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RHS RURAL HEALTH SOLUTIONS Enabling care close to home

Reversing the Great Outmigration and Increasing RHC Reimbursement

Critical Access Hospital Care Coordination Health Strategies – Where Are the Opportunities?

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RHS | RURAL HEALTH SOLUTIONS

- **Physician-Led Hospital and Clinic Operations, Staffing and Revenue Cycle Company Dedicated to Rural Hospitals**

- **Mission**: To increase hospital financial viability and reverse Rural Hospital Outmigration through introduction of:
  - Impactful patient recruitment programs
  - Augmented prevention and wellness programs
  - Integrated care coordination initiatives
  - New inpatient surgical capabilities
  - New outpatient service capabilities
  - New quality programs linked to revenue and growth
  - Revenue cycle and cost management programs
  - Provider and nurse staffing

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Overview

Reversing the Great Outmigration and Increasing RHC Reimbursement | Critical Access Hospital Care Coordination Health Strategies – Where Are the Opportunities?

May 19, 2022

1. Where We Are Today
2. Outmigration - Scope of the Challenge
3. Care Coordination Programs
4. Using Care Coordination to Reverse Outmigration
5. Financial Impact of Care Coordination
6. How to Implement

Challenges Facing Rural Hospitals Are Real

Demographics of CAHs

- 50% of rural hospitals have < 25 inpatient/swing beds
- 90% of CAHs have average daily census of < 5 inpatients
- >50% of CAH net revenue comes from government payors

Financial Performance

- 50 CAHs have net revenue < $5MM/year
- >40% of CAHs have negative operating margin
- Average rural hospital Medicare margins are negative 7.4%
- 60% of hospital closures in the last 5 years were rural

What We Have Learned

Lessons from Rural Hospital Communities Show Significant Opportunity to Grow

Rural hospitals have significant opportunity to increase services to their communities and stop outmigration

With CMS waivers continuing, rural hospitals can add significant number of service line additions with relatively small investments

Opportunities in most organizations to double outpatient volumes within 6 months of decision to start an integrated growth strategy

“Superior care is the best strategy for a financially successful health system”

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Outmigration Assessment Methodologies

Outmigration Lessons Learned

- Specialty – decreasing to tertiary with increase in competing smaller hospitals as they develop capabilities
- Primary Care Analysis – 20 rural hospitals assessed for outmigration over last 7 years
  - All had > 50% loss
  - 25% had > 75% loss
  - Much of loss was to competing smaller hospitals
- Key Lessons
  - Not losing patients just to tertiary facilities
  - Local competing hospitals are not standing still

Outmigration Analysis Report

- Evaluation of primary and secondary service areas for 5-7-year trends to identify where your service area zip codes are receiving their care and how much that has changed during study are by specialty service lines and by high revenue procedures and care.

- Identify case mix and payor mix by zip code of outmigration by diagnosis and procedure categories for those who receive their care elsewhere.
  - What is the payor mix for the outmigration compared to your current mix
  - Which hospitals are receiving which type of medical and surgical specialty care
  - Create procedure lists by estimated net revenue to project largest financial opportunity if they remained in market
  - Identify which procedures have the highest new income to focus new service lines

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Care Coordination Activities

Care Coordination Overview

Providing care coordination, particularly for chronic illness management and transitional care, is a priority in the healthcare reform movement and the most significant change in ambulatory care.

Care coordination is the deliberate planning of patient care activities and sharing information to offer patients safer and more effective care. This implies that the patient's needs, and preferences are known ahead of time and communicated to the appropriate individuals at the appropriate time. This information is used to provide the patient with safe, appropriate, and effective treatment. If care coordination is successful, it will increase the quality of care while reducing the cost of care.

Common themes that dominate effective care coordination include:

- High risk patient populations are targeted
- Increased intentional and focused communications between patients and providers
- Coach providers to adoption of new workflows and areas which care is not consistent with evidence-based guidelines
- Monitor patients' symptoms and physiologic parameters more closely and frequently
- Ensure that patient continues to follow up in their care

The high-risk/high-cost patients can be assigned to active care coordination while the moderate to low risk patients can be assigned to passive care coordination.

Active Care Coordination consists of assigning responsibility to manage the care of a patient through the PCP-defined care plans, standing order sets, and remote monitoring.

Passive care coordination is accomplished through passive interaction with patients to include addressing gaps in care and monitoring for events that would increase their risk score.

All Medicare Innovation Programs (CCM, CoCM, RPM, RTM) have specific intervention timing, quality indicators, documentation and billing requirements. The ability to track quality and compliance is critical to hospital's success in these programs

Annual Wellness Visits (AWV)

- IPPE (Intro to Medicare)initial introduction to Medicare requires visual acuity and EKG and therefore needs to be done onsite. AWVs do not require onsite presence.
- Service provided for all Medicare patients once/12 months without copay requirement. Not a physical exam. Does not require to be done by patient's regular provider.
- Telehealth AWV components include:
  - Patient-completed Health Risk Assessment,
  - Family History, Current Medications and Providers,
  - Risk Screening Assessment for cognition, depression, substance abuse, alcohol misuse, and evaluation of functional status and fall risk
  - Written screening schedule for colorectal and lung cancer, mammography, Pap screening, bone density testing, Abdominal Aortic Aneurysm screening ultrasound, prostate cancer screening, Hepatitis C and HIV, Influenza, Pneumococcal and Hep B vaccinations
  - Personalized advice with Identification of risk factors and conditions that require intervention with treatment options
  - Refer patient for specialist disease management, case management, health education, counseling for tobacco cessation, nutrition, weight loss and fall prevention, or behavioral health evaluation
- Perform additional needed preventive services or screening:
  - Cardiovascular screening blood tests
  - Screening and Behavioral Counseling Interventions (Cardiovascular Disease, Obesity)
  - Vaccine administration
  - Diabetes Screening Tests
  - Advanced Care Planning
- E/M codes can be billed with -25 modifier if active disease management necessary on day of service.
- Clinic Referral for breast/pelvic/prostrate exam, visual acuity and certain counseling if needed.
- Enrollment for Chronic Care Management, Remote Patient Monitoring, Remote Therapeutic Monitoring, and Behavioral Health/Collaborative Care Programs can be done during this visit.

More Billing Information: https://www.youtube.com/watch?v=Yz_uLHvFrHo

Chronic Care Management (CCM)

- Chronic disease represents 90% of the nation's $3.8 trillion in annual health care expenditures, with ¼ of population with chronic and mental health conditions responsible for two-thirds of healthcare costs. Managing patients' healthcare costs is critical to success in value-based models.
- CCM services may be furnished to Medicare patients with two or more chronic conditions who are significant risk of acute exacerbation/ decompensation or functional decline.
- CCM is a time-measured, non-face-to-face service that clinical staff furnish to patients under direction of the billing practitioner. It improve both patient and caregiver engagement through patient receives timely recommended preventive care services with prompt sharing of patient health information.
- Provider needs to create a comprehensive care plan that includes assessment of patient's medical, functional and psychosocial needs, review of medications for any potential interactions, expected outcomes and prognosis, measurable treatment goal, symptom management, planned interventions, medication management, caregiver assessment, requirements for periodic review, and when applicable, revision of care plan.
- Patient must be able to communicate with their practitioners about their care by phone 24/7 and through secure messaging, secure web, or other asynchronous non-face-to-face consultation methods (like email or secure electronic patient portal).
- Offers monthly reimbursement to care providers for the support regularly provided to patients between visits. Services involves continuous patient relationship with chosen care team member and may be billed if at least 20 minutes of care coordination has been provided/month.
- Initiating Visit begins with AWV or face-to-face meeting before beginning CCM. Patient must give written consent, including 20% co-payment ($8/month) requirement for some services and right to stop CCM on a monthly basis. RHCs/FQHCs use G0511 for CCM, BHI, and PCM. Can bill TCM at same time. Only 1 provider can bill for CCM.

More Billing Information: https://www.youtube.com/watch?v=DwpZZaePwJw&list=PLsE-pNAtllKjtsgFRgVPan4mCBv4MtwjH

Principle Care Management (PCM)

Introduced in 2020, designed for specialty providers to provide care to patient outside of physical appointments who have single, high-risk chronic condition lasting > 3 months, placing patient at risk for hospitalization, or caused recent hospitalization. These conditions generally require development or revision of disease-specific care plan and is designed to decrease hospitalizations.

It is of such complexity that it cannot be managed effectively by primary care and requires management by another, more specialized practitioner. Primary Care MD still supervises the patient's overall care. Patient can receive multiple specialists at the same time.

Candidates require frequent medication or increased care management due to complexity of illness, including vital sign tracking, medication adjustment, management of communication/transitions with other providers, and higher level of management. May have had recent hospitalization and patient at risk for decompensation.

Require an initiating, face-to-face visit, consent to enroll, and 30 up to 60 minutes of non-face-to-face service/month. Patient must give written consent, including acknowledging co-payment requirement for some services and the right to stop CCM on a monthly basis.

More Billing Information for Codes - 99424-99427

https://www.youtube.com/watch?v=6YKT0h2PVRg&list=PLsE-pNAtllKjtsgFRgVPan4mCBv4MtwjH&index=3

Remote Physiologic Monitoring (RPM)

Remote patient monitoring is one of the most effective ways to manage chronic diseases, including like diabetes, heart failure, obesity, COPD, hypertension, and chronic kidney disease, and, most recently, acute diseases.

RPM has been shown to enable early detection of clinical deterioration and to reduce ED visits, hospitalizations, hospital readmission rates and overall medical costs. RPM has been shown to improve adherence to medical treatment plan.

Common devices include self-measure BP monitoring, pulse oximeter, EKG/Stethoscope, glucometer, weight scale, thermometer, spirometer, continuous glucose monitoring. Patient can be given up to 3 devices.

RPM involves the asynchronous collection and later analysis by auxiliary personnel under the general supervision of the billing practitioner of patient physiologic data that are used to develop and manage a treatment plan related to either an acute or chronic condition.

Specific FDA-approved automated equipment, such as those capable of wirelessly syncing and uploading data points to the patient portal, is required. Equipment allows physicians to receive notifications if any high-risk readings are identified, allowing them to take proactive measures to handle the situation before it becomes worse.

Billing Information and Requirements:

- Requires an established evaluation prior to prescribing the service after PHE expires. Exam could be done via telehealth.
- Requires data from devices to be collected and transmitted electronically to bill (data cannot be self-reported)
- Requires monthly 20 minutes of 'interactive communication" including synchronous patient communication, time in review, analysis, interpretation, development of treatment plan and treatment management
- Can bill RPM with Chronic Care Management, Transitional Care Management, and Behavioral Health Management services
- Remote physiologic monitoring data must be collected for at least 16 days out of 30 days.
- More billing information:

More Billing Information:
https://www.youtube.com/watch?v=H7QZGIF3kqM&list=PLsE-pNAtllKjtsgFRgVPan4mCBv4MtwjH&index=4

Remote Therapeutic Monitoring (RTM)

- RTM will enable practices to expand the conditions eligible for remote monitoring, including pain, musculoskeletal and respiratory systems, and therapy adherence and response. RTM codes acknowledge the importance of therapeutic response to treatment in addition to receipt of physiologic data.
- RTM improves remote monitoring coverage by including monitoring for non-physiological data, allowing inclusion of self-reported therapeutic data, and use of an online platform that is shared with the provider.
- Monitoring and improving medication adherence is recognized as one of lowest hanging fruit in all of healthcare when it comes to improving patient outcomes.
- RTM also expands who can order and deliver those services. RPM codes are evaluation and management (E/M) services, whereas the RTM codes are general medicine codes, which allows a broader range of providers to order and bill for RTM. Ordering providers can include physical therapists, occupational therapists, dietitians, clinical psychologists. Physician or non-physician practitioner supervision is not needed. However, work associated with recording, reviewing data may be done by clinical staff under direct supervision..
- Providers can leverage these codes to monitor and support patients' medication adherence and response to those medications. With US medication adherence for chronic condition estimated to be only 50 percent and with 125,000 deaths a year driven by medication nonadherence, providers using RTM will better understand if a patient's regimen needs to be adjusted or if other behavioral or social support is needed to help the patient be successful.
- RTM codes promise greater use cases and applications in patient care. Patient self-reported data is a major reason why RTM is likely to increase engagement among a wide range of individuals. RTM code usage could be one of the most important approved services in the providers toolkit.

Transitional Care Management (TCM)

TCM prepares high-risk hospitalized patients for successful transition for health care professionals taking responsibility for patient's care that follow patients for a limited, intense period after discharge with focus on teaching and coaching patients about their medications, self-care, symptom recognition, and management. The focus reminds, encourages, and assists patients to attend follow-up appointments with their primary care providers

Target audience includes moderate or high complexity medical decision making for patients who have medical or psychosocial problems

The 30-day TCM period begins on a patient's inpatient discharge or hospital observation discharge date and continues for the next 29 days for the patient's return to their community setting (Home, SNF, ALF, etc.). TCM does not have to be provided by the primary care physician.

TCM Components:

- Interactive Phone Contact - within 3 days of discharge - by provider or clinical staff to address patient status and complete medication reconciliation.
- Face to Face visit can be also provided via telehealth– within 7 or 14 days – Required to be able to bill for services. Components include:
  - Review discharge information (for example, discharge summary or continuity-of-care documents)
  - Review the patient's need for, or follow-up on, pending diagnostic tests and treatments
  - Interact with other health care professionals who may assume or reassume care of the patient's system-specific problems
  - Educate the patient, family, guardian, or caregiver
  - Demonstrate the complexity of decision making as moderate to high.
  - Establish or re-establish referrals and arrange needed community resources
  - Help schedule required community providers and services follow-up
- TCM codes are care management codes. As care management codes, auxiliary personnel may provide the non-face-to-face services of TCM under the general supervision of the physician or APP
- Case Managers and others can communicate with the patient, agencies and community service providers that the patient uses, educate the patient, family, guardian, or caregiver to support self-management, independent living, and activities of daily living, assess and support treatment adherence including medication management, identify available community and health resources, and help the patient and family access needed care and services

RHCs/FQHCs can now bill for CCM and TCM at the same time. Providers who are billing for a 90-day global surgery period cannot bill TCM. More billing information: https://www.youtube.com/watch?v=H7QZGIF3kqM&list=PLsE-pNAtllKjtsgFRgVPan4mCBv4MtwjH&index=4

Behavioral Health Integration

- Integrating behavioral health care with primary care (behavioral health integration or BHI) is an effective strategy for improving outcomes for millions of Americans with mental or behavioral health conditions.
- CMS has improved payment for care management services by expanding the suite of codes describing care management services. New codes for behavioral services include direct and non-client facing services, address specific patient conditions, and cover timed services for both single encounter and monthly services..
- BHI is a type of behavioral care management service that is not the CoCM model (may have neither a behavioral care manager nor a psychiatric consultant) and is managed by primary care physician. Can by used with CCM but activity work time cannot be used for both.
- Must have 1 eligible conditions are mental, behavioral health, or psychiatric conditions or evidence of substance use disorders.
- BHI services require an initiating visit to begin the patient's relationship with the billing provider and ensure the patient has been assessed prior to BHI services request. Requires 20 minutes of non-face-to-face services
- Psychiatric consultants and other team members of the care team are allowed to provide certain services remotely for BHI codes , Clinical staff can use qualified contractors for behavioral health care manager or psychiatric consultant
- Bill 99484 - monthly services delivered using BHI model of care. Care components can include service elements such as assessment and monitoring, coordination of behavior, health treatment care plan revisions for patients whose condition is not improving and continuing relationship with appointed care team member. Practitioner is typically a primary care provider.
- More information on Billing Rules: https://www.youtube.com/watch?v=HNi7_UZumXw

Behavioral Health Integration – Collaborative Care Management (CoCM)

- Collaborative Care Management is a form of BHI which includes the primary care team and care management support for patients receiving behavioral health treatment as well as regular psychiatric inter-specialty consultation who is qualified to prescribe the full range of behavioral medications.

- Patient populations can include behavioral health medication usage, antidepressant usage or opioid utilization> 6 months , antipsychotic medication management, schizophrenia medication adherence, or follow up from behavioral treatment, psychiatric hospitalization, residential treatment, or detoxification program. ED Visit surveillance can also include mental illness, alcohol abuse, or drug use. Patient may have other comorbid, chronic or other medical conditions, but they are not required.

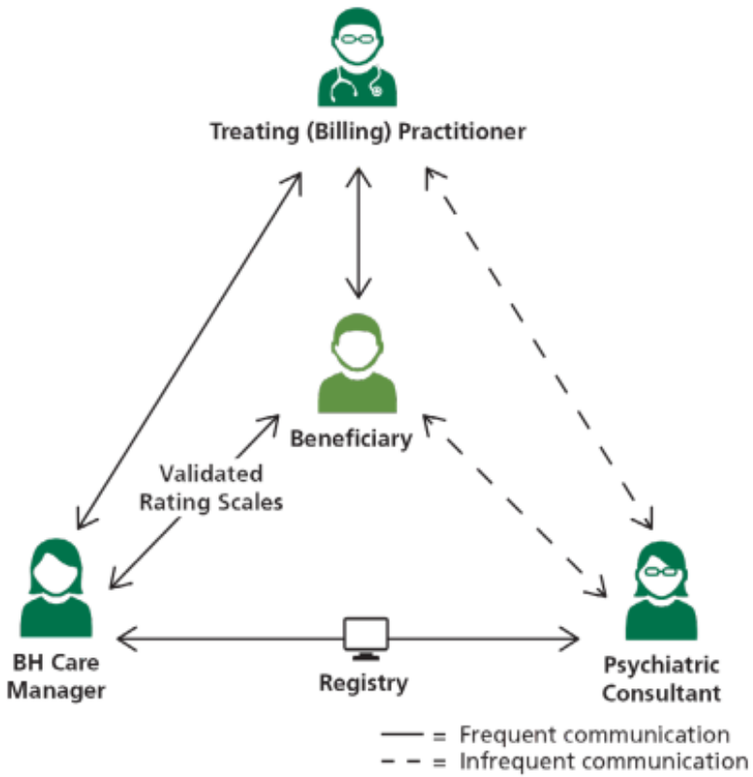
- Primary Care Team performs initial assessment with a validated rating scale

- Primary Care Team and behavioral health care manager develop care plan including pharmacotherapy, psychotherapy, or other indicated treatments.

- Care Management Support member develops CoCM patient registry

- Care Manager and Psychiatrist review cases weekly to review high-risk patient population, including those not improving or worsening and team decides to adjust treatment or refer to behavioral health resources for therapy.

- Time requirements are minimum 70 minutes for initial care and 60 minutes for monthly care thereafter. Codes - 99492, 99493, and 99494



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Implementation Program to Reverse Outmigration

Rural Hospital Financial Opportunities

Rapidly reverse outmigration and increase financial viability of rural hospitals by increasing local care delivery model capability.

Care Coordination/Wellness

- Develop robust health wellness recruitment campaigns aimed at Primary and Secondary Service Areas
- Increase Annual Wellness Visits
- Increase Prevention and Wellness Services
- Increase Principal and Chronic Care Management
- Develop Remote Patient Monitoring, and Remote Therapeutic Monitoring
- Increase Behavioral Health and Collaborative Care Management
- Decrease patient transfers of lower acuity patients
- Actively manage all external transfers back to Hospital/RHC

Efficiency and Quality

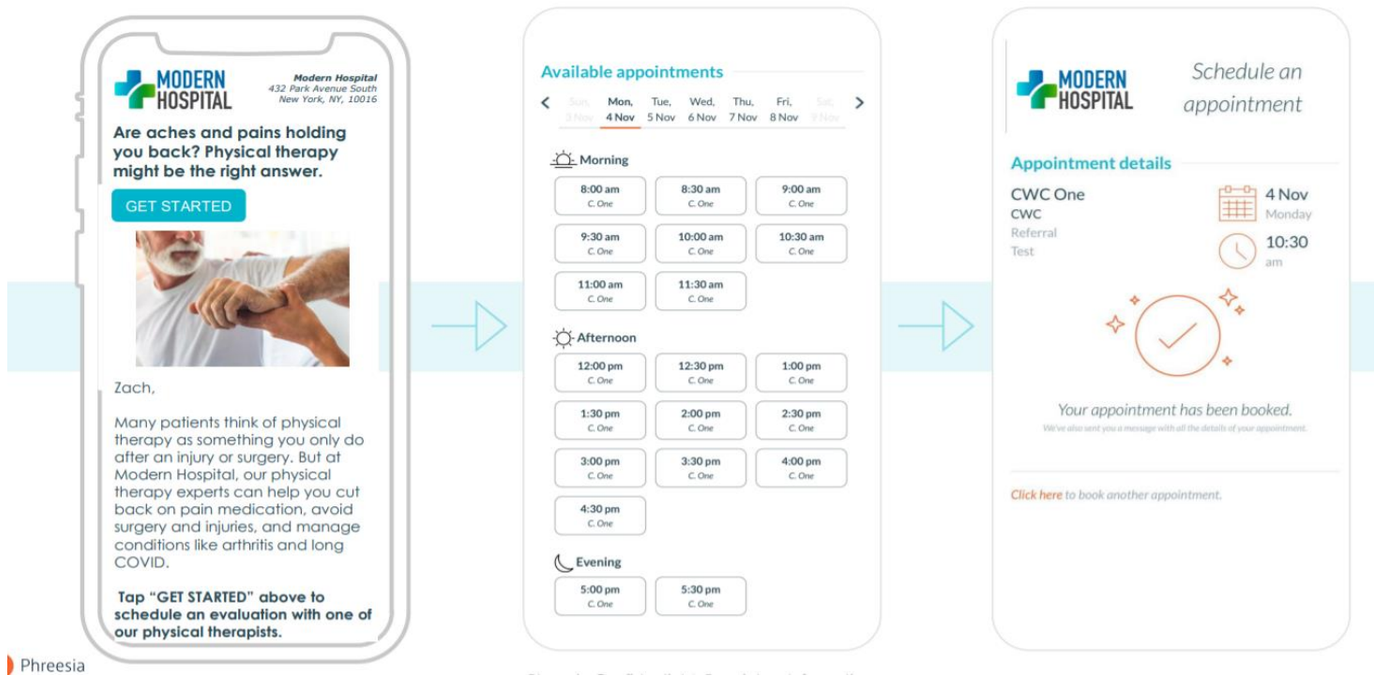
- New specialty/ambulatory programs
  - Primary Care Geriatrics
  - Patient Centered Medical Home
  - DM Center of Excellence
  - Retinal Screening
  - Infusion/Dialysis
  - Telehealth Specialists
  - Surgical/Procedure Specialists
- Swing Bed Recruitment Program
  - New Patient Recruitment
- Clinic Optimization Program
  - Scheduling Management
  - Access Management
  - "20 Patients/Day" Provider Capability
  - Provider Incentives
  - F/U Appt Scheduling
- Quality Program Initiatives
  - HACs
  - Readmissions
  - Value Base Purchasing
- MIPS Participation

Financial Management

- Revenue Cycle
  - Pre-Reg/POS Cash Collection
  - Insurance Verification/ Authorization
  - Coding and Documentation Integrity Program
  - Provider Enrollment
  - AR/Denial Management
- Physician Advisor Program
  - Status Assignment
  - LOS Variance
- 340-B Program
- Grant Identification/Management
- Cost Report Allocation
- Current contracts analysis
- Clinic Integration
  - Internal
  - External
- Rural Emergency Hospital Conversion

General Health Care Campaign

- Targeted to all audiences in primary and secondary service areas
- Organized curriculum pushed out on a weekly basis for various parts of wellness and the prevention campaign
- Ability of patient to self-schedule is a critical feature



Patient Recruitment for AWVs

- Traditional methods to invite communities to participate in healthcare systems are passive
- Recruitment initiative needs to match the scope of the opportunities
- Call Center model with both text and email follow up on frequent basis to target population of Primary and some Secondary Service Area zip codes
- Offered to all patients, even if they have a primary MD

Advanced Practitioners Perform AWVs

- Order appropriate immunizations, vaccines, lab tests, and imaging
- Make appropriate specialty referrals
- Key focus on ensuring appropriate patient enrollment in all other Care Coordination programs (CCM, PCM, RPM, RTM, BHI, and CoCM)

Chronic Care and Behavioral Management

- Instead of using phone calls once/month, use frequent text-based communications with client that is AI driven and tracks patient's progress

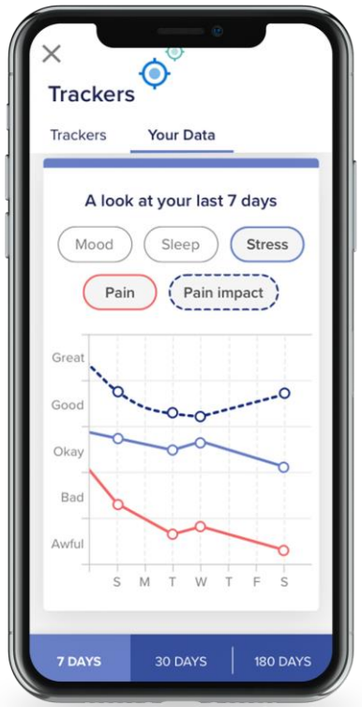


Fig. 1 - Avg. 3 annual visits: Fewer opportunities for care and reimbursement

Fig. 2 - Avg. 4 annual visits, 12 CCM claims, 24 patient interactions: More frequent opportunities for care and

- Care Coordination programs show increase in ambulatory patient visits and decrease in ED visits and hospitalizations

Attention to All Outbound Transfers – Robust Repatriation Program

- Critical Access Hospitals access to Swing Bed utilization is compelling patient reason for patient transfer back to CAH
- Standard communication to patient and family while still in your hospital and prior to transfer of repatriation plan
- Create patient registry for tracking all outbound transfers so that can be tracked 7 days/week
- Daily automated and verbal communication with patient/family and Case Management at outside facility to plan patient transfer back into rural hospital care system
  - If LOS > 3 days, repatriate back for last 1-2 days of hospitalization and utilize swing beds
  - If LOS< 3 days, schedule patient for 3-day follow up phone call for medication reconciliation and 7-day face to face visit.
- Analytics Program
  - All outbound transfers (ED and Hospital) for destination and patient population trends. Development strategies to decrease transfers for lower acuity patients on monthly basis.
  - Measure % successful repatriation by destination facilities with monthly meeting with facilities with lowest compliance to review

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Financial Impact of Integrated Care Coordination Programs

Impact of Getting Patients into Care Coordination Programs – Before and After Program Implementation

CARE COORDINATION CATEGORY	PROJECTED INCREASES WITH CARE COORDINATION PROGRAMS		
	VISITS	REIMBURSEMENT	RATINGS
1 Annual Wellness Visit (3% baseline utilization)	**+3.5 additional follow-up visits**	**$875 per patient** (additional labs, imaging, and meds)	*Improvement in HEDIS, HCC, CMS*
Chronic Care Management (5% baseline utilization)	**+4 additional follow-up visits**	**$1,280 per patient** (additional labs, imaging, and meds)	*Improvement in HEDIS, HCC, CMS*
Behavioral Health Collaborative Care* (0% baseline utilization)	**+7 additional follow-up visits**	**$1,080 per patient** in additional Behavioral Health Management Fees	*Improvement in HEDIS, HCC, CMS*

**Initial clinical evaluation for high-risk patient*

Financial Models for Care Coordination

- 5,419 Annual Visits
- 1,333 Medicare/MA Patients
- 2,665 Medicare/MA Visits
- Low utilization of Annual Wellness Visits, Chronic Care Management Programs, Behavioral health Integration, Remote Patient/Therapeutic Monitoring

RHS Care Coordination Program Financial Model Summary				
	Visits		Revenue	
Specialty	Current	Future	Current	Future
AWV	10	2,399	$15,705	$821,985
CCM	0	2,132	$0	$1,283,032
BHI	0	1,599	$0	$263,547
Tot Well Visits	45	6,130	$15,705	$2,368,563
Non-Well Visit	5,374	5,374	$1,263,652	$1,263,652
Total Visits	5,419	11,504	$1,279,357	$3,632,216
% Wellness	1%	53%	1%	65%
Incremental Increase		6,085		$2,352,858
% Incremental Increase		640%		184%

Financial Models for Care Coordination

Medium Medicare Patient Visits and Medium Care Coordination

Mid-West 6 Clinics

- Clinic Visits 35,100
- Distinct Medicare Pts 3,498
- Total Medicare Visits 11,540
- Average Visits/Medicare Pt 3.3
- % Medicare Visits 32.8%

RHS Care Coordination Program Financial Model				
	Visits		Revenue	
Specialty	Current	Future	Current	Future
AWV	4820	6,296	$1,527,801	$2,157,566
CCM	109	5,597	$61,511	$4,297,671
BHI	0	4,198	$0	$1,129,172
Tot Well Visits	4,929	16,091	$1,589,313	$7,584,409
Non-Well Visit	30,504	30,504	$6,462,327	$6,462,327
Total Visits	35,433	46,595	$8,051,640	$14,046,736
% Wellness	14%	35%	20%	54%
Incremental Increase		11,162		$5,995,096
% Incremental Increase		32%		74%

Low Medicare Patient Visits and Low Care Coordination

Mid-West 2 Clinics

- Clinic Visits 8,100
- Distinct Medicare Pts 2,830
- Total Medicare Visits 3,150
- Average Visits/Medicare Pt 1.1
- % Medicare Visits 38.8%

RHS Care Coordination Program Financial Model				
	Visits		Revenue	
Specialty	Current	Future	Current	Future
AWV	158	5,094	$45,329	$1,433,791
CCM	0	4,528	$0	$2,289,923
BHI	0	3,396	$0	$559,661
Tot Well Visits	158	13,018	$45,329	$4,283,375
Non-Well Visit	8,107	8,107	$1,544,873	$1,590,201
Total Visits	8,264	21,125	$1,590,201	$5,873,576
% Wellness	2%	62%	3%	73%
Incremental Increase		12,861		$4,238,046

Financial Models for Care Coordination

Medium Medicare, Low Utilization

Southwest 2 Clinics

- Clinic Visits 7,871
- Distinct Medicare Pts 2,152
- Total Medicare Visits 2,804
- Average Visits/Medicare Pt 1.3
- % Visits Medicare Pts 35.6%

High Medicare, Medium Utilization

Southwest 6 Clinics

- Clinic Visits 23,734
- Distinct Medicare Pts 4,942
- Total Medicare Visits 11,657
- Average Visits/Medicare Pt 2.4
- % Visits Medicare Pts 48.7%

RHS Care Coordination Program Financial Model				
	Visits		Revenue	
Specialty	Current	Future	Current	Future
AWV	41	3,541	$14,135	$1,213,246
CCM	0	3,147	$0	$1,893,749
BHI	0	0	$0	$388,994
Tot Well Visits	41	6,688	$14,135	$3,495,988
Non-Well Visit	7,831	7,831	$1,738,636	$1,738,636
Total Visits	7,871	14,518	$1,752,770	$5,234,624
% Wellness	1%	46%	1%	67%
Incremental Increase		6,647		$3,481,854
% Incremental Increase		84%		199%

RHS Care Coordination Program Financial Model				
	Visits		Reimbursement	
Specialty	Current	Future	Current	Future
AWV	1782	8,896	468,275	2,514,151
CCM	0	7,907	0	4,679,813
BHI	0	5,930	0	1,629,786
Tot MC/MA Well Visits	1,782	22,733	$468,275	$8,823,749
Tot MC/MA NonWell	9,875	9,875	$2,594,960	$2,594,960
Non-Well Visit	12,077	12,077	$1,922,087	$1,922,087
Total Visits	23,734	44,685	$4,985,323	$13,340,797
% Medicare	49%	73%	61%	86%
% Wellness	8%	51%	9%	66%
Incremental Increase		15,021		$8,355,474
% Incremental Increase		63%		168%

Merit-Based Incentive Program (MIPS) And Care Coordination

- Applied to all Part B claims based on prior year performance
- Measures quality of care (30%), costs (30%), EMR usage (25%), and practice improvement (15%)
- Incentives and penalties to achieve high scores for value-based activities –
- MIPS Points Scale of 0-100
  - Sliding 9% reduction in payment effective 2024 based on 2022 performance with penalty threshold moved to <75 or if don't submit data
  - Exceptional performance incentives >89 with 2022 last year that this is available.
- 25% of All MIPS Quality Activities Associated with Care Coordination

Diabetes
HbA1c Control
Exam
- Fundoscopic
- Peripheral Neuropathy
- Foot Exam
- Ulcer Prevention Footwear

Renal Screening
Retinopathy
Communication

Care Plan
Medication Reconcile
Advanced Care Plan
Patient Experience
Screening
- BMI
- Fall

Assessments
- Functional Outcome
- Obstructive Sleep Apnea

Behavioral Health
Cognitive Assessment
Dementia
- Assessments : Functional, Cognitive, Behavioral, Safety & Safety Follow Up, Caregiver Depression
- Screening
- Follow Up -30 Days
- Follow Up - 12 Months

Suicide Risk Assessment
Alcohol Drug Dependence Tx
F/U After Hospitalization

Cancer Screening
Breast
Cervical
Colorectal
Lung

Infectious Disease Screening
Hepatitis C
HIV, GC, VDRL
Chlamydia

Counseling
Tobacco
Alcohol

Cardiovascular Screening
Medication Interaction
HTN Control
HTN Follow Up
Statin Usage
Cardiac Rehab Referral

Medication Usage
Opiates
Antidepressants
Antipsychotics

Osteoporosis
Female Screening – 65-85

Immunization
Influenza
Pneumococcal
Hep C

Other
- MCC Patient Admissions
- Unplanned Readmission <30 days
- Pt Reported Outcomes

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RHS RURAL HEALTH SOLUTIONS
Enabling care close to home

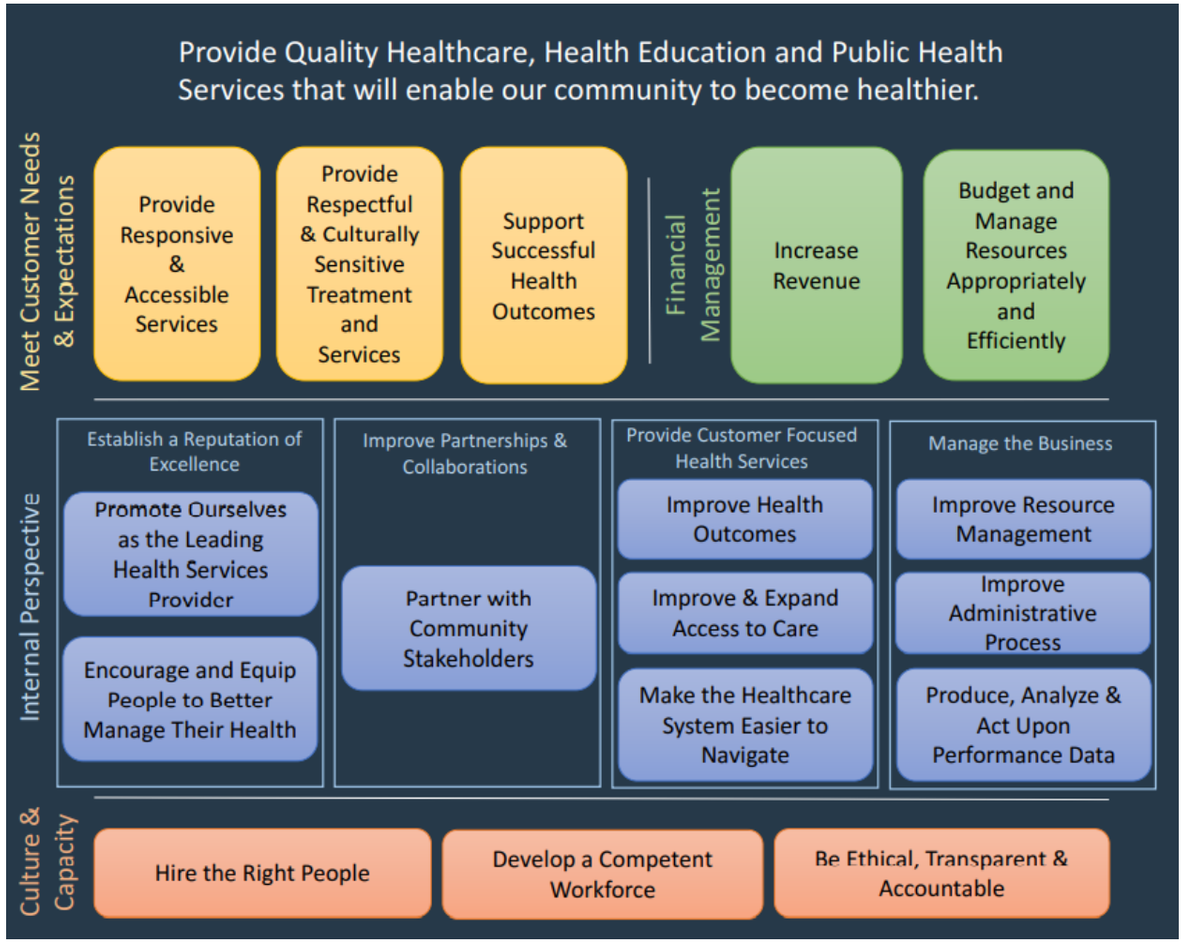
Key Lessons Learned for Reversing Outmigration

Primary Care Outmigration Reversal Lessons

- Primary Care Outmigration must be top of mind in almost all CAH strategic plans
- Aggressive Healthcare Campaign to both Primary and Secondary Service Areas
- Resourced Recruitment Program for AWVs signup
- AWV ordering of all preventive/wellness CMS recommended care and ancillary studies with referral to clinic for follow-up
- Focused Enrollment for all Care Coordination Management Programs
- Part of CCM and Behavioral Health Programs include low threshold for Clinic Referrals for provider follow up

Strategically Focus on Wellness As Core Initiative

Care Coordination Initiatives Must Be Integrated into Your Organization's Strategic Vision of Care



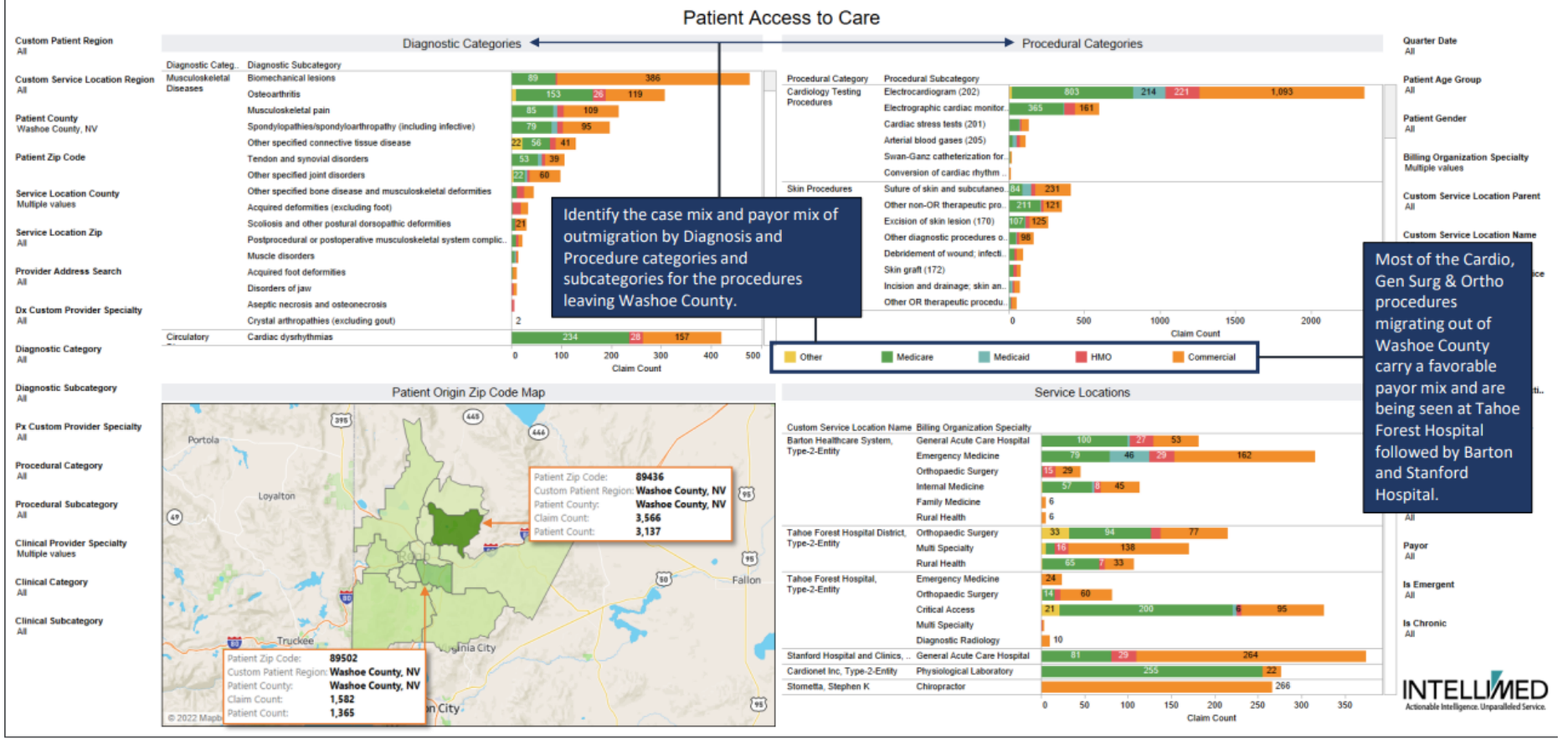
Care Coordination Goal-Based Strategic Planning Process

Outmigration Analysis - Detailed

Washoe County Outmigration:

Reviewing procedures for residents of Washoe County performed at service locations located in the state of California.

**IntelliMarket Vue Claims Data – Nevada & California combined dataset. Periods 2020Q3-2021Q3; Washoe County Patient Origin; Clinical Provider Specialties: Cardiology, General Surgery, Orthopedics*



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Questions

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