BVR
What It's Worth

Valuing Rural Health Clinics

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Presenter Bio

Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures involving acute care hospitals and health systems; physician practices; ambulatory surgery centers; diagnostic imaging centers; accountable care organizations, managed care organizations, and other third-party payors; dialysis centers; home health agencies; long-term care facilities; and, numerous other ancillary healthcare service businesses. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of the "*Adviser's Guide to Healthcare – 2nd Edition*" (AICPA, 2015), numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies*; *Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Presenter Bio

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She serves on the Editorial Board of NACVA's *QuickRead* and of the American Health Law Association's (AHLA's) *Journal of Health & Life Sciences Law*. Additionally, she is the current Chair of the American Bar Association's (ABA) Young Lawyers Division Health Law Committee and a Young Lawyer Liaison for the ABA Health Law Section. She has previously presented before the ABA, NACVA, BVR, and the National Society of Certified Healthcare Business Consultants (NSCHBC).

Ms. Bailey-Wheaton is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the *Journal of Health Law & Policy*.

Introduction

- Overview of Rural Health Clinics
- Current and Future Trends
  - Regulatory
  - Reimbursement
  - Competition
  - Technology
- Value Drivers of Rural Health Clinics
- Conclusion

RHC Overview

- What is a **Rural Health Clinic** (RHC)?
  - Specially certified entities created to increase access to primary care services in rural areas
  - Established via the *Rural Health Clinic Service Act of 1977*
  - Specially licensed through Medicare
  - May be operated as either a for-profit or a non-profit entity
- Characteristics
  - Generally primary care
  - Higher reimbursement from Medicare and Medicaid
  - Dubious profitability
  - Require licensure through Medicare

"Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics (Accessed 3/19/19). "Rural Health Clinic Services Act of 1977" Pub. L. No. 95-210, 91 Stat. 1485 (December 13, 1977). "Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics#certified (Accessed 12/14/18); "Rural Health Clinic" MLN Fact Sheet, ICN 006398, January 2018, available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf (Accessed 12/14/18), p. 1-2.

RHC Overview

- Types of RHCs
  - Provider-based
    - Owned by hospital
    - Owned by home health agency
    - Owned by nursing home
  - Independent
    - Owned by individual provider
    - Owned by provider group

"Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics (Accessed 3/19/19). "Rural Health Clinic Services Act of 1977" Pub. L. No. 95-210, 91 Stat. 1485 (December 13, 1977). "Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics#certified (Accessed 12/14/18); "Rural Health Clinic" MLN Fact Sheet, ICN 006398, January 2018, available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf (Accessed 12/14/18), p. 1-2.

RHC Overview

- Licensure Requirements
  - Must be located in a rural, underserved area
    - Defined by the U.S. Census Bureau and the Health Resources and Services Administration (HRSA)
  - Must be in a Health Professional Shortage Area (HPSA)
  - 4 qualifying types of shortage areas:
    - Geographic-Based HPSAs: Population-based areas that have workforce shortages in primary medical care, mental health, or dental health
    - Medically Underserved Areas (MUAs): Shortage of primary care providers, a high infant mortality, high poverty, and/or a high elderly population
    - Population-Group HPSAs: Have barriers preventing the patient population from accessing primary care providers within their area
    - Governor Designated and Secretary Certified Areas: Designated by the state and certified by Health and Human Services (HHS) as an area with a shortage of healthcare services

"Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics#certified (Accessed 12/14/18); "Rural Health Clinic" MLN Fact Sheet, ICN 006398, January 2018, available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf (Accessed 12/14/18), p. 2. "Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics#difference (Accessed 3/8/19).

RHC Overview

- Licensure Requirements
  - Must utilize non-physician providers (NPPs) in rendering patient services
    - Types of NPPs
      - Nurse practitioners (NP)
      - Certified nurse-midwives (CNM)
      - Physician assistants (PA)
    - NPPs required to see patients a minimum of 50% of the time the RHC is open
      - Can use employment agreements or contracts
      - Can use locum agency
  - Maintains certification unless its location changes or the location no longer meet location requirements, i.e., is no longer in an HPSA

"Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics#certified (Accessed 12/14/18)."Chapter 13 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services" in "Medicare Benefit Policy Manual" Centers for Medicare & Medicaid Services, December 7, 2018, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf (Accessed 3/19/19); "Revised Rural Health Clinic (RHC) Guidance State Operations Manual (SOM) Appendix G Advanced Copy" By Director, Survey and Certification Group, Letter to State Survey Agency Directors (December 22, 2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-09.pdf (Accessed 3/19/19), p. 54.

RHC Overview

- RHC Statistics
  - As of 2020, there are 5,266 certified RHCs
    - All offer primary care services
  - 46% of RHCs are operating at a loss
  - From 2010 to 2019, there have been 98 closures
- HPSA statistics as of end of 2018
  - Approximately 7,026 primary care HPSAs
    - 59% were rural areas
    - Need a projected 3,871 providers to remove rural HPSA designation

According to most recent data from HRSA website, calculated on January 1, 2020. "Data Explorer" Health Resources and Services Administration, 2020, https://data.hrsa.gov/tools/data-explorer (Accessed 1/31/20). "United States: Rural Healthcare Facilities" Rural Health Information Hub, https://www.ruralhealthinfo.org/states/united-states (Accessed 3/27/19); "Rural Hospital Closures to Ninety-Eight" By Jessica Seigel, National Rural Health Association, February 20, 2019, https://www.ruralhealthweb.org/blogs/ruralhealthvoices/february-2019/rural-hospital-closures-rise-to-ninety-seven (Accessed 3/7/19).

Current and Future Trends

- Regulatory
  - Anti-Kickback Statute
    - Felony for any person to “knowingly and willfully” solicit or receive, or to offer or pay, any “remuneration,” directly or indirectly, in exchange for the referral of a patient for a healthcare service paid for by a federal healthcare program
    - Carries both criminal penalties (up to a 5-year prison term per violation) and civil penalties.
    - Safe harbors specific to RHCs:
      - » Practitioner recruitment safe harbor: Protects recruitment payments to physicians
      - » Joint venture safe harbor: Allows for investments in joint ventures

"Criminal Penalties for Acts Involving Federal Health Care Programs" 42 U.S.C. º 1320a-7b(b)(1). "COMPARISON OF THE ANTI-KICKBACK STATUTE AND STARK LAW" Office of Inspector General, 2019, https://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf (Accessed 10/16/19). "Exceptions" 42 CFR º 1001.952(e)(2)(iii); "Federal Anti-Kickback Law and Regulatory Safe Harbors" Office of Inspector General, Office of Public Affairs, Fact Sheet, November 1999, https://oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm (Accessed 6/18/19).

Current and Future Trends

- Regulatory
  - Stark Law
    - Governs physicians (or their immediate family members) who have a financial relationship (i.e., an ownership investment interest or a compensation arrangement) with an entity
    - Specifically addresses referrals from physicians to entities with which the physician has a financial relationship for the provision of defined services paid for by Medicare or Medicaid
    - Carries only civil penalties
    - Exceptions specific to RHCs:
      - » Assistance to compensate an NPP
      - » Rural Provider exception
    - October 2019 Stark Law Proposed Rule – Proposed removing 15% contribution requirement for donations of cybersecurity equipment

"Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rule" Federal Register, Vol. 80, No. 220 (November 16, 2015), p. 71303-71306. "Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations; Proposed Rule" Federal Register, Vol. 84, No. 201 (October 2019), p. 55834-55835.

Current and Future Trends

- Reimbursement
  - Medicare Reimbursement
    - *All-inclusive rate* (AIR) for "medically-necessary primary health services and qualified preventative health services furnished by an RHC practitioner"
    - Calculation:

      AIR = Total Allowable Costs ÷ Total Number of Visits

      - Total Allowable Costs: i.e., costs reasonable and necessary, including practitioner compensation, overhead, and other costs applicable to the delivery of RHC services

"Rural Health Clinic" MLN Fact Sheet, ICN 006398, January 2018, available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf (Accessed 12/14/18), p. 1. "Chapter 13- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services" in "Medicare Benefit Policy Manual" Centers for Medicare & Medicaid, 2018, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf (Accessed 12/14/18).

Current and Future Trends

- Reimbursement
  - Medicare Reimbursement
    - AIR takes into consideration productivity, payment limits, and other factors
      - » Productivity calculated in terms of visit numbers
      - » Physician and NPP productivity can be combined
      - » Patient encounters with multiple RHC practitioners or multiple encounters with the same practitioner on the same day only constitute a single visit
      - » The recalculation at the end of the cost reporting year, if there are fewer visits based on these productivity standards, the AIR rate is lowered
    - Only reimburses for professional services – not for any facility fees

"Rural Health Clinic" MLN Fact Sheet, ICN 006398, January 2018, available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf (Accessed 12/14/18), p. 1. "Chapter 13- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services" in "Medicare Benefit Policy Manual" Centers for Medicare & Medicaid, 2018, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf (Accessed 12/14/18).

Current and Future Trends

- Reimbursement
  - Medicare Reimbursement
    - 2020 RHC payment limit per visit is $86.31 (increase of 1.9% from 2019)
      - Payment cap updated annually by the Medicare Economic Index (MEI)
      - Current RHC payment cap is not enough to cover the average cost per visit to an RHC
      - RHCs that are part of a critical access hospital network can be exempt from payment limit
      - Can also bill Medicare for chronic care management services
        - » Rate is $66.77 for 2020 (down from the 2019 rate of $67.03)
      - Can bill for facilitation of telemedicine services
        - » RHC may serve as the “originating site”
      - RHC receives less than what it cost them to provide the service

"Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2020" Centers for Medicare & Medicaid, October 4, 2019, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11498.pdf (Accessed 3/23/20). "Chapter 13- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services" in "Medicare Benefit Policy Manual" Centers for Medicare & Medicaid, 2018, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf (Accessed 12/14/18). "Modernizing Rural Health Clinic Provisions: Policy Brief and Recommendations" National Advisory Committee on Rural Health and Human Services, December 2017, https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-Rural-Health-Clinic-Provisions.pdf (Accessed 12/28/18), p. 5.

Current and Future Trends

- Reimbursement
  - RHC Mean Adjusted Cost per Visit (ACPV)

	A	B	C	D	E	F
	RHC Characteristics (n)		n	Mean ACPV	2017 Cap	Shortfall
1	**Independent RHCs**		1,235	$112.12	$82.30	$29.82
2	***Size***	Small (1-4,342 visits)	324	$126.40	$82.30	$44.10
3		Medium (4,343-9,324 visits)	408	$106.83	$82.30	$24.53
4		Large (9,325-28,040 visits)	402	$106.01	$82.30	$23.71
5		Extra-Large (28,041+ visits)	101	$112.03	$82.30	$29.73
6	***Ownership***	Private/for profit	883	$103.96	$82.30	$21.66
7		Non-profit/publicly owned	296	$130.70	$82.30	$48.40
8	**Provider-Based RHCs**		1,904	$176.73	$82.30	$94.93
9	***Size***	Small (1-4,342 visits)	650	$186.64	$82.30	$104.34
10		Medium (4,343-9,324 visits)	571	$170.02	$82.30	$87.72
11		Large (9,325-28,040 visits)	571	$171.02	$82.30	$88.72
12		Extra-Large (28,041+ visits)	112	$182.52	$82.30	$100.22
13	***Subject to Cap?***	Yes	421	$163.38	$82.30	$81.08
14		No	1,254	$181.00	N/A	N/A
15	***Attached to Critical Access Hospital?***	Yes	1,026	$182.06	N/A	N/A
16		No	778	$168.54	Varies	Varies

"Modernizing Rural Health Clinic Provisions: Policy Brief and Recommendations" National Advisory Committee on Rural Health and Human Services, December 2017, https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-Rural-Health-Clinic-Provisions.pdf (Accessed 12/28/18), p. 7.

Current and Future Trends

- Reimbursement
  - Medicaid Reimbursement
    - Reimburses for RHC visits under a prospective payment system (PPS)
      - State calculates a per-visit rate based on reasonable costs for an RHC's first 2 years of operation, increasing the baseline rate each year by the MEI
    - RHC may seek an agreement with the state's Medicaid program under which the RHC receives reimbursement through an alternative payment model (APM)
      - At least as much as the PPS rate

"Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics (Accessed 12/14/18).

Current and Future Trends

- Reimbursement
  - Physician Shortage Effect on Reimbursement
    - Shortage of primary care services, especially in areas that are already underserved
    - RHCs may be relatively immune to the physician workforce shortage because of use of NPPs
    - Because of AIR, reimbursement may not rise to reflect physician shortage

Current and Future Trends

- Competition
  - Telehealth Providers
    - Deliver health-related services via telecommunications technology
    - Can supplement or replace face-to-face encounters with physicians
    - Can address rural patient needs, rural provider shortage
    - Not required to have physical presence in rural area
    - Number of telehealth companies expected to grow by 41.5% in the next 5 years
    - Increasing private insurance coverage
    - Many states are passing telehealth reimbursement parity laws

"IBISWorld Industry Report OD5775: Telehealth Services in the US" Jack Curran, IBISWorld, October 2019.

Current and Future Trends

- Competition
  - Critical Access Hospitals
    - Critical Access Hospital (CAH) is a designation given to qualifying rural hospitals by the Centers for Medicare & Medicaid Services (CMS)
      - Requirements:
        - » Must have < 25 acute care inpatient beds
        - » Must be located > 35 miles away from another hospital
        - » Must maintain an annual length of stay of ≤ 96 hours
        - » Must provide 24/7 emergency care services

"Critical Access Hospitals (CAHs)" Rural Health Information Hub, 2020, https://www.ruralhealthinfo.org/topics/critical-access-hospitals (Accessed 1/28/20). "Reassessing Financial Peer Groups for Critical Access Hospitals" By Walter L. Hawkins, Kristin L. Reiter, George H. Pink, Flex Monitoring Team, November 2016, p. 3.

Current and Future Trends

- Competition
  - Critical Access Hospitals
    - Attempt by Congress to reduce the financial vulnerability of rural hospitals and increase access to healthcare for rural Americans
    - CAH-designated facility may receive significantly higher Medicare reimbursement, state benefits, qualification for federal grants, and Medicare compliance flexibility through *Medicare Rural Hospital Flexibility Program*
    - 56% of CAHs operate RHCs

"Critical Access Hospitals (CAHs)" Rural Health Information Hub, 2020, https://www.ruralhealthinfo.org/topics/critical-access-hospitals (Accessed 1/28/20).
"Reassessing Financial Peer Groups for Critical Access Hospitals" By Walter L. Hawkins, Kristin L. Reiter, George H. Pink, Flex Monitoring Team, November 2016, p. 3.

Current and Future Trends

- Competition
  - Physician Practices
    - Provide primary care services and directly compete
    - Independent practices are least likely form of competition:
      - Only 31.4% of physicians report any ownership stake in an independent practice, lowest ever reported rate
      - Physician-owned practices have been slowly declining over the past 10 years
      - Older physicians are selling practices to hospitals

"IBISWorld Industry Report 62111a: Primary Care Doctors in the US" Anna Miller, IBISWorld, June 2019.

Current and Future Trends

- Competition
  - Physician Practices
    - Increases in primary care practices owned by hospitals
    - Medicare reimbursement disadvantage compared to RHCs
    - Fight with RHCs over the same limited resource in rural areas – Providers
    - Physicians are less likely to open an independent physician practice in rural areas

"IBISWorld Industry Report 62111a: Primary Care Doctors in the US" Anna Miller, IBISWorld, June 2019.

Current and Future Trends

- Technology
  - Healthcare information technology (HIT)
    - May lead to improved efficiency and quality management, especially in rural areas
    - "*Uses technology to store, secure, retrieve, and transfer protected health information electronically*"
    - Includes a variety of software applications:
      - Electronic health records (EHR)
      - Digital networks to electronically transmit medical test results and patient records
      - Electronic communication between providers and with patients
      - Electronic prescribing/ordering
      - Digital support systems
      - Billing software
      - Staffing models

"Medical Practice Efficiencies & Cost Savings" The Office of the National Coordinator for Health Information Technology, https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/medical-practice-efficiencies-cost-savings (Accessed 7/17/19); "Understanding the Costs and Benefits of Health Information Technology in Nursing Homes and Home Health Agencies: Case Study Findings" By Andrew Kramer MD, et al., U.S. Department of Health and Human Services, June 2009, http://aspe.hhs.gov/sites/default/files/pdf/75876/HITcsf.pdf (Accessed 7/17/19), p. iv-v, 1; "Health Information Technology in Rural Healthcare" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/health-information-technology (Accessed 7/17/19).

Current and Future Trends

- Technology
  - Healthcare information technology (HIT)
    - HIT can help rural areas in the following ways:
      - Improving access to and coordination of care
      - Improving the surveillance of disease
      - Promoting health education
      - Assisting in the compilation of regional data
    - Can be very expensive for small rural providers
    - Requires constant maintenance

"9.2 Improve Care in Rural Areas" in Section 9 of "Health IT Playbook" The Office of the National Coordinator for Health Information Technology, https://www.healthit.gov/playbook/care-settings/#section-9-2 (Accessed 7/17/19).

Current and Future Trends

- Technology
  - Healthcare information technology (HIT)
    - Telemedicine/Telehealth
      - Can significantly increase patient access to healthcare in rural areas
      - Can take many forms, including:
        - » Provider/patient videoconferencing
        - » Remote patient monitoring (which may be the most common form of telehealth in rural healthcare)
        - » “Store and forward transmission” of medical data & information
        - » Mobile health communication (mHealth), such as through various smartphone apps

"IBISWorld Industry Report OD5775: Telehealth Services in the US" Jack Curran, IBISWorld, October 2019.
"Telehealth Use in Rural Healthcare" Rural Health Info, https://www.ruralhealthinfo.org/topics/telehealth (Accessed 7/17/19).

Current and Future Trends

- Technology
  - Healthcare information technology (HIT)
    - Telemedicine/Telehealth
      - Benefits for rural providers:
        - » "*Give[s] health care clinicians instant access to information to make timely, vital decisions and save lives*
        - » *Decrease[s] travel time for patients and their families*
        - » *Help[s] rural hospitals use remote clinicians, pharmacists, and staff to improve and extend access*
        - » *Simplif[ies] efficient transfer to other facilities for vital services*
        - » *Facilitate[s] post-hospitalization care close to patients' families and primary care clinicians.*"

"9.2 Improve Care in Rural Areas" in Section 9 of "Health IT Playbook" The Office of the National Coordinator for Health Information Technology, https://www.healthit.gov/playbook/care-settings/#section-9-2 (Accessed 7/17/19).

Current and Future Trends

- Technology
  - Healthcare information technology (HIT)
    - Drawbacks:
      - Restrictions on Medicare reimbursement of telemedicine services (including geographic/originating site, provider, and service type)
      - Interstate licensure issues
      - Lack of broadband access (i.e., internet connection with sufficient upload/download speeds to support data transmission) in rural communities
        - » Federal Communications Commission (FCC) – nearly 40% of Americans in rural areas lack access to adequate broadband
    - Telemedicine can be utilized by RHCs to mitigate physician shortage problems

"Telehealth Use in Rural Healthcare" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/telehealth (Accessed 7/17/19); "Fact Sheet: Telehealth" American Hospital Association, February 2019, https://www.aha.org/system/files/2019-02/fact-sheet-telehealth-2-4-19.pdf (Accessed 7/17/19), p. 2.

Valuation Methodology Considerations

- Income Approach
- Market Approach
- Asset/Cost Approach

"Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics#certified (Accessed 12/14/18); "Rural Health Clinic" MLN Fact Sheet, ICN 006398, January 2018, available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf (Accessed 12/14/18), p. 2-3.

Value Drivers

- Scope of services
  - RHCs must provide outpatient primary care services as well as:
    - Chemical examination of urine by stick or tablet method or both
    - Hemoglobin or hematocrit
    - Blood sugar
    - Examination of stool specimens for occult blood
    - Pregnancy tests
    - Primary culturing for transmittal to a certified laboratory access
  - Some RHCs also provide mental and/or dental health services

"Rural Health Clinics (RHCs)" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-health-clinics#certified (Accessed 12/14/18); "Rural Health Clinic" MLN Fact Sheet, ICN 006398, January 2018, available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf (Accessed 12/14/18), p. 2-3.

Value Drivers

- Capacity
  - Number of providers
  - Productivity of those providers

Value Drivers

- Supply
  - 5,266 certified RHCs
  - Closures rising
  - Currently an insufficient supply of RHCs for U.S. population living in rural areas
  - Primary care physician to patient ratio is 39.8 physicians per 100,000 people in rural areas (compared to 53.3 in urban areas)

"United States: Rural Healthcare Facilities" Rural Health Information Hub, https://www.ruralhealthinfo.org/states/united-states (Accessed 3/7/19). "Rural Hospital Closures to Ninety-Eight" By Jessica Seigel, National Rural Health Association, February 20, 2019, https://www.ruralhealthweb.org/blogs/ruralhealthvoices/february-2019/rural-hospital-closures-rise-to-ninety-seven (Accessed 3/7/19). "Rural Providers Need New Strategies to Succeed" By Erin Hennessey, MA, NHA, CPG, Provider Magazine, December 2018, http://www.providermagazine.com/archives/2018_Archives/Pages/1218/Rural-Providers-Need-New-Strategies-to-Succeed.aspx (Accessed 4/10/19).

Value Drivers

- Demand Drivers
  - Social Determinants
    - Rate of social determinants higher in rural areas
    - Greater need in rural areas
    - Lower quality of health in rural areas

Value Drivers

- Demand Drivers
  - Social Determinants Comparisons between Urban Rural Areas

Social Determinant	Urban Figure	Rural Figure
Average Per Capita Income	$59,652	$44,020
Poverty Rate	14.3%	17.2%
Unemployment Rate	4.8%	5.4%
Percent that Lacks a High School Diploma	12%	14%

"Poverty Rates/Median Household Income in United States by County Type: 2013-2017" United States Census Bureau, https://www.census.gov/library/visualizations/2018/comm/acs-5yr-poverty-type.html (Accessed 4/10/19). "Rural Employment and Unemployment" United States Department of Agriculture, Economic Research Service, 2017, https://www.ers.usda.gov/topics/rural-economy-population/employment-education/rural-employment-and-unemployment/ (Accessed 4/10/19). "Rural education levels are increasing, but still lag behind urban areas" By Economic Research Service, 2018, https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=90366 (Accessed 4/10/19).

Value Drivers

- Demand Drivers
  - Health Determinants
    - Worse health determinants in rural areas than urban areas:
      - Smoking
        - » Higher smoking rates
        - » Earlier age of smoking
        - » More likely to smoke more frequently (> 15 cigarettes a day)
      - Obesity
        - » Higher obesity rates
        - » 26% higher chance of developing childhood obesity
        - » Less physical activity
        - » Increased complications from obesity

"Tobacco Use in Rural Areas" Rural Health Information Hub, https://www.ruralhealthinfo.org/toolkits/tobacco/1/use-in-rural (Accessed 3/7/19); "Cutting Tobaccos Rural Roots: Tobacco Use in Rural Communities" American Lung Association, 2010, https://www.lung.org/assets/documents/research/cutting-tobaccos-rural-roots.pdf (Accessed 4/11/19), p. 6. "Prevalence of Obesity Among Adults from Rural and Urban Areas of the United States: Findings From NHANES (2005-2008)" By, Christie Befort, Niaman Nazir, and Michael Perri, Journal of Rural Health, Vol. 28, No. 4, (May 31, 2012), p. 1; "The Impact of Obesity on Health Care Utilization and Expenditures in a Medicare Supplement Population" By Shirley Musich, et al., Gerontology & Geriatric Medicine, (January 19, 2016), p. 1; "Urban-Rural Differences in Childhood and Adolescent Obesity in the United States: A Systematic Review and Meta-Analysis" By James Allen Johnson III, and Asal Mohamadi Johnson, Vol. 11, No. 3 (June 2, 2015), p. 1; "Promoting Active Living in Rural Communities" Active Living Research, September 215, https://activelivingresearch.org/sites/activelivingresearch.sdsc.edu/files/ALR_Brief_RuralCommunities_Sept2015.pdf (Accessed 4/11/19).

Value Drivers

- Demand Drivers
  - Driven by patient proximity to RHCs
  - Population loss
    - Significant population declines since 2000
    - Many people leaving are younger, causing median age to rise

"Demographic and economic trends in urban, and suburban and rural communities" By Kim Parket, et al., Pew Research Center, May 22, 2018, https://www.pewsocialtrends.org/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/ (Accessed 4/10/19); "Rural America is Losing Young People Consequences and Solutions" Wharton University of Pennsylvania, Public Policy Initiative, March 23, 2018, https://publicpolicy.wharton.upenn.edu/live/news/2393-rural-america-is-losing-young-people- (Accessed 4/4/19); "Demographic and economic trends in urban, and suburban and rural communities" By Kim Parket, et al., Pew Research Center, May 22, 2018, https://www.pewsocialtrends.org/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/ (Accessed 4/10/19).

Value Drivers

- Revenue Stream
  - Heavy reliance on Medicare and Medicaid reimbursement
    - Heavy reliance on stable AIR
  - Low revenue volatility because primary care services have stable demand
  - Physician shortages may effect revenue
    - Physician could retire – leaving absence
    - Higher compensation costs could cut into profit
  - Favorable cost-sharing for primary care services

"IBISWorld Industry Report 62111a: Primary Care Doctors in the US" Anna Miller, IBISWorld, June 2019; "Modernizing Rural Health Clinic Provisions: Policy Brief and Recommendations" National Advisory Committee on Rural Health and Human Services, December 2017, https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-Rural-Health-Clinic-Provisions.pdf (Accessed 1/29/20), p. 5.

Value Drivers

- Revenue Stream
  - Other impacts:
    - Quality reporting programs
    - Rate updates
    - Stability of payment rates
    - Dependency on payor mix
  - New revenue opportunities:
    - Billing of chronic care management
    - Facilitation of telemedicine services

"IBISWorld Industry Report 62111a: Primary Care Doctors in the US" Anna Miller, IBISWorld, June 2019; "Modernizing Rural Health Clinic Provisions: Policy Brief and Recommendations" National Advisory Committee on Rural Health and Human Services, December 2017, https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-Rural-Health-Clinic-Provisions.pdf (Accessed 1/29/20), p. 5.

Value Drivers

- Payor Mix
  - Similar payor mix to rural hospitals
    - More Medicare and Medicaid (56% or net revenue)
    - Rural hospitals have margins of -7.4%
  - Reliance on Medicare and Medicaid leaves RHCs vulnerable to policy changes
  - Many states with large rural populations have not expanded Medicaid
    - Providers in these states experience higher rates of unrecoverable debt and charity care

"Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-Quality, Affordable Care" American Hospital Association, 2019, p. 4.

Value Drivers

- Operating Expenses

Necessary Expenses	Other Expenses
Pharmaceuticals	Rental/Mortgage Costs
Medical Instruments	Capital Costs
Medical Supplies	EMR Costs
Diagnostic Supplies	
Employee Wages	
Largest cost	
Primary care provider compensation lower than most specialties	

"Healthcare Finance: An Introduction to Accounting and Financial Management, Third Edition" By Louis C. Gapenski, Third Edition, Chicago, IL: Health Administration Press, 2005, p. 38; "Introduction to Health Services" 7th ed., Stephen J. Williams and Paul R. Torrens, eds., Clifton Park, NY: Thomson Delmar Learning, 2008, p. 124; "IBISWorld Industry Report 62111a: Primary Care Doctors in the US" Anna Miller, IBISWorld, June 2019, p. 13; "Family Physician Salaries Up but Still Trail Those of Subspecialists" by Michael Laff, American Academy of Family Physicians, May 13, 2015, https://www.aafp.org/news/practice-professional-issues/20150513salaryreport.html (Accessed 1/29/20).

Value Drivers

- Operating Expenses
  - Additional considerations:
    - The size of the facility
    - The ability of the RHC to manage supply costs
    - Whether the RHC directly employees all providers or contracts the providers
    - Whether a third party performs the management of the RHC
    - Whether a hospital owns the RHC

"Healthcare Finance: An Introduction to Accounting and Financial Management, Third Edition" By Louis C. Gapenski, Third Edition, Chicago, IL: Health Administration Press, 2005, p. 38; "Introduction to Health Services" 7th ed., Stephen J. Williams and Paul R. Torrens, eds., Clifton Park, NY: Thomson Delmar Learning, 2008, p. 124; "IBISWorld Industry Report 62111a: Primary Care Doctors in the US" Anna Miller, IBISWorld, June 2019, p. 13; "Family Physician Salaries Up but Still Trail Those of Subspecialists" by Michael Laff, American Academy of Family Physicians, May 13, 2015, https://www.aafp.org/news/practice-professional-issues/20150513salaryreport.html (Accessed 1/29/20).

Value Drivers

- Capital Structure
  - Similar to outpatient facilities such as physician professional practices
  - Factors:
    - Mix of debt and equity financing affects the risk-adjusted required rate of return for investment in the subject enterprise
    - Debt financing is typically cheaper than equity financing
    - Financing costs reflect the risks associated with each type of capital provided

"Fixed Income Analysis for the Chartered Financial Analyst Program" By Frank Fabozzi, PhD, CFA, Second Edition, 2005, p. 572.

Value Drivers

- Capital Structure
  - Consider four C's of the obligor:
    - **C**redit risk (default risk) of the borrower
    - **C**apacity of the borrower to make timely repayments of both principal and interest (short term liquidity and interest coverage)
    - **C**ollateral to cover the lender in case of borrower default
    - Analysis of the **C**ovenants included in the indenture agreement

"Fixed Income Analysis for the Chartered Financial Analyst Program" By Frank Fabozzi, PhD, CFA, Second Edition, 2005, p. 572.

Value Drivers

- Capital Structure
  - Examples of Leverage Ratios for Outpatient Facilities [SIC 8093]
    - Data for SIC code 8093 was used when possible, otherwise, SIC code 809 and NAICS code 621493 were utilized
  - RHCs have a lower dependency compared to specialty care on complex technology, consequently, taking on less debt for equipment

Value Drivers

- Suppliers
  - Main suppliers:
    - Physicians
    - Commercial landlords
    - Healthcare systems
    - Medical supply and pharmaceutical companies
    - Billing and insurance companies
  - More bargaining power comes with size allowing better negotiating of supply prices

Value Drivers

- Market Rivalries, Competitors, and Consolidation
  - Consolidation
    - Many RHCs are integrating with CAHs
      - CAH-owned RHCs operate at loss and require subsidies from hospital
      - Fulfills CAH's need to keep market share

"Rural Health Clinics (RHCs)" Rural Health Information Hub, 2020, https://www.ruralhealthinfo.org/topics/rural-health-clinics (Accessed 1/29/20); "March 2019 Report to the Congress: Medicare Payment Policy: Chapter 4: Physician and other health professional services" MedPAC, March 2019, p. 117; "IBISWorld Industry Report 62111a: Primary Care Doctors in the US" Anna Miller, IBISWorld, June 2019.

Value Drivers

- Market Rivalries, Competitors, and Consolidation
  - Fragmented primary care industry
    - No large players in industry
    - Still prevalence of independent practices
    - Industry considered unprofitable in rural markets
    - Overall primary care industry seeing declining profit margins
  - Independent RHCs dwindling
    - Acquired by CAHs
    - Closed altogether
  - Telehealth companies are poised to replace many of the face-to-face encounters treating minor health concerns for rural patients

"Rural Health Clinics (RHCs)" Rural Health Information Hub, 2020, https://www.ruralhealthinfo.org/topics/rural-health-clinics (Accessed 1/29/20); "March 2019 Report to the Congress: Medicare Payment Policy: Chapter 4: Physician and other health professional services" MedPAC, March 2019, p. 117; "IBISWorld Industry Report 62111a: Primary Care Doctors in the US" Anna Miller, IBISWorld, June 2019.

Value Drivers

- Subject Entity Specific/Non-Systematic Risk
  - Subject Entity Specific/Non-Systematic Risk factors for most RHCs include:
    - The uncertainty related to the continuity of the projected revenue stream based on the probability of achieving the projected productivity volume and the efficacy of the projected reimbursement yield utilized in the analysis
    - The risk related to the probability of achieving industry indicated operational and financial benchmarks used in the analysis
    - The competitive marketplace within which the RHC operates
    - The historical operations of the RHC in comparison to the industry benchmarks

Value Drivers

- Subject Entity Specific/Non-Systematic Risk
  - Examples of subject entity-specific/non-systematic risk considerations related to the valuation of an RHC include:
    - Number of available providers
    - Percentage of out-of-network patient volumes
    - Capital needs related to the facility and equipment
    - Operating performance
    - Stability and relative size of current and future reimbursement revenues
    - Relationship with local hospitals

Physician/Provider Compensation

As required by Revenue Rulings 59-60 and 68-609, as well as promulgated under the standard of Fair Market Value (which assumes a hypothetical *willing buyer* rather than an individual specific buyer), owner compensation, i.e., the physician shareholders, should be restated to "a reasonable amount for the services performed by the owner or partners engaged in the business."

Physician compensation must be adjusted (normalized) to reflect the amount that an unrelated third party would pay for performing similar duties, i.e., the amount it would cost to replicate or replace the aggregate services of the physicians, based upon their economic input to the RHC.

Physician/Provider Compensation

Sources for Physician Compensation

- Medical Group Management Association (MGMA)

Demographic Classification (Expanded)

PRO REPORT BUILDER ONLY

Metro – Counties in metro areas of fewer than 250,000 population: The county in which the practice is located is a Census Bureau defined urbanized area with a population less than 250,000.
Metro – Counties in metro areas of 250,000 to 1 million population: The county in which the practice is located is a Census Bureau defined urbanized area with a population of 250,001 to 1,000,000.
Metro – Counties in metro areas of 1 million population or more: The county in which the practice is located is a Census Bureau defined urbanized area with a population of 1,000,001 or more.
Nonmetro – Completely rural or less than 2,500 urban population: The county in which the practice is located is referred to as "rural." It may or may not be adjacent to a metropolitan area and has a population less than 2,500.
Nonmetro – Urban population of 2,500 to 19,999: The county in which the practice is located is referred to as "rural." It may or may not be adjacent to a metropolitan area and has a population between 2,500 and 19,999.
Nonmetro – Urban population of 20,000 or more: The county in which the practice is located is referred to as "rural." It may or may not be adjacent to a metropolitan area and has a population of 20,000 or more.

- Sullivan Cotter and Associates

COMPENSATION TRENDS

TABLE 7.4 – TCC for Staff Physicians by Community Type – Primary Care

TCC for Staff Physicians by Community Type – Primary Care					
Code	Specialty	Community	n Orgs	n Incumbents	Median
9904	Primary Care Specialty Group	Rural	65	1,485	$229,688
		Suburban	127	9,216	$238,328
		Urban	175	16,940	$245,243

Commercial Reasonableness

- Fraud and abuse laws scrutinize many aspects of healthcare transactions under both the valuation standard of Fair Market Value and the separate, but related, threshold of commercial reasonableness
- CMS has interpreted the term "*commercially reasonable*" to mean that an arrangement appears to be:

  "*a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals*."
- The Stark II, Phase II commentary also suggests that:

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

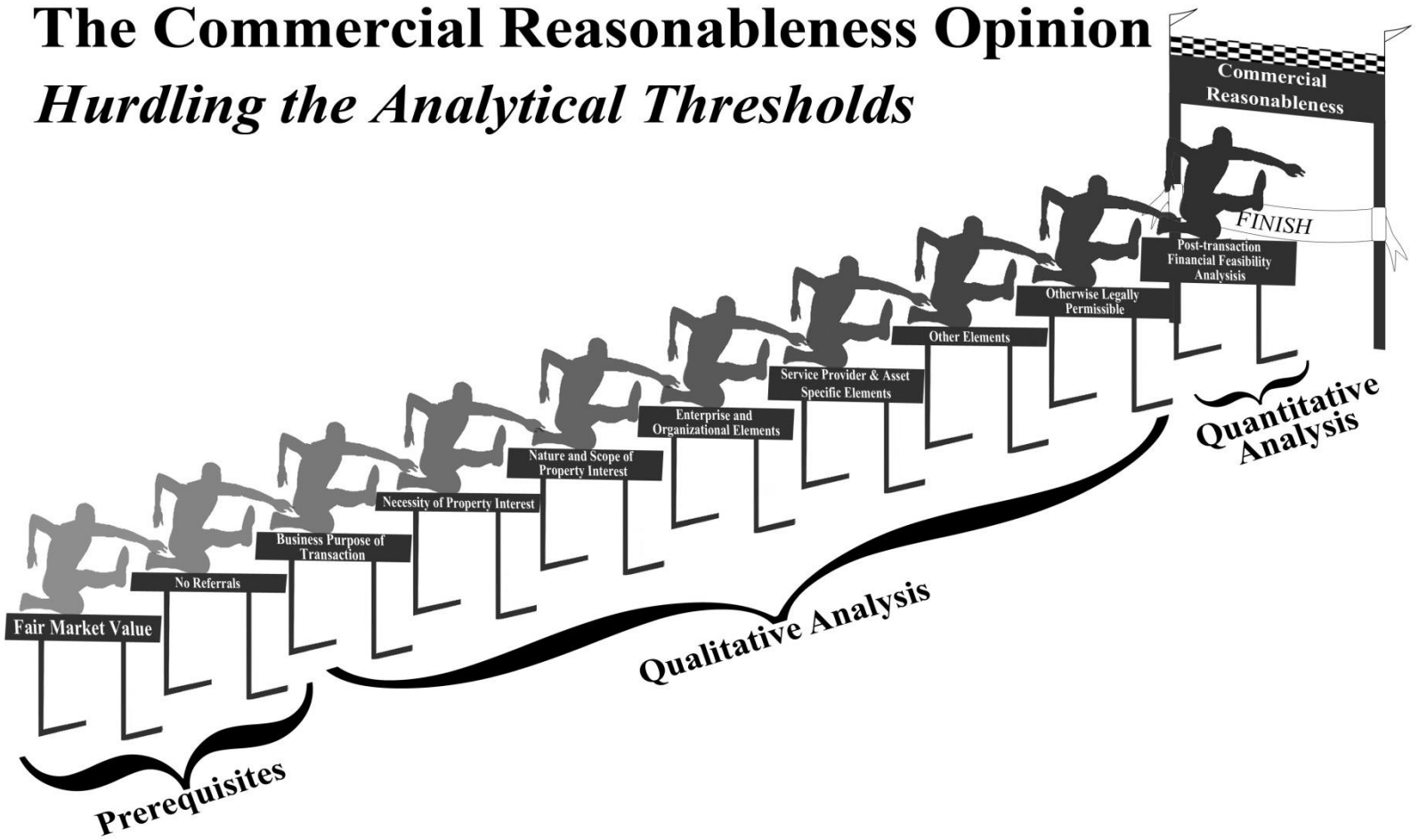
"Medicare and Medicaid Programs; Physician Referrals to Health Care Entities With Which They Have a Financial Relationship: Proposed rule" Federal Register Vol. 63, No. 6 (January 9, 1998), p. 1700. "Medicare and Medicaid Programs; Physician Referrals to Health Care Entities With Which They Have a Financial Relationship: Interim final rule with comment period" Federal Register Vol. 69, No. 59 (March 26, 2004), p. 16093.

Commercial Reasonableness

- In the October 2019 proposed rule suggesting several revisions to the Stark Law, CMS proposed two alternative definitions for "*commercially reasonable*," i.e.:
  - "...*the particular arrangement further a legitimate business purpose of the parties and is on similar terms and conditions as like arrangements*"; or,
  - "...*the arrangement makes commercial sense and is entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty*."
- Importantly, CMS asserted in the proposed rule that "*compensation arrangements that do not result in profit for one or more of the parties may nonetheless be commercially reasonable*." [Emphasis added.]

"Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations: Proposed rule" Federal Register Vol. 84, No. 201 (October 17, 2019), p. 55790. A final rule has yet to be published.

Commercial Reasonableness



Commercial Reasonableness

- Business Purpose of Transaction
  - Beyond monetary (cash) benefits (i.e., collections/revenue from direct patient care services provided by the physician)
  - Expanding into new (possibly previously unserved) geographic areas
  - For non-profit entities, accomplishing their charitable mission
    - Providing a continuum of care
    - Population health management
    - Providing critical access to healthcare services

"Medicare and State Health Care Programs: Fraud and Abuse: Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute," 64 Federal Register 63525 (11/19/99). "Hospital Mergers: Why They Work, Why They Don't," By Larry Scanlan, Chicago, IL: Health Forum, 2010, p. 27. "Joint Ventures for Hospitals and Physicians: Legal Considerations," By Ross Stromberg and Carol Boman, American Hospital Publishing, 1986, p. 5." Mergers, Acquisitions, and Corporate Restructurings," By Patrick Gaughan, Hoboken, NJ: John Wiley & Sons, 2011, p. 175.

Commercial Reasonableness

- Necessity of Transaction
  - May be relatively easy to substantiate compared to other transactions, as CMS has already determined that the area in which the RHC operates is underserved
- Nature and Scope of Subject Interest
  - Especially if buyer is a CAH, the acquisition of an RHC may be:
    - A "*cost of carrying on its business*"
    - "*Reasonable in terms of the responsibilities and activities… assumed under the contract*"

"Unrelated Trade or Business" in "Taxation of Business Income of Certain Exempt Organizations", 26 USC Section 513 (1/3/12). "Trade or Business Expenses for Itemized Deductions for Individuals and Corporations for the Computation of Taxable Income for Normal Taxes and Surtaxes", 26 USC Section 162 (1/3/12). "IRS Revenue Ruling 69-383, 1969-2 CB 113", Internal Revenue Service, 1969. "Health Care Provider Reference Guide", By Janet Gitterman and Marvin Friedlander, Internal Revenue Service, 2004, p. 19.

Conclusion

- Despite current instability in the RHC market, as well as in rural healthcare generally, CMS is taking steps to implement new policies that will positively impact rural healthcare
- September 20, 2018 – CMS released a proposed rule to reduce unnecessary regulatory burdens within the Medicare program, including several proposals to reduce burdens for RHCs
  - May increase the ease of entry into the rural health market or improve the financial status of RHCs, potentially increasing RHC supply in the future

"CMS Seeking to Reduce RHC Regulatory Burden" By Nathan Baugh, Director of Government Affairs, National Association of Rural Health Clinics, September 21, 2018, https://www.web.narhc.org/News/27611/CMS-Seeking-to-Reduce-RHC-Regulatory-Burden (Accessed 4/10/19).

Conclusion

- RHC Modernization Act of 2019
  - Introduced by Senators John Barrasso, MD (R-WY) and Tina Smith (D-MN)
  - Aims to ensure that people in rural areas have access to healthcare services, as there is still a shortage of providers
  - Seeks to update how NPPs are used by RHCs
  - Proposes to increase RHC reimbursement (i.e., the AIR) – has not been legislatively updated since 1988

"Rural Health Clinic Modernization Act" Nathan Baugh, Director of Government Affairs, National Association of Rural Health Clinics, April 4, 2019, https://www.web.narhc.org/News/27847/RHC-Modernization-Act-Introduced-by-Senator-Barrasso-and-Senator-Smith (Accessed 4/19/19); "Barrasso, Smith Introduce Bipartisan Rural Health Clinic Modernization Act" John Barrasso, April 3, 2019, https://www.barrasso.senate.gov/public/index.cfm/2019/4/barrasso-smith-introduce-bipartisan-rural-health-clinic-modernization-act (Accessed 4/11/19).

Conclusion

- Reimbursement increase could draw more physicians into rural areas, as well as loan forgiveness and repayment options available to physicians practicing in HPSAs
- NPPs can fill shortage of physicians required in rural markets that allow for full autonomous practice
- Continuation of trends:
  - Aging population
  - Social and health determinants in rural communities
  - Consolidation in rural markets
  - Unattainable profitability

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