Repaving a Path to Profitability

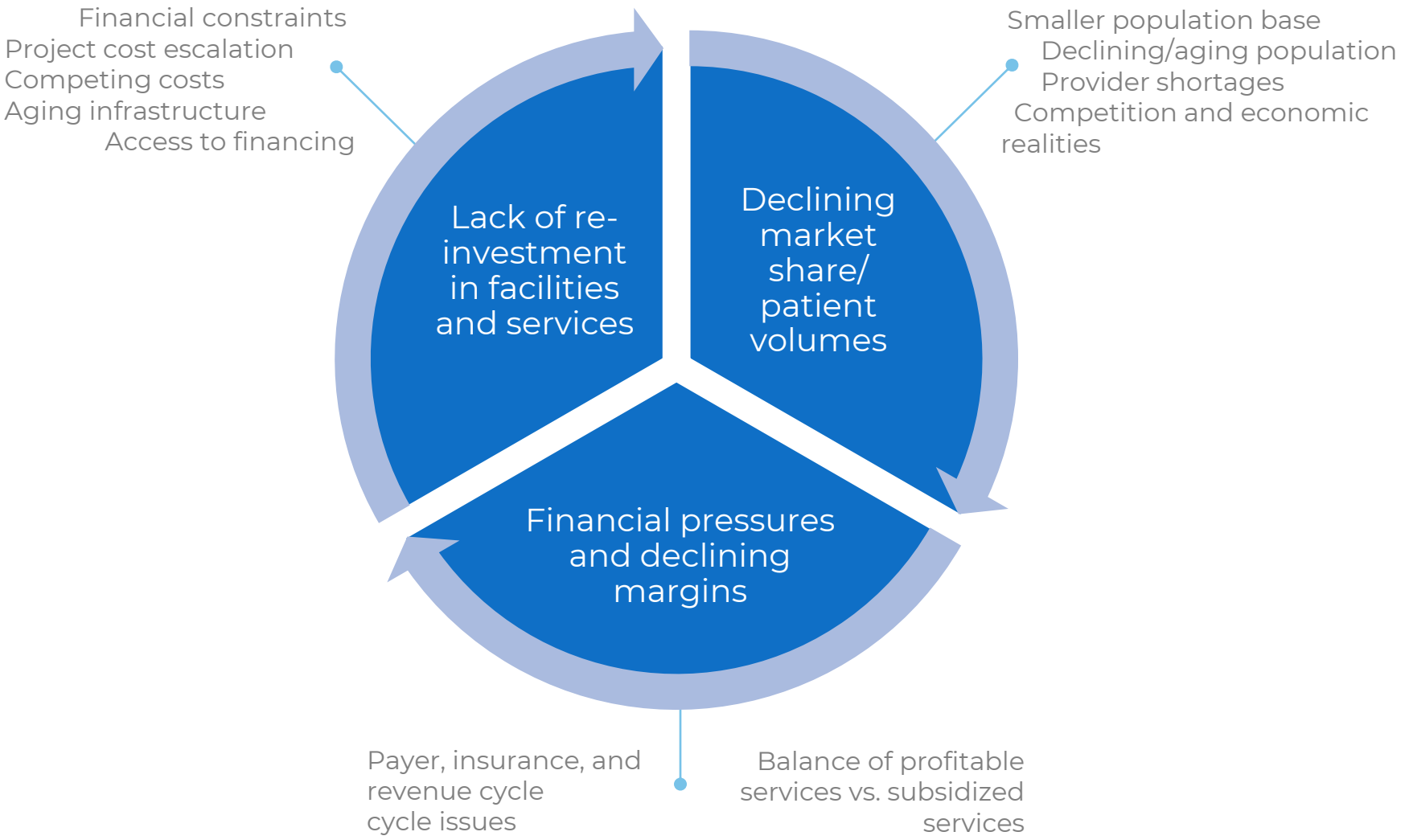
Presented to: Rural MN Health Forum

WIPFLI

Top rural healthcare challenges

Over 135 rural hospital facilities have closed since 2010

Factors driving rural hospital closure:

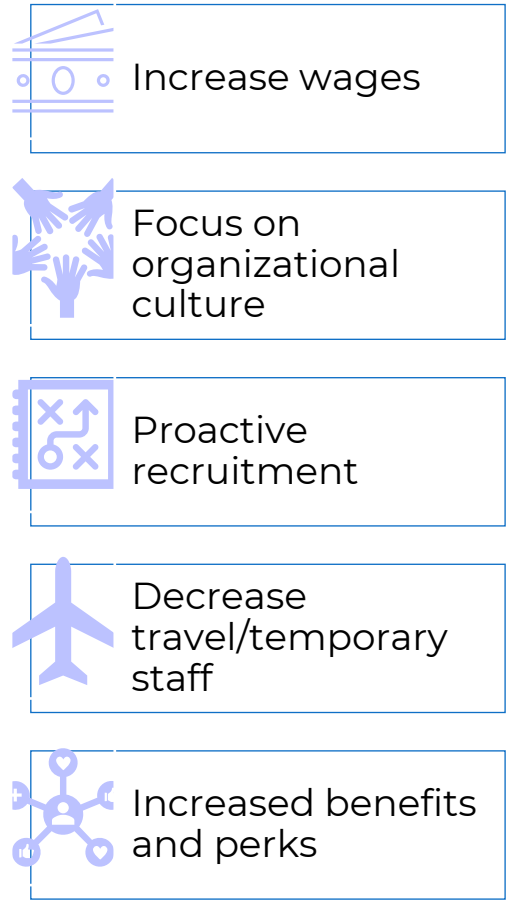


Staffing challenges continue, resulting in need to consider innovative solutions

People management considered #1 strategic priority for rural healthcare entities surveyed by Wipfli LLP (100+ respondents)

- Staffing shortages for all position types continue to persist, but industry lacking influx needed to support rising demand
- Employee recruitment, retention, and outsourcing strategies are becoming essential
  - Building the provider pipeline through partnerships
  - Organizational culture and employee experience as a differentiator
  - Easing workloads with technology/automation
  - Upskilling/developing for needed skillsets from within
  - Succession planning and transfer of knowledge

Top strategies rural healthcare organizations are using to respond to the labor shortage, 2024



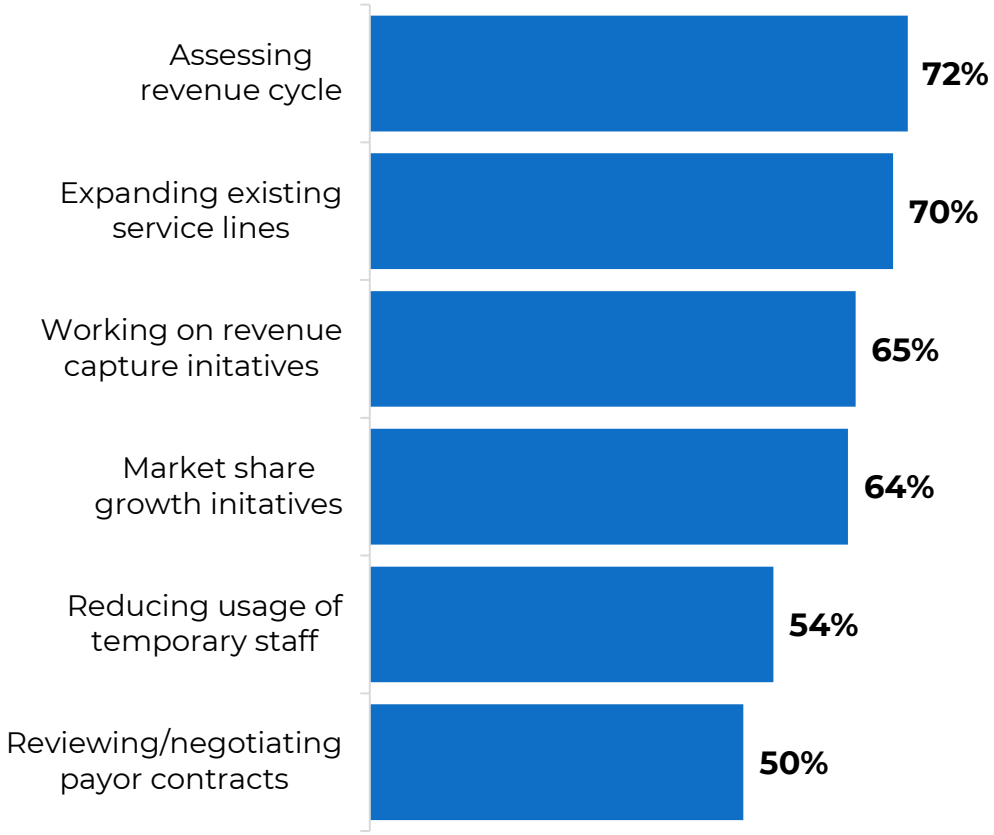
Source: Wipfli LLP. The state of rural healthcare: Research and outlook for 2024.

Financial challenges re-emerging as supplemental government relief funding dissipating, but rural healthcare orgs remaining optimistic

According to the Center for Healthcare Quality & Payment Reform, nearly 30% of all rural hospitals in the United States are at risk of closing

- Revenue and reimbursement growth largely not keeping up with inflation of expenses (labor, supplies, etc.)
- Rural hospitals leveraging cost reduction measures, revenue cycle management, and payer negotiations to avoid cutting services/staff
  - Understanding weak points in revenue cycle process through reviews – AR, claims denials, etc.
  - Visibility into payer contracts to inform negotiations
  - Understanding service line profitability and when to divest from laggards

Top strategies rural healthcare organizations are using to increase revenue, 2024

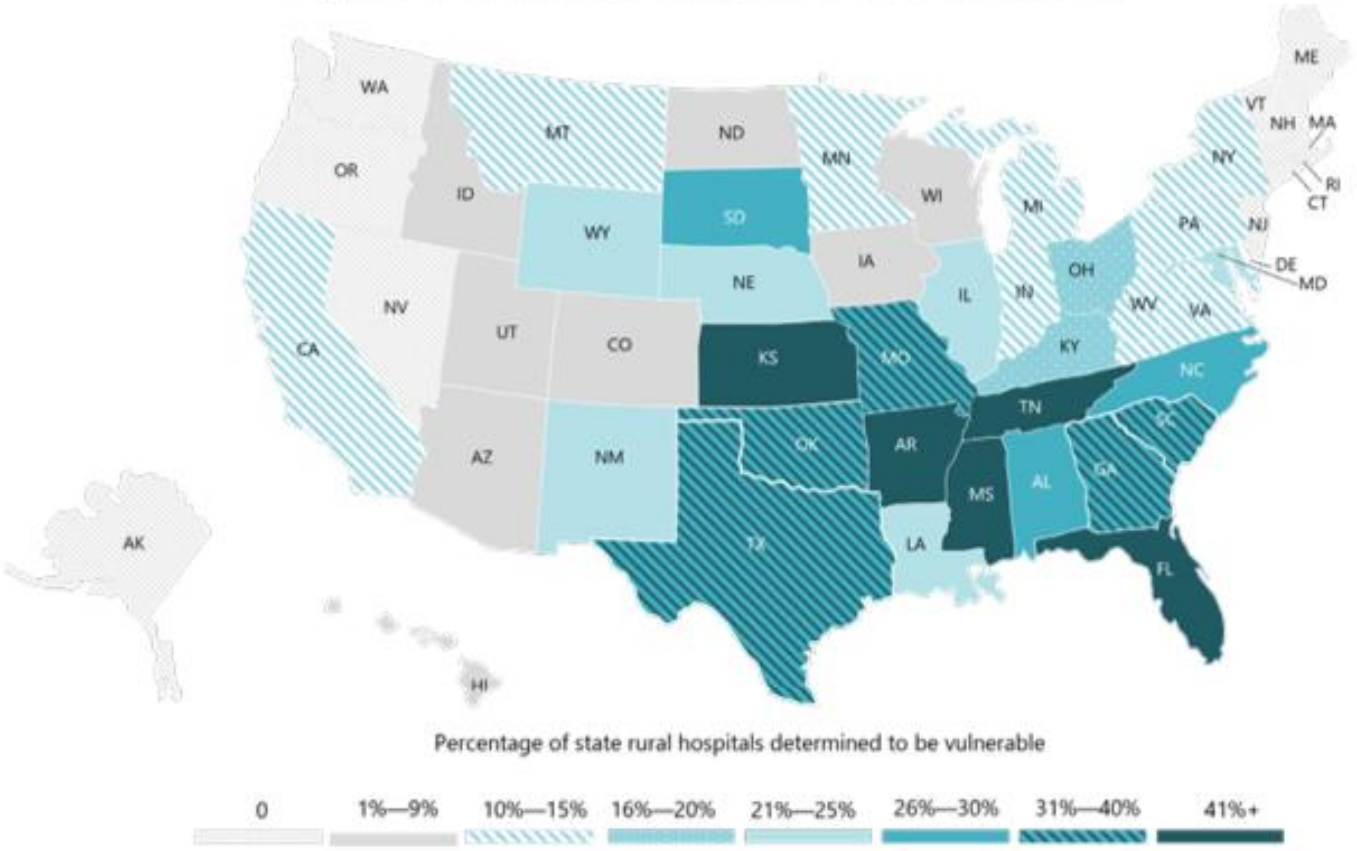


Source: Wipfli LLP. The state of rural healthcare: Research and outlook for 2024.

MN hospitals are on the lower end, but not immune

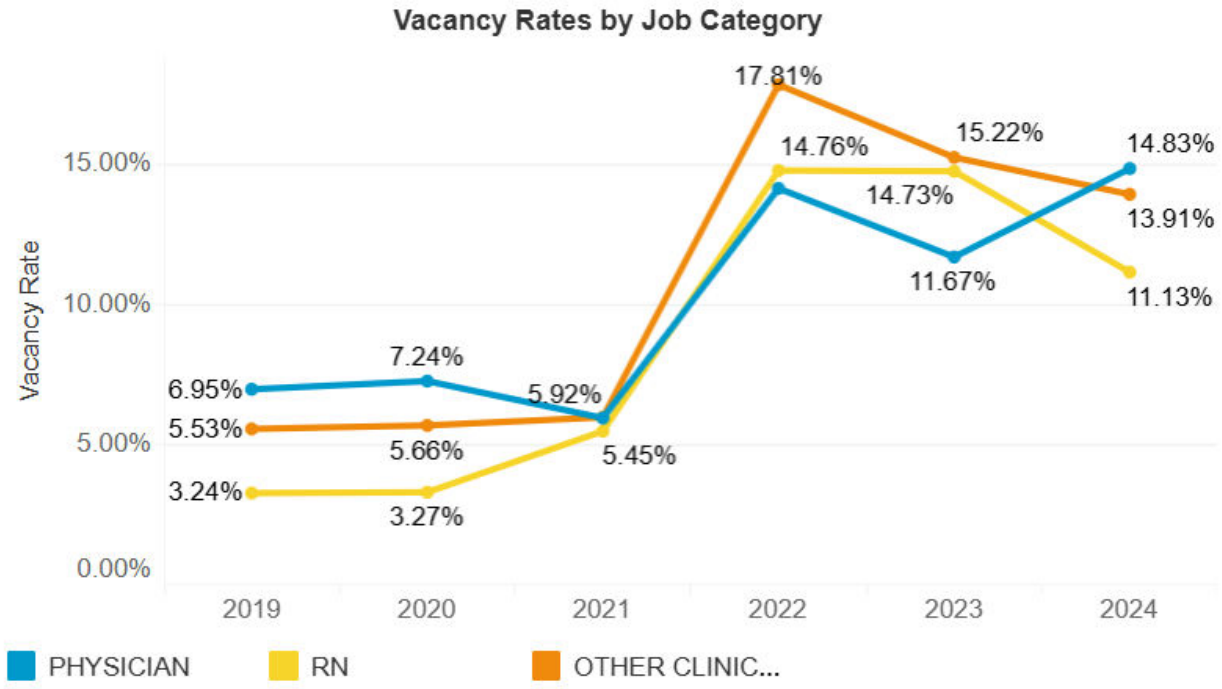
432 rural hospitals are vulnerable to closure

Figure 1: Rural hospitals vulnerable to closure



Source: Chartis

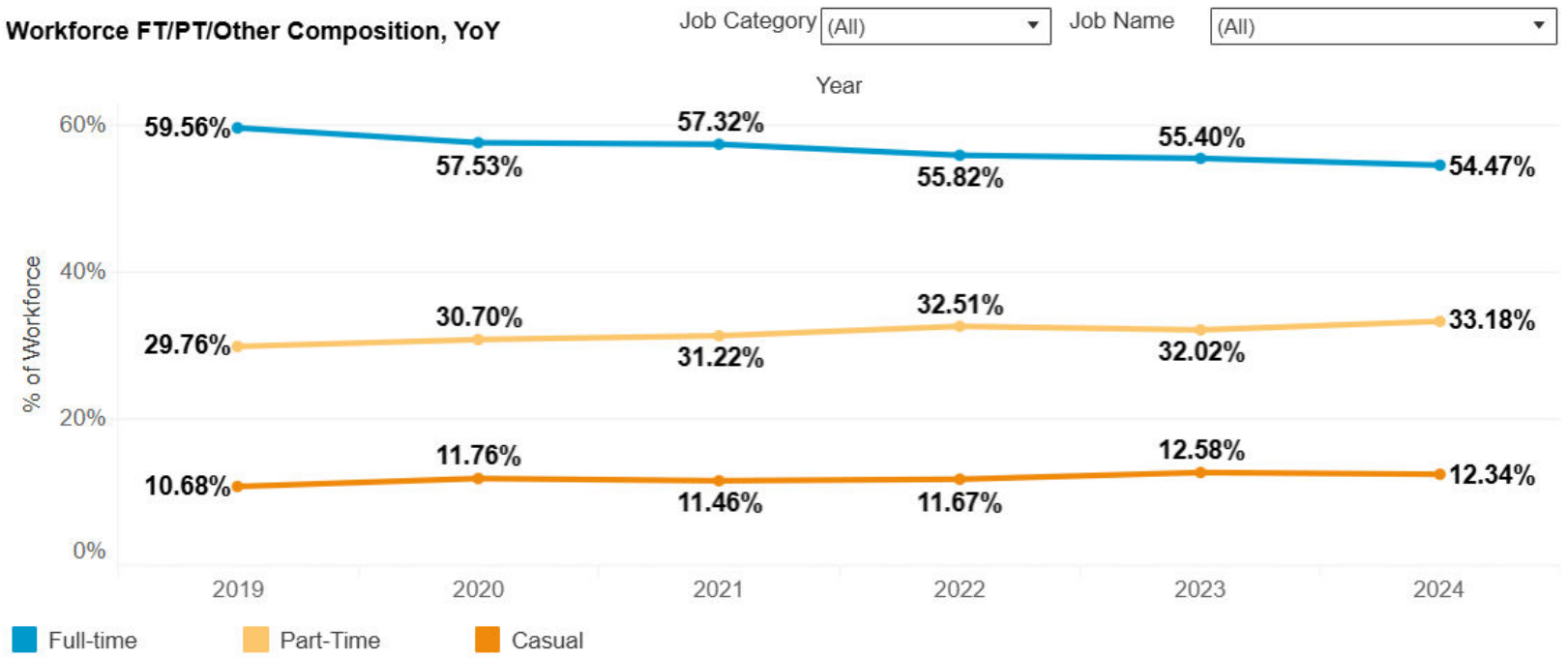
Vacancy rates still high… pressure on wages



Overall Vacancy Rate by Year	
2019	4.68%
2020	4.79%
2021	5.74%
2022	16.22%
2023	14.78%
2024	12.99%

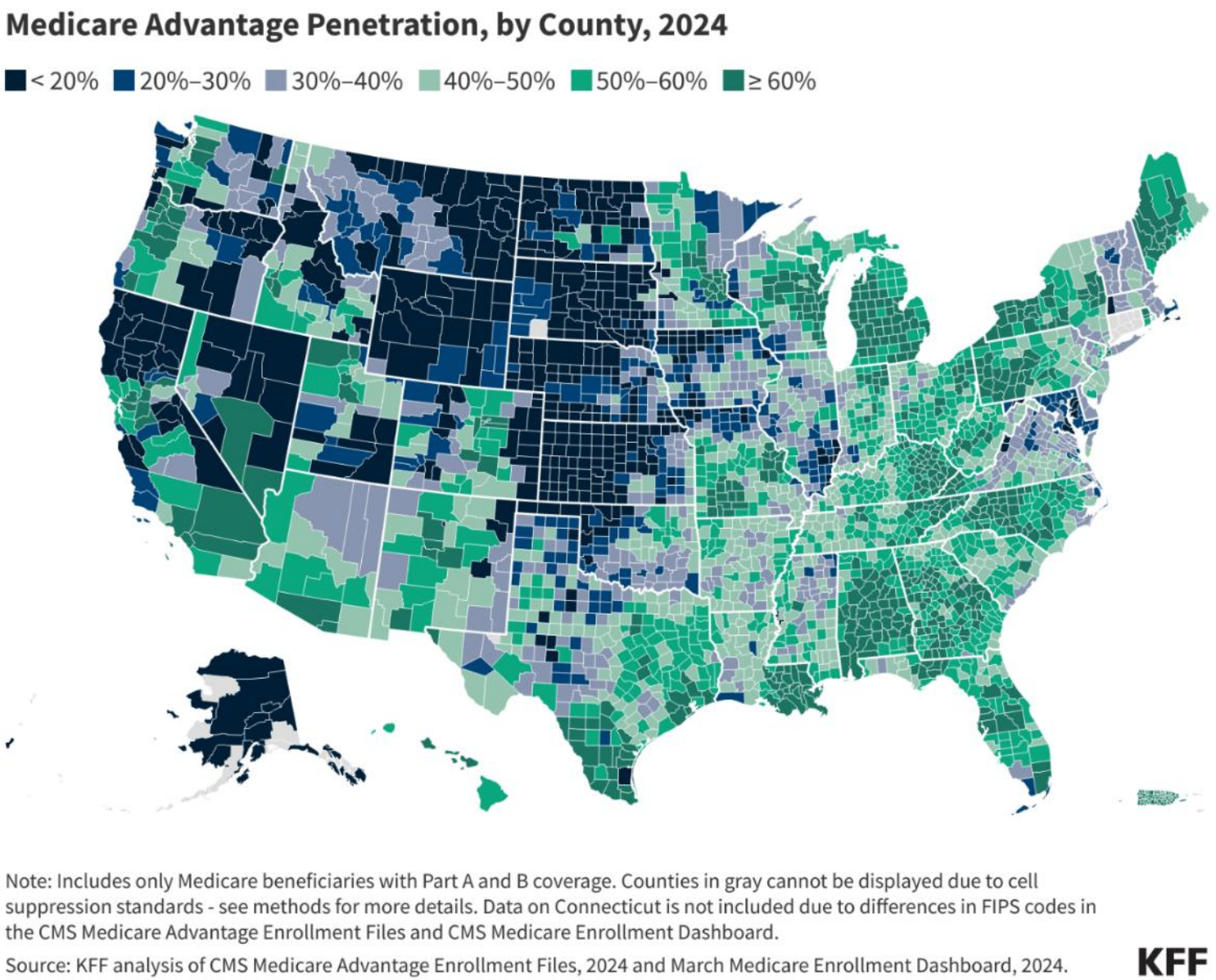
Source: MN Hospital Association

Rise in part-time and casual employees



Source: MN Hospital Association

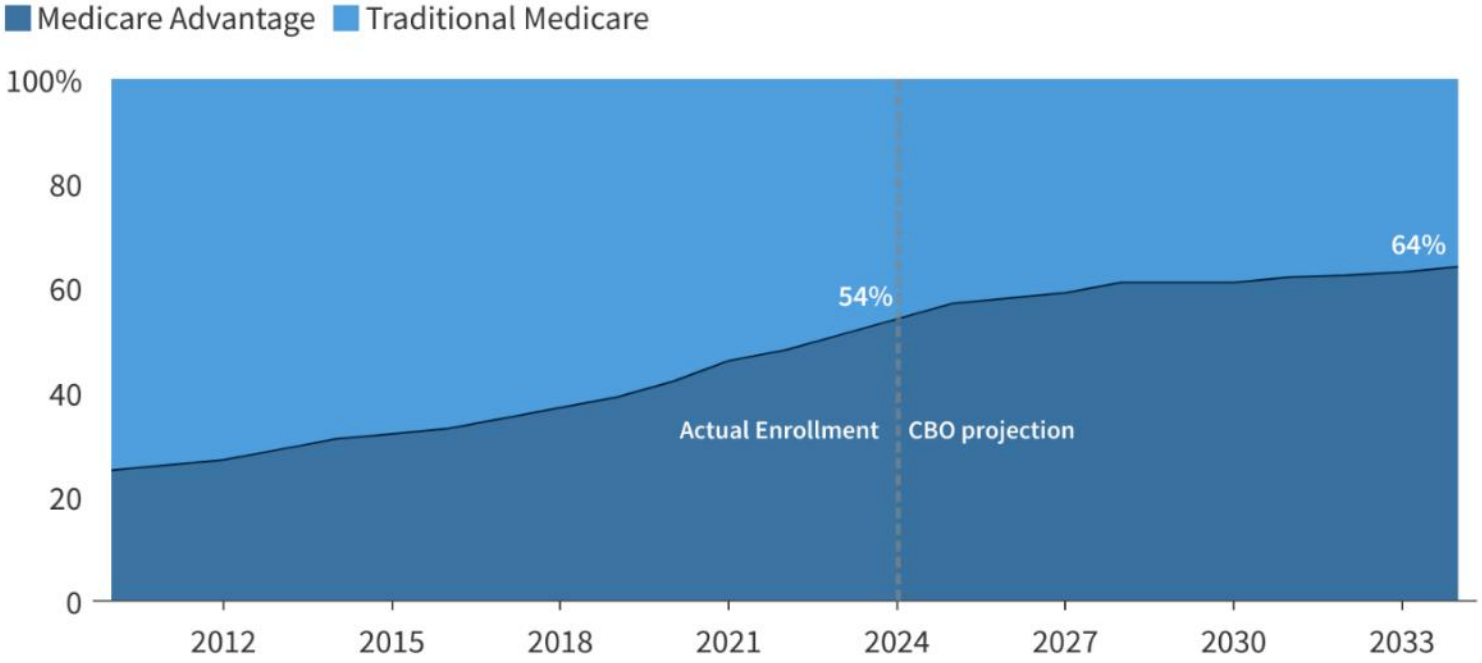
- Medicare Advantage pressure in the MN metro; southwest and northwest MN penetration is low so far



We haven’t hit the Medicare Advantage ceiling

Figure 2

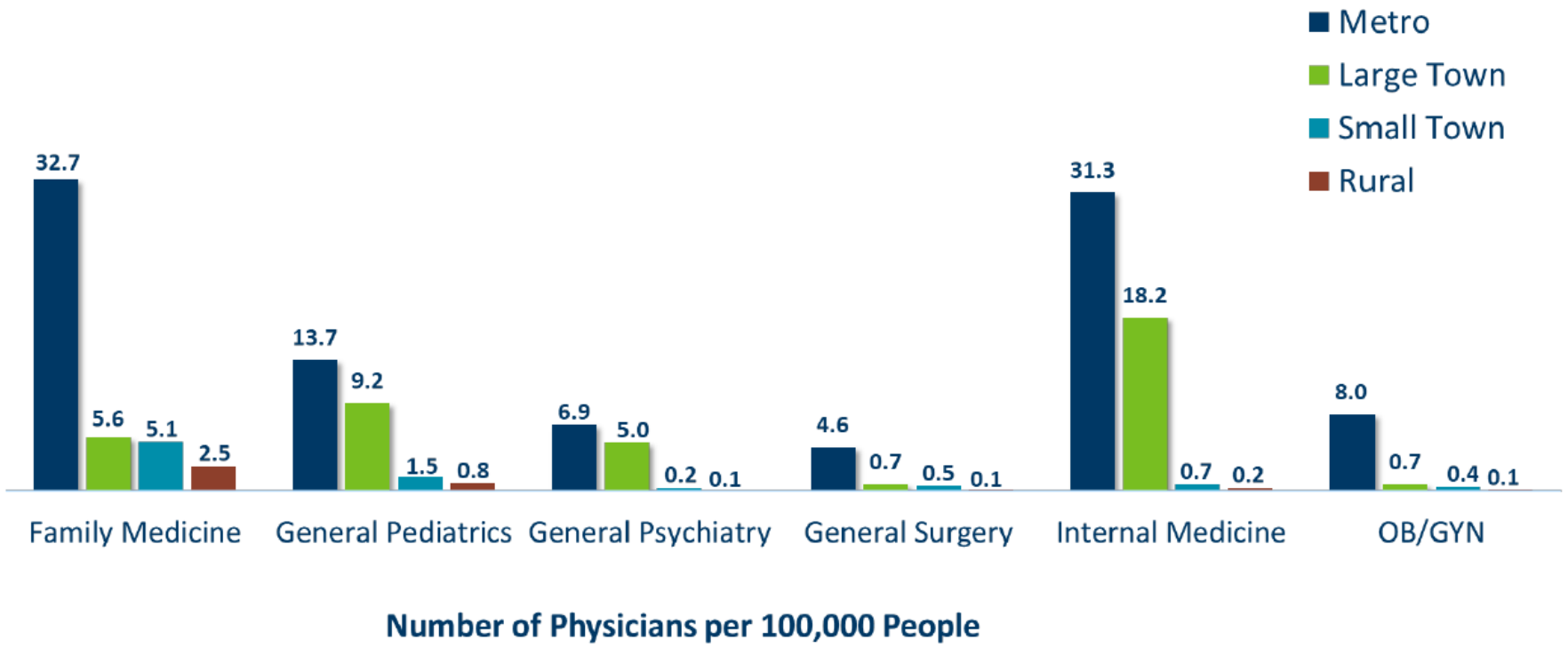
Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024. Enrollment numbers from March of the respective year. Projections for 2025 to 2034 are from the June Congressional Budget Office (CBO) Medicare Baseline for 2024.

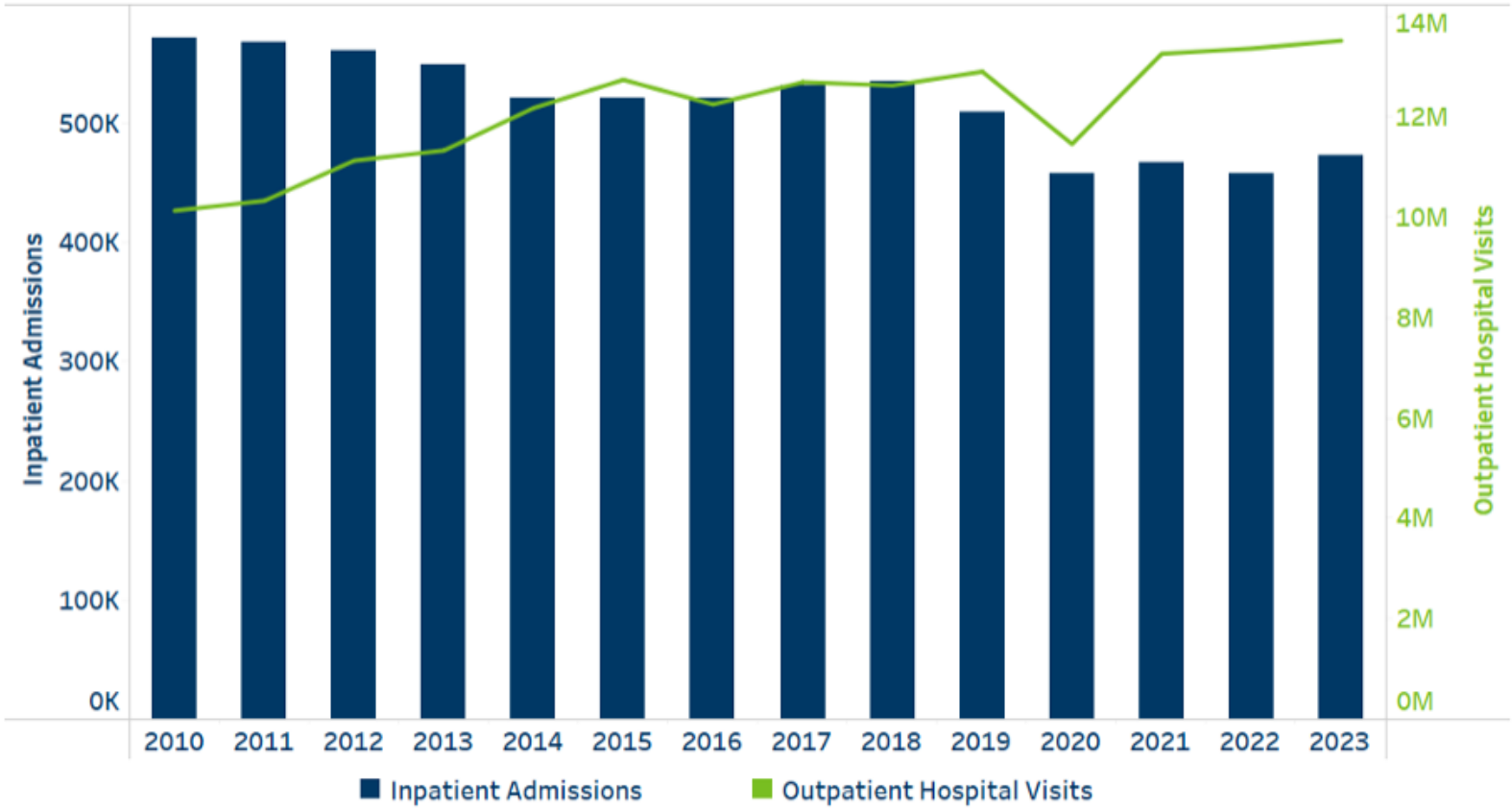
KFF

Still major disparities in rural provider supply



Source: MN Hospital Association

MN inpatient, outpatient volume rising



Source: MDH Health Economics Program analysis of hospital annual reports, Nov. 2024.

MN Rural Hospitals/CAHs performing slightly better financially

Number of Available Beds	Net Income ($ Millions)	Net Income as a percent of Revenue
Under 25 Beds	$142.0	11.0%
25 to 49 Beds	$140.4	4.3%
50 to 99 Beds	$76.9	3.5%
100 to 199 Beds	$58.1	2.0%
200 Beds or More	$1,462.8	8.9%
Type of Hospital		
Critical Access Hospital (CAH)[1]	$240.5	8.1%
Other Hospitals	$1,639.7	7.1%
All Hospitals	**$1,880.3**	**7.2%**

[1]A critical access hospital (CAH) is a federal designation for a rural hospital that meets certain criteria.
Source: MDH Health Economics Program analysis of hospital annual reports, Nov. 2024.

Payer mix shift continues

	Rural Facilities		Urban Facilities		Facilities Statewide	
	2022	2023	2022	2023	2022	2023
Medicare	41.6%	42.2%	31.5%	32.2%	33.6%	34.2%
State Public Programs[1]	11.9%	11.9%	14.9%	15.1%	14.3%	14.4%
Private Insurance	40.0%	39.9%	49.2%	48.9%	47.3%	47.1%
Self-Pay	2.8%	2.5%	2.4%	2.5%	2.5%	2.5%
Other Payers	3.8%	3.4%	2.0%	1.4%	2.4%	1.8%
Hospital Patient Revenue, All Payers	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

[1]Includes Medical Assistance and MinnesotaCare.
Percent shown is a percent of Hospital Patient revenue.
Hospital rural/urban classification is based on hospital location in relation to Rural-Urban Commuting Areas. Isolated rural, small rural town, and large rural city are combined under the "Rural" category.
Source: MDH Health Economics Program analysis of hospital annual reports, Nov. 2024.

Successful rural hospitals focus on the needs of their communities first

The “right” strategic plan should align the needs of your community with the appropriate complement of providers, services, and facilities

- Rural communities generally experience **greater barriers in accessing healthcare** due to their geographic isolation, which can result in poorer health outcomes
- However, Rural Hospitals also struggle with unique challenges in serving their smaller communities, needing to **balance providing access to necessary healthcare services with the long-term viability** to ensure the hospital can continue to serve its community

Rural Hospital best practices

Certain traits that characterize high performing CAHs

“Blocking and tackling” your way to profitability

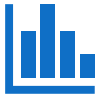
Governance and leadership

Strategic alignment

Engaged and aligned providers

Financial and revenue cycle performance

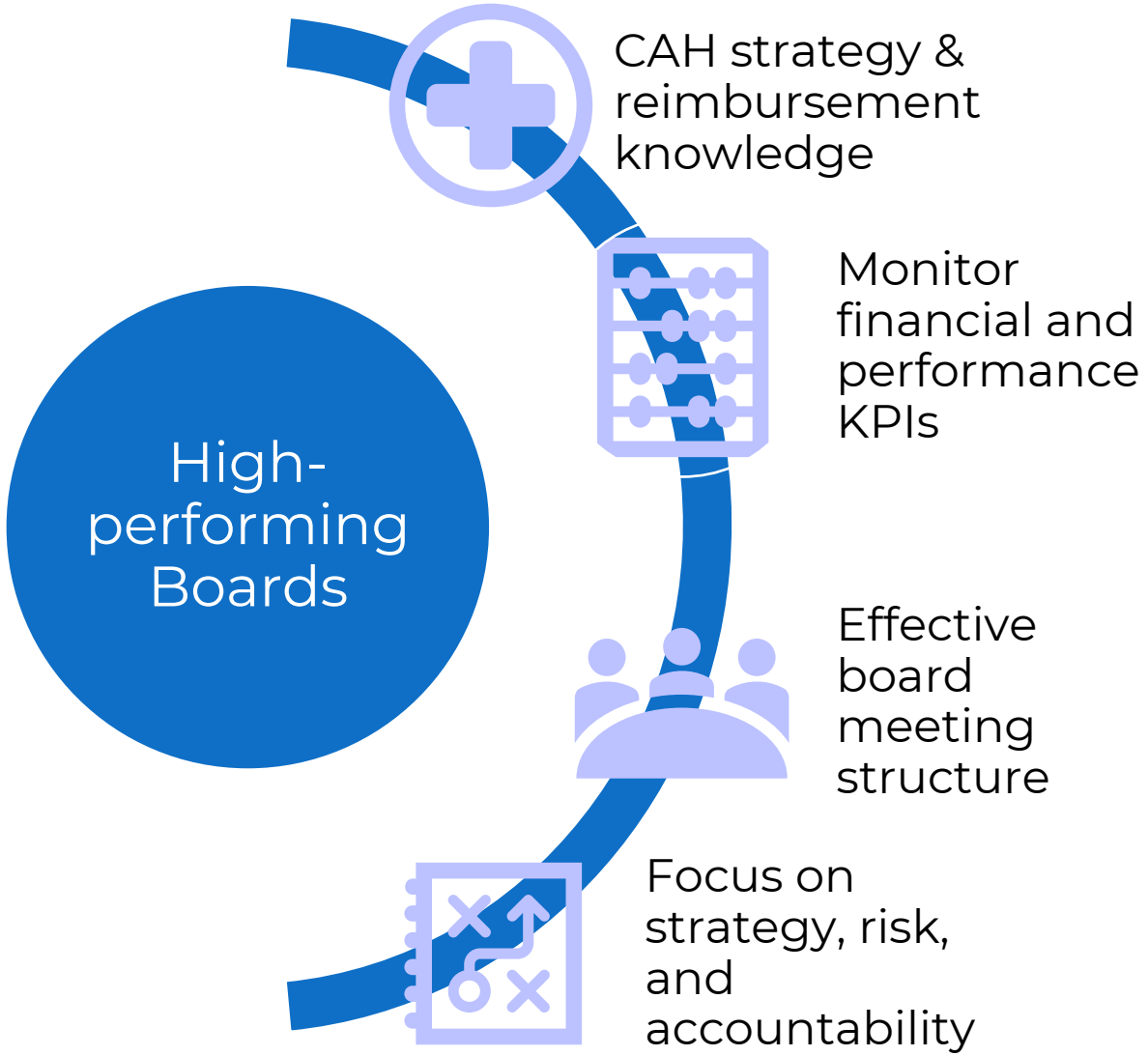
Optimized cost report



Performance management framework and measurement

Rural Hospital best practices – governance and leadership

Strong governance and leadership is the cornerstone of high performing CAHs

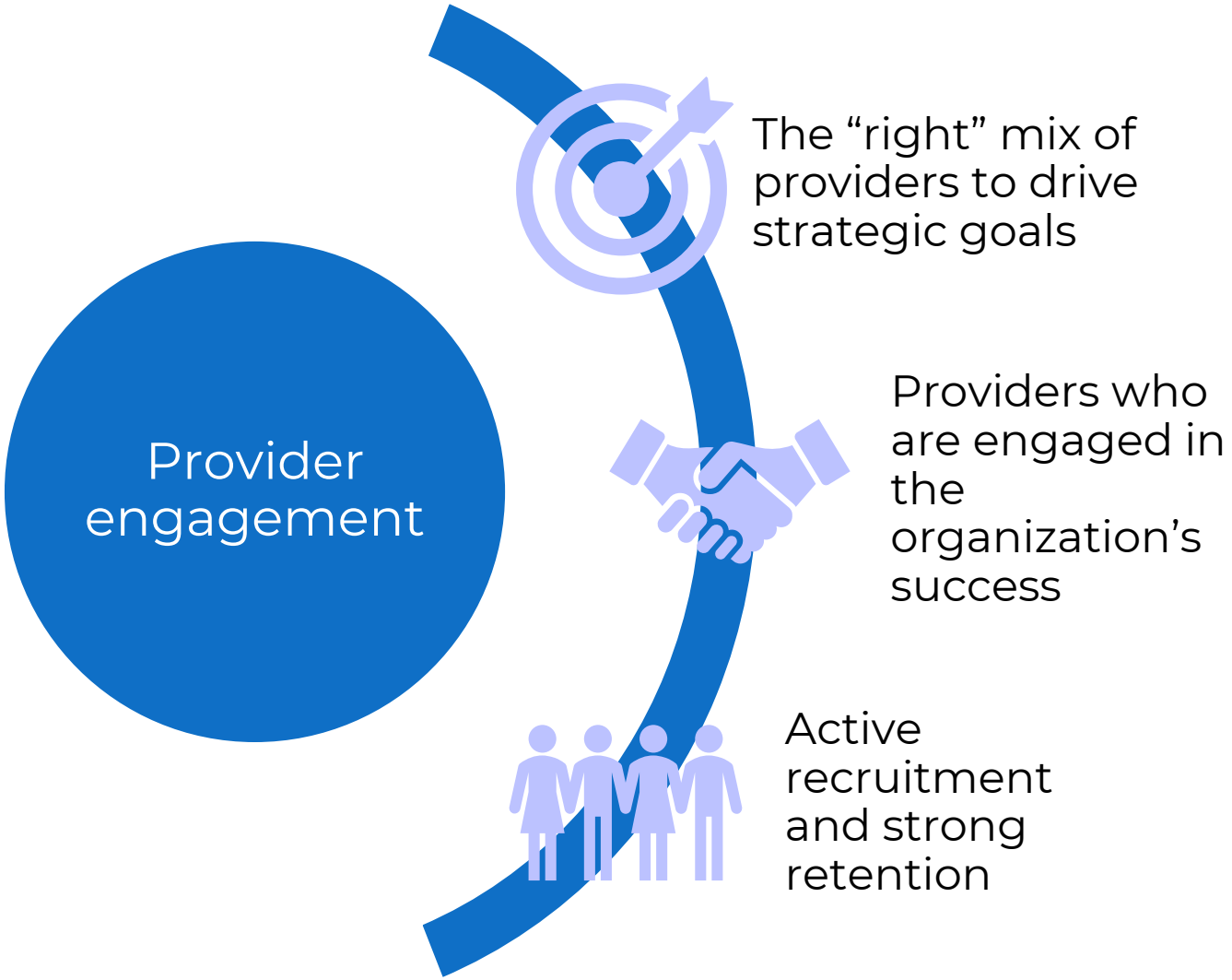


Rural Hsopital best practices – strategic alignment

When board, leadership, staff and providers are all marching in the same direction toward common goals

Rural Hospital best practices – provider engagement

Providers that are engaged in the hospital, the community, and patients' well being

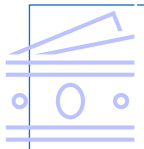


02

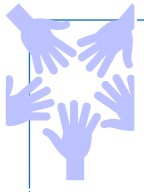
Building Blocks

What have we observed performing rural hospital turnaround projects this past year

Building blocks for hospital turnaround and return to profitability

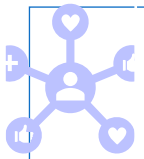


Market/Strategy



Staffing/productivity

Finance/Revenue Cycle



Leadership/Culture

Market/Strategy

Integrated primary care / provider engagement – are we capturing everything we can?

Convenient access to care – are we providing easy access for patients to interact with us?

Right mix of specialties – do we have the right mix of primary care and specialty care

Are we getting downstream referrals

Provider growth

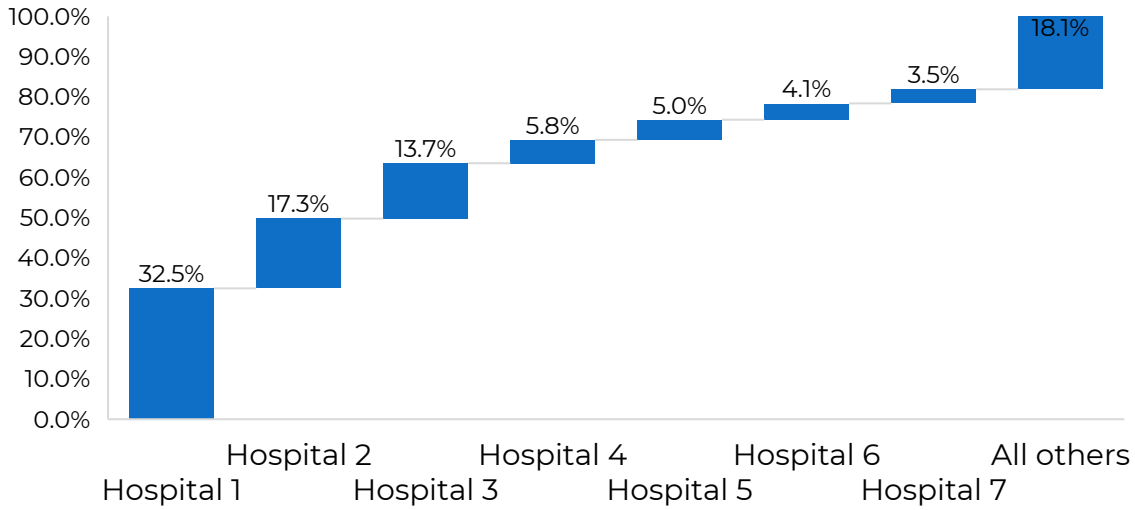
- Grow market share
- Inpatient and surgery growth
- Downstream ancillary volume growth

2030	PSA			SSA			Total		
	Supply	Demand	Variance	Supply	Demand	Variance	Supply	Demand	Variance
Primary Care									
Family Practice	3.6	2.1	1.5	40.8	20.1	20.7	44.4	22.2	22.2
Internal Medicine	0.0	1.7	(1.7)	5.0	16.7	(11.7)	5.0	18.4	(13.4)
Obstetrics/Gynecology	0.4	0.7	(0.3)	4.9	6.8	(1.9)	5.3	7.5	(2.2)
Pediatrics	0.0	0.9	(0.9)	6.9	8.5	(1.6)	6.9	9.4	(2.5)
Total	4.0	5.4	(1.4)	57.6	52.1	5.5	61.6	57.5	4.1
Medical Specialties									
Allergy/Immunology	0.0	0.1	(0.1)	0.0	0.7	(0.7)	0.0	0.8	(0.8)
Cardiology	0.0	0.4	(0.4)	1.0	3.4	(2.4)	1.0	3.8	(2.8)
Dermatology	0.0	0.2	(0.2)	0.0	1.9	(1.9)	0.0	2.1	(2.1)
Endocrinology	0.0	0.1	(0.1)	0.0	1.0	(1.0)	0.0	1.1	(1.1)
Gastroenterology	0.0	0.3	(0.3)	0.0	2.3	(2.3)	0.0	2.6	(2.6)
Hematology/Oncology	0.0	0.2	(0.2)	0.0	1.9	(1.9)	0.0	2.1	(2.1)
Infectious Disease	0.0	0.1	(0.1)	0.0	1.1	(1.1)	0.0	1.2	(1.2)
Nephrology	0.0	0.1	(0.1)	1.0	1.2	(0.2)	1.0	1.3	(0.3)
Neurology	0.0	0.2	(0.2)	1.0	1.7	(0.7)	1.0	1.9	(0.9)
Pulmonary Medicine	0.0	0.1	(0.1)	0.0	1.3	(1.3)	0.0	1.4	(1.4)
Rheumatology	0.0	0.1	(0.1)	0.0	0.7	(0.7)	0.0	0.8	(0.8)
Total	0.0	1.9	(1.9)	3.0	17.2	(14.2)	3.0	19.1	(16.1)
Surgical Specialties									
General Surgery	0.1	0.6	(0.5)	5.0	5.3	(0.3)	5.1	5.9	(0.8)
Cardio/Thoracic Surgery	0.0	0.1	(0.1)	0.0	0.8	(0.8)	0.0	0.9	(0.9)
Neurosurgery	0.0	0.1	(0.1)	0.1	0.8	(0.8)	0.1	0.9	(0.9)
Ophthalmology	0.0	0.3	(0.3)	1.0	3.2	(2.2)	1.0	3.5	(2.5)
Orthopedic Surgery	0.0	0.4	(0.4)	3.5	3.8	(0.3)	3.5	4.2	(0.7)
Otolaryngology	0.0	0.2	(0.2)	2.0	1.8	0.2	2.0	2.0	0.0
Plastic Surgery	0.0	0.1	(0.1)	0.0	1.1	(1.1)	0.0	1.2	(1.2)
Urology	0.0	0.2	(0.2)	2.0	1.9	0.1	2.0	2.1	(0.1)
Vascular Surgery	0.0	0.1	(0.1)	0.0	0.6	(0.6)	0.0	0.7	(0.7)
Total	0.1	2.1	(2.0)	13.6	19.3	(5.7)	13.7	21.4	(7.7)

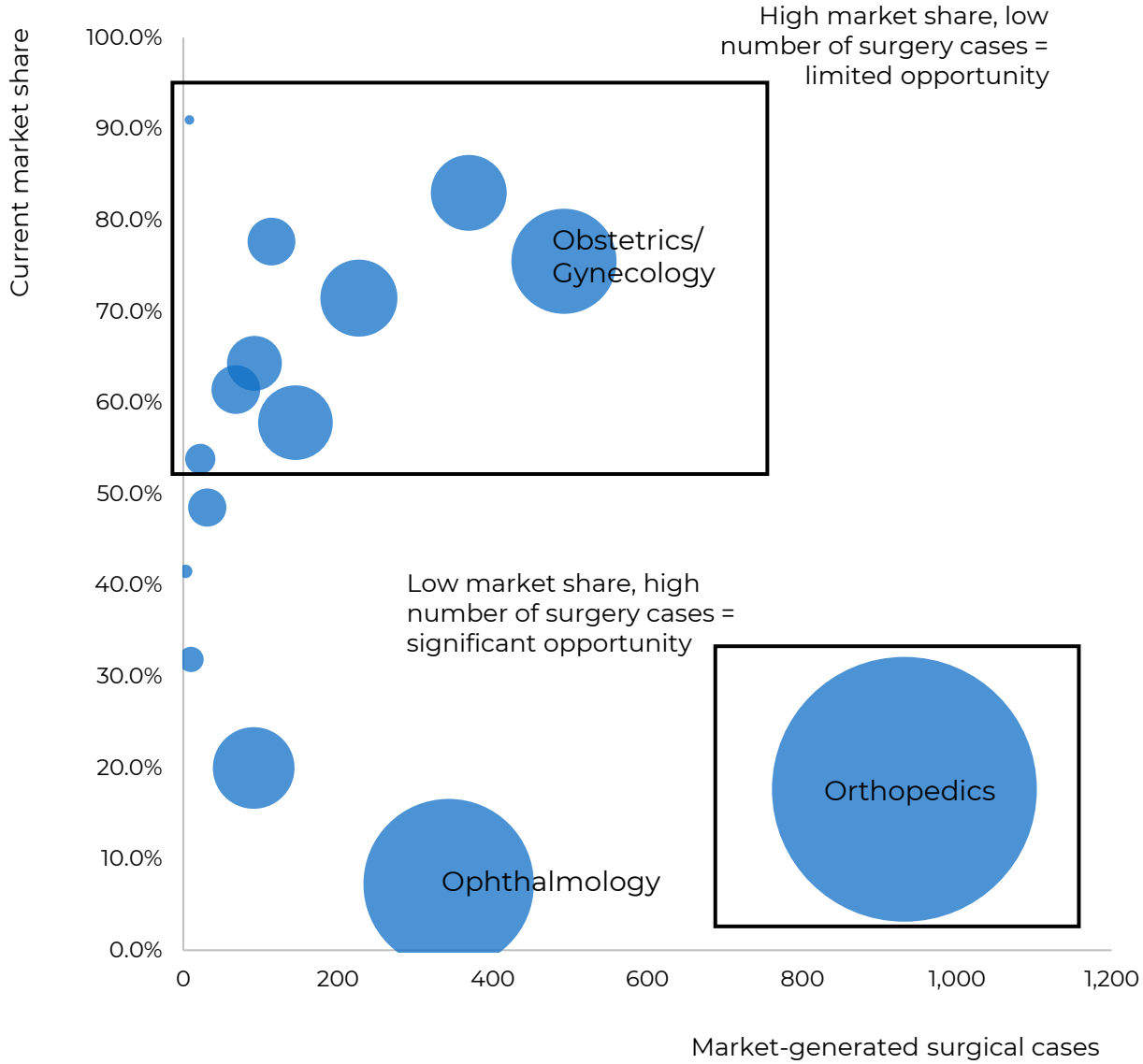
Market share analysis and growth opportunities

Analyze market share, influence of the hospital's competitors on the market today, and areas for targeted capture by service are, zip code, and/or service line

Inpatient market share trends



Service line opportunities

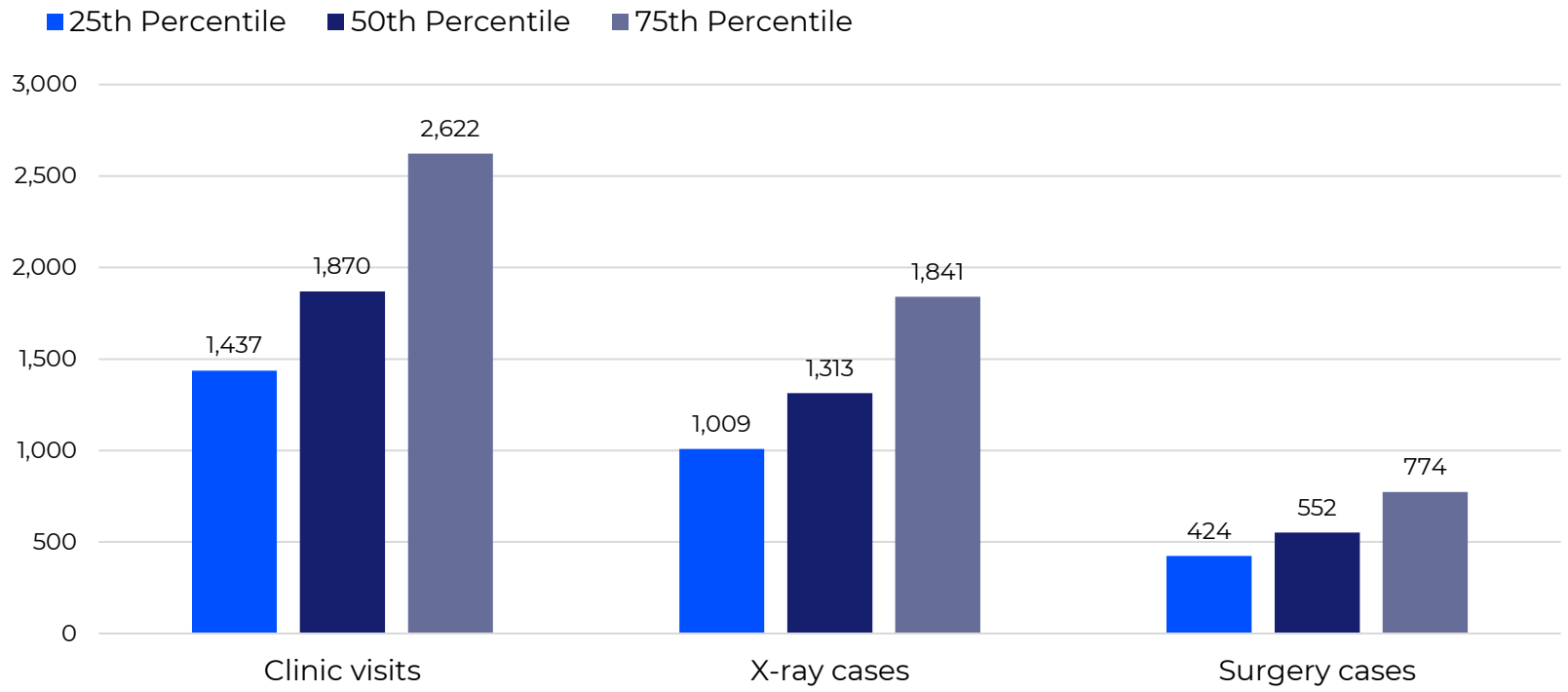


Determine impact of provider recruitments on volume

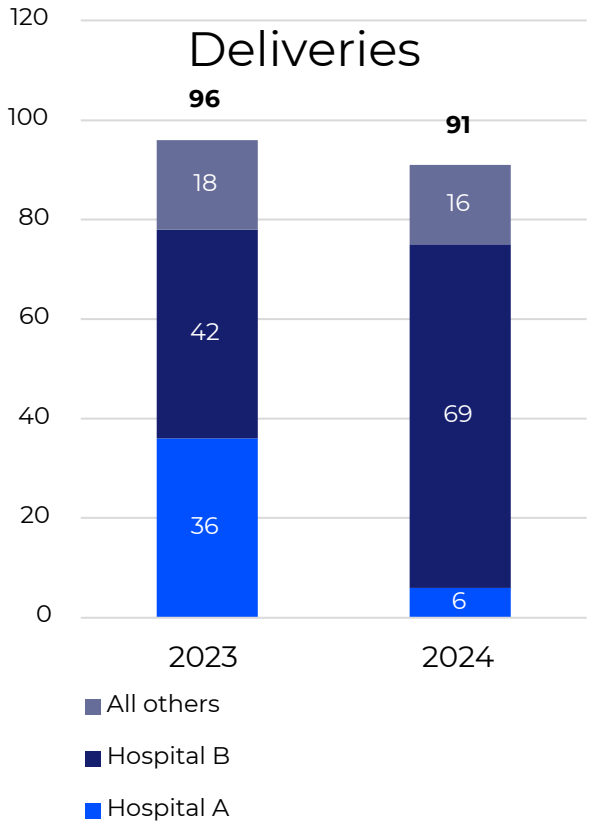
New providers generate more downstream referrals for ancillary services like lab, imaging, and surgery

Estimated impact of new 1.0 FTE orthopedic surgeon by productivity level

Sample based on productivity benchmarks from the Medical Group Management Association, 2021 data



Difficult Decisions – OB example



	2023
Deliveries	36
Total Expenses	(684,053)
MCD payments	258,323
Delivery Professional Payments	64,286
Overhead reallocation	(68,801)
DSH Payments	102,094
Estimated Loss on Labor & Delivery	$ (328,152)

Difficult decisions – Elimination of LTC and conversion to Swing Bed example

- Components of LTC Swing Bed conversion:
  - Operational Savings of both direct and indirect expenses
  - Additional capital costs reimbursed at a higher cost reimbursed rate
  - Infusion of overhead costs to CAH departments
  - Reduction in LTC revenue (reduced days)

		2025
Operational Changes		
Reduced Overhead Expense	$	(1,120,000)
Swing Bed Direct Expense		1,298,000
Reduced Direct LTC Expenes		(2,794,000)
Additional Capital Costs		4,418,000
Reduced LTC Revenue		(2,500,000)
	$	(698,000)
Anticipated CAH Cost Based Reimbursement Increase	$	3,495,000
Change in Net Income	$	2,797,000

Staffing/Productivity

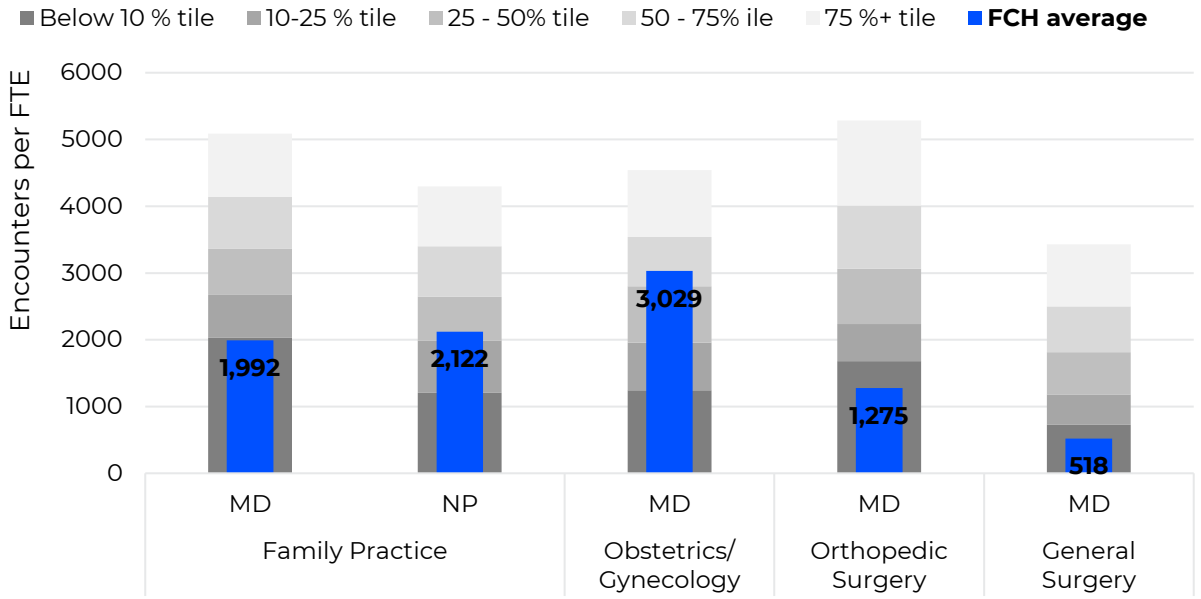
Are we tracking provider productivity?

Do we have benchmarking for staffing clinical and non-clinical departments?

How are we handling ER and hospitalist coverage?

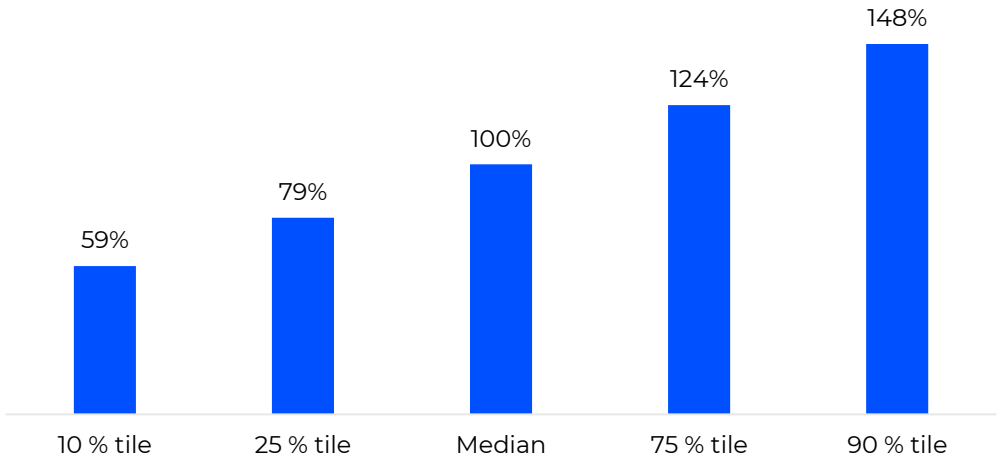
Productivity considerably impacts access; This can limit growth and also leads to RHC productivity exception ramifications

Provider benchmarking analysis



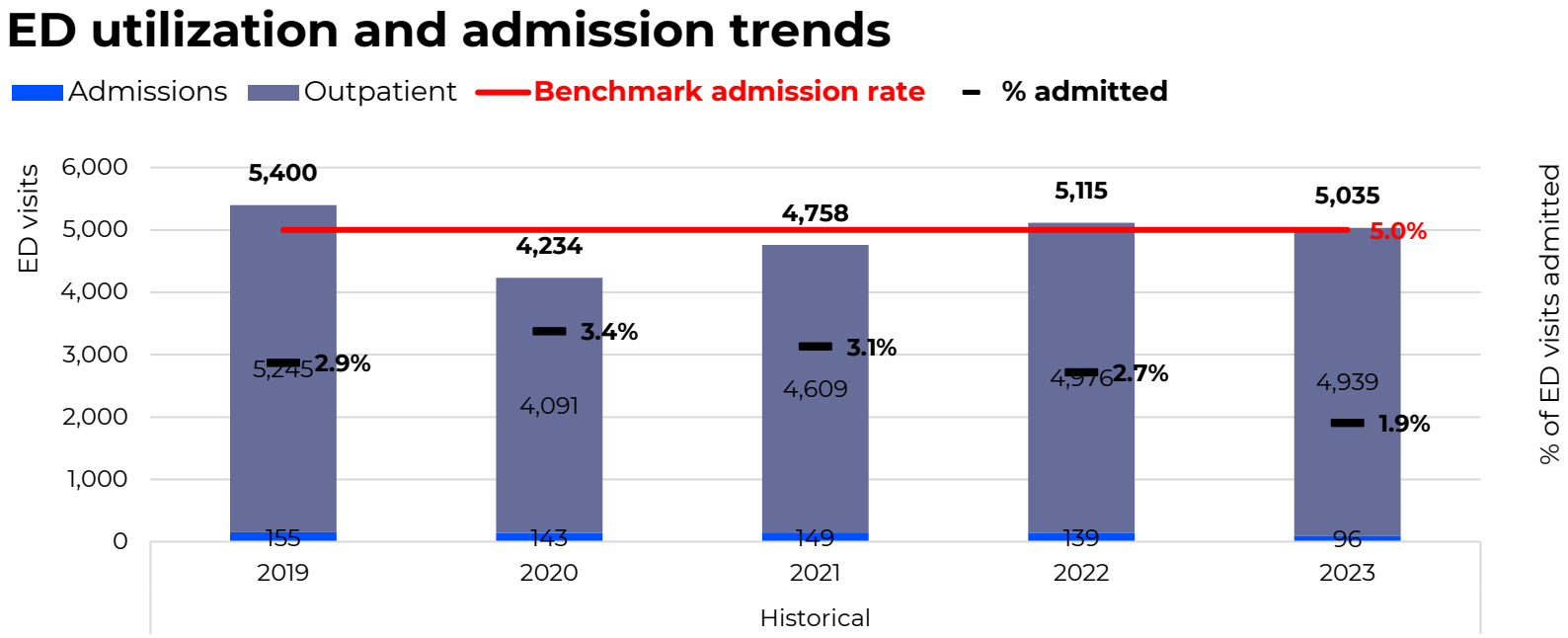
Benchmarking example: family practice

Demonstrates percentage of median productivity encounters realized at each productivity level e.g. a provider operating at 10th percentile productivity sees 59% of the encounters seen by a provider operating at median productivity

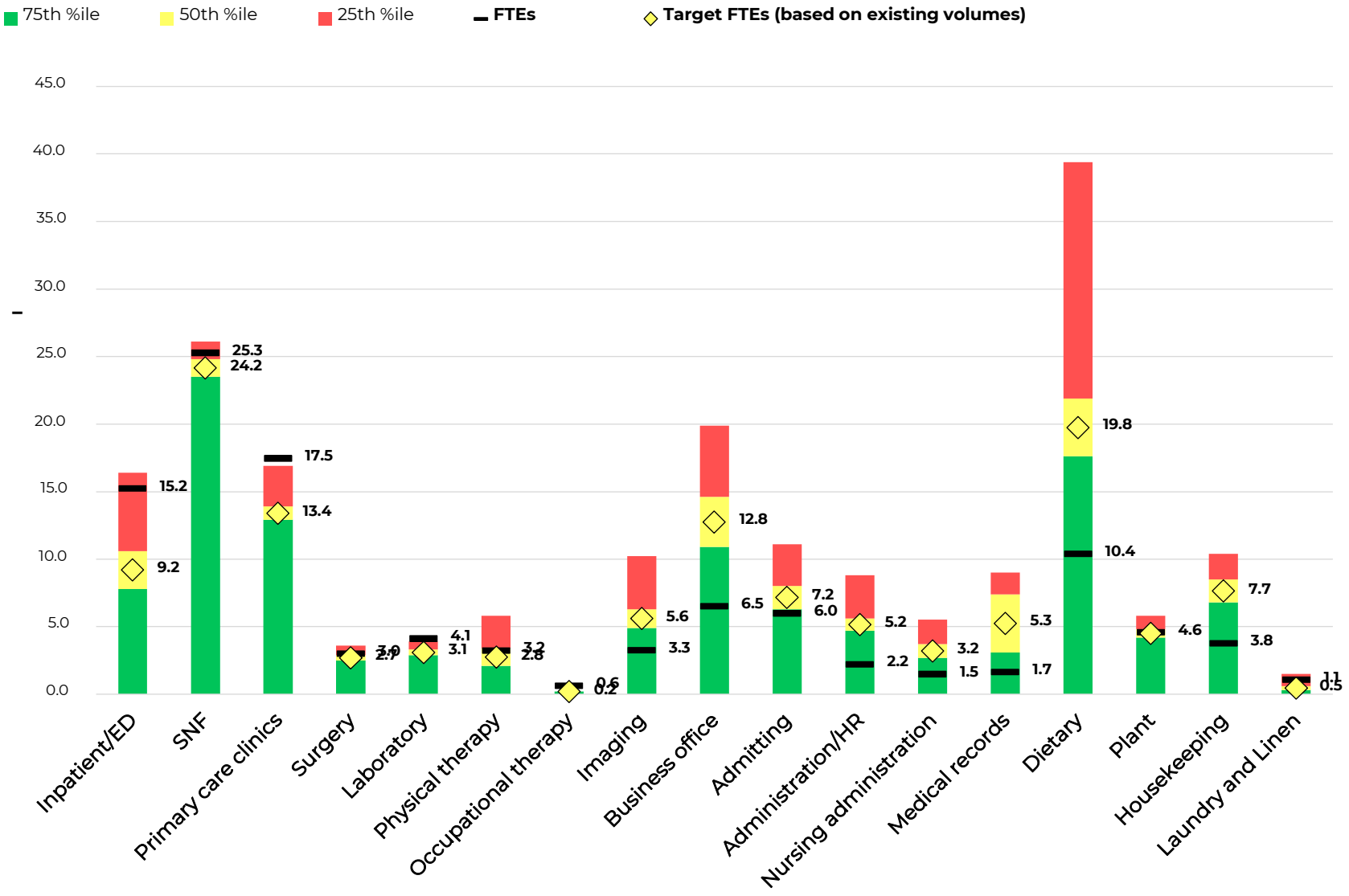


Source: MGMA

ED/Hospitalist coverage can have significant impact on admission and volume trends



Staffing can be considered if it is way out of line from peers



Finance/Revenue Cycle

Understanding our payers. Can we even find our contracts?

Coding/billing staff. Huge turnover, check the pulse

Benchmarking key stats… denials, days in AR, etc.

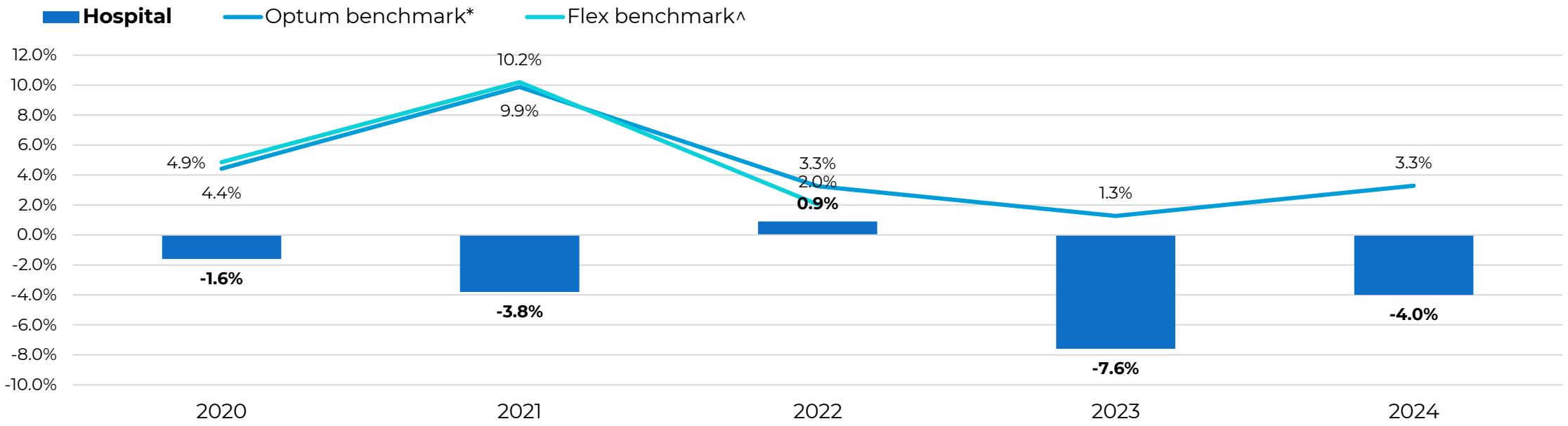
Taking advantage of programs… cost report, Rural Health Clinic, 340b, swing bed

Operating margin

Measures income (loss) from operations as a percentage of total operating revenue

- Can you get to breakeven operating margin?

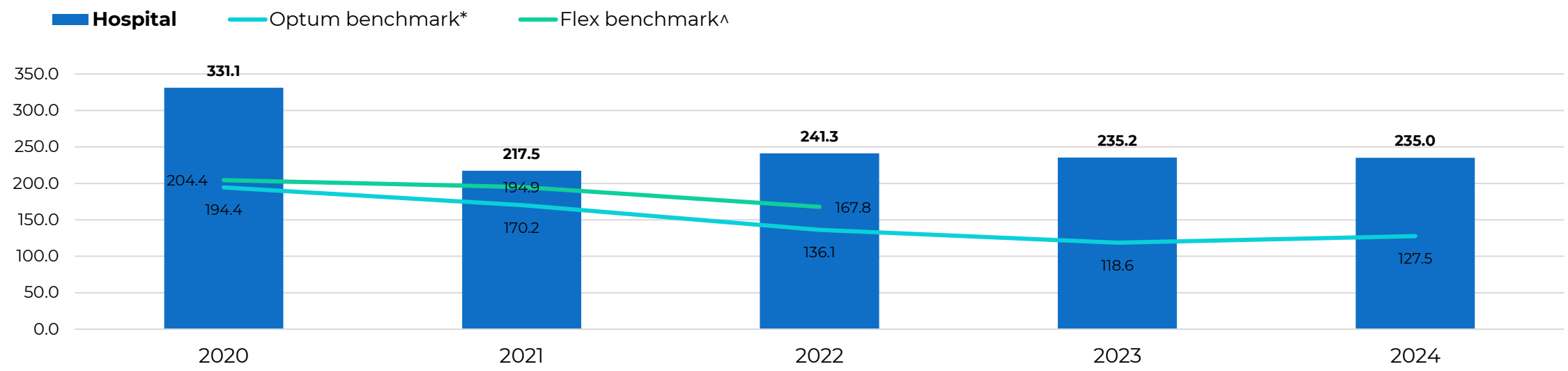
Operating margin



Days cash on hand

Measures the number of days of average cash expenses that the entity maintains in cash

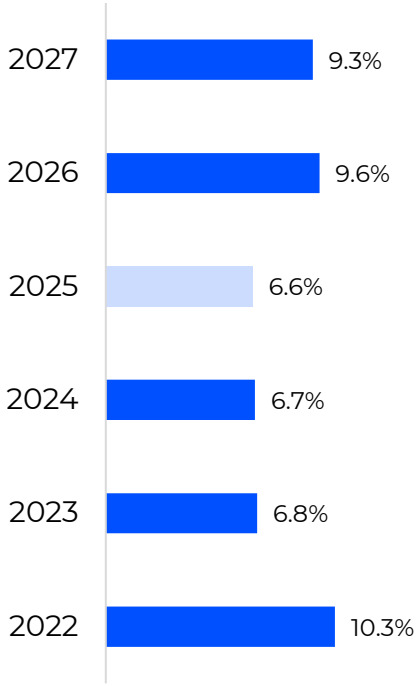
Days cash on hand



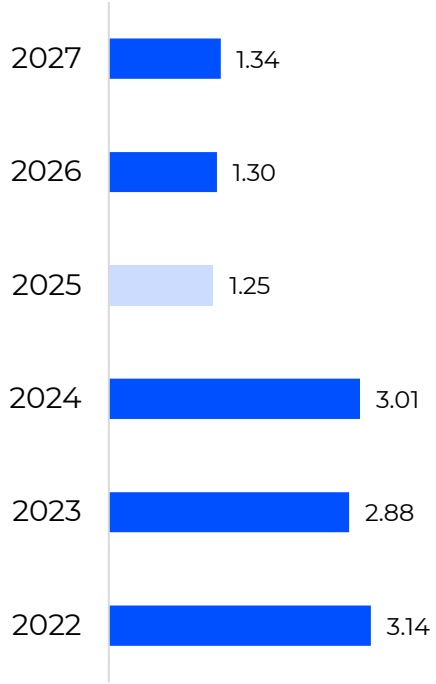
When thinking about investing in a campus or facility, financial feasibility is an essential part of the planning process

Forecast the debt capacity that can be undertaken by the entity and its impact on cash flow and key financial ratios

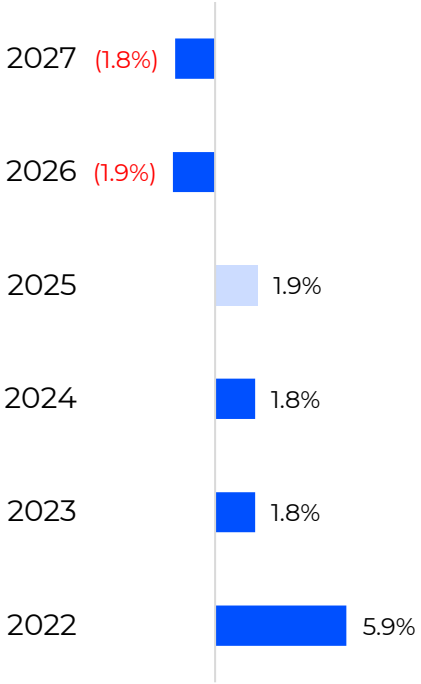
EBIDA ratio



Debt service coverage



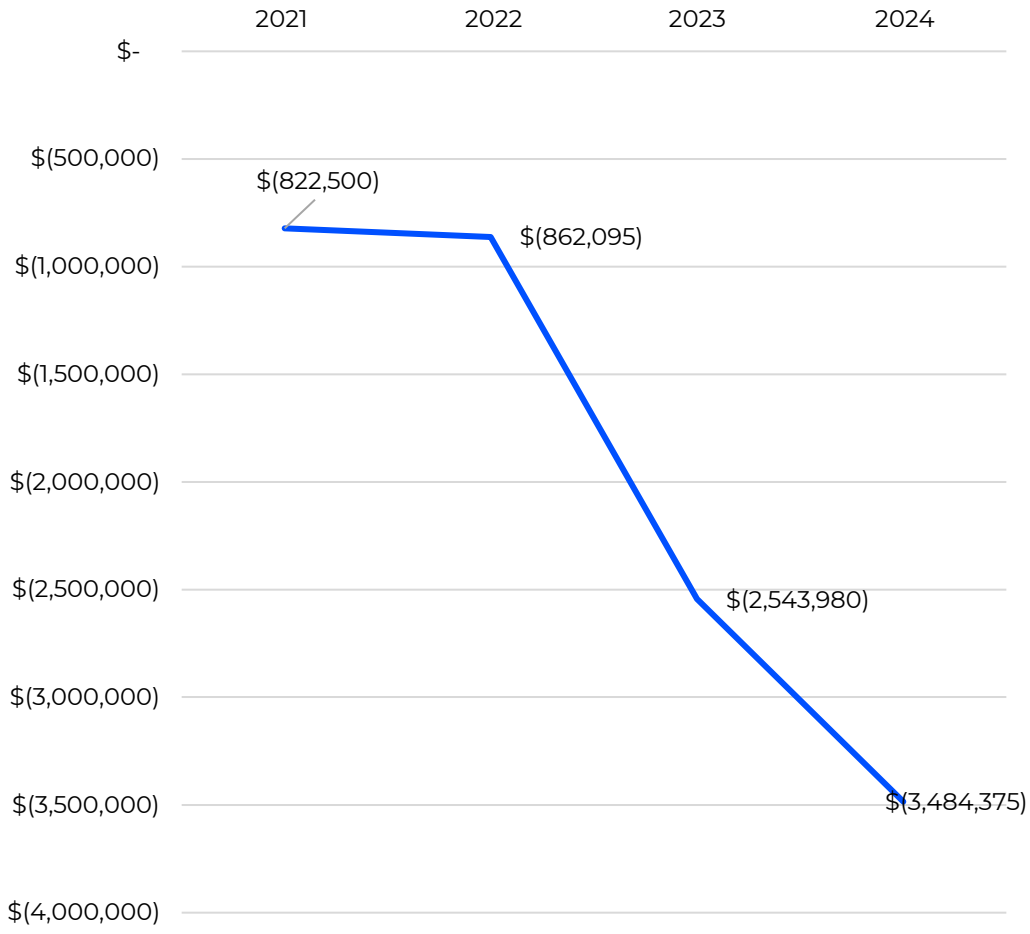
Operating margin



Massive wave of billing staff turnover at rural hospitals

- High turnover, lack of local staff with revenue cycle training
- Lack of metrics, education, monitoring

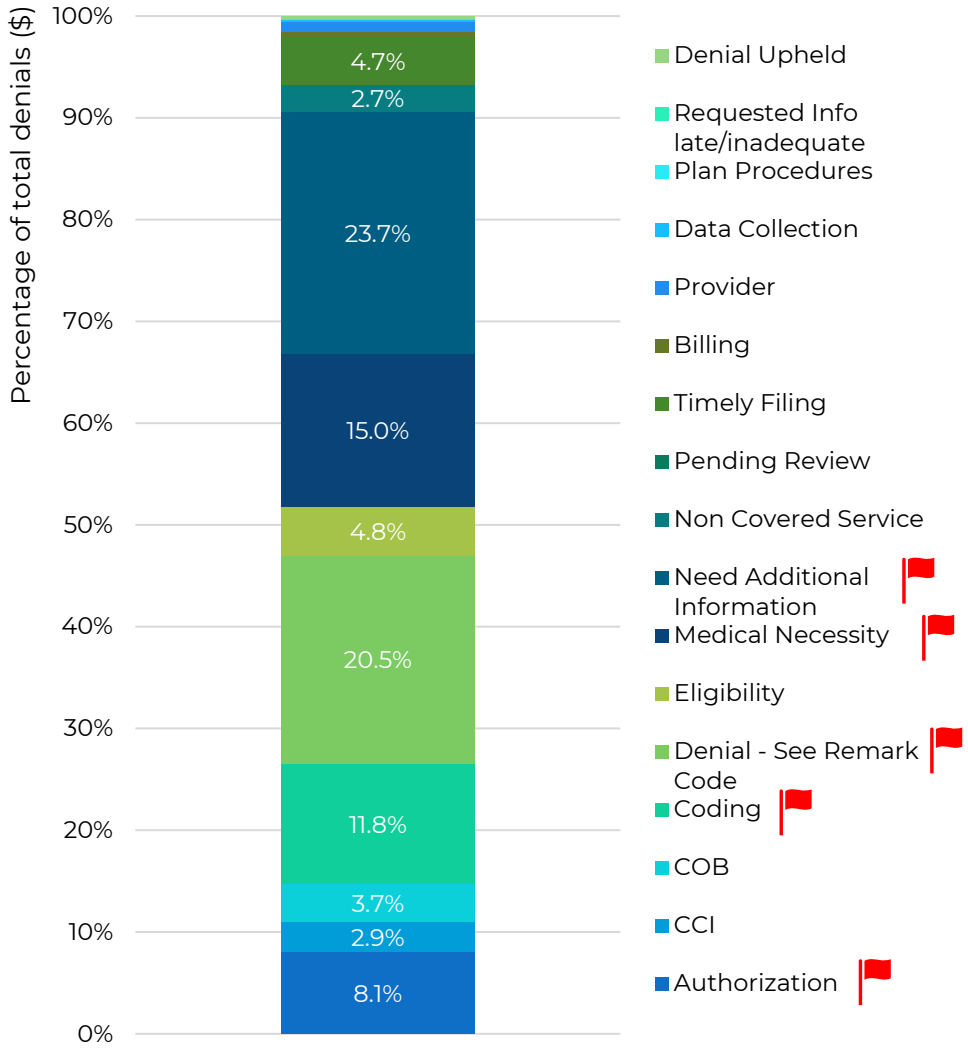
Historical allowance for bad debts



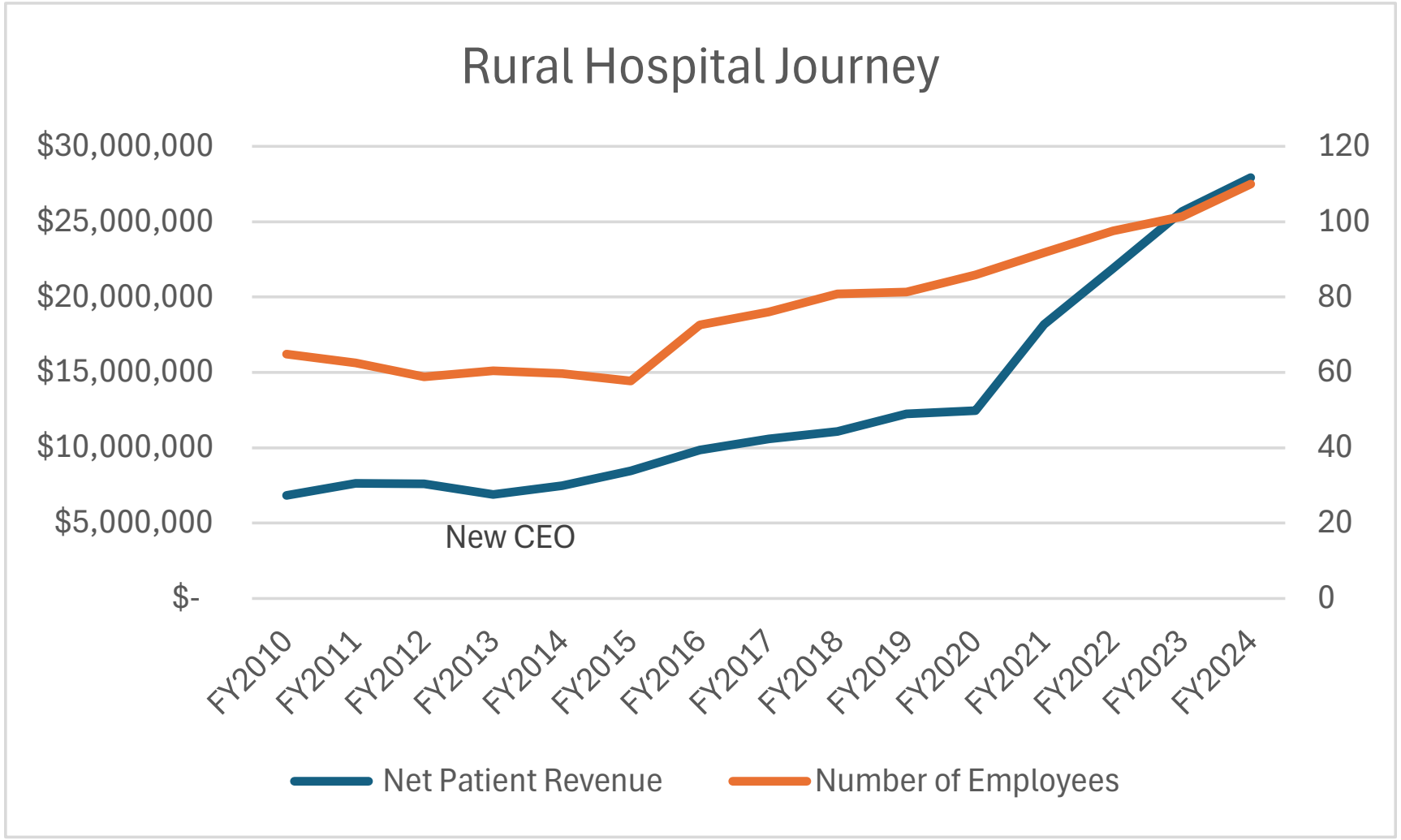
Revenue cycle (denials)

- Findings
  - Often we find numerous process issues across all stages of the revenue cycle, resulting in significant amount of denials
    - **Can lead to numerous “workarounds” which negatively impact charge capture, coding, and billing, resulting in higher denials**

Reasons for hospital claim denial, all payers



Leadership and Culture – A Rural hospital journey




Thank you!

Your healthcare planning team

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