# Healthcare in a Rural Environment

**Creating a Sustainable Care Delivery Model During a Time of Uncertainty**

*Presented Wednesday November 10th 2021*

2021
Annual
Conference

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November 8–10
Minneapolis and Virtual

2021

# Annual Conference


November 8-10,
Minneapolis and Virtual

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# Objective

**Introduce and discuss tactics and considerations for establishing a sustaining care delivery model**

**At the end of this session, participants should:**

- **Have an inventory of levers to contemplate in pursing sustained operating performance and balance sheet strength**
- **Discuss frameworks to support a culture of continuous performance improvement and optimization**
- **Introduce various reimbursement opportunities tied to facility status**

# Today's presenters

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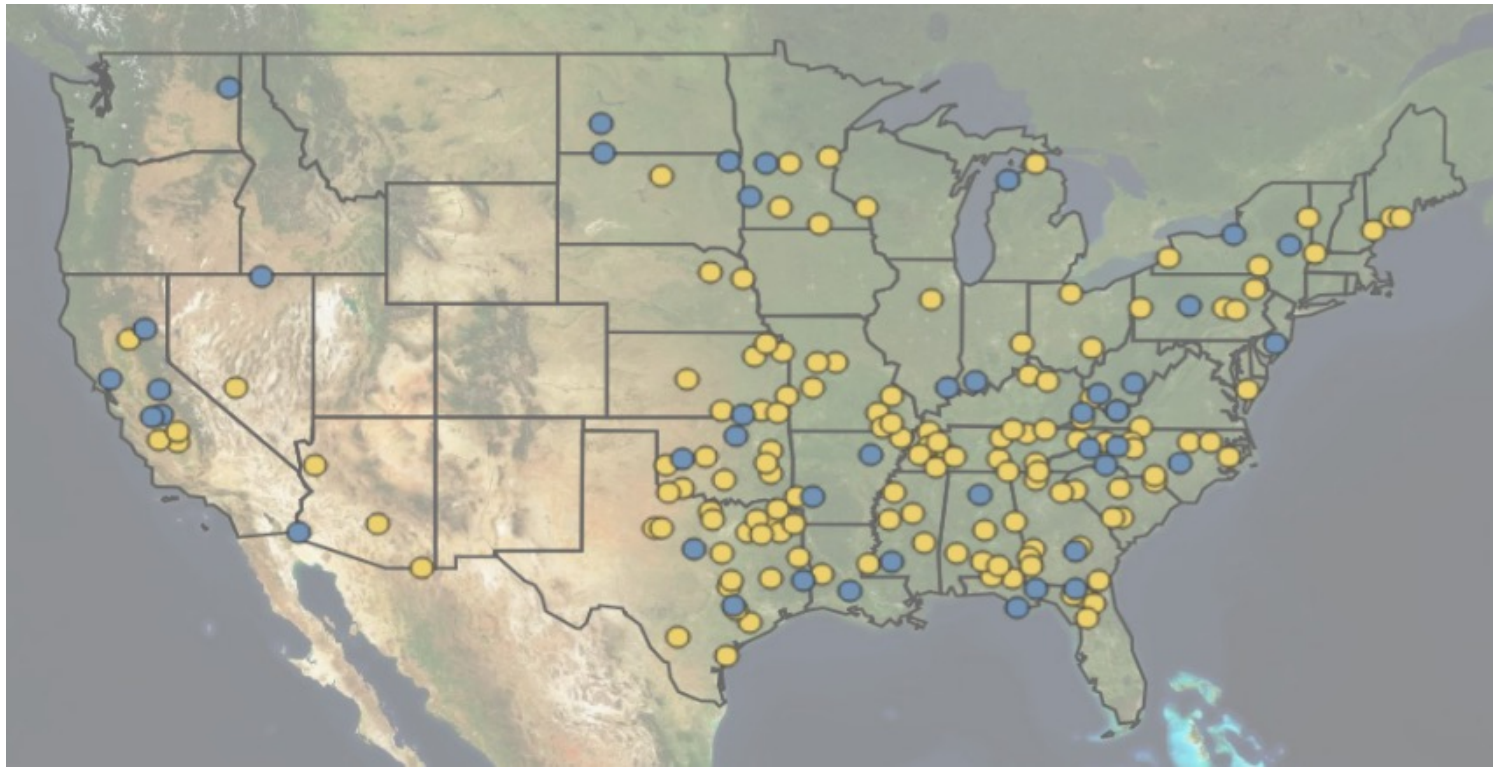
[1]Source: Cecil G. Sheps Center for Health Services Research

# There have been over 180 rural hospital closures since 2005[1]



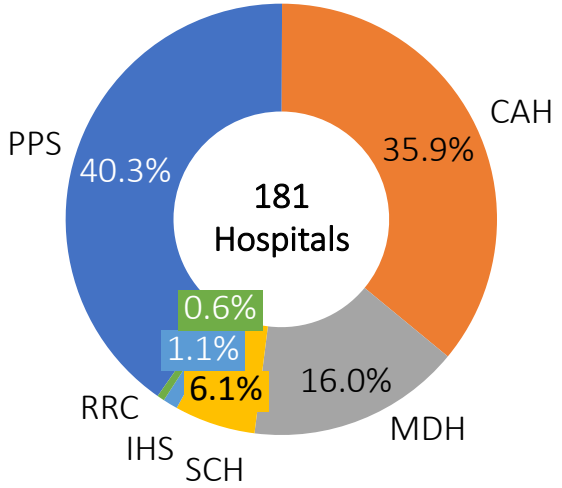
- ***In conjunction with these closures, a number of rural-based providers have also taken steps to rationalize footprint aligned in some fashion with large provider organizations***



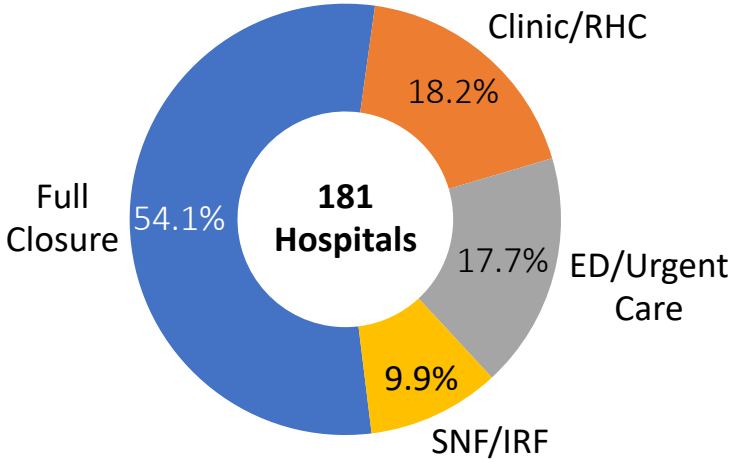
[1]Source: Cecil G. Sheps Center for Health Services Research

# From 2013 to 2020, rural hospital closures have averaged more than one per month[1]

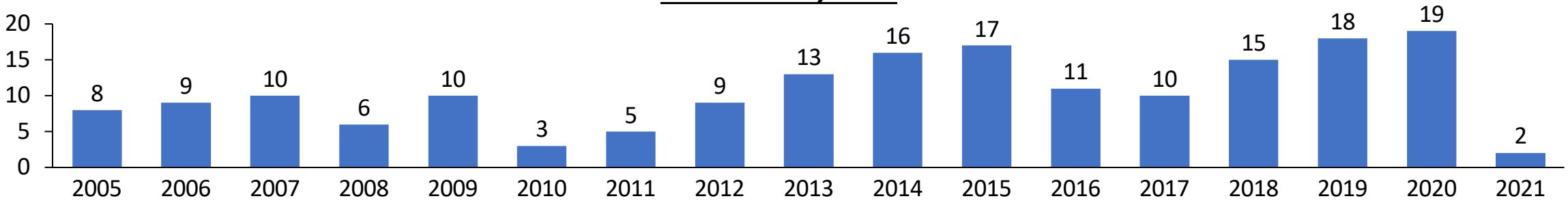
***Closures by Medicare Status***
***2005 thru July 2021***




***Closures Action Taken***
***2005 thru July 2021***




***Closures by Year***
***2005 thru July 2021***



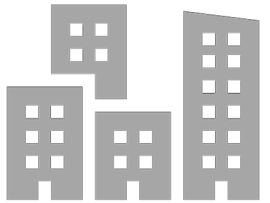



[1]Source: Cecil G. Sheps Center for Health Services Research

# Rural versus Urban Facilities
## *Different realities*

### Rural

- Larger geographic service areas/lower population density
- Fewer local competitors for the same patients
- Lower volumes and often more impacted by seasonality
- Closer “connection” to community
- Excess capacity caused by differences in care patterns compared to when facilities were built (migration to ambulatory settings)
- Age of physical plant due to margin constraints
- Generally older population and greater Medicare utilization
- Significant reliance on outbound transfers to larger facilities



### Urban

- Smaller physical service area/higher population density
- Greater level of competition
- Higher volumes, seasonality
- Formalized corporate governance structure
- Space utilization easily repurposed for emerging demand and/or new clinical disciplines
- More current structures and technologies with annual capital investment plan
- Greater distribution of age and payer mix
- Receives transfers from smaller facilities

# While rural hospitals are a vital to local communities, they face escalating headwinds

| Pandemic "Aftermath" | Resource Scarcity | Business Model Risk |
|---|---|---|
| • Shrinking tax base<br>• CMS funding gaps<br>• Crowding out of donations<br>• Payers shifting mindset | • Labor shortages<br>• Medical supply shocks<br>• Escalating costs of capital projects<br>• Single practitioners | • Inflow of private equity funding<br>• Acceleration of virtual tools and capabilities<br>• CMS Payment Innovations and |

- ***As rural hospitals often serve as a critical employers and economic drivers to their local communities, closure can have significant implications on local economics, growth and moral***
  - A 2017 AHA study highlighted that "ripple effect" of a hospital's activity generates twice as many jobs than the hospital directly employs[1]



[1]Source: American Hospital Association, "Hospitals are Economic Anchors in their Communities"

# When transforming a rural practice, leaders have several short-term and long-term tactics at their disposal

## Revenue

- Revenue Cycle
- Reimbursement
  - Medicare
  - Medicaid
- Contracting Strategy
- Alternative Revenue Strategies

## Expense

- Technology and automation
- Vendor/contracting strategy
- Cancelling unused evergreen contracted services
- Role Definitions & Productivity
- Metrics to monitor quality and productivity performance

## Talent & Tools

- Need to compete in an ever-changing landscape

## Strategy & Capital Investment

- Capital investment decision-making
- Strategic service line assessment
- Disciplined approach to capital sourcing/funding

# Revenue Cycle Optimization
## *Get credit for what you do*

### Front End

- "Schedgistration" staffing model
- High focus on financial counseling
- Pre-authorization management
- Alternative sources of funding

### Middle

- Complete and timely documentation
- Monitor and resolve incomplete items

### Back End

- Timely coding and billing
- Denials management
- Disciplined collection process

### System Maintenance & Validation

- Continuously audit key mappings, charge flow, and other related elements

# Unique Rural Reimbursement Opportunities
## *Choose the right horse*

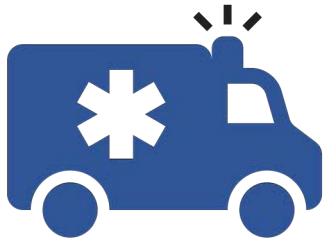
- **Critical Access Hospitals (CAH)**
  - Rural hospitals < 25 beds (or necessary providers) receive 101% of cost reimbursement
  - Must be greater than 35 miles from nearest PPS hospital or other CAH
  - Eligible to participate in 340B program
- **Medicare Dependent Hospital (MDH)**
  - Rural hospital < 100 beds with over 60% Medicare (days or discharges) in last 2 of 3 settled cost reports
  - Payment adjustment based on 75% of the difference between IP PPS payments and historic hospital specific rate
  - Program is continually evaluated
- **Low Volume Adjustment**
  - Rural hospitals based on mileage requirement (15 miles)and fewer than 3800 total discharges (current regulations)
  - Reimbursement adjustment up to 25% of the greater of the IP PPS amount or Hospital Specific Rate (for MDHs and SCHs)
  - Adjustment paid through interim payments, subject to final cost report settlement

# Unique Rural Reimbursement Opportunities (continued)
## *The little things add up*

- **Rural Referral Centers**
  - Rural hospitals > 275 beds or based on case mix criteria and medical staff criteria
  - Favorable treatment for wage index classification resulting in higher reimbursement compared to smaller rural hospitals
  - Not subject to 12% cap for empirically justified DSH payments
  - Favorable adjustment for IME cap amounts
  - 340B eligibility based on lower DSH threshold
- **Sole Community Hospital (SCH)**
  - Based on geographic  (35 miles)and “like hospital”  considerations
  - Reimbursed greater of PPS amount or Hospital Specific Rate
  - Favorable treatment for MGCRB wage index determinations (mileage requirements)
  - 7.1% increase in outpatient PPS payment rates and favorable treatment for separately payable drugs

# New Opportunity: Rural Emergency Hospitals
## *The final frontier?*

- Included in Consolidated Appropriations Act (December 2020)
- Medicare payments for REH services to commence by 1/1/2023
- Permits CAHs and rural hospitals <50 beds in certain states to be considered hospitals even without providing inpatient care
- REH facilities would not provide inpatient care (ALOS <24hours)
- Must provide emergency and observation and can offer certain ancillary services
- Reimbursement based on 105% of OP PPS rates
- Requires transfer agreement with Level I or Level II trauma center
- Fixed annual payment to cover overhead costs based on “savings” compared to 2019 PPS amounts.  May be key to survival
- Annual reporting of the use of the additional facility payment
- *Final enabling regulations still in progress*



# Other Considerations
## *Playing Jenga®*

- Every operational change will impact how the facility's cost report will look, so consider these changes when doing cost report comparative analysis.
- Before implementing any changes, the impact should be modeled through the cost report to determine a potential range of outcomes.
- Actual results should be compared to the projections and differences should be explainable.
- Certain changes (i.e. statistical allocations; home office methodologies) may require prior MAC approval
- Any changes should be evaluated for impact on compliance or financial assistance policies.
- Is the person signing the cost report familiar with how any changes have impacted operations and are they still comfortable with the statement "the cost report is prepared in accordance with applicable instructions"

# Contracting Strategies
## *One size doesn't fit all*

### Understand your position within the market

- Network with key brokers, consultants and employers to inform your strategy and position
- Policy latitude can have as much impact to reimbursement as explicit rate structures
  - Treatment of transfers and virtual care delivery
- Continuously monitor performance and develop Joint Operating Committee cadence

### Value Based Arrangements

- Understand the why and benefit for both sides
- Don't be too aggressive/"too far out in front of your skis"
- Be creative

# Alternative revenue strategies
## *Being resourceful with the assets you have*

- **Grants**
  - Private donations (restricted or unrestricted)
  - National organizations that support grant funding, i.e. National Rural Hospital Association, United Way
  - Research-driven grants through universities

- **Special Payment Arrangements**
  - Medicare payment innovation/CMMI programs
  - Federal and state waivers
  - Seasonal occupational health arrangements

- **Non-traditional services**
  - Social determinants of health assessments
  - Special interest classes

# Technology and Automation
## *Own your strategy but maybe not your technology*

- **Establish a system strategy**
  - Contemplate the data flow map with focus on data leakage
- **Software as a Service**
- **Direct to vendor vs. multi-tenant structure**
- **What is your automation value proposition?**
  - Mitigate difficult to fill roles versus productivity improvement

# Vendor and contracting strategy
## *Make good choices*

**“Sweat the Details”**

- Review inventory for non-relevant contracts
- Tight monitoring of renewal and evergreen language
- Establish and/or monitor service line agreement performance

**Strategic Contracting**

- Establish tools for outsource versus insource evaluation
  - Financials/Net operating income impact
  - Service Consistency
  - Pace of transformation

# Role Definitions & Productivity
## *What's in and who's out*

- **Staffing models must be balanced with technology and vendor strategy**
  - Complement the responsibilities that are outsourced

- **Employee engagements and joy is paramount**
  - Think creatively around staff responsibilities
  - Opportunity to introduce some unique roles in the industry

- **Quality performance weighs traditional industry productivity metrics**

# Talent & Tools
## *Find the talent and feed them well*

- **Personnel**
  - Identify the specific skills or experiences needed for each role
  - Consider remote workers, when possible, to expand the applicant pool
  - Build a network of trusted resources from various services (e.g. Purchasing, Quality, and Facilities)
  - Understand the “person-centric” risks of the rural model

- **Tools**
  - Focus on the question at hand
  - Be adaptable in the tools being used
  - Make visual observation part of your assessment process

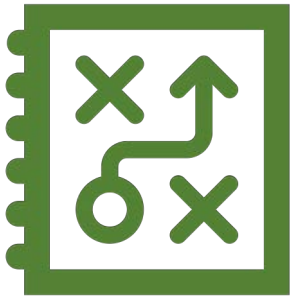
- **Training**
  - Utilize training and educational opportunities from various sources
  - Expand knowledge of reimbursement from Medicare and Medicaid
  - Learn the triggers for value-based contract rewards

# Education
## *Knowledge is power*

- **Assess the governance structures understanding of Medicare principles of reimbursement**
- **Explain that the laws and regulations governing Medicare are complex and subject to interpretation**
- **Present the cost report with the same level or rigor as applied to the 990 and particularly Schedule H)**
- **Demonstrate Medicare margin calculation**
  - Boards may not understand the complexities of Medicare reimbursement, but they will understand that when their largest source of revenue may not pay its full share of costs it's not a model for long term viability

# Analytics Based on Medicare Cost Report Data
## *The gold is in the numbers*

- **Medicare Margin Analysis**
  - How does Medicare revenue stream influence overall profitability
- **Per Diem; Per Case; Per Adjusted Discharge Metrics**
  - Can be used to compare across facilities or time periods
- **Payer Mix**
  - Establish baseline and trends to closely monitor
- **Cost to Charge ratio analysis**
  - Measures sensitivity of any price changes
  - Changes in CCRs may indicate underlying operational issues or cost report misalignment



# Strategy & Capital Investment
## *Think novel to keep your story going*

**The Fundamentals**

- Let community needs assessment inform service offerings and investments
- Under the total cost of ownership (cash flow, operating costs, recurring/future capital obligations and duration)
- Intentionally evaluate risk and know your exit strategies
- Does a merger/alliance make sense for us?

**Thinking Novelly**

- Investments that enable the expansion of footprint (e.g. platform, virtual)
  - Expensed versus traditional capital
- Alternative revenue streams given unique internal expertise
- Merge/absorb complementary functions

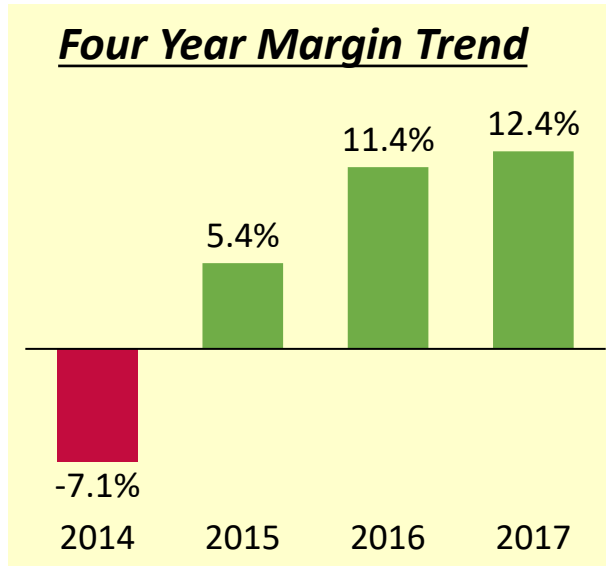
# Putting it all together
## *Fortune favors the bold*

**Real Case Study**

- **Organization was hemorrhaging cash and within weeks of closing its doors**
- **Board highly dissatisfied with executive leadership; recruit new COO & CFO**
- **Significant "tail expenses" for lapsing grants**
- **Credit worthiness concerns makes borrowing nearly impossible**

**Actions Taken**

- **Corrected significant Rev Cycle deficiencies across access, charge capture, coding and A/R services**
  - Worked with state to accelerate Medicaid status determination and claims payment
- **Right-sized capacity or sunset non-core services with low utilization**
- **Introduced disciplined approach to investment considering full life cycle**
- **Revamped facility reimbursement status**
- **Re-Organized Grants Program**
  - Funding for community workers, "boots on the ground" financial counselors and virtual care capabilities
- **Modernized technologies (EMR/Rev Cycle, ERP & EPM tools)**
  - Expanded virtual health capabilities and received reimbursement waivers through the state
  - Updated job descriptions and structure to reflect new needs & priorities




**Within two years of turnaround, organization moved from negative NI margins and cash flow to positive margins, a very happy board and the establishment of an endowment to fund future investment**

# Questions