Provider Shortages – Financial and Compliance Considerations for Keeping Providers Rural

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Today's Agenda and Key Objectives

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Agenda

- Brief Overview of the Market
  - Provider Supply and Demand
- Provider Recruitment/Compensation Models
- Primary Care Options in Rural

Key Objectives

- Rural practices must always be planning for the future and recruiting physicians
  - A critical component of succession planning is understanding the financial implications
- Attendees will learn best practices around APP utilization and maximizing the financial impact

OVERVIEW OF MARKET

An Overview of the National Physician/Provider Market

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- Review current trends in medical education
- Physician/Provider Supply and Demand
- Factors impacting recruitment
- Quantitative versus qualitative community needs analysis

Major Professional Activity of Physicians, 2017

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Specialty	Total Active Physicians	Patient Care	Teaching	Research	Other
Internal Medicine	115,557	101,953	1,414	1,475	10,715
Family Medicine/General Practice	113,514	104,937	1,622	253	6,702
Pediatrics	58,435	52,824	841	662	4,108
Emergency Medicine	42,348	38,964	469	96	2,819
Anesthesiology	41,762	38,960	553	187	2,062
Obstetrics and Gynecology	41,656	38,850	503	192	2,111
Psychiatry	38,205	33,364	573	752	3,516
Radiology and Diagnostic Radiology	27,719	24,682	418	153	2,466
General Surgery	25,042	21,644	262	139	2,997
Cardiovascular Disease	22,211	20,303	299	584	1,025
Orthopedic Surgery	19,001	18,069	118	57	757
Ophthalmology	18,817	17,488	155	127	1,047
Otolaryngology	9,526	8,932	93	23	478
Gastroenterology	14,747	13,488	186	292	781
Urology	9,921	9,374	78	39	430
Neurology	13,717	11,674	244	638	1,161
Other	280,678	227,079	4,719	7,169	41,711
All Specialties	**892,856**	**782,585**	**12,547**	**12,838**	**84,886**

- Primary Care (IM, FM, Peds and OB/GYN) comprises of 36.9% of all physicians currently active, 38.2% of physicians focused primarily on patient care
- 12.4% of physicians are engaged primarily in non-patient care activities

Source: Association of American Medical Colleges; "Active Physicians in the Largest Specialties, 2017"

US Medical Education

2018

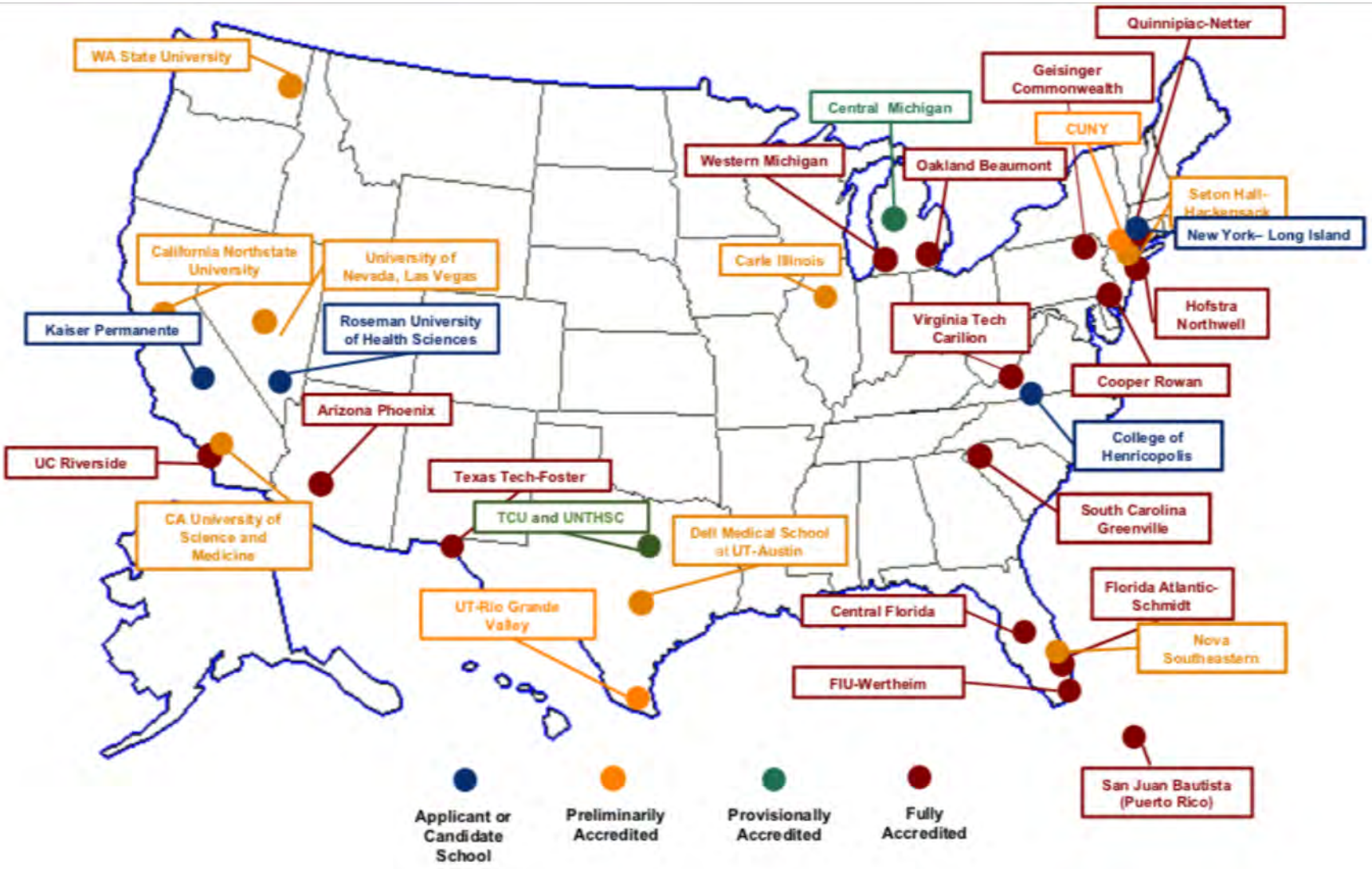
- Total US Graduates: 19,553 MDs (2017-2018) 6,416 DOs (2017-2018)
  - Female: MD – 9,260 (47.3%) DO – 2,796 (43.6%)
  - Male: MD – 10,293 (52.6%) DO – 3,614 (56.3%)
- 25,969 US Graduates

- 30,232 US Residency openings in 2018 (13% increase between 2014-2018) in 4,523 programs – Growth in Family Medicine and Internal Medicine
  - 31,899 (96.2%) Filled
  - 19,634 (59.2%) Filled with US Grads
  - 1,165 Graduate Couples in 2018, 95.8% both couples matched

Sources:

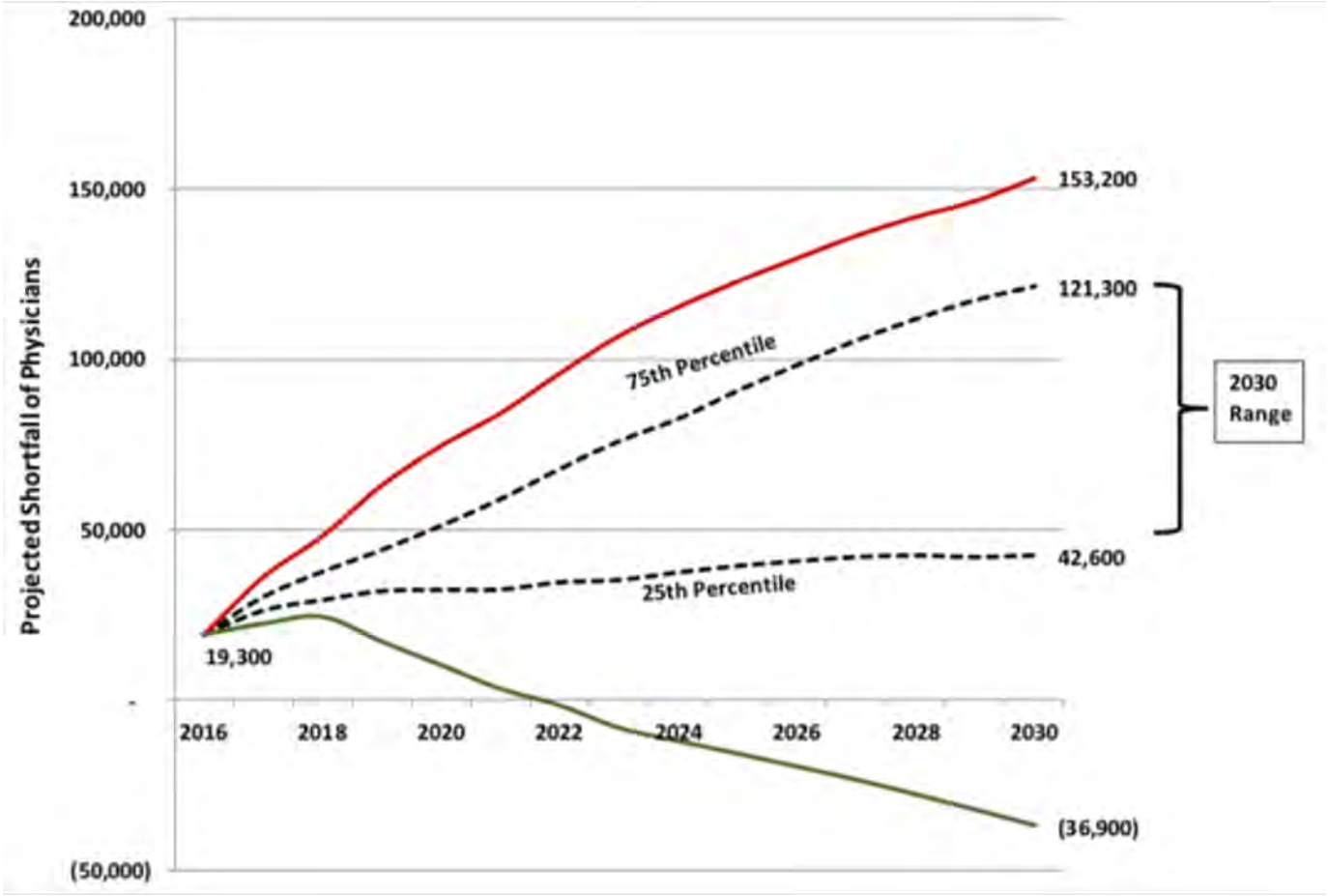
1. American Association of Colleges of Osteopathic Medicine: https://www.aacom.org/reports-programs-initiatives/aacom-reports/graduates
2. American Association of Medical Colleges: https://www.aamc.org/download/321532/data/factstableb2-2.pdf
3. National Residency Matching Program; Results and Data; 2018 Residency Match: https://mk0nrmpcikgb8jxyd19h.kinstacdn.com/wp-content/uploads/2018/04/Main-Match-Result-and-Data-2018.pdf

27 New Medical Schools since 2006



Source: Association of American Medical Colleges; "Results of the 2017 Medical School Enrollment Survey" May 2018

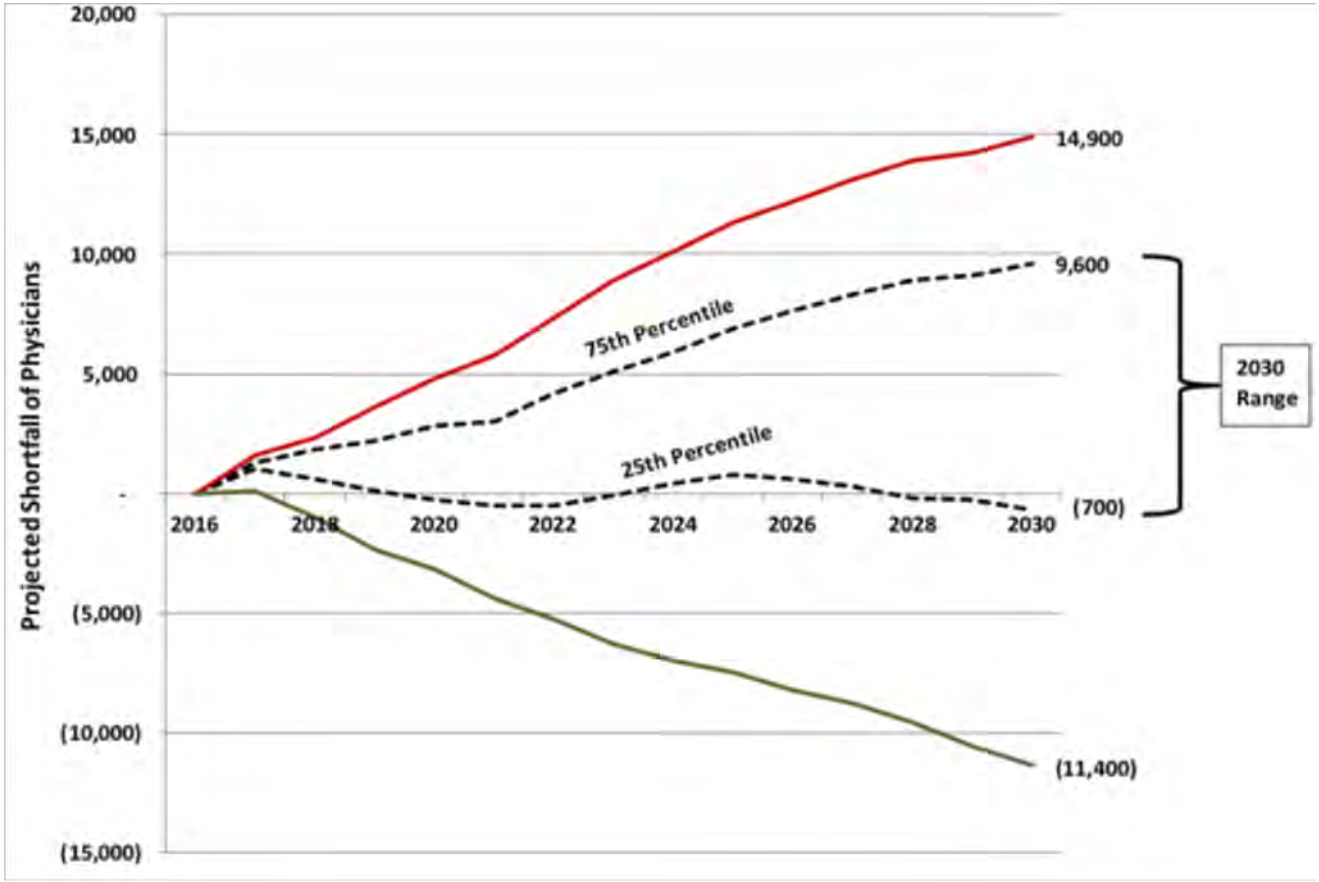
Projected Total Physician Supply/Demand by 2030



- Total Physician demand **continues to grow faster than supply**, leading to a projected total physician shortfall of between 42,600 and 121,300 physicians by 2030
- A **primary care shortage** of between 14,800 and 49,300 physicians is projected by 2030

Source: AAMC, 2018 Update: Complexities of Physician Supply and Demand: Projections from 2016 to 2030

Projected Specialty Physician Supply/ Demand by 2030

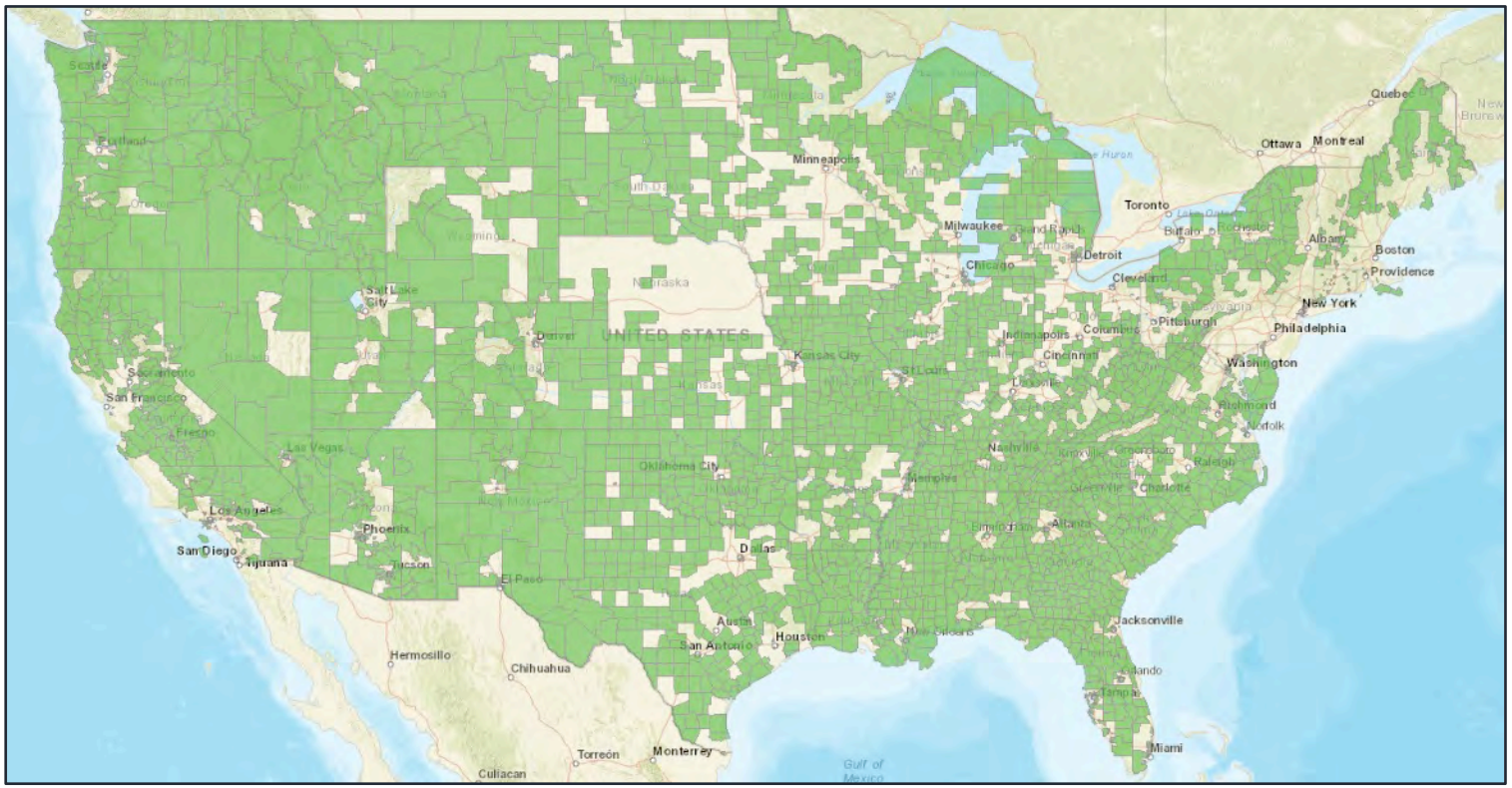


- Physician supply is **growing in medical specialties,** but not at a rate to keep pace with demand according to AAMC
- Medical specialist physician supply and demand ranges from a **surplus of 700 to a deficit of 9,600 by 2030**

Source: AAMC, 2018 Update: Complexities of Physician Supply and Demand: Projections from 2016 to 2030

Rural Supply and Demand

- As of 2018, there were 6,917 Health Care Professional Shortage Areas (HPSAs) for primary care in the United States, about double the number identified by HRSA 15 years ago
  - These are areas with less than one primary care physician per 3,500 people (or less than one primary care physician per 3,000 people in designated “high need” areas)



Source: HRSA: Designated HPSA Statistics, October 29, 2018

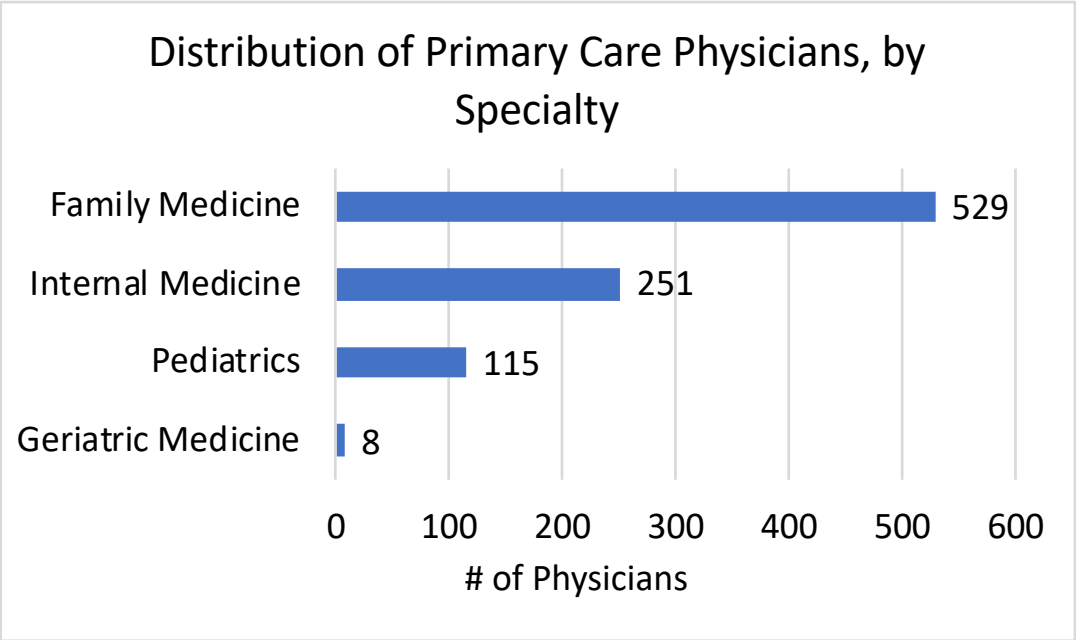
Rural Supply and Demand

- Approximately 76 million Americans live in primary care shortage areas, with only 43.8% of primary care need met
  - It would require 14,343 additional primary care providers to end the shortage designations, according to HRSA
  - Approximately 67% of primary care HPSAs are in rural areas
- 20% of Americans live in rural areas with no easy access to primary care or specialist services, only 10% of physicians practice in rural areas

Source:
1. HRSA: Designated HPSA Statistics, October 29, 2018
2. Trend Watch AHA, January 2015

Montana Physician Workforce Profile

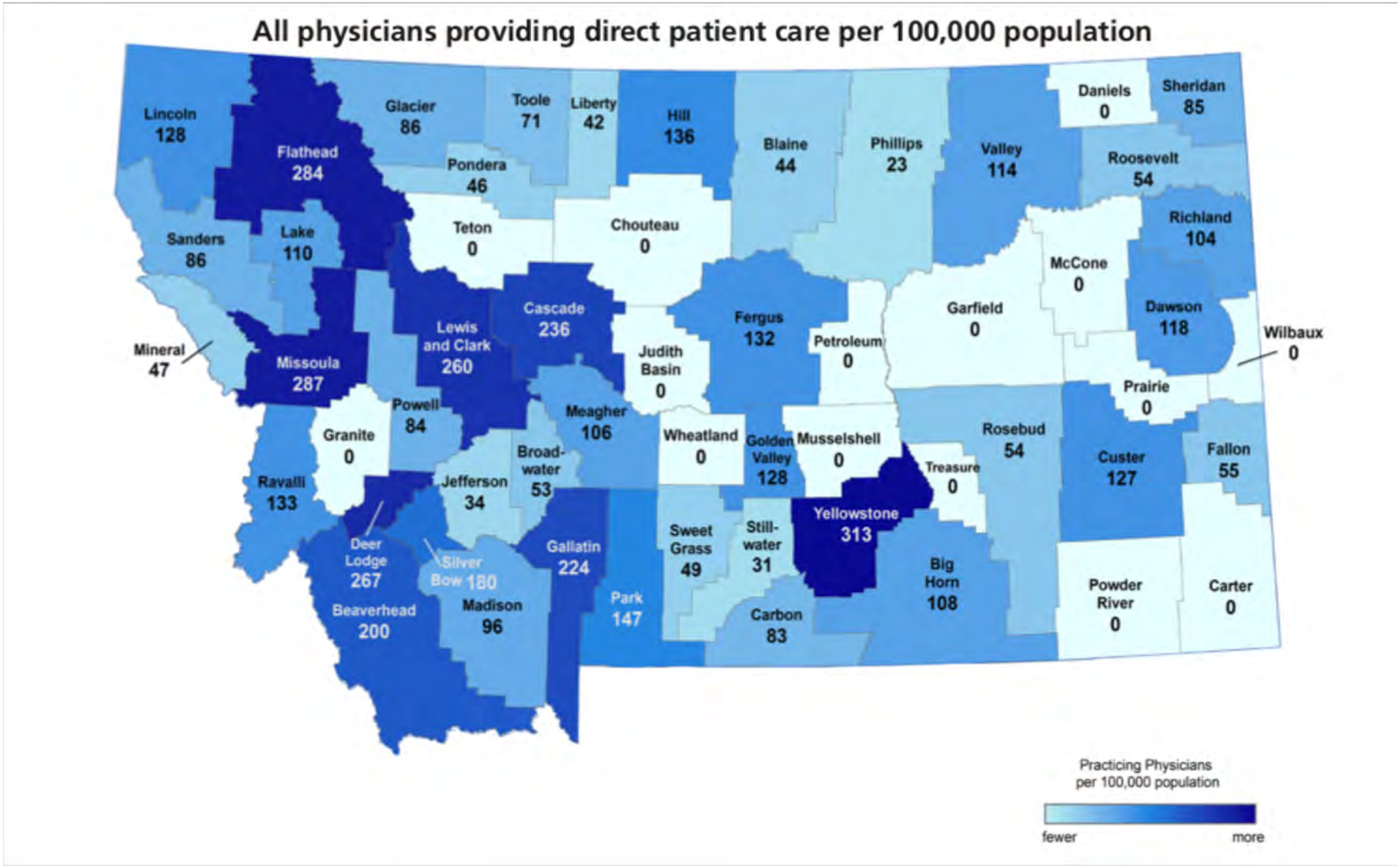
- Total Active Physicians: 2,401 in 2016
- Primary Care Physicians: 903 (37.6%)
- Total Female Physicians: 705 (29.4%)
- Physicians Age 60+: 839 (35.0%)



MT Residency Program	Location	# of Residents
Montana Family Medicine Residency	Billings	24 residents/8 per class
Family Medicine Residency of Western Montana	Missoula and Kalispell	30 residents/10 per class
Billings Clinic Internal Medicine Residency	Billings	24 residents/8 per class

Source: 2016 American Medical Association (AMA) Physician Masterfile

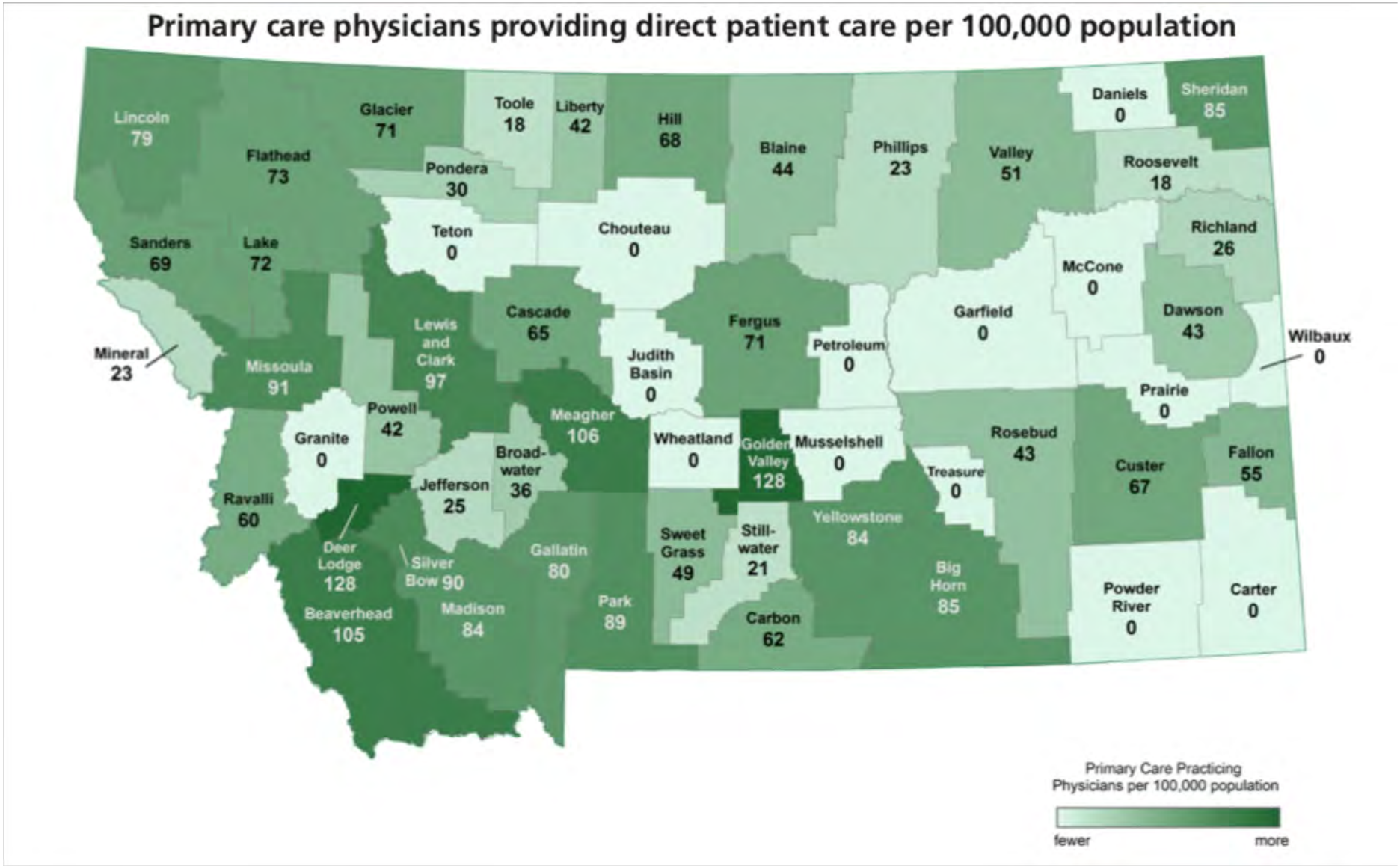
Montana Physician Workforce Profile



Source:

1. 2016 American Medical Association (AMA) Physician Masterfile
2. Center for Health Workforce Studies, University of Washington: Montana's Physician Workforce 2016

Montana Physician Workforce Profile



Source:

1. 2016 American Medical Association (AMA) Physician Masterfile
2. Center for Health Workforce Studies, University of Washington: Montana's Physician Workforce 2016

Advanced Practice Provider Supply/Demand

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- The number of NPs and PAs will **grow by 6.8% and 4.3% annually**, respectively, relative to physician average annual growth of 1.1% by 2030

Historical and Projected Numbers of Physicians, Nurse Practitioners, and Physician Assistants.*

Provider Group	No. of Full-Time Equivalents				Average Annual Growth (%)		
	2001	2010	2016	2030 (projected)	2001–2010	2010–2016	2016–2030 (projected)
Physicians	711,357	862,698	920,397	1,076,360	2.2	1.1	1.1
Nurse practitioners	64,800	91,697	157,025	396,546	3.9	9.4	6.8
Physician assistants	44,282	88,047	102,084	183,991	7.9	2.5	4.3

* Based on data from the American Community Survey (ACS) and the National Sample Survey of Registered Nurses. Estimates for NPs in 2001 are interpolated on the basis of data from the 2000 and 2004 surveys. Full-time equivalents are defined on the basis of reported usual weekly hours worked and a 40-hour workweek for NPs and PAs and a 50-hour workweek for physicians. NPs include a small number of certified nurse midwives who were not separately identified in the ACS because of their small numbers. PAs in the ACS reporting an associate's degree or less education were excluded. All estimates are based on sample weights provided in each survey.

Advanced Practice Provider Supply/Demand

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Rural Physician Assistants (PAs)

- About 16% of all PAs in clinical practice were located in rural counties
- 39% of these rural PAs were practicing in primary care, compared with 21% of urban PAs
- Family medicine was the primary specialty of 33% of rural PAs, in contrast to 14% of those in urban areas

Rural Nurse Practitioners (NPs)

- As of 2012 there were 2.8 rural NPs per 10,000 people, compared with 3.6 in urban areas
- Male NPs were more likely to practice in rural areas: 8.9% of rural NPs are men compared with 6.8% in urban areas.

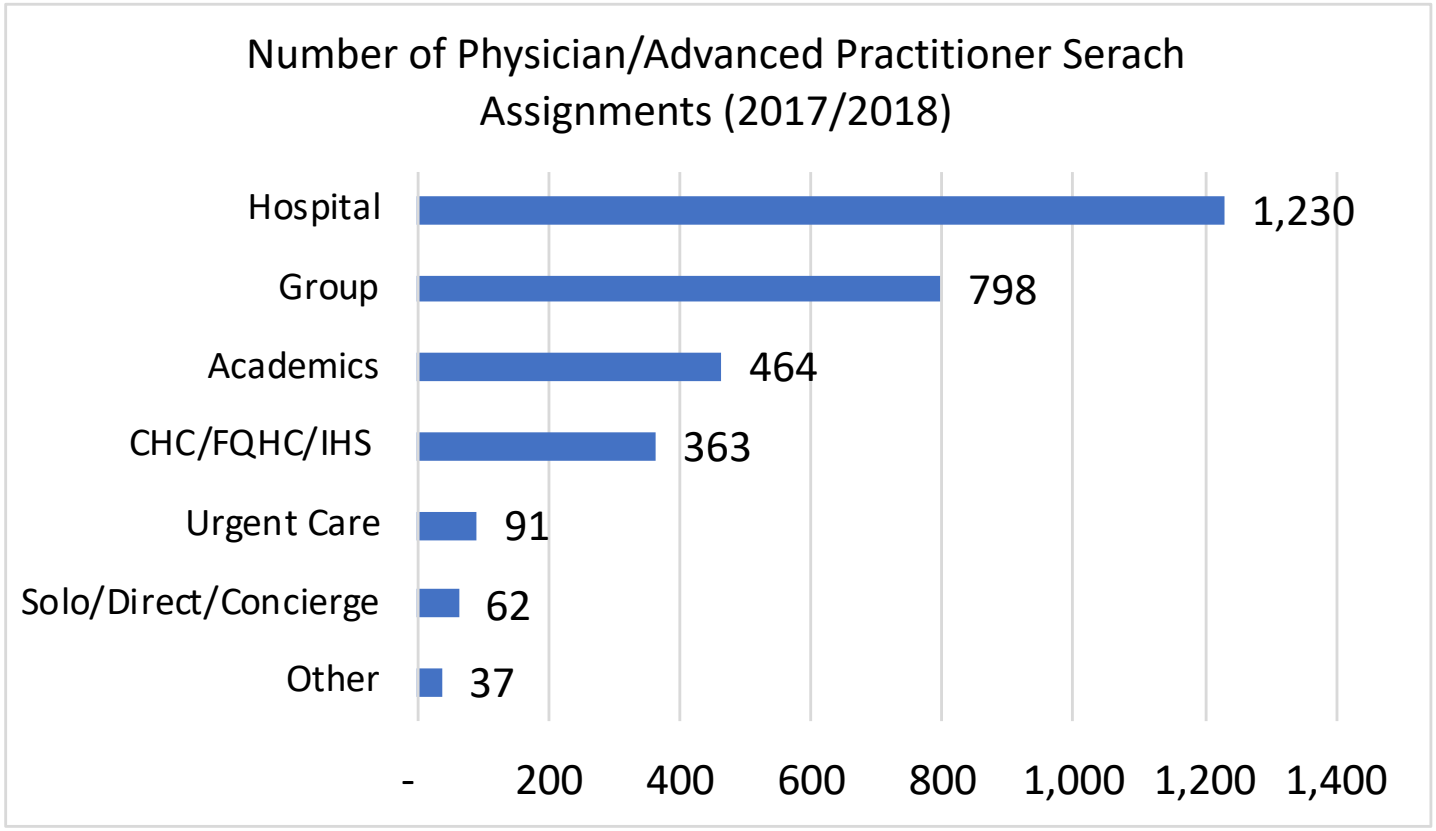
Rural Certified Registered Nurse Anesthetists (CRNAs)

- As of 2010 there were 0.9 rural CRNAs per 10,000 people, compared with 1.2 in urban areas.
- Among rural CRNAs, 66.8% practiced in large rural areas, 25.8% in small rural areas, and 7.3% in isolated small rural areas.

Source:

1. AAPA: PAs in Rural Locations Ready to Meet Primary Care Needs
2. ANA: Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data

Practice Settings of Physician/Advance Practitioner Search Assignments



- Providers are primarily seeking hospital employment, with group practice settings being the 2nd most sought type of placement
- The decline in physicians setting up solo practice offices is meaningful in rural mark ets where this was once the dominant provider with whom hospitals aligned

Source: Merritt Hawkins, 2018 Review of Physician and Advance Practitioner Recruiting Incentives

PROVIDER RECRUITMENT/COMPENSATION MODELS

Recruitment: Understand Community Need

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- Quantitative
- Qualitative
  - Demographics
  - Disease morbidity and mortality
- Resources:
  - University of Wisconsin Population Health Institute - http://www.countyhealthrankings.org/
  - University of Missouri - http://ims2.missouri.edu/tool/maps/Default.aspx
  - ICommunity Commons - http://assessment.communitycommons.org/CHNA/
  - WVDHHR

Recruitment: Physician Need

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Specialty	Approx. Required Population
Allergy and Immunology	*119,000*
Anesthesiology	*12,000*
Cardiology	*31,000*
Child Psychiatry	*27,000*
Dermatology	*35,000*
Emergency Medicine	*18,000*
Endocrinology	*119,000*
Gastroenterology	*37,000*
General / Family Practice	*4,000*
Hematology – Oncology	*27,000*

Specialty	Approx. Required Population
Hematology – Oncology	*27,000*
Infectious Diseases	*108,000*
Internal Medicine	*3,500*
Neonatology	*187,000*
Nephrology	*89,000*
Neurology	*44,000*
Neurosurgery	*92,000*
Nuclear Medicine	*61,000*
Obstetrics / Gynecology	*10,100*

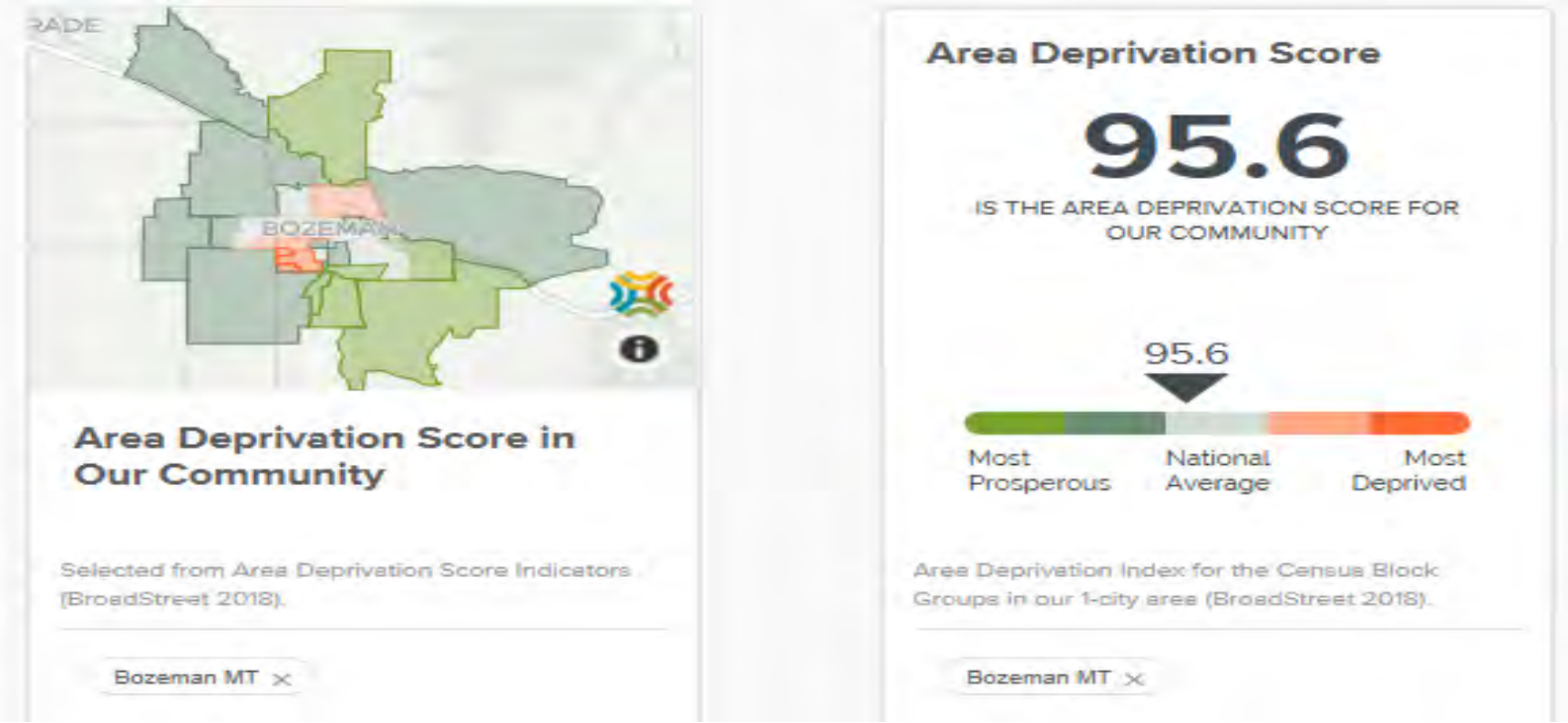
Recruitment: Physician Need

Specialty	Approx. Required Population
Ophthalmology	*21,000*
Orthopedic Surgery	*16,000*
Otolaryngology	*30,000*
Pathology	*18,000*
Pediatric Allergy	*271,000*
Pediatric Cardiology	*212,000*
Pediatric Endocrinology	*304,000*
Pediatric Hematology-Oncology	*149,000*
Pediatric Nephrology	*696,000*
Pediatrics	*7,800*

Specialty	Approx. Required Population
Physical Medicine and Rehabilitation	*76,000*
Plastic Surgery	*90,000*
Preventive Medicine	*33,000*
Pulmonary Diseases	*68,000*
Psychiatry (General)	*6,300*
Radiology	*14,000*
Rheumatology	*143,000*
Surgery (General)	*10,400*
Thoracic Surgery	*119,000*
Urology	*32,000*

Source: General Medical Education National Advisory Committee – 1990 Revision

Health Needs of the Community



The Area Deprivation Index (ADI) measures social vulnerability. The ADI combines 17 indicators of socioeconomic status (e.g. income, employment, education, housing conditions) and has been linked to health outcomes such as 30-day rehospitalization rates, cardiovascular disease death, cervical cancer incidence, cancer deaths, and all-cause mortality. These disparities may contribute to unique health challenges for those living in the most deprived areas.

Source: www.communitycommons.org

Physician Compensation: Factors to Consider

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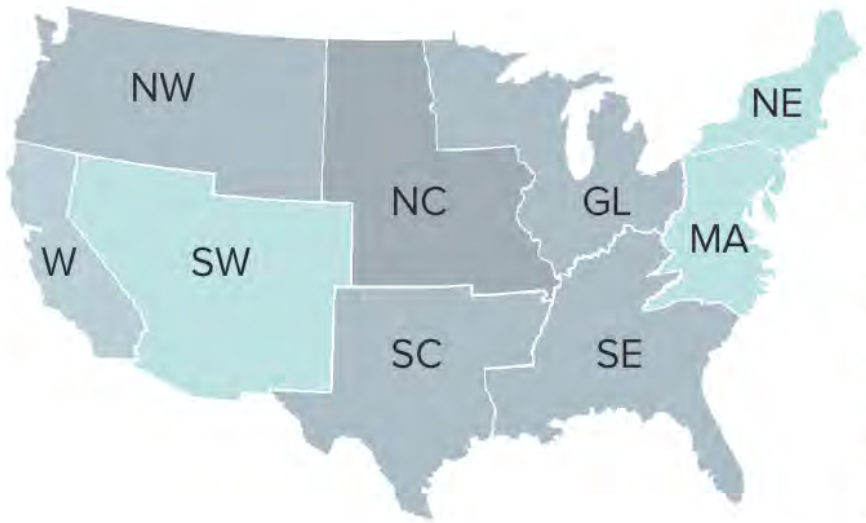
Hospital considerations when determining FMV for physician services:
• Physician specialty/subspecialty • Physician's duties and responsibilities • Community need (e.g., deficits, wait times, closed specialties, high disease incidence, out-migration, seasonality) • Community benefit (e.g., new specialty or service) • Time it takes to fill position • Physician's training and experience • Compensation methodology

Overview of the Compensation Market

- The **North Central and Southeast regions are the highest for physician compensation**, while the Northeast is ranked third highest overall

Physician Compensation by Geographic Area



$319K	North Central
$309K	Southeast
$306K	Northwest
$303K	South Central
$303K	Great Lakes
$299K	West*
$281K	Mid-Atlantic
$277K	Southwest
$275K	Northeast

*West includes Alaska and Hawaii

Source: Medscape 2018 Physician Compensation Report

Overview of the Compensation Market

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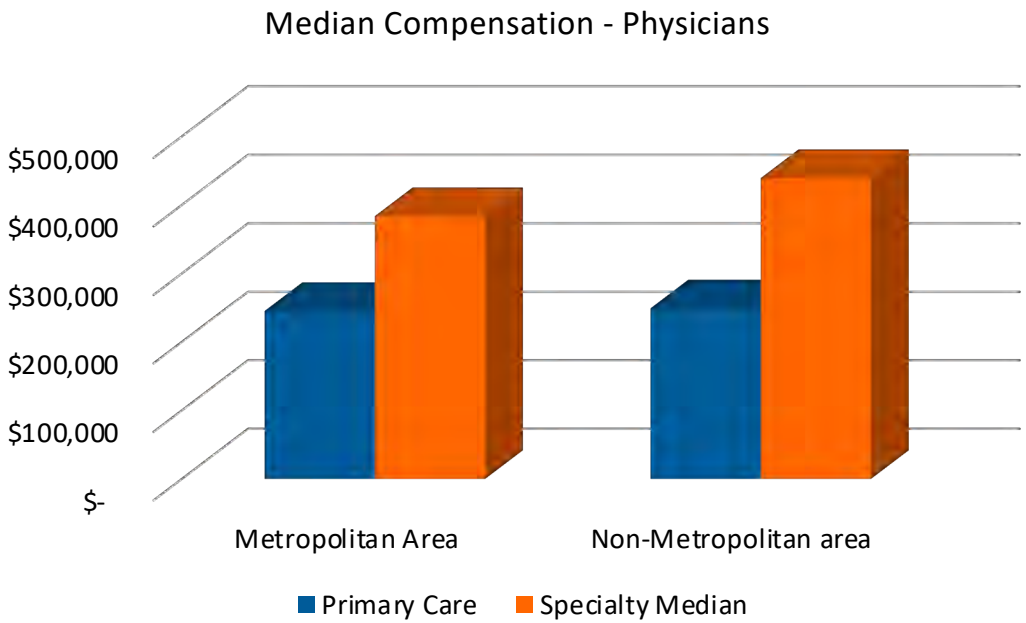
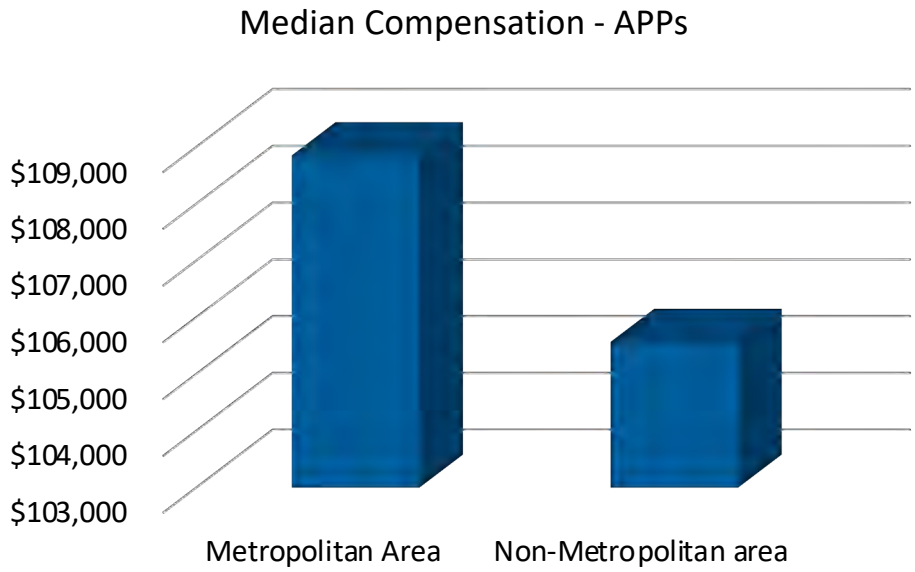
- The **Midwest/Great Plains region is the highest for physician compensation** for the top five requested specialties

	Northeast	Midwest/ Great Plains	Southeast	Southwest	West
Family Practice	$226,000	$245,000	$231,000	$239,000	$242,000
Psychiatry	$252,000	$305,000	$300,000	$275,000	$265,000
Nurse Practitioner	$110,000	$125,000	$119,000	$129,000	$135,000
Internal Medicine	$230,000	$282,000	$239,000	$273,000	$246,000
Radiology	$375,000	$405,000	$400,000	$390,000	$388,000

Source: Merritt Hawkins, 2018 Review of Physician and Advanced Practitioner Recruiting Incentives

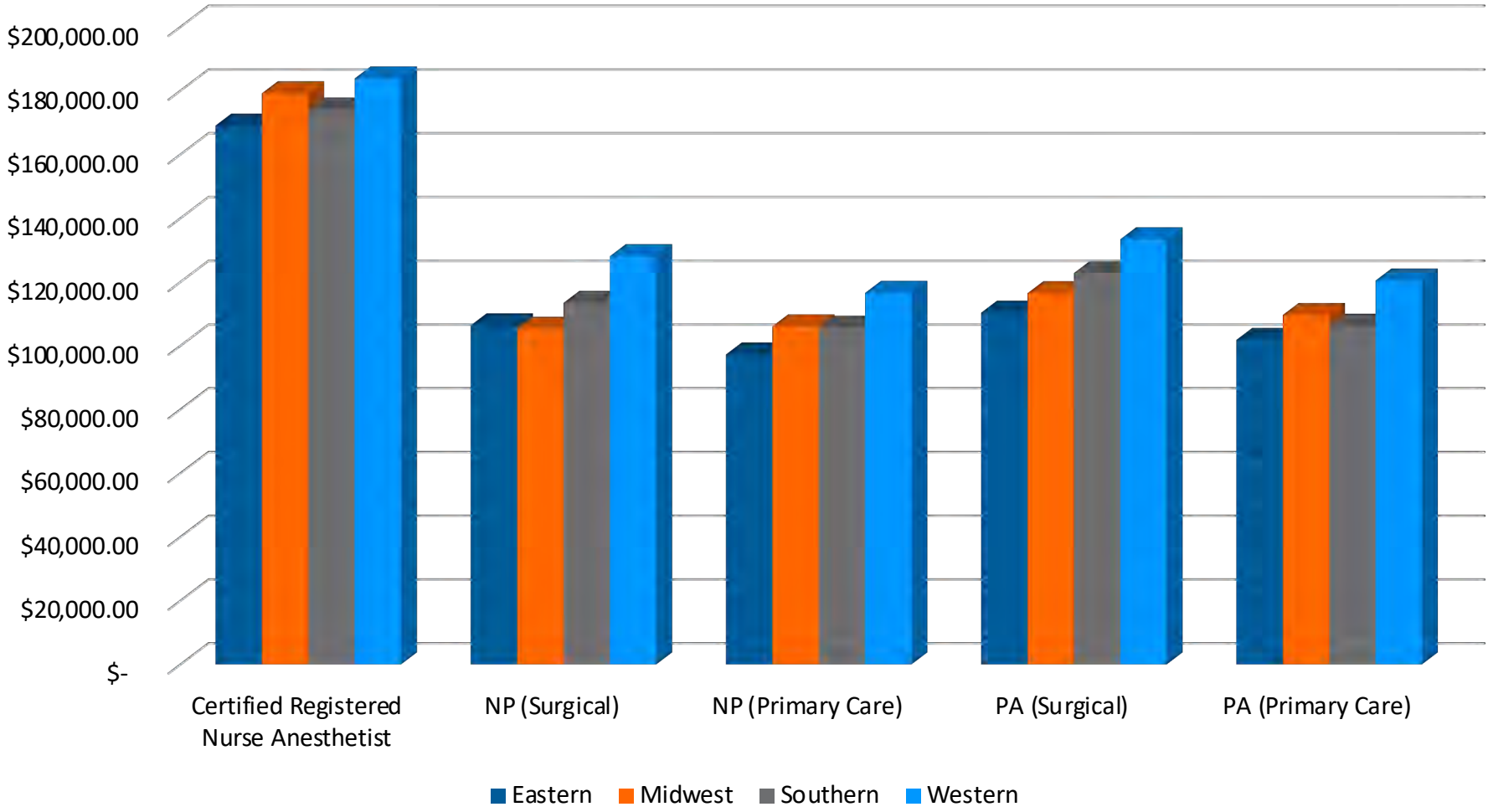
Overview of the Compensation Market





Source: MGMA 2018 Provider Compensation, 2017 Data

APP Compensation



Source: MGMA 2018 Provider Compensation, 2017 Data

What's Being Offered?

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	Salary	Salary with Bonus	Income Guarantee	Other
2017/18	515(17%)	2,285(75%)	89(3%)	156(5%)
2016/17	723(22%)	2,359(72%)	121(4%)	84(2%)
2015/16	767(23%)	2,512(75%)	32(1%)	31(1%)
2014/15	715(23%)	2,219(71%)	124(4%)	62(2%)
2013/14	633(20%)	2,335(74%)	127(4%)	63(2%)

	RVU Based	Net Collections	Gross Billings	Patient Encounters	Quality	Other
2017/18	50%	10%	1%	4%	43%	4%
2016/17	52%	28%	6%	14%	39%	9%
2015/16	58%	22%	2%	8%	32%	8%
2014/15	57%	23%	2%	9%	23%	4%
2013/14	59%	21%	5%	11%	24%	9%

- **Top compensation model in 2017/2018 was salary with bonus (75%)**, **RVU based** (50%) bonus and **quality** (43%) bonus were the top types of metrics the bonus was based on

Source: Merritt Hawkins, 2018 Review of Physician and Advanced Practitioner Recruiting Incentives

What's Being Offered? Loan Forgiveness

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If Educational Loan Forgiveness was Offered, What Was the Term?
(of 547 searches offering educational loan forgiveness)

	2017/18	2016/17	2015/16	2014/15	2013/14
One Year	18(3%)	40 (5%)	45(5%)	61(8%)	90(11%)
Two Years	104(19%)	191(23%)	155(18%)	104(13%)	173(21%)
Three Years	425(78%)	592(72%)	671(77%)	619(79%)	557(68%)

If Education Loan Forgiveness Was Offered, What Was the Amount?
(Physicians only)

	Low	Average	High
2018/18	10,000	$82,833	$300,000
2016/17	$10,000	$80,923	$260,000
2015/16	$10,000	$88,068	$300,000
2014/15	$2,500	$89,479	$250,000
2013/14	$4,000	$77,000	$336,000

If Education Loan Forgiveness Was Offered, What Was the Amount?
(NPs and PAs only)

	Low	Average	High
2017/18	$25,000	$59,860	$100,000
2016/17	$35,000	$56,442	$100,000
2015/16	$30,000	$61,667	$100,000
2014/15	$30,000	$54,286	$100,000
2013/14	$20,000	$40,000	$60,000

Source: Merritt Hawkins, 2018 Review of Physician and Advanced Practitioner Recruiting Incentives

What's Being Offered? Relocation Allowance

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	2017/18	2016/17	2015/16	2014/15	2013/14
Yes	2,999(98%)	3,132(95%)	3,173(95%)	2,623(84%)	2,845(90%)
No	46(2%)	155(5%)	169(5%)	497(16%)	313(10%)

Amount of Relocation Allowance

(Physicians only)

	Low	Average	High
2017/18	$2,500	$9,441	$25,000
2016/17	$2,500	$10,072	$44,000
2015/16	$2,500	$10,226	$30,000
2014/15	$2,000	$10,292	$50,000
2013/14	$1,000	$9,849	$25,000

Amount of Relocation Allowance

(NPs and PAs only)

	Low	Average	High
2017/18	$1,500	$6,250	$25,000
2016/17	$2,500	$8,063	$25,000
2015/16	$2,500	$8,649	$25,000
2014/15	$2,500	$9,436	$35,000
2013/14	$3,500	$6,904	$10,000

Source: Merritt Hawkins, 2018 Review of Physician and Advanced Practitioner Recruiting Incentives

Issues Regarding Physician/APP Compensation

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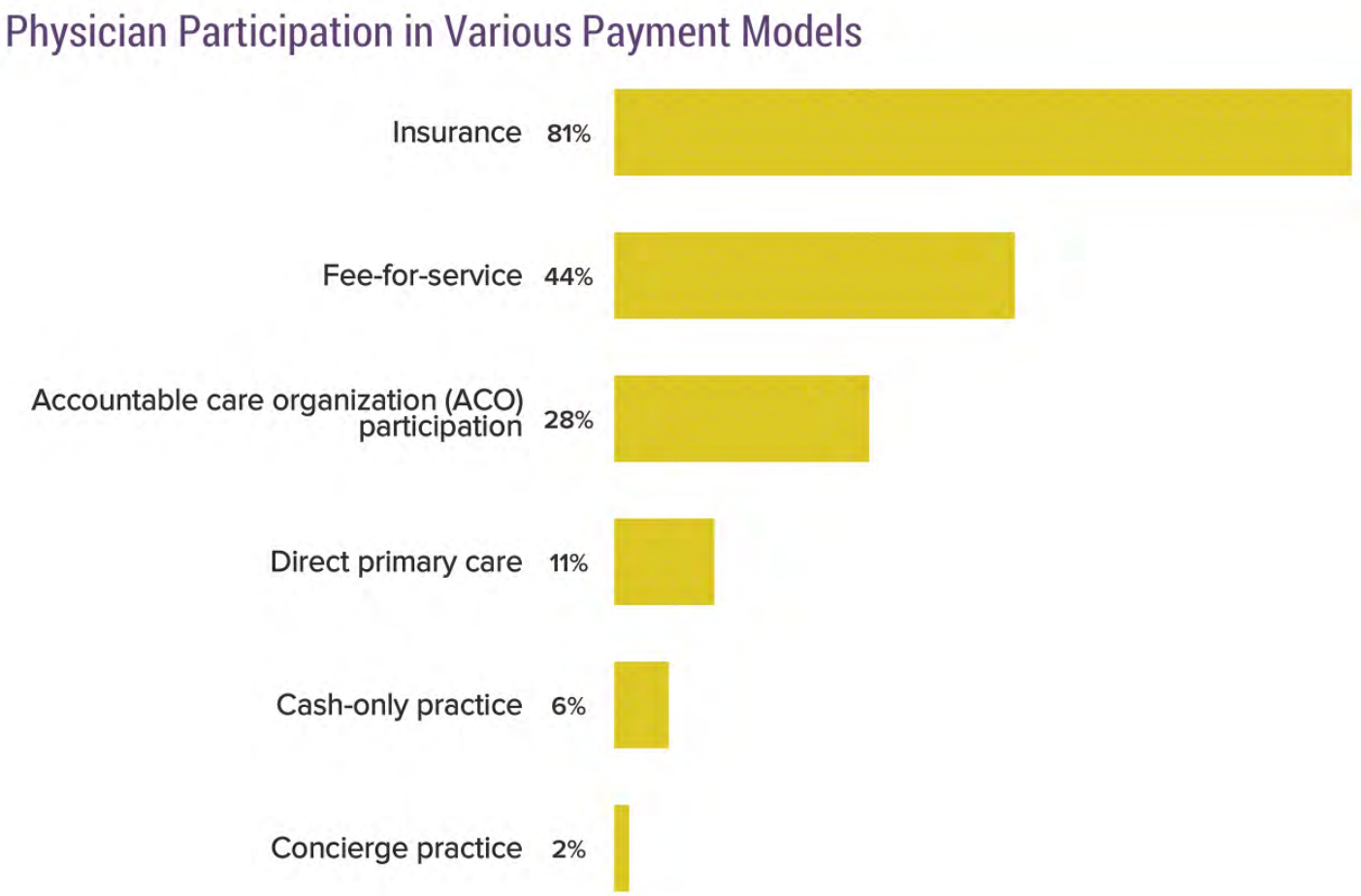
- Regulatory Issues - question whether they are at fair market value (FMV) and “reasonable” (additional detail refer to Appendix I)
  - The Accountable Care Act
  - Stark Regulations
  - Federal Anti-Kickback Statute
  - IRS Regulations
- Too many caveats and “side deals”
- No uniform approach
- Potential “Excess Benefits”
- Identify compensation trends for primary care physicians and specialists
- Describe market forces impacting physician compensation models
- Utilize benchmarking data in compensation planning

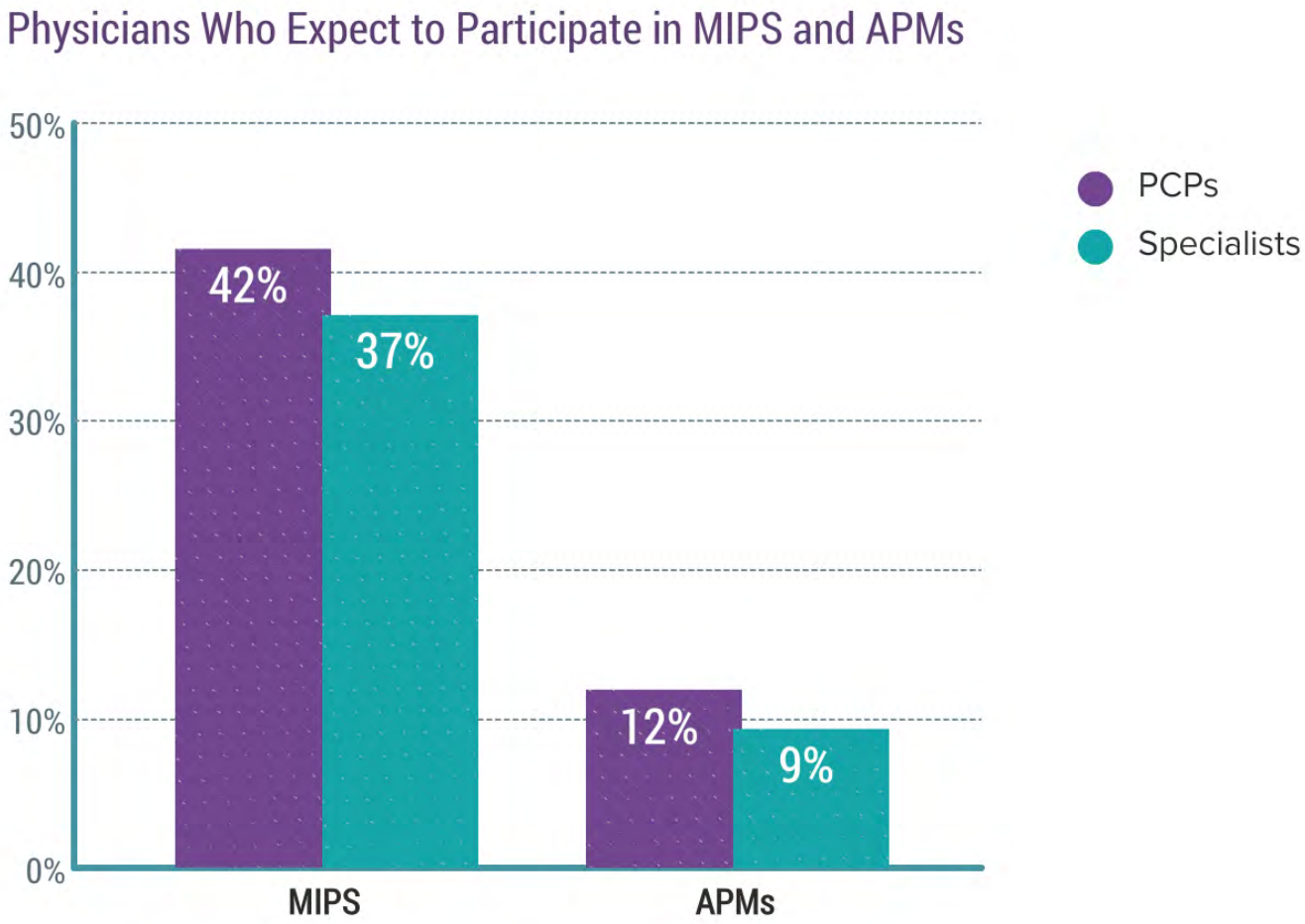
Payment Models



- ACO participation has increased from 3% in 2011 to 36% in 2017, but has decreased to 28% in 2018, while the number of ACOs have increased from 480 in 2017 to 561 in 2018

Source: Medscape 2019 Physician Compensation Report

Payment Models



- A larger portion of physicians are participating in MIPS than APMs, which is more appropriate for large practices and hospitals

Source: Medscape 2019 Physician Compensation Report

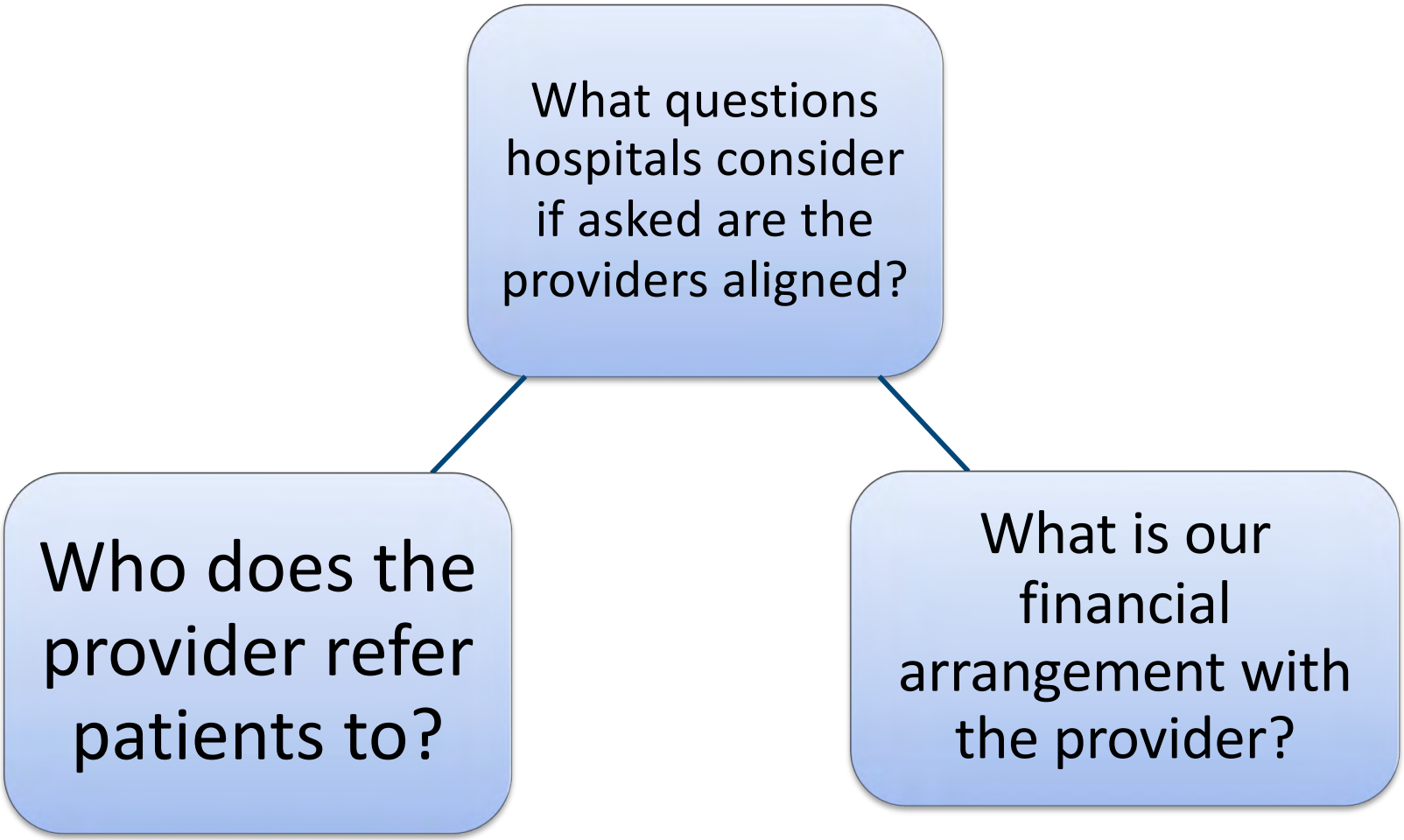
Lifestyle Issues

- Physicians want a balance of work and family
- Many physicians are in two-physician families (in 2013 7.3% of matched residents were “couples”)
  - Increasing number of physicians are coupled with another post-graduate degree spouse, limiting the types of opportunities for spousal employment
- Many physician couples want less than two full time positions
- Income is still important to today’s physicians, but it will be easily sacrificed for more free time

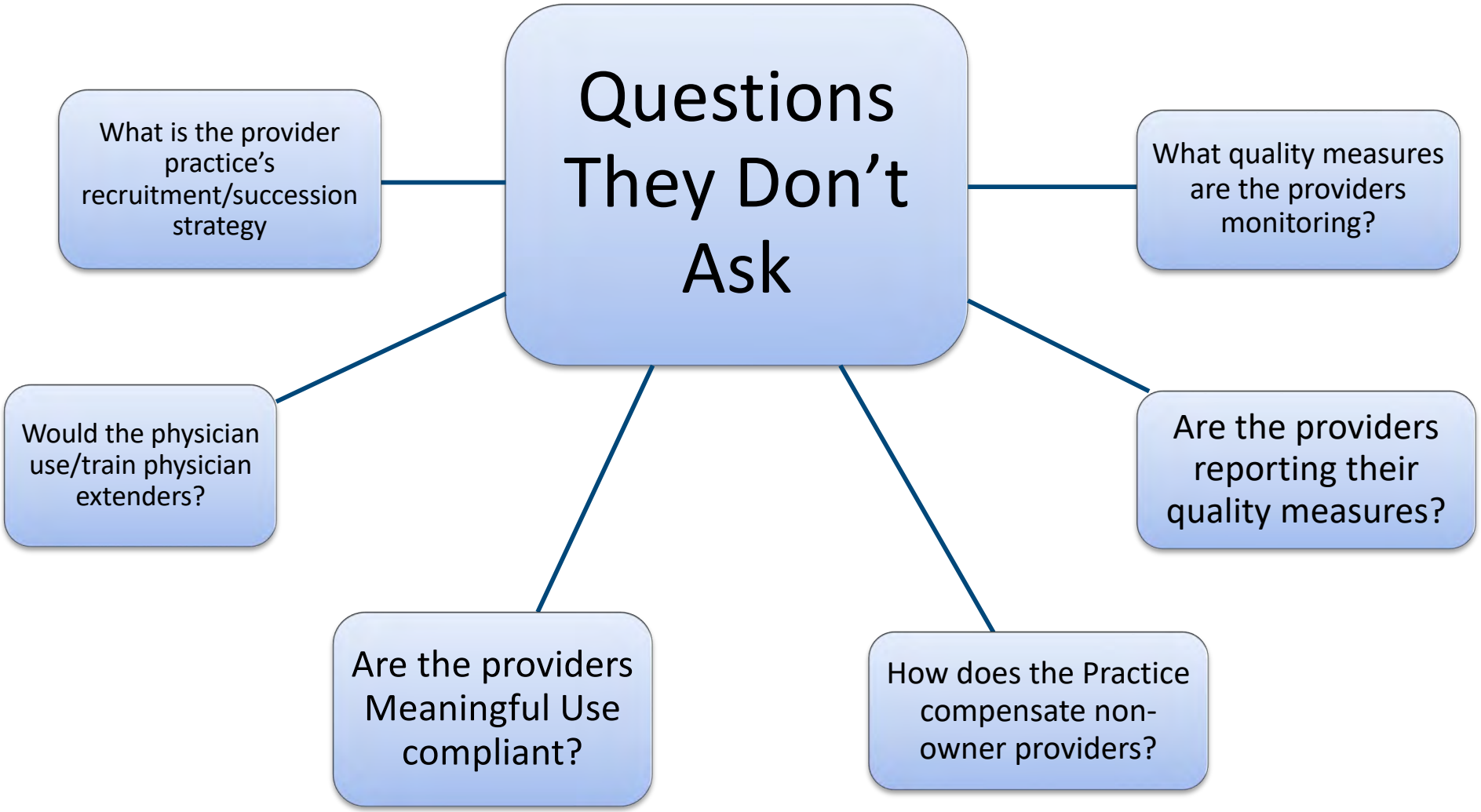
Work Time Considerations

- Flexible work options
  - Work fewer hours than older generations
- Call of at worst 1/4; 1/5 or better is preferred
  - Call compensation has been increasing as pay is often compared to the cost of locums
  - Rural markets often do not pay for call compensation since they often are having to employ an additional physician to meet acceptable call ratios
- Interest in part-time or job sharing
- Off work means off work – little or no interest in practice management, etc.

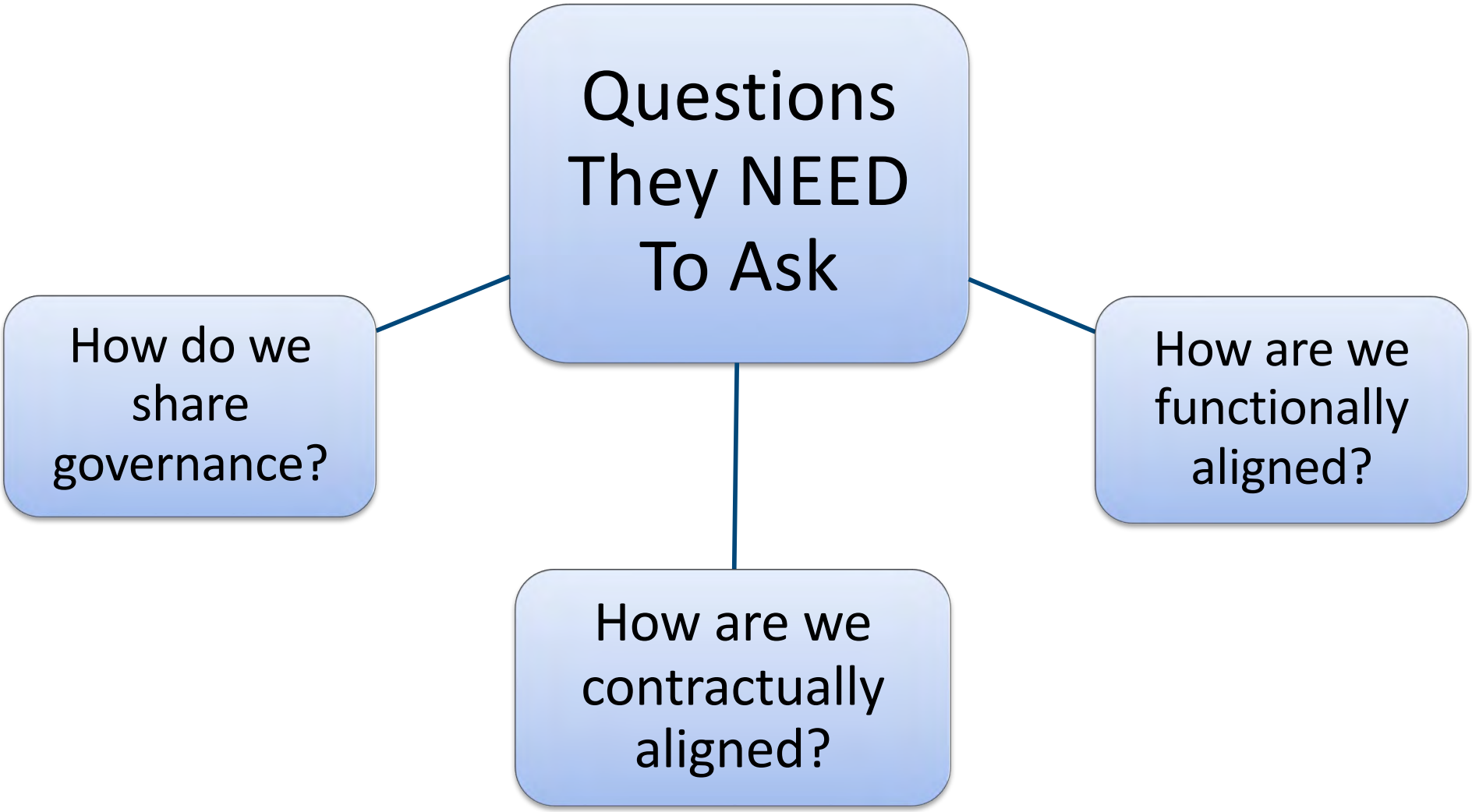
Alignment Strategies



Alignment Strategies



Alignment Strategies



What Do Hospitals Want?

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- Local Control
- Community support
- Access to Patients
- Access to Capital
- Positive relationships with payers
- Equitable reimbursement for both public and private patients
- Positive relationships with physicians
- Ability to achieve sustainable margins

What Do Providers Want?

- Control
- Independence/Professional Autonomy
- Access to Patients
- Access to Capital
- Equitable compensation
- Security
- Work/Life Balance

The Alignment Spectrum

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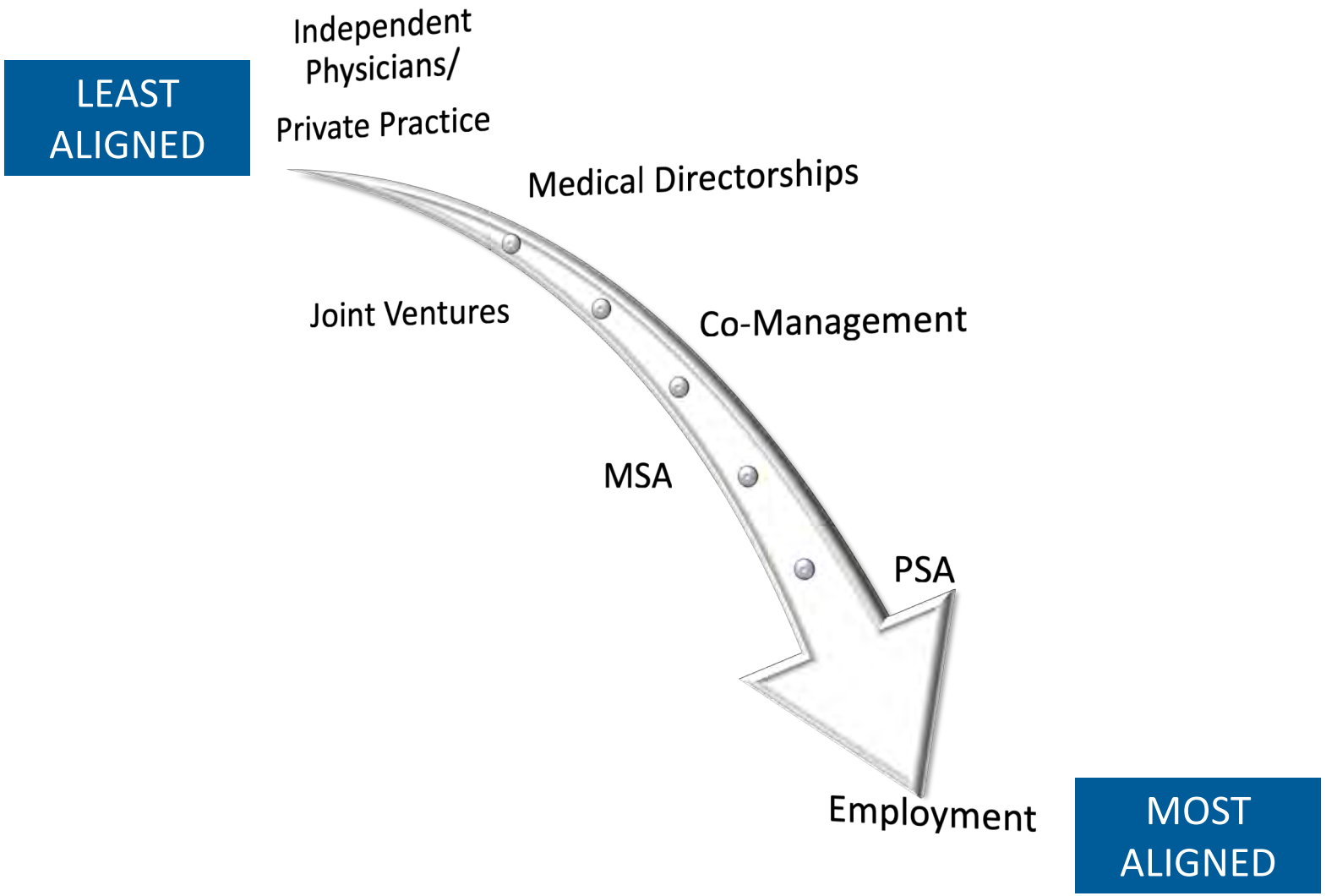
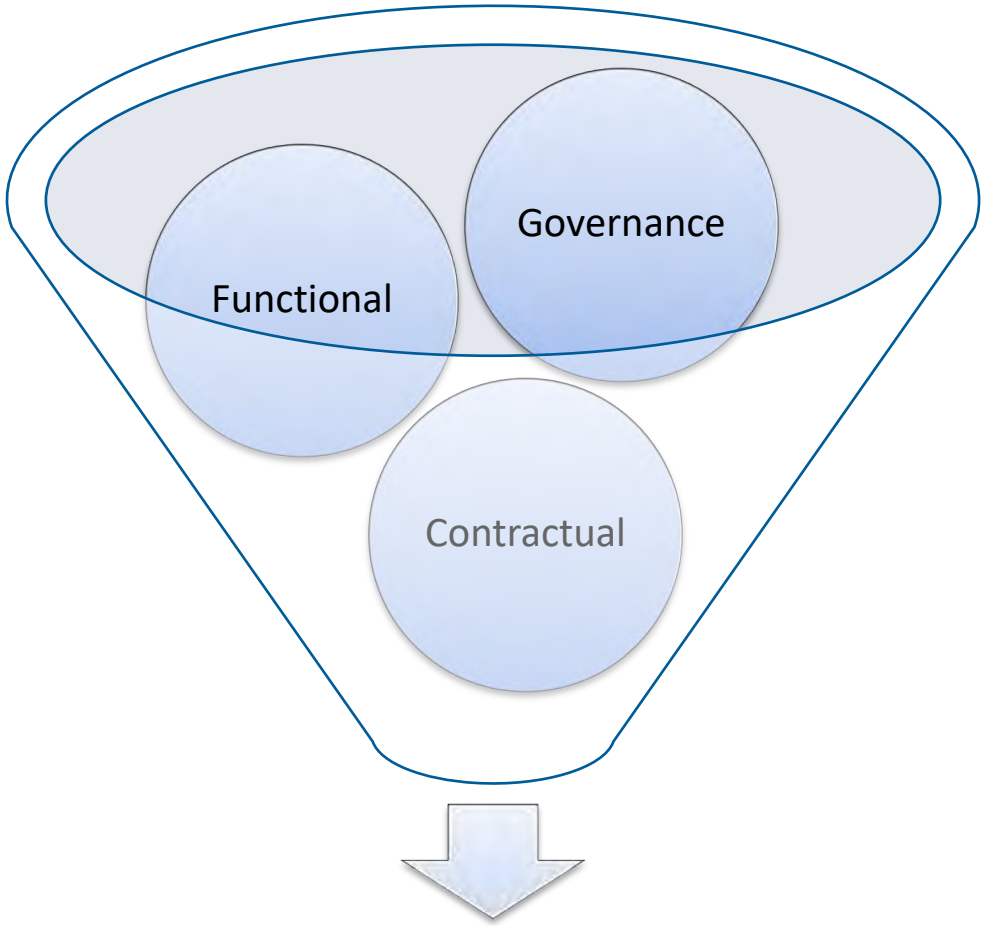


Alignment in Three Parts



COMPENSATION MODELS

Compensation Models

- Individual Physician Compensation
  - Individual performance determines compensation
- Group or specialty “pool” models
  - Group or specialty’s performance and/or outcomes determine a pool of revenue. This pool is then distributed based on the individual physician’s performance based on set criteria
- “Stacking” compensation
  - ED Call coverage
  - Medical Directorships
  - Clinical or service line management agreements
  - APP supervision

Types of Compensation Models

- Annual Guarantee
- Percentage of Net Patient Revenue
- Compensation per WRVU
- Value-based compensation
  - Contingent compensation and holdbacks
- The use of quality/value-based physician compensation is rising although, quality on average determines only 8% of total physician compensation packages

Source: Merritt Hawkins, 2018 Review of Physician and Advanced Practitioner Recruiting Incentives

Primary Care Vs. Specialty Care

- While both primary and specialty care have increasing trends to incorporating productivity (or in many cases, moved entirely to productivity models) into their compensation structures they still differ
- Primary care compensation models frequently incorporate the following:
  - Productivity based on:
    - Patient panel size
    - Visits
    - WRVUs
  - APP supervision
  - Service line management
- Specialty Care compensation models:
  - Productivity based on WRVUs
  - APP supervision
  - Call coverage
  - Service line management

Primary Care Example

- Family Medicine physician providing supervision of 4.0 FTE NPs across 3 locations
- Contract requirements
  - Minimum of 32 hours of direct patient care per week
  - Minimum of 6 hours APP supervision per week in addition to being available for consult at all times APPs are working
- Compensation
  - Base Salary: 75% of MGMA Median for rural: $182,589
  - Productivity Incentive:
    - 2 Locations supervised include RHCs; RHC minimum thresholds are used
    - Minimum patient panel size: 4,200 visits per year
    - Total Panel Size bonus: up to $20,000 if RHC visits cumulative for physician and APPs exceed RHC minimum, physician eligible for bonus tied to % over minimum threshold
  - Supervision: $500 per month per provider ($24,000 total per year)
  - Medical Directorship
    - $1,000 per month ($12,000 total per year)
  - Quality Compensation
    - $12,000 bonus will be available based on meeting quality metrics based on Press Ganey survey (80% positive response to patient question “What is your overall assessment of your experience with this provider?”

Specialty Care Example

- Orthopedic surgeon providing supervision of 1.0 FTE PA at one location
- Practice has an additional 1.5 FTE physicians providing coverage
- Contract requirements:
  - Minimum of 40 hours work per week, with 32 hours of direct patient care per week as a portion of the 40 hours
  - Minimum of 2 8-hour surgical blocks per week
  - Minimum of 12 days call coverage per month and 1 weekend per month
- Compensation
  - Base Salary: $444,014 (70% of MGMA Median for rural)
  - Productivity Incentive:
    - $74.94 per WRVU for WRVUs that exceed 5,978 per year (75% of MGMA Median)
  - Supervision: $500 per month per provider ($6,000 total per year)
  - Quality Compensation
    - $12,000 bonus will be available based on meeting quality metrics based on Press Ganey survey (80% positive response to patient question "What is your overall assessment of your experience with this provider?"

Quality Bonus

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- Hospital conducts quarterly surveys using the NCR Picker measurement tool known as the “Stoplight Report”
- 25 quality elements are measured
- On a quarterly basis, physician will:
  - Receive $100/green light
  - Receive $50/yellow light
  - Pay a penalty of $100 per red light
- Maximum Quality Bonus is $2500 per quarter

	Picker Dimensions	Benchmarks	Rolling Averages up to 6/7/2012	Stevens, Rachel		
Overall		NRC Average*	3 Months‡	Qtr 2 2012‡	Qtr 1 2012	Qtr 4 2011
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?		77.1% (n=351,296)	93.8%μ PR=95 (n=16)	92.9%μ PR=93 (n=14)	75.0%μ PR=41 (n=8)	80.0%μ PR=57 (n=20)

Key Drivers		NRC Average*	3 Months‡	Qtr 2 2012‡	Qtr 1 2012	Qtr 4 2011
During your most recent visit, if you had any tests, were your test results explained in a way that you could easily understand?	Information and Education	84.8% (n=197,461)	80.0%μ PR=23 (n=10)	77.8%μ PR=16 (n=9)	40.0%μ PR=1 (n=5)	83.3%μ PR=34 (n=12)
In the last 12 months, when you phoned this provider's office during regular office hours, how often did you get an answer to your medical question that same day?	Access to Care	61.8% (n=133,322)	50.0%μ PR=21 (n=8)	50.0%μ PR=21 (n=8)	50.0%μ PR=21 (n=4)	42.9%μ PR=11 (n=14)
During your most recent visit, were you comfortable talking with this provider about any of your health questions or concerns?	Emotional Support	91.5% (n=305,682)	93.8%μ PR=57 (n=16)	92.9%μ PR=50 (n=14)	100.0%μ PR=100 (n=8)	90.0%μ PR=33 (n=20)
Do you have confidence and trust in this provider?	Emotional Support	89.7% (n=305,901)	93.8%μ PR=66 (n=16)	92.9%μ PR=59 (n=14)	75.0%μ PR=4 (n=8)	100.0%μ PR=100 (n=20)
During your most recent visit, did this provider explain what to do if problems or symptoms continued, got worse, or came back?	Continuity and Transition	82.2% (n=248,326)	81.3%μ PR=40 (n=16)	78.6%μ PR=29 (n=14)	85.7%μ PR=61 (n=7)	94.1%μ PR=94 (n=17)
In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	Access to Care	72.1% (n=243,082)	75.0%μ PR=55 (n=12)	70.0%μ PR=38 (n=10)	80.0%μ PR=73 (n=5)	77.8%μ PR=64 (n=18)
Does this provider involve you in	Respect for Patient	85.6%	81.3%μ	78.6%μ	87.5%μ	85.7%μ

During your most recent visit, did clerks and receptionists at this provider's office treat you with courtesy and respect?	Respect for Patient Preferences	92.7% (n=351,064)	87.5%µ PR=13 (n=16)	85.7%µ PR=9 (n=14)	87.5%µ PR=13 (n=8)	95.0%µ PR=60 (n=20)
During your most recent visit, did this provider spend enough time with you?	Respect for Patient Preferences	90.2% (n=352,391)	87.5%µ PR=27 (n=16)	85.7%µ PR=20 (n=14)	100.0%µ PR=100 (n=8)	85.0%µ PR=18 (n=20)
Wait time includes time spent in the waiting room and exam room. During your most recent visit, did you see this provider within 15 minutes of your appointment time?	Access to Care	79.3% (n=349,351)	93.8%µ PR=85 (n=16)	100.0%µ PR=100 (n=14)	87.5%µ PR=62 (n=8)	85.0%µ PR=54 (n=20)
In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	Access to Care	67.2% (n=157,172)	75.0%µ PR=69 (n=8)	71.4%µ PR=57 (n=7)	60.0%µ PR=26 (n=5)	50.0%µ PR=11 (n=16)
Did someone from this provider's office follow up to give you those results?	Coordination of Care	85.1% (n=183,150)	77.8%µ PR=17 (n=9)	75.0%µ PR=13 (n=8)	80.0%µ PR=22 (n=5)	90.9%µ PR=60 (n=11)

Green - score is equal to or greater than the NRC Average

Yellow - score is less than the NRC Average, but may not be significantly

Red - score is significantly less than the NRC Average

µ - Warning: n-size is low! ‡ - Data is not final and subject to change. * - Benchmark that is used to determine the color on each line. PR=Percentile Rank

PRIMARY CARE OPTIONS IN RURAL

Overview

- An effective hospital primary care strategy is an essential component to address those market changes; especially in rural healthcare
  - The patients served, clinic location, and provider productivity must all be considered when developing a primary care strategy
- Since the hospital and clinic designation type can impact reimbursements and other opportunities received by the clinic, hospitals should evaluate each of the following clinic designation types to ensure an appropriate strategy:
  - Federally Qualified Healthcare Center (FQHC)
  - Provider-Based Clinic (PBC)
  - Rural Health Clinic (RHC)
  - Includes Provider-Based Rural Health Clinic (PB-RHC)
  - Free-Standing Health Clinic (FSHC)

Rural and Shortage Designations

- Some clinic designation types require the clinic to provide services to a specific group of patients and or operate in a certain location such as the following:
  - **Rural Area Location**
  - **Health Professional Shortage Area (HPSA)**
    - Primary care HPSAs are based on a physician-to-population ratio of 1:3,500
  - **Medically Underserved Area (MUA)**
  - **Medically Underserved Population (MUP)**

Primary Care Clinic Designations

- As seen, each of the four clinic types evaluated encompass different reimbursement methodologies that greatly impact reimbursements received from Medicare and Medicaid
- The table below highlights those differences

Reimbursement Options	FQHC	CAH	<50 Beds	FSHC
		PBC	PB-RHC	
330 Grant	Yes	No	No	No
340B Pharmacy	Yes	Yes	Yes*	No
Un-Capped Technical Charge	No	Yes	Yes	No
Method II Billing	No	Yes	No	No
Tort Reform - Malpractice Savings	Yes	No	No	No
Enhanced PPS Reimbursement	Yes	Yes	Yes	No

- ** For non-CAHs, Hospital needs to meet DSH % to qualify for 340B*

Rural Health Clinic

- RHCs must **employ a physician assistant (PA), certified nurse midwife (CNM), and/or nurse practitioner (NP) for at least 50% of the time** that the practice is open to see patients
- RHCs must be engaged in providing **primary care services 50% or more of the time** the clinic operates
- APPs have a minimum productivity threshold of 2,100 visits/year

- **Montana has 61 RHCs**, according to HRSA as of January 2019

Benefits of APP utilization in the RHC

- Lower compensation cost relative to physician (median compensation ratio of 2 APP to 1 MD)
- Lower productivity threshold to meet RHC requirements (4,200 vs 2,100)
- Appropriate physician supervision ratio of 3-5 APPs per 1 MD make APPs ideal workforce for outreach clinics, including RHCs
- Montana is a 'full practice' state, giving APPs the greatest autonomy
    - APPs have greater flexibility of managing their own patient panel

Systems Approach to Revenue Optimization

STROUDWATER

- With declining reimbursements, all systems need to leverage available reimbursement opportunities to improve financial performance
- The following opportunities are available to hospitals and systems to improve reimbursements when those practices can meet certain eligibility requirements:
  1. Convert eligible practices within a health system or at a hospital to a designation that provides the most advantageous reimbursement opportunity
  2. Realign practices within a health system to leverage reimbursement advantages and additional revenue available to the system
  3. Integrate specialty practices, when possible, with PB-RHCs under a hospital of less than 50 beds to leverage cost-based reimbursement
  4. Acquire independent practices to leverage provider-based reimbursement opportunities and other additional revenue streams available to hospitals
- *This opportunity may not lead to a net positive return; however, will increase in functional, contractual, and governance alignment and increase the attributed lives associated with the hospital/health system*

Systems Approach to Revenue Optimization

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- A health system in New York would realize a $1.1M net financial benefit by converting 5 practices to provider-based Rural Health Clinics
  - *(5 practices had a combined 47K visits)*
- A health system in Virginia would realize a $7.1M net financial benefit by converting 3 practices from free-standing health clinics to provider-based Rural Health Clinics
  - *(3 practices had a combined 116k visits)*
- A hospital in Missouri would realize a $505K net financial benefit by integrating 8 provider-based specialty providers with their provider-based Rural Health Clinic
  - *(8 providers had a combined 4k visits)*
- A hospital in Massachusetts would realize a $396K net financial benefit by converting a freestanding health clinic to a provider-based Rural Health Clinic
  – *(practice had 14k visits)*

Parting Thoughts

- What is the hospital's strategic plan regarding physicians slowing down or exiting entirely?
- How long did it take to recruit a physician the last time?
- Are succession plans in place?
- What relationships have been built with medical schools?
- Have they considered recruiting from the PGY 2 and 3 classes?
- Have they considered providing a PGY 3 or 4 a monthly stipend and an employment contract now?
- What's the competition doing?

APPENDIX I: REGULATIONS BRIEFING

Anti-Kickback

- The Anti-Kickback Statute forbids making or receiving kickbacks for items or services covered by Medicare, Medicaid, and other federal healthcare programs. Specifically, a kickback is an illegal remuneration paid to induce a patient referral.
- OIG Letter to the IRS – payment for goodwill, non-competes and patient records is questionable
- 42 U.S. Code § 1320a–7b

Stark Law

- A physician who has a financial relationship with certain entities may not refer patients to those entities for the furnishing of designated health services for which payment may be made by Medicare, unless the relationship falls within a Stark exception (FMV **and** commercially reasonable)
- STRICT liability - Your feelings and thoughts don't matter
- Penalties:
  - Denial of payments
  - Refund requirements
  - Civil penalties up to $15,000 for each item or service rendered
  - Exclusion from the Medicare and Medicaid programs

IRS Inurement

- 501(c)(3) entities are prohibited from using public funds to benefit private individuals or for-profit entities
- Requires legitimate compensation:
  - Payments must be only for those items/services needed to ensure the non-profit mission of the entity is met
  - Payments must not exceed FMV for items/services provided by private individuals/entities
- Penalties
  - Loss of non-profit status (enjoy those back taxes!)

Commercial Reasonableness Test

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"An arrangement will be considered commercially reasonable if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and reasonable physician of similar scope and specialty, even if there were no potential for DHS referrals."

-Internal Revenue Code Section 4958(f)(1) and IRS Regulations Section 53.4958-3

Examples of Unreasonable Structures:

- Lease arrangements for equipment that should be purchased
- Hospital transaction costs that exceed the value of the underlying transaction
- Payment to physicians to coordinate their own call schedule

No Excess Benefits Transactions

- Financial relationships between physicians and other providers and tax-exempt 501(c)3 healthcare organizations necessitate compliance with Section 4958 of the Internal Revenue Code (IRC), which prohibits excess benefit transactions. An excess benefit transaction consists of the payment of unreasonable compensation or another transaction in which a “disqualified individual” is overpaid for the goods or services provided, or receives the benefit of the excess value provided to the tax-exempt organization.
- A disqualified individual is defined as one who is in a position to exert substantial influence over the affairs of an organization at any time during a five-year period prior to the excess benefit transaction.
- Internal Revenue Code Section 4958(f)(1) and IRS Regulations Section 53.4958-3

Isolated Transaction Exception

Isolated transaction

- Do not set up installment payments for a physician practice
- Must have a written agreement signed by the parties that specifies the services to be covered under the agreement
- Term of the agreement should be at least one year
- Aggregate services contracted for should not exceed those that are reasonable and necessary for the legitimate business purpose of the subject arrangement
- Compensation to be paid by the healthcare entity over the term of the agreement should be defined in advance
- Not in excess of FMV
- Not determined in a manner that takes into account patient volume or the value of any patient referrals or other business generated by the parties