# Comparative Review and Update on Rural Health Systems Models

Presented by

Scott V. Carroll, Lippes Mathias Wexler Friedman LLP

David R. Beauregard, Monument Square Advisors, LLC

# Rural Healthcare – New York State – Perspectives and ideas

- Brief Overview of Rural Healthcare
  - Introduction
  - Demographic, Legal and Healthcare Economics
  - Hill Burton Act Legacy
- Comparative Structure for Rural Healthcare Entities
  - Legal and Governance requirements
  - Financial support
- Overview of Financial and Operating Performance – Rural Hospitals
  - New York Hospitals and Rural Hospitals comparison to National Data
- Population Health Characteristics – by County – New York
  - Overview of New York State Data Reviewed
    - USC Data - Identification of High-Need Rural Counties for Additional Safety Net Providers
    - County Data and Rankings – How are these utilized in Measurement and Planning
    - Presenters Data
      - Hospitals,  FQHCs, RHCs

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# Rural Healthcare – New York State – Perspectives and ideas – Cont.

- Rural Health Provider Collaboration Structures
  - Hospital Affiliation Structures (Affiliation, Ownership, Non-Ownership)
  - Rural Health Networks

- The Rural Health Zone as a Consolidating Rural Healthcare Governance Structure
  - Provider Scale, Performance, Financing
  - RHZ Commission (Public, Health Professionals, Government, Affiliated Health Systems) membership
  - Health Policy Oversight and alignment with Demonstrated Need
  - Annual Reporting – Financial & Clinical Measures and alignment  RHZ Healthcare Needs and Resource requirements

- Rural Healthcare Legislative Initiatives
  - RHZ Authorization
  - Alignment and Coordination of Rural Healthcare Financing
  - Health Policy alignment with State Budgets and Federal Funding
  - Partners Program re-authorization

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# Rural Healthcare Hill-Burton Act Legacy Impact

- By 1945 and the end of World War II, many American Hospitals were obsolete and half of the nation's counties had no hospitals at all.
- There was a post World War II emphasis on the general hospital as the focus of local health care.
- The Hospital Survey and Construction Act (or the Hill-Burton Act) was passed in 1946 in response to a push to improve the health and health care of Americans.
- It called for the construction of hospitals and related health care facilities and provided federal grants and loans to communities that could demonstrate viability for the construction and improvement of the nation's hospital systems.
- The goal was to create 4.5 beds per 1,000 people.
- By 1975 Hill-Burton was responsible for the construction of one-third of the nation's hospitals.
- The largest portion of the program's funds were allocated to construct and modify general hospitals in localities with fewer than 50,000 people.

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# Critical Access Hospitals

- A designation given to eligible rural hospitals by CMS to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities.
- Established by the Balanced Budget Act of 1997
- Must meet various conditions to obtain CAH designation such as:
  - Have 25 or fewer acute care inpatient beds
  - Be located more than 35 miles from another hospital
  - Maintain an annual average length of stay of 96 hours or less for acute care patients
  - Provide 24/7 emergency care services
- A quarter of all U.S. Hospitals and more than two-thirds of all rural community hospitals
- CAH status includes the following benefits:
  - Cost-based reimbursement from Medicare. As of January 1, 2004, CAHs are eligible for allowable cost plus 1% reimbursement.
  - However, as of April 1, 2013, CAH reimbursement is subject to a 2% reduction due to sequestration.
  - In some states, CAHs may also receive cost-based reimbursement from Medicaid.
  - Flexible staffing and services, to the extent permitted under state licensure laws.
  - Capital improvement costs included in allowable costs for determining Medicare reimbursement.
  - Access to Flex Program educational resources, technical assistance, and/or grants.

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# Critical Access Hospital v. Acute Care Hospital

| | Critical Access Hospital | Acute Care Hospital |
|---|---|---|
| # of Beds | No more than 25 | Only limited by need |
| Distance requirement | Must be more than 35 Miles from any hospital or Critical Access hospital | No distance requirement |
| Length of Stay Requirement | Must have average length of stay of 96 hours or less | No length of stay requirement |
| Staffing Requirement | Not required to have a MD or DO on site 24/7 | Must have an MD or DO on site 24/7 |
| Capital Improvement costs | included in allowable costs of determining Medicare reimbursement | Costs not included in determination of Medicare reimbursment |
| Reimbursment | Cost based reimbursment plus 1% from Medicare | Mostly value based and fee-schedule reimbursment. |

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# Federally Qualified Health Centers (FQHCs)

- A community-based organization that provides comprehensive primary care and preventative care to all individuals regardless of ability to pay.
- 90 FQHC sites in New York State outside of urbanized areas as of 2019. Can be located in urban and non-urbanized areas.
- Qualify for specific enhanced reimbursement under Medicare and Medicaid
- Receive funds from the HRSA Health Center Program
- Federal tort protection
- Once certified by the Centers for Medicare and Medicaid (CMS) as an FQHC, health centers are eligible for several benefits including:
  - Medicare reimbursement under a Prospective Payment System (PPS), in which Medicare payment is made based on a national rate which is adjusted based on the location of where the services are furnished. CMS provides a brief overview of the FQHC PPS.
  - Medicaid reimbursement under the Prospective Payment System (PPS) or other state-approved Alternative Payment Methodology (APM) for services provided under Medicaid. A 2017 Medicaid and CHIP Payment and Access Commission (MACPAC) issue brief, Medicaid Payment Policy for Federally Qualified Health Centers, provides an overview of Medicaid reimbursement for FQHCs.
- Must meet the following requirements:
  - Not-for-profit
  - Governance requirements (majority who are current patients).
  - Independence (can have common governance with another organization)
  - Provide comprehensive services and have an ongoing quality assurance program
  - Meet other health and safety requirements
  - Not be concurrently approved as a Rural Health Clinic

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# Rural Health Clinics

- Established by the Rural Health Clinic Service Act of 1977
- Addresses a shortfall in physicians to serve Medicare beneficiaries in rural areas.
- Must embrace a team approach of physicians working with mid-levels
- Receives an “all inclusive rate” for medically-necessary primary health services.
- Can be provider based (affiliated with hospital or other Medicare provider)
- Required to operated in non-urbanized areas.
- No express governance requirements and does not have to be a not-for-profit
- Not required to charge sliding scale fee structure
- No federal tort program protection

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# Hospital Affiliation Structures

| Type | Description |
|---|---|
| Clinical Affiliation | • Agreement for organizations to collaborate on an initiative or to provide a specific service together.<br>• Allows organizations to focus on strengths and combine clinical acumen |
| Merger/Acquisition | • Formal purchase of one organization's assets by another, or the combination of two organizations' assets into a single entity.<br>• Legal, financial risk assumed by acquirer. Subject to regulatory approvals and CON process. |
| Strategic Partnership | Regional collaboration to provide services to patients either jointly or to loan staff or resources and share in beneficial referring relationships. No regulatory approval |
| Active Parent/Passive Parent | Formal relationship in which a hospital or system assumes "control" of another hospital or system without a full merger. Accomplished through legal membership. Both entities retain their own board. |
| Clinically Integrated Hospital/System Network | Regional affiliation of hospitals and system related entities in delivery network. Facilitates care coordination and payor contracting strategies. |

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# Development of Rural Health Networks

- “Integrated” networks of independent regional healthcare institutions and providers
  - Clinical and financial integration
  - Collaboration and care management
  - Shared resources
- Evidence of improvement of care through coordination
- NYS-current grant-based program – 32 networks covering 30 rural counties
- Sustainability, effectiveness, availability of resources
- Non-integrated (ad hoc) programmatic support

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# Rural Classifications in New York and Impact on Measurement

- US Department of Agriculture Economic Research Service uses census and OMB data and criteria to assign urban influence and separate metro and non-metro counties using an Urban Influence Code 1-2 (metro) and 3-12 (non-metropolitan) to categorize counties.
- USDA ERS also produces Rural-Urban Commuting Area (RUCA) Codes measures of population density, urbanization, and daily commuting. RUCA codes range from 1-10.
- Federal Office of Rural Health Policy accepts all non-metropolitan counties as rural, and in addition, treats as rural (with associated grant eligibility) of census tracts with RUCA codes of 4 or higher.

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# Regions/Counties – UIC >2 –Safety Net Provider Count
# Counties with Rural Census Tracks

| NYS Region | NAME | FQHCs | IHS | RHCs | CAHs | RUCA | UIC Code | UIC Category |
|---|---|---|---|---|---|---|---|---|
| Capital | Columbia | 1 | 0 | 0 | 0 | Yes | 3 | Micropolitan |
| Capital | Greene | 0 | 0 | 0 | 0 | Yes | 6 | Small Adjacent |
| Central NY | Cayuga | 5 | 0 | 0 | 0 | Yes | 5 | Micropolitan |
| Central NY | Cortland | 11 | 0 | 0 | 0 | Yes | 5 | Micropolitan |
| Finger Lakes | Schuyler | 0 | 0 | 0 | 1 | Yes | 7 | Small Adjacent |
| Finger Lakes | Seneca | 1 | 0 | 0 | 0 | Yes | 3 | Micropolitan |
| Finger Lakes | Steuben | 6 | 0 | 2 | 0 | Yes | 3 | Micropolitan |
| Mid-Hudson | Sullivan | 5 | 0 | 0 | 1 | Yes | 4 | Small Adjacent |
| Mohawk Valley | Fulton | 0 | 0 | 0 | 0 | Yes | 5 | Micropolitan |
| Mohawk Valley | Montgomery | 1 | 0 | 0 | 0 | Yes | 5 | Micropolitan |
| Mohawk Valley | Otsego | 0 | 0 | 1 | 0 | Yes | 8 | Micropolitan |
| North Country | Clinton | 1 | 0 | 0 | 0 | Yes | 8 | Micropolitan |
| North Country | Essex | 4 | 0 | 0 | 2 | Yes | 6 | Small Adjacent |
| North Country | Franklin | 1 | 0 | 0 | 0 | Yes | 8 | Micropolitan |
| North Country | Hamilton | 1 | 0 | 0 | 0 | Yes | 7 | Small Adjacent |
| Southern Tier | Chenango | 0 | 0 | 0 | 0 | Yes | 6 | Small Adjacent |
| Southern Tier | Delaware | 0 | 0 | 0 | 3 | Yes | 6 | Small Adjacent |
| Tug Hill Seaway | Lewis | 1 | 0 | 0 | 1 | Yes | 6 | Small Adjacent |
| Tug Hill Seaway | St. Lawrence | 2 | 0 | 0 | 2 | Yes | 5 | Micropolitan |
| Western NY | Allegany | 2 | 0 | 0 | 1 | Yes | 9 | Remote Rural |
| Western NY | Cattaraugus | 1 | 0 | 0 | 0 | Yes | 3 | Micropolitan |
| Western NY | Chautauqua | 4 | 0 | 0 | 0 | Yes | 3 | Micropolitan |
| Western NY | Genesee | 0 | 0 | 0 | 0 | Yes | 3 | Micropolitan |
| Western NY | Wyoming | 1 | 0 | 0 | 0 | Yes | 4 | Small Adjacent |
| | | 48 | 0 | 3 | 11 | | | |

19 additional counties with Rural Census Tracks (RUCA)

Dutchess
Erie
Herkimer
Jefferson
Livingston
Madison
Niagara
Oneida
Onondaga
Ontario
Orange
Orleans
Oswego
Suffolk
Ulster
Warren
Washington
Wayne
Yates

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# New York Rural Safety Net Facilities

- 18 Critical Access Hospitals
- 8 Rural Health Clinics
- 90 Federally Qualified Health Center sites located outside of Urbanized Areas.

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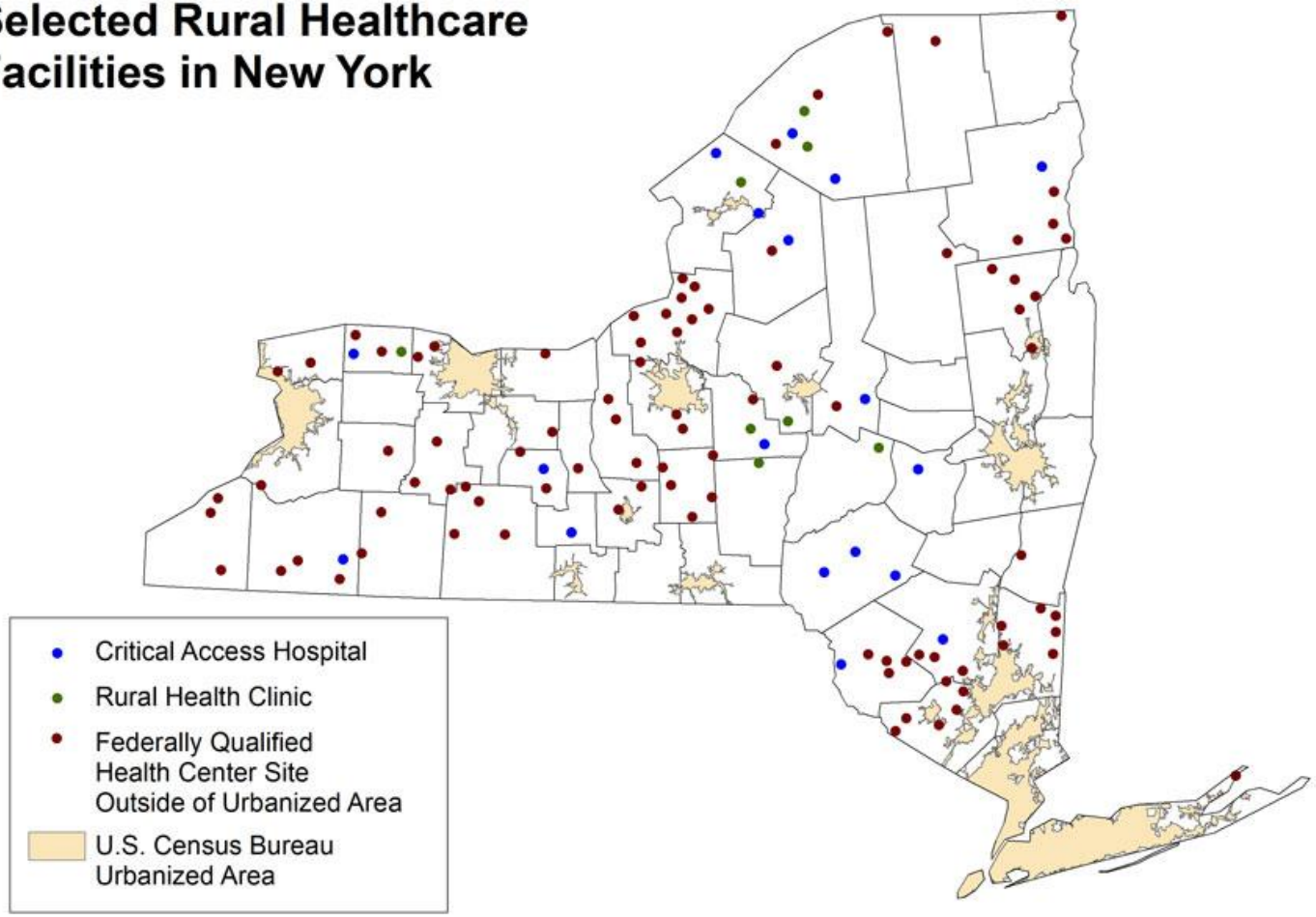
# Selected Rural Healthcare Facilities in New York




RHIhub
Rural Health Information Hub

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, April 2019

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# Low Rural Hospital Closures in NYS Compared to National Trends

- 1 rural hospital closure in NYS in 2018 (Moses-Ludington Hospital)
- Nationally, continued rural closures prevalent in Appalachia/Southeast (TN,GA,NC,AL,MS), Midwest, Texas and California
- YTD 2019 16
- 2018 15
- 2017 8
- 2016 12

Source: North Carolina Rural Health Research Program

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# Trends in Inpatient Hospital Utilization
# % Change – Reporting Years 2015 to 2016

| | National n=4746 | NY State n=172 | Rural NY n=36 |
|---|---|---|---|
| Staffed Beds | 0.21% | -1.82% | -8.03% |
| Inpatient Days | 1.23% | -1.94% | -5.95% |
| Inpatient Discharges | 1.26% | -1.02% | -1.78% |
| Average Length of Stay | -0.03% | -0.93% | -4.25% |

- Rural NY hospitals are trending down at a greater rate than the State of NY. National Averages represent a slight upward trend.

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# Hospital Operating Metrics
# Reporting Year 2016

| | National n=4746 | NY State n=172 | Rural NY n=36 |
|---|---|---|---|
| Days in net A/R | 50.60 | 45.27 | 78.63 |
| Current ratio | 2.08 | 1.44 | 2.04 |
| Operating margin | 2.24% | 0.60% | -3.19% |
| Return on equity | 5.69% | 6.77% | 0.19% |

- National Operating margins returned to pre-2011 levels, or 4.65%, for 2018
- National ROE has declined from a 2010 level of 10.38% to 5.97% for 2018
- NYS Operating margins have trended down to -1.03% for 2018
- NYS ROE has dropped to 2.69% for 2018

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# Cost-to-charge ratios for Rural Health Clinics (RHC) and Federally Qualified Health Clinics (FQHC)

| | RHC 2015 | RHC 2016 | FQHC 2015 | FQHC 2016 |
|---|---|---|---|---|
| Total Cost-to-charge ratio | 56.54% | 56.40% | 66.49% | 92.28% |
| Inpatient Cost-to-charge ratio | 69.36% | 66.54% | 63.78% | 86.68% |
| Outpatient Cost-to-charge ratio | 56.48% | 56.36% | 66.50% | 89.61% |

- National Data only. Not Reported for NY State and Rural NY Hospitals
- RHC Cost to Charge Ratios have declined steadily each year since 2011
- FQHC Cost to Charge Ratios increased for years 2011 thru 2016, and declined for years 2017 and 2018

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# Outpatient Hospital Service Metrics for Reporting Year 2016

| | National n=4746 | NY State n=172 | Rural NY n=36 |
|---|---|---|---|
| Outpatient Charges as a % of Total Charges | 48.31% | 41.93% | 71.22% |
| Outpatient Cost to Charge Ratio | 19.24% | 27.94% | 28.03% |
| Inpatient Cost to Charge Ratio | 25.64% | 28.51% | 51.60% |

- Outpatient charges

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# Identification of High-Need Rural Counties & Resource Allocation Planning

- "Analyses of location selection by healthcare providers in the U.S. are often retrospective, mapping the results of previous decisions" [3]
  - Examples include:
    - The location of new physicians, freestanding emergency departments and diabetes self-management education programs
    - The bias is toward urban, sub-urban locations that are well resourced and not areas with high rates of illness and/or low-income populations
- Prospective analyses of Need are more common in situations where resources are administered through a Central authority

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# Social Determinants of NYS Rural Counties Healthcare Needs with National Comparisons

| Characteristic | NY Rural Counties Without Safety-Net Provider (n=5) | | | | NY Rural Counties (n=23) [2] | | | | National (n= 3136) |
|---|---|---|---|---|---|---|---|---|---|
| | Mean | Med | Min | Max | Mean | Med | Min | Max | Mean |
| Travel Time to nearest Core Safety-Net Provider (in min) | | | | | | | | | |
| Health Outcomes | | | | | | | | | |
| Adults reporting fair to poor health (%) | 13.9 | 14.1 | 12.4 | 14.9 | 13.8 | 13.7 | 11.8 | 17.4 | 17.0 |
| Average number of poor physical health days per adult | 3.8 | 3.9 | 3.7 | 4.1 | 3.8 | 3.7 | 3.3 | 4.1 | 3.9 |
| Average number of poor mental health days per adult | 3.9 | 3.9 | 3.7 | 4.1 | 3.9 | 3.9 | 3.5 | 4.1 | 3.8 |
| All cause mortality rate per 100,000 | 771.7 | 760.6 | 754.6 | 784.7 | 767.2 | 774.7 | 706.0 | 817.2 | 823.5 |
| Socioeconomic Factors | | | | | | | | | |
| Poverty (%) | 15.2 | 15.3 | 13.2 | 17.1 | 15.3 | 15.3 | 10.7 | 20.6 | 16.3 |
| Unemployment rate | 5.96 | 6.0 | 5.0 | 6.6 | 5.96 | 6.0 | 4.1 | 7.1 | 5.5 |
| Children in single parent households (%) | 34.4 | 36.0 | 27.0 | 41.0 | 34.3 | 35.0 | 25.0 | 41.0 | 32.6 |
| Adults ≥age 25 with some college or more (%) | 56.8 | 57.2 | 50.5 | 64.8 | 56.9 | 56.9 | 50.5 | 64.8 | 56.8 |

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# Social Determinants of NYS rural counties Healthcare Needs with National Comparisons (cont.)

| Characteristic | NY Rural Counties Without Safety-Net Provider (n=5) | | | | NY Rural Counties (n=23) [2] | | | | National [1] |
|---|---|---|---|---|---|---|---|---|---|
| | Mean | Med | Min | Max | Mean | Med | Min | Max | Mean |
| Health Behaviors | | | | | | | | | |
| Adult smoking (%) | 16.8 | 16.9 | 15.9 | 18.1 | 17.2 | 17.1 | 14.5 | 18.6 | 17.9 |
| Adult obesity (%) | 29.2 | 30.8 | 26.8 | 30.8 | 28.5 | 28.2 | 25.0 | 33.7 | 31.0 |
| Physical Inactivity (%) | 23.9 | 22.8 | 22.3 | 26.5 | 23.3 | 22.7 | 19.5 | 27.8 | 26.0 |
| Food environment index | 8.3 | 8.5 | 7.8 | 8.5 | 8.0 | 8.1 | 6.4 | 8.5 | 7.0 |
| Excessive drinking (%) | 18.7 | 18.4 | 18.2 | 19.8 | 19.1 | 19.2 | 17.1 | 21.3 | 16.6 |
| Access to Care | | | | | | | | | |
| Primary care physicians per 100,000 | 50.0 | 45.0 | 37.0 | 81.0 | 50.4 | 48.0 | 21. | 116.0 | 52.8 |
| Dentists per 100,000 | 30.6 | 30.0 | 22.0 | 37.0 | 35.7 | 37.0 | 0 | 64.0 | 42.2 |
| Uninsured (%) | 8.5 | 8.4 | 7.4 | 9.6 | 8.7 | 8.8 | 7.3 | 10.8 | 14.4 |
| Physical Environment | | | | | | | | | |
| Severe housing problems(%) | 13.8 | 16.0 | 11.0 | 16.0 | 14.7 | 15.0 | 10.0 | 22.0 | 14.5 |
| Drive alone to work (%) | 79.4 | 81.0 | 74.0 | 83.0 | 78.4 | 79.0 | 72.0 | 83.0 | 79.2 |
| Long commute to work (%) | 33.0 | 32.0 | 29.0 | 41.0 | 31.3 | 31.0 | 19.0 | 41.0 | 30.4 |

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# Identifying Rural Counties with the Greatest Health Needs Using Indexing by Domains

| Domain | Number of Counties Threshold of >= 8 | Number of Counties Threshold of >= 7 |
|---|---|---|
| Health Outcomes | 6 | 9 |
| Socioeconomic Factors | 3 | 8 |
| Health Behaviors | 1 | 6 |
| Access to Health Care | 3 | 7 |
| Physical Environment | 3 | 4 |

- Each County was given an index score for each domain based on its ranking for the characteristics in that domain relative to the other counties. A higher score indicates higher need.
- One county had an index score of greater than seven in all five domains.
- One county had an index score of greater than eight in three of the five domains.

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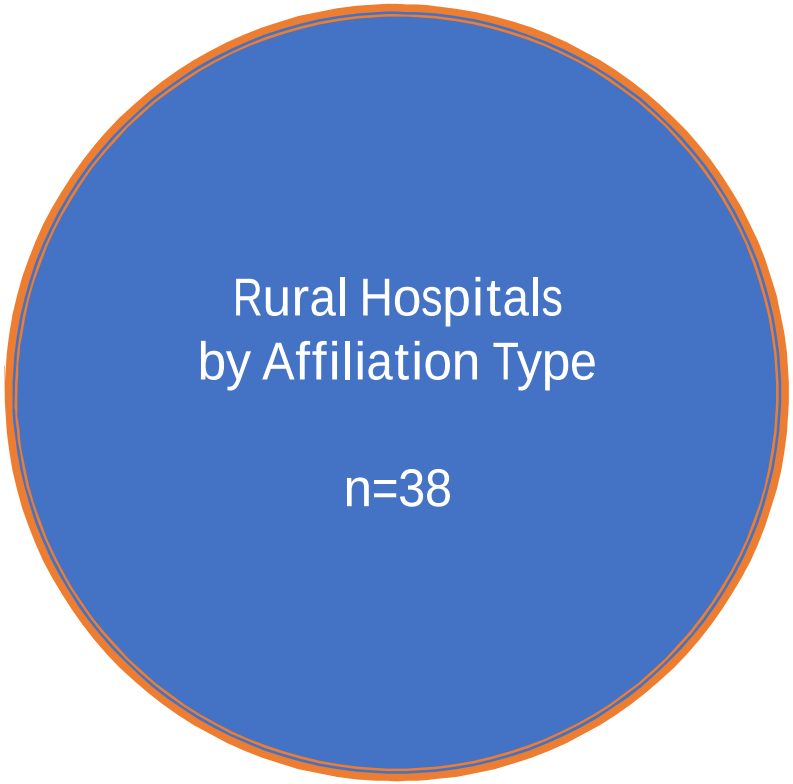


| | |
|---|---|
| Mergers | 9 |
| Affiliation Agreement | 6 |
| Corporate Affiliation | 1 |
| Management Contract | 4 |
| Active Parent/Ownership & Control | 4 |
| Single Entity | 3 |
| Strategic Partnership | 1 |
| Affiliation Not Available | 8 |
| Not Affiliated | 2 |

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Rural Hospitals Average Return on Assets (2015-2016) by Affiliation Type

n=35

| | 2015 | 2016 |
|---|---|---|
| Mergers | 0.4% | -1.0% |
| Affiliation Agreement | -5.0% | 1.8% |
| Corporate Affiliation | -9.2% | 32.4% |
| Management Contract | -2.0% | 1.6% |
| Active Parent/Ownership & Control | -7.8% | 4.4% |
| Single Entity | 7.6% | -0.4% |
| Strategic Partnership | 8.0% | 14.6% |
| Affiliation Not Available | 4.0% | 3.2% |
| Not Affiliated | 4.4% | 10.5% |

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# The Rural Health Zone – a Collaboration - Rural Healthcare Oversight

- Rural Health Zone objectives:
  - Alignment of Health Policy goals with RHZ Health needs
  - Develop Effective Provider Scale, Capital planning and Finance channels
  - Performance measurement and Reporting
  - Prospective insights and response to changing Zone health Determinants

- The RHZ Commission (the Commission)
  - Broad Membership (citizens, providers, NY Department of Health, Partner Affiliated Health Systems)
  - Independent oversight of the RHZ
  - Collaboration with RHZ Partner Health Systems
  - Report on RHZ performance versus Rural Health policy goals
  - Respond to Changing RHZ Health Needs and Capital Requirements

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# The Rural Health Zone – a Collaboration for Rural Healthcare Oversight – cont.

- Advantages
  - Collaborative Healthcare delivery platform, yielding
    - Improved patient outcomes & higher quality care
    - Efficiencies of Scale (larger geographic and provider base)
    - Improved access to care
    - Lower costs of care

- Advantages driven by:
  - Collaborative decision making by the Commission
  - Flexibility and anticipation of changing Zone health characteristics/needs
  - Budget driven Government Transfer funding
  - Commission Performance measurement and Reporting

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# Regional Zone Approach Policy Opportunities

- Continued operating subsidies for rural health
- Decreased barrier to entry for clinics (FQHC and RHC requirements)
- Rural healthcare economic incentives
  - Mirror economic development zones from Tax Cuts and Jobs Act
  - Tax abatement, income tax credits, loan forgiveness,
  - Private practice eligibility
  - Expanded tort protection
  - Local determination of zone composition and boundaries
  - Relaxation of AKS/Stark Law/Regulations for recruitment and subsidization

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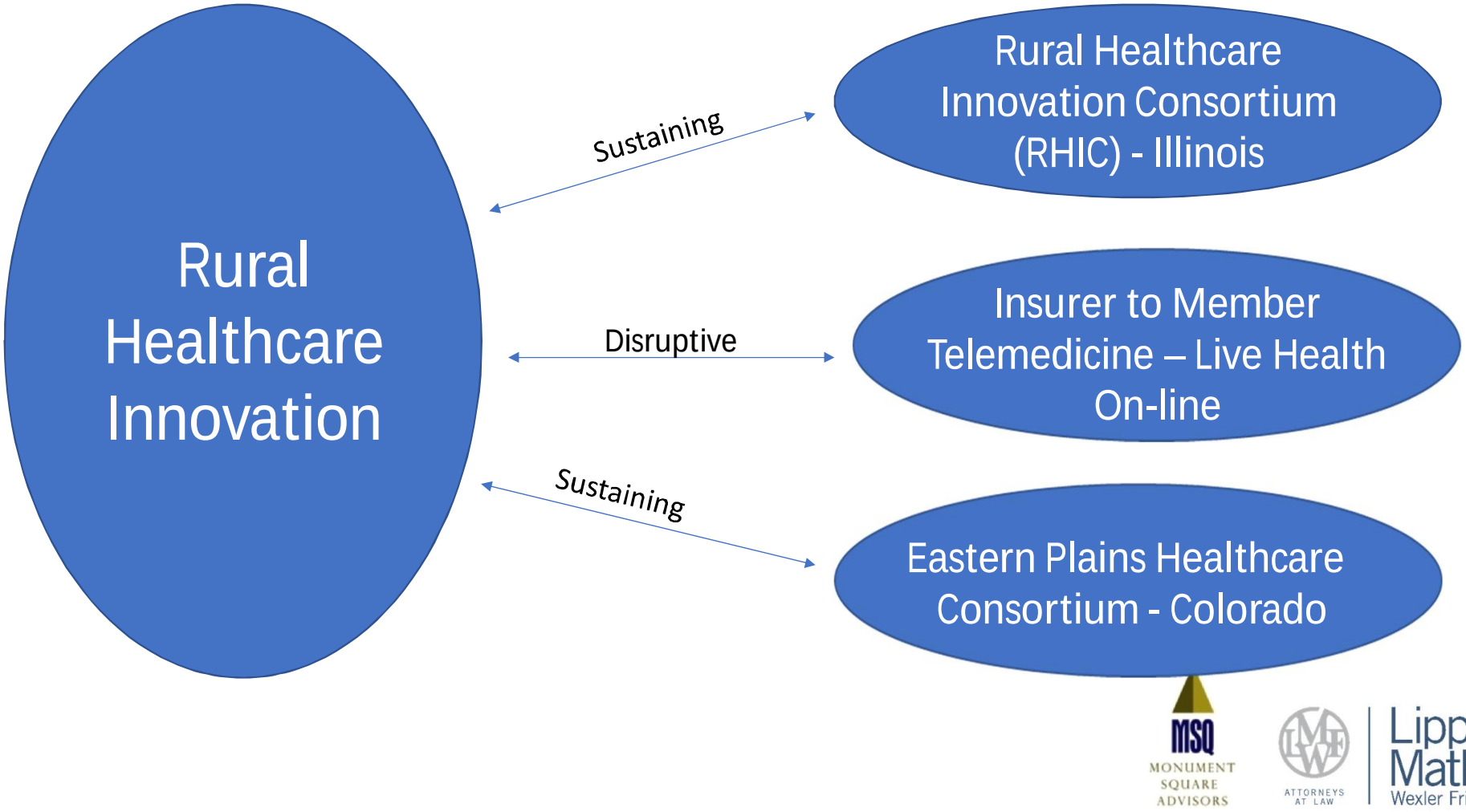


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# Rural Healthcare – New York State – Perspectives and ideas – Cont.

Summary and Conclusions

- Improved oversight of Rural Healthcare is desired
- Beyond the County - Rural Health Zone scale, is thought to be a key to lowering costs and improving clinical capacity and outcomes
- The Rural Health Zone Commission, a collaborative Governance entity, will improve Rural Health Oversight; including the deployment of resources, capacity and capabilities and innovation
- Payers will welcome stronger Zone focused Governance approach, the flexibility to anticipate changes in health Needs and will become willing partners in directing resources toward achieving Health Policy goals
- New York State will likely approve of the ability of Rural Health Zones to efficiently manage resources and meet health population needs

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# David R. Beauregard
# Biography

Mr. Beauregard is an experienced Healthcare executive and advisor, who has worked with clients and shareholders to build markets, improve operating performance and develop, align and execute strategic priorities. Through his leadership, innovative solutions and operations management skills; he has accumulated a solid track record for change management, performance improvements, entrepreneurial execution, hands-on leadership and increased enterprise value.

David has held leadership roles as a hospital Chief Financial Officer, as the CFO for a regional real estate development company, as the CEO of the Physician Practice Management division of NCRIC (NCRI: NASDAQ) and as a member of the corporate finance team of a multi-national hospital corporation, Charter Medical Corp (CM: Amex). As a Senior Manager with Ernst & Young, Mr. Beauregard advised the managements of Academic Medical Centers, Regional Health Systems and Children's Hospitals; seeking access to capital markets; evaluating strategic positioning, programs and costs; adjusting to the operating impact of changes in health policy.

David holds a Master of Accountancy from Virginia Commonwealth University and a BBA in Accounting from the Marshall University. He holds the CPA designation and the Series 7 and 66 securities licenses (inactive). He is a veteran having served four years in the United States Air Force – Medical Corps.

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# Scott V. Carroll
# Biography

Scott Carroll has spent his entire legal career representing physicians, medical groups, hospitals, health plans, specialty service organizations and pharmaceutical manufacturers. Scott's experience includes counseling clients on health care corporate finance; managed care and insurance regulation; intellectual property and information technology; public policy and government advocacy; government investigations and fraud and abuse; antitrust law and health care litigation, and health care bankruptcies and reorganizations.

**Partner and Co-Leader, Health Care Practice Group**
Tel: 716.853.5100
Fax: 716.853.5199
Email: scarroll@lippes.com

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# Appendices

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# Clinical Affiliation

- Agreement for organizations to collaborate on an initiative or to provide a specific service together.
- Benefits
  - Allows for co-branding of clinical services
  - Supports mutually beneficial exchange of referrals
  - Enables shared investment in expensive  resources including staff and equipment

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# Merger or Acquisition

- Formal purchase of one organization's assets by another, or the combination of two organizations' assets into a single entity.
- Must go through full acquisition process.
- Must be approved by Department of Health and faces significant regulatory scrutiny.
- Benefits
  - Enables joint contracting with private payers
  - Facilitates some degree of clinical integration
  - Places both entities under common control

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# Strategic Partnership

- Agreement for organizations in a similar region to collaborate to provide services to patients either jointly or to loan staff of resources and share in beneficial referring relationships.
- Does not need regulatory approval
- Benefits:
  - Allows the partners to provide services to patients that they may not otherwise be able to.
  - Allows for patients to be referred to a partner for services they may not have otherwise been connected to
  - Allows rural hospitals to take advantage of the expansive resources of a larger partner.

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# Active Parent /Passive Parent

- Formal relationship in which a hospital or system assumes “control” of another hospital or system without a full merger. Both entities retain their own board but the parent assumes control.
- Faces regulatory scrutiny and must be approved by the Department of Health.
- Does not require Certificate of Need
- Benefits:
  - Can jointly purchase and recruit.
  - Can streamline services and end duplication of services.
  - Can streamline back office and administrative functions and cut costs that make smaller hospitals more difficult to operate.

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# Difference in powers of Active/Passive Parent

- Passive Parent
  - A passive parent typically holds only the power to elect the governing body of subsidiary corporations.
- Active Parent
  - An active parent is able to possess the following powers:
    - Appointment or dismissal of Management-level employees and medical staff, except the election or removal of corporate officers.
    - Approval of operating and capital budgets
    - Adoption or approval of operating policies and procedures
    - Approval of certificate of need applications filed by or on behalf of the facility
    - Approval of debt necessary to finance the cost of compliance with operational or physical plant standards required by law.
    - Approval of contracts for management or clinical services
    - Approval of settlements of administrative proceedings or litigation to which the facility is a party, except approval of settlements of litigation that exceed insurance coverage or any applicable self-insurance fund.

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# Clinically Integrated Hospital Network

- Collection of hospitals that enter into joint payer contracts to improve care coordination and clinical outcomes.
- Faces substantial regulatory scrutiny (e.g., antitrust).
- Benefits:
  - Enables joint contracting with private payers
  - Facilitates some degree of clinical integration
  - Establishes performance-based incentives

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