Growing your RHC

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Learning objectives for today's session

- Identify sources of data used in evaluating the need for services in the community
- Evaluate the benefits of potential new services that can be offered in the RHC setting
- Consider the financial and operational challenges of introducing new services or care delivery

Today's agenda

- Data Collection
- Facility Planning
- Service Expansion
- Considerations
- Implementation

Initial questions – What kind of growth?

What exactly are we talking about when we are referring to GROWTH?

- Addition to existing facility
  - To support additional volumes and/or additional services
- Expansion of hours
  - i.e. - “Walk-in” / “Urgent Care”
- Increasing market footprint
  - Additional clinic locations

Initial questions – Should we grow?

Should we do this?

- Are we able to support increased volumes?
  - How is recruitment and retention for our providers?
- Do we have a facility that is ready for growth?
- Is there a need?
- Are we RHC compliant if we do?

Data collection

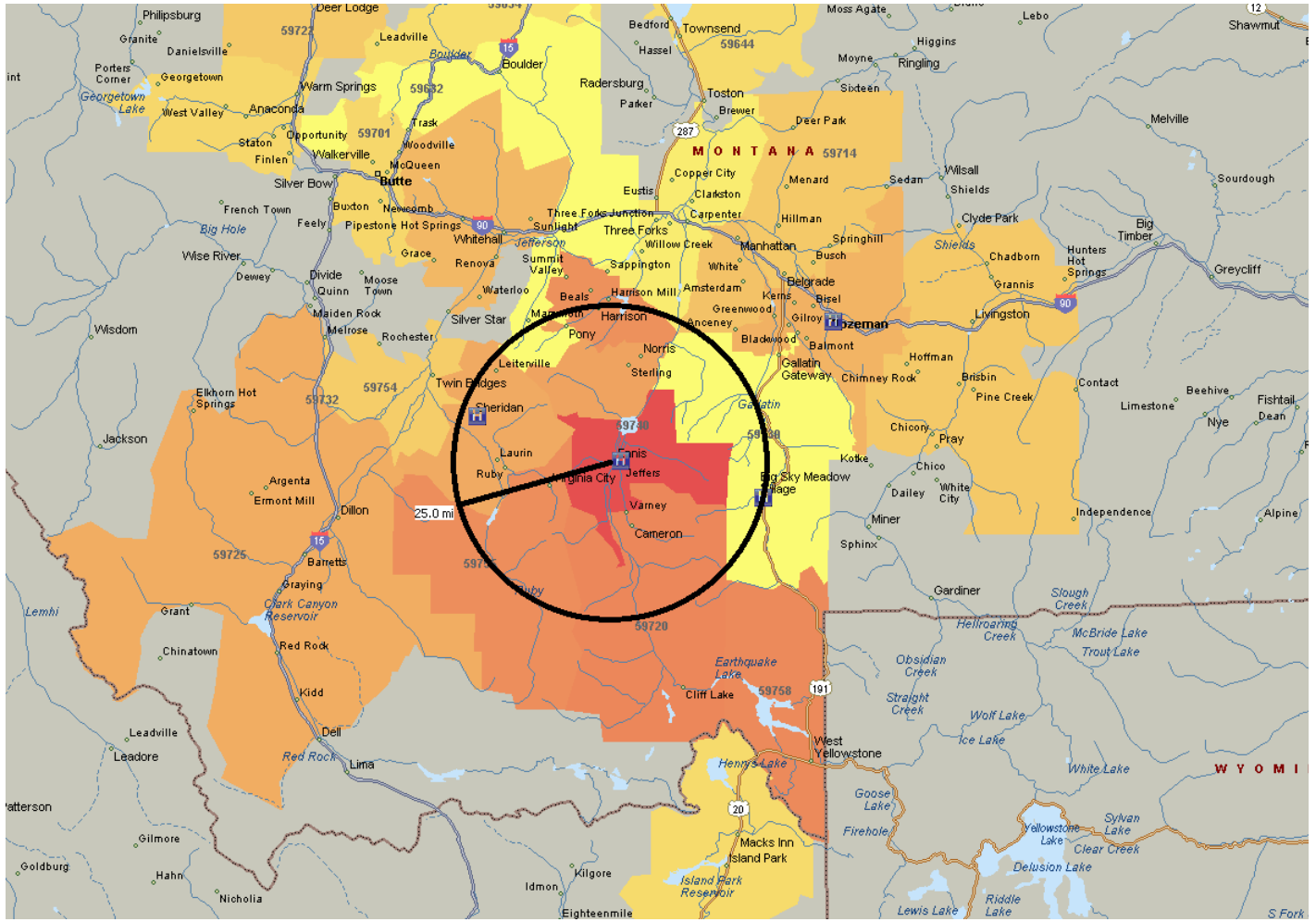
Data collection

Data is critical in both formulating the initial strategy and planning the specific service line.

Types of data required:

- Market share
- Population demographics
- Physician supply
- Competition

Defining the market



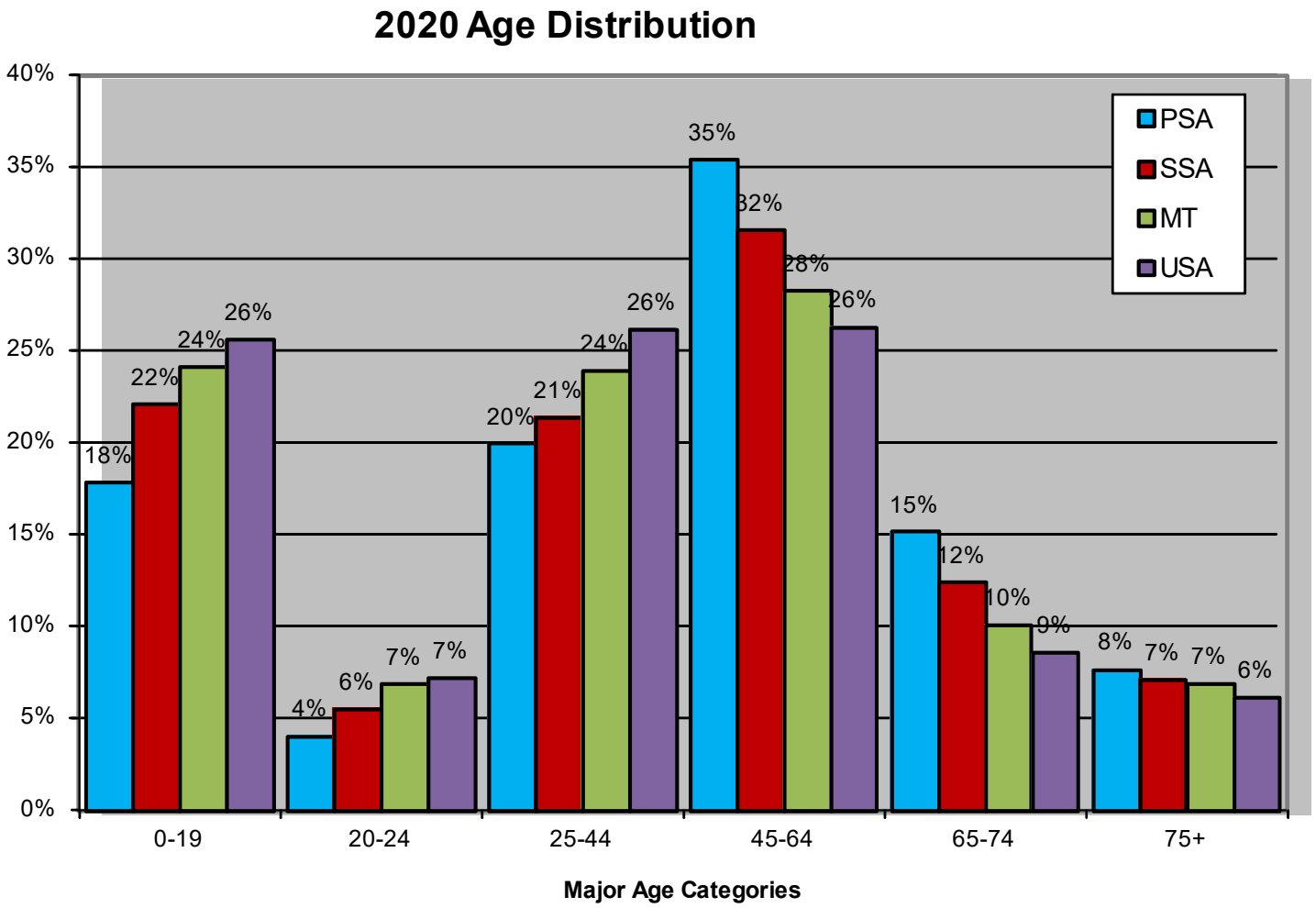
Market position

Age	2019 Total Service Area Population	Population (Hundreds)	Clinic Visits Per 100 people[1] (all specialties)	Total Encounters
<15	5,378	53.78	241.2	12,972
15-24	1,182	11.82	166.3	1,966
25-44	5,007	50.07	231.5	11,591
45-64	6,632	66.32	355.5	22,250
65-74	2,377	23.77	532.2	12,650
75+	1,748	17.48	669.9	11,710
	22,324		Total PSA Estimated Visits	73,139

[1] 2015 National Ambulatory Medical Care Survey (based on '12 data)

Total Estimated Clinic Visits in the Service Area (primary and specialty)[1]	**73,139**
Clinic Visits	**29,312**
2016 Estimated Market Share for Clinic Visits	**40.1%**

Demographics



- Understand how many people in Primary and Secondary Population and Age Distribution
- Helps assess types of providers and likely services

Physician supply

Key Findings

- No shortage in primary care in PSA
- Only slight demand for medical subspecialties
- Could support some general surgery and ortho surgery

Primary Service Area						
Specialty	2015 Supply	2015 Demand	Overage/ (Shortage)	2020 Supply	2020 Demand	Overage/ (Shortage)
Primary Care						
Obstetrics/Gynecology	0.1	0.4	(0.3)	0.1	0.5	(0.4)
Family Medicine	4.8	1.2	3.6	4.8	1.3	3.5
Internal Medicine		1.1	(1.1)		1.1	(1.1)
Pediatrics		0.5	(0.5)		0.5	(0.5)
Sub-Total	**4.9**	**3.2**	**1.7**	**4.9**	**3.4**	**1.5**
Medical Subspecialties						
Audiology	0.1	0.2	(0.1)	0.1	0.2	(0.1)
Allergy		0.0	(0.0)		0.0	(0.0)
Cardiology	0.1	0.2	(0.1)	0.1	0.2	(0.1)
Dermatology		0.1	(0.1)		0.1	(0.1)
Endocrinology		0.0	(0.0)		0.0	(0.0)
Gastroenterology	0.1	0.1	(0.1)	0.1	0.1	(0.1)
Hematology/Oncology	0.1	0.1	(0.1)	0.1	0.1	(0.1)
Infectious Disease		0.0	(0.0)		0.0	(0.0)
Nephrology		0.1	(0.1)		0.1	(0.1)
Neurology		0.1	(0.1)		0.1	(0.1)
Pulmonary Medicine		0.1	(0.1)		0.1	(0.1)
Rheumatology		0.0	(0.0)		0.0	(0.0)
Sub-Total	**0.3**	**1.0**	**(0.8)**	**0.3**	**1.1**	**(0.9)**
Surgical Subspecialties						
General Surgery		0.4	(0.4)		0.4	(0.4)
Neurosurgery		0.0	(0.0)		0.0	(0.0)
Ophthalmology		0.2	(0.2)		0.2	(0.2)
Ortho Surgery		0.3	(0.3)		0.3	(0.3)
Otolaryngology		0.1	(0.1)		0.1	(0.1)
Plastic Surgery		0.0	(0.0)		0.0	(0.0)
Thoracic Surgery		0.0	(0.0)		0.0	(0.0)
Urology	0.1	0.1	(0.1)	0.1	0.1	(0.1)
Sub-Total	**0.1**	**1.3**	**(1.2)**	**0.1**	**1.3**	**(1.3)**

Data collection

Internal - Financial:

- Cost information (Medicare cost report)
- Preliminary financial projection

Internal - Customer and operations:

- Satisfaction data
- Quality data
- Utilization

Facility planning

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Facility planning

Adding space to our current clinic:

- Do you have a facility master plan (typically part of your strategic plan)?
  - Sizes up current space needs
  - Provides future look at space planning needs
  - Important to go through this process before engaging architects
- Are there any state licensing requirements/construction code standard requirements?
- Are there resurvey requirements?
- Is this still considered part of the current address?

Facility planning

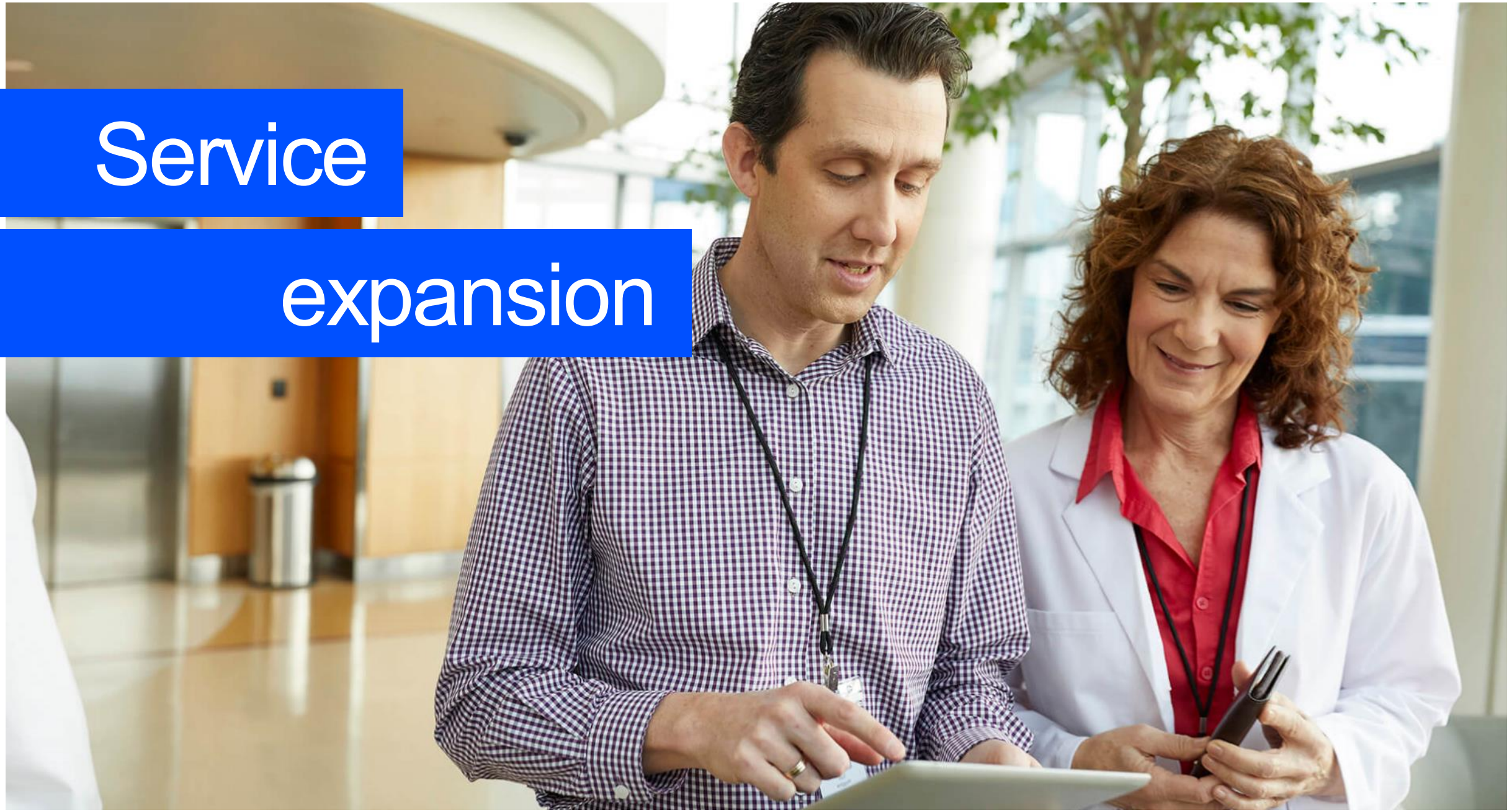
Moving our current clinic:

- Is the HPSA and rural status current?
  - Note – 2020 Census!

Other facility planning considerations:

- Should part of the space be provider-based vs. provider-based rural health clinic space?
- Will other non-RHC related entities rent space?

Service expansion



Service expansion opportunities

RHC Myths:

Specialists cannot be included as RHC covered or allowable providers…

Service expansion opportunities

RHC Fact:

Generally most specialists can be included in the RHC as long as services meet RHC encounter definitions and the primary focus of the RHC remains primary care.

Service expansion opportunities

Expanding capacity of the existing organization with added services, e.g. chiropractors, podiatrists, mental health providers, walk-in services etc.

- Mental health services
  - RHCs for Medicare and in some states can receive RHC payment for a mental health visit and another RHC visit on the same day.
- Other specialties
  - What is the payer mix?
  - How will these providers affect your productivity standard calculation (does it matter?)

Service expansion opportunities

- "Walk-In" / "Urgent care"
  - These services are still considered primary care and on their own can be certified as rural health clinics
  - We are seeing many hospitals implement this type of RHC next to the emergency room
  - **How will other payers reimburse for these services???**

Service expansion opportunities

- School-based clinics
  - Will your state recognize this as an RHC
  - Will they recognize it as an expansion of an existing RHC?
- Mobile clinics
  - Services must be provided in a current HPSA
  - Other requirements – see appendix G of the State Operations Manual

Service expansion opportunities

Developing networks and partnerships with hospitals and health systems or other clinics

- What services might your clinic be able to contract through an agreement with other providers?
  - RHC services can be contracted as long as the clinic bills for the service (and the mid-level requirement is met).

Service expansion opportunities

Moving into different service areas

- No mileage requirements apply unless the hospital to which the RHC is provider-based is considered located in an urban area.
  - Note that provider-based RHCs can be located in an adjacent state

Considerations

Considering opportunities for potential growth

Potential new service line based on market need

Analyze, analyze, analyze!!!

- Medicare & Medicaid
  - How will the new cost-per-visit, if changed, affect Medicare reimbursement (not just for the clinic, but for the organization as a whole)?
- Commercial payers
  - What is our estimated commercial payer percentage of the new service line?

Consider RHC Medicaid rate strategies

Medicaid

***This should be included as part of decision-making process of whether or not to expand and how.

- How does your state treat expansion of services, new footprint of clinic, or an additional clinic for RHC rate-setting purposes:
  - Does this qualify as a change in scope of service and a new rate can be calculated? How is a new rate calculated (is a rebasing of the rate in it's entirety or an incremental change in the rate)?
  - Are productivity standards included in the rate calculation?
  - How are providers defined in your state or the adjacent state?
  - Can a new RHC adopt the rate of a clinic under the same tax ID?

Consider RHC Medicaid rate strategies

Medicare

***This should be included as part of decision-making process of whether or not to expand and how.

- How will additional providers affect your Medicare rate?
- Will these providers cause a productivity standard problem in your rate calculation?
- Will addition of costs equate to additional Medicare reimbursement (freestanding RHCs are currently capped at the federal rate)
- With the services that are added, will the overall predominant service be primary care?

Consideration of other staffing costs

- What additional staff will be needed for additional service lines/additional hours?
  - Nursing staff
  - Administrative staff
  - Billing staff
    - (By the way, do you know the implications of billing for this additional location or service line? Have you discussed this with revenue cycle??)

Enrollment consideration

- An expansion of services in an existing RHC does not require notification to Medicare.
  - You may, however, want to request an interim rate adjustment from the intermediary.
- What does your state requirement for expansion of services?
- What does your accrediting agency require?

Implementation

Keys to success

Three imperatives to achieving alignment

1. Everyone must know the organization's goals (vision)
2. Everyone must feel a personal connection with the vision
3. Everyone must know how to align their individual work to achieve the vision

Conclusion

To Achieve Results:

- Establish a common fact base
- Identify strategic objectives
- Quantify potential impacts of objectives
- Prioritize
- Implement
- **Monitor**

Questions?

The Wipfli Way

Your presenter

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