *REHs are not considered an eligible provider for 340B drug pricing*
- REH-designated hospitals can no longer provide inpatient or swing -bed care and must have a transfer agreement with at least one Medicare -certified hospital designated as a Level I or Level II trauma center. (REHs can provide SNF services; however, must gain licensure and create a distinct part unit for SNF services which may have previously been done under a hospital's swing bed license.)
- With this being a brand -new provider type there are a lot of unknowns and there could be several changes to this provider type in the future periods
- Not all states have established REH rules yet regarding REH's
- Hospitals that are currently operating with an inpatient unit would have to make determinations on what to do with staff that would no longer be needed (terminations or transfers to other locations)
- Community perspective of no longer offering inpatient services and handling of employees who would no longer be needed
- REHs that would make the determination to transition back to old hospital type could have challenges filling positions

Rural Health Clinics

Strategy: Mobile RHCs

- Mobile RHCs for Medicare use an existing Medicare RHC rate:
  - So, in theory, if a hospital developed a mobile RHC, it may not be subject to the new Medicare RHC caps
- No new certification – The RHC is basically an extension of the existing RHC
  - RHC conditions of participation do not have to be met in the mobile unit as long as the clinic as a whole (permanent and mobile unit) meet the requirements
  - Must provide services in a rural area and that location must have a current shortage designation
  - Services in the location must have a consistent schedule

Strategy: Mental health services

- Beginning in 2022, Medicare pays mental health telehealth services as a “distant site” paying at the AIR
  - Patients must have been seen within the last 12 months (there are exceptions to the rule)
- This change in reimbursement allows RHCs to contract with remote behavioral health providers to offer telehealth visits and receive their AIR payment

Strategy: HOPD to RHC or stay as existing HOPD?

- As the Medicare cap continues to grow, it may be advantageous to convert existing hospital outpatient department (HOPD) clinics to RHCs
  - Why? Medicare RHC rates may eventually be higher than the Medicare fee for service rates
  - HOPD status could be advantageous depending on the service mix; specialty services are often reimbursed higher by Medicare in a HOPD
  - The 2021 increases in the Medicare physician fee schedule may be a factor
- Does the state recognize HOPD status?

Strategy: Change of address

- “Grandfathered” RHCs can move and keep the existing RHC rate intact (note that Health Professional Shortage Area (HPSA)/Medically Underserved Area (MUA), rural, and conditions of participation must be met).
- Does your organization have a larger clinic that does not currently have RHC status? Could you move an already existing certification to that location and recertify and smaller/less Medicare & Medicaid -utilized clinic?

Strategy: Review the Medicaid RHC rate

- Make sure your RHC Medicaid rates are maximized
- Has your clinic considered a change in scope of services request?

Note: A loss in Medicare RHC reimbursement may be offset by a gain in Medicaid RHC reimbursement. RHC status may still make sense depending on your state's RHC reimbursement rates and your clinic's payer mix.

Strategy: Addition of RHC -defined practitioners

- Beginning 1/1/2024, the following additional RHC practitioners will be recognized by CMS and with services paid at the AIR
  - Marriage and Family Therapists
  - A Mental Health Counselor is recognized as an individual who
    - ‘‘(A) possesses a master’s or doctor’s degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services described in paragraph (3); ‘‘(B) is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished; “(C) after obtaining such a degree has performed at least 2 years of clinical supervised experience in mental health counseling; ‘‘(D) meets such other requirements as specified by the Secretary.’’

Strategy: Productivity Standard Exception Request

- RHC productivity exemptions were NOT included in the Section 1135 waivers for the COVID -19 public health emergency.
- During the pandemic, The Centers for Medicare & Medicaid Services (CMS) provided guidance to the Medicare Administrative Contractors that burdens should be eased during this timeframe and staffing shortages or lack of volumes due to COVID -19 could be a reason to grant an RHCs request for exemption to the productivity standards; however, there is no specific waiver for the exemptions.
- RHCs can continue to request exemptions to the standards with the understanding that the Medicare Administrative Contractors (not CMS) make the decision whether or not to grant the exception.
- What justifications might your clinic have after the end of the PHE ?

Strategy: Productivity Standard Exception Request

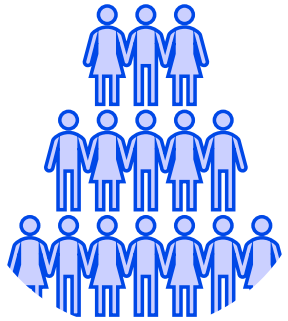
Example Calculation of Productivity Standards:

	FTEs	Actual Visits in RHC	Minimum Required Visits
Physicians	1.50	3,500	6,300
Physician Assistants	0.90	1,500	1,890
Nurse Practitioners	0.80	2,000	1,680
Certified Nurse Mid-Wives	-	-	-
		7,000	9,870
Total Allowable RHC Costs		$ 2,000,000	$ 2,000,000
Calculated Cost Per Visit		$ 285.71	$ 202.63
Medicare Visits		1,750	
Reimbursement Impact of Productivity Limits		$ (145,390)	

“If you fail to plan, you are planning to fail .”

– Benjamin Franklin

The facility planning continuum



People

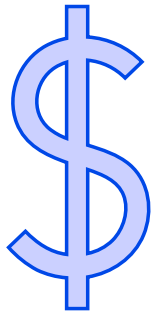
- Service area definition
- Population demographic trends
- Utilization trends

Market/strategy

- Market share
- Growth opportunities
- Volume projections
- Key Rooms needed
- Provider need
- Strategic objectives

Facility

- Appropriate services
- Key Room requirements to meet future need



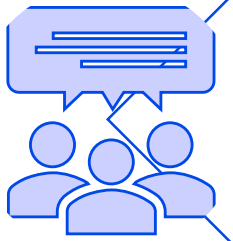
Finance

- Financial performance
- Affordability

Facility assessment methodology

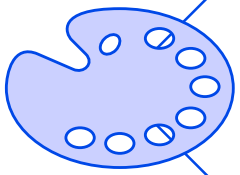
Location

- Is the department appropriately located for the customers it serves as well as proximity relationships to related departments/functions?



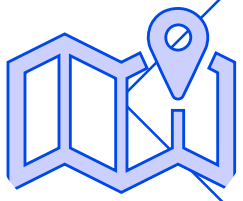
Customer service

- Does the department have positive “first impression” attributes, easy wayfinding, privacy, confidentiality, and needed amenities to serve patients, families, staff, and physicians? Are you able to service the needs of patients appropriately and provide quality care in the space?



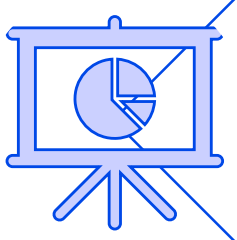
Design

- Is the department appropriately designed for ease of access and egress, as well as operating efficiency and patient safety?



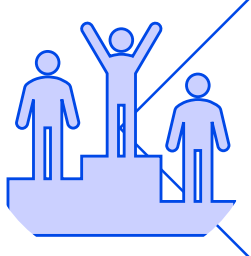
Off-site potential

- Could the department be situated outside of the Hospital proper, either on site (detached) or off site?



Space

- Is the department appropriately sized for the functions it serves, the modalities required, and needed support spaces?



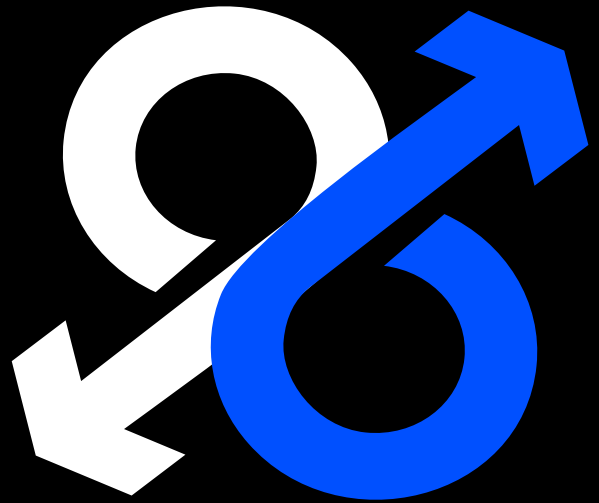
Overall priority

- Decided based on weighted consideration of assessment criteria, space benchmarks, and overall contribution to clinical outcomes

Provider need assessment methodology

Supply counts updated to adjust for provider productivity

Transformative Leadership Linkage



YOUR PEOPLE STRATEGY MUST CONNECT TO YOUR BUSINESS STRATEGY

WIPFLI

The process

01 Business plan

Cascades throughout the organization.

02 People strategy

Broad strategies identified for people to implement the business strategy.

03 Standards

Leader standards or philosophy created summarizing what leaders need to know.

04 Development plan

Development plan created from standards and from gaps identified with current leaders for existing and future roles.

05 Execution

Programs, coaching, and other traction items put into play for all leaders.

06 Measure throughout

03

Closing comments and Q&A

Q & A

Things to think about

- Benchmarking: How do you stack up?
- Reimbursement strategies: Where to focus?
- Planning for the future:
  - Strategic planning?
  - Capital planning ?
  - People planning ?

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