CAH Financial & Operational Best Practices

June 3, 2025

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Upcoming Webinars

- Wintergreen will offer the following webinars to CAHs at 11:00a on the following dates:
  - July 10, 2025 - VA: CAH Reimbursement Heuristic: Using Medicare Cost Reports to Reveal Opportunities
    - Registration Link: https://us06web.zoom.us/meeting/register/oUpXYvVES3-33EH86XmhdA
  - July 31, 2025: VA: Understanding Your Options: Primary and Specialty Care Designation Strategies
    - Registration Link: https://us06web.zoom.us/meeting/register/5QZu6HvxTJO-IupRpx3ESg
  - August 21, 2025: VA: Data, Analytics, and Technology: The Untapped Value of Leveraging Available Data
    - Registration Link: https://us06web.zoom.us/meeting/register/UoV3p_TaT2SBn2N3QXbqSA

The Rural Environment

Market

One in five Americans live in rural communities

Barriers

Highly fragmented provider community with various clinic designations

Entrenched need for autonomy and cultural resistance to change -- coupled with trust issues

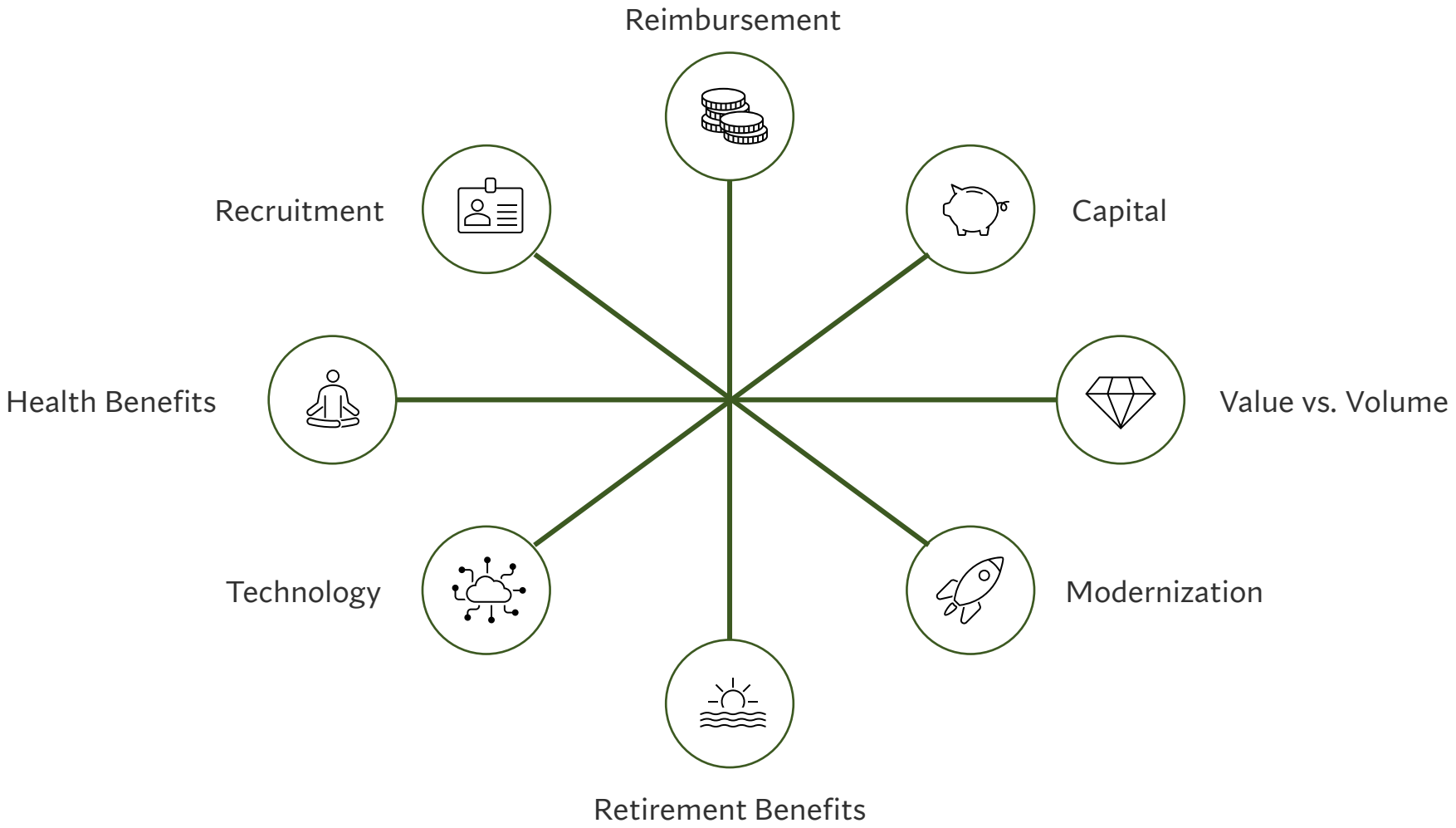
Complex, arcane and fluid regulatory environment tied to optimal reimbursement

Opportunity

Organizations must take steps to improve their operational performance, service delivery, and financial position: specifically looking at the alignment and designation of each rural practice to improve performance

Rural markets are built on relationships that strengthen trust, honor legacy models and provide the type of innovation and expertise that is not present in the current, inefficient industry

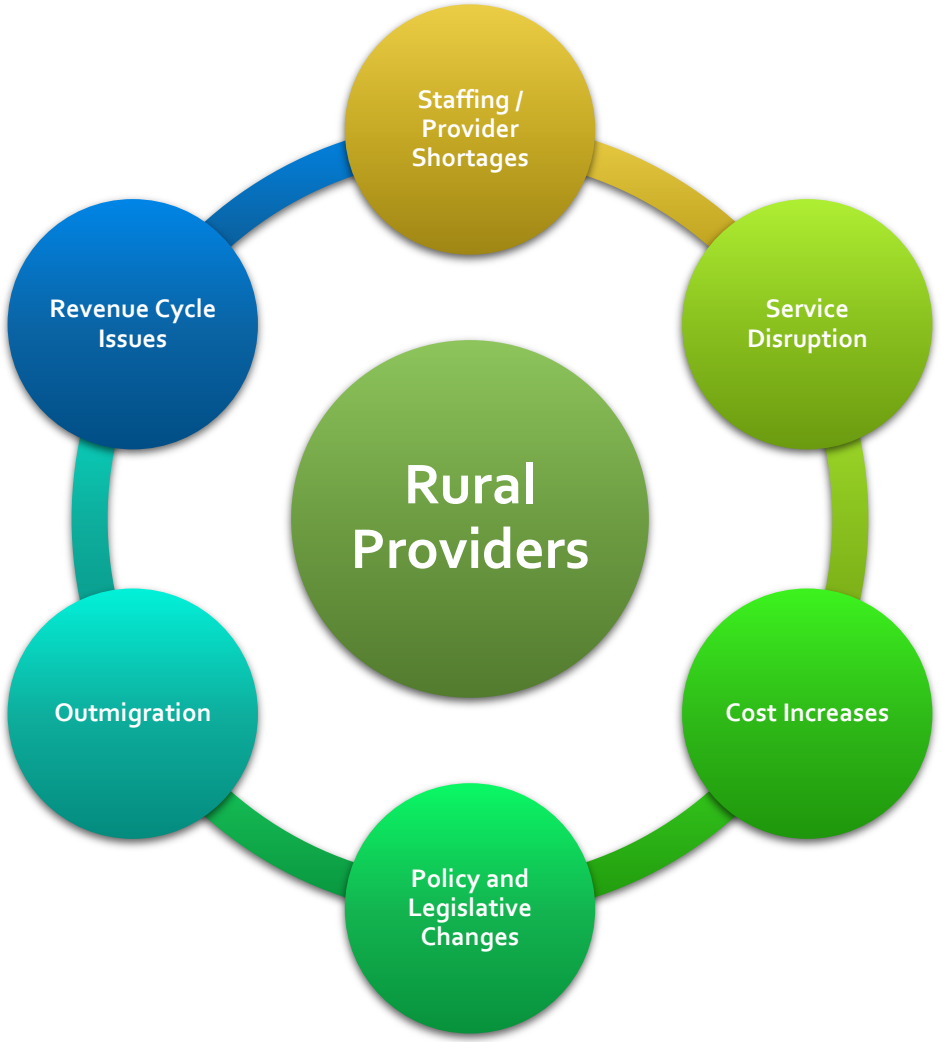
Interdependence of Major Drivers



The Current Landscape

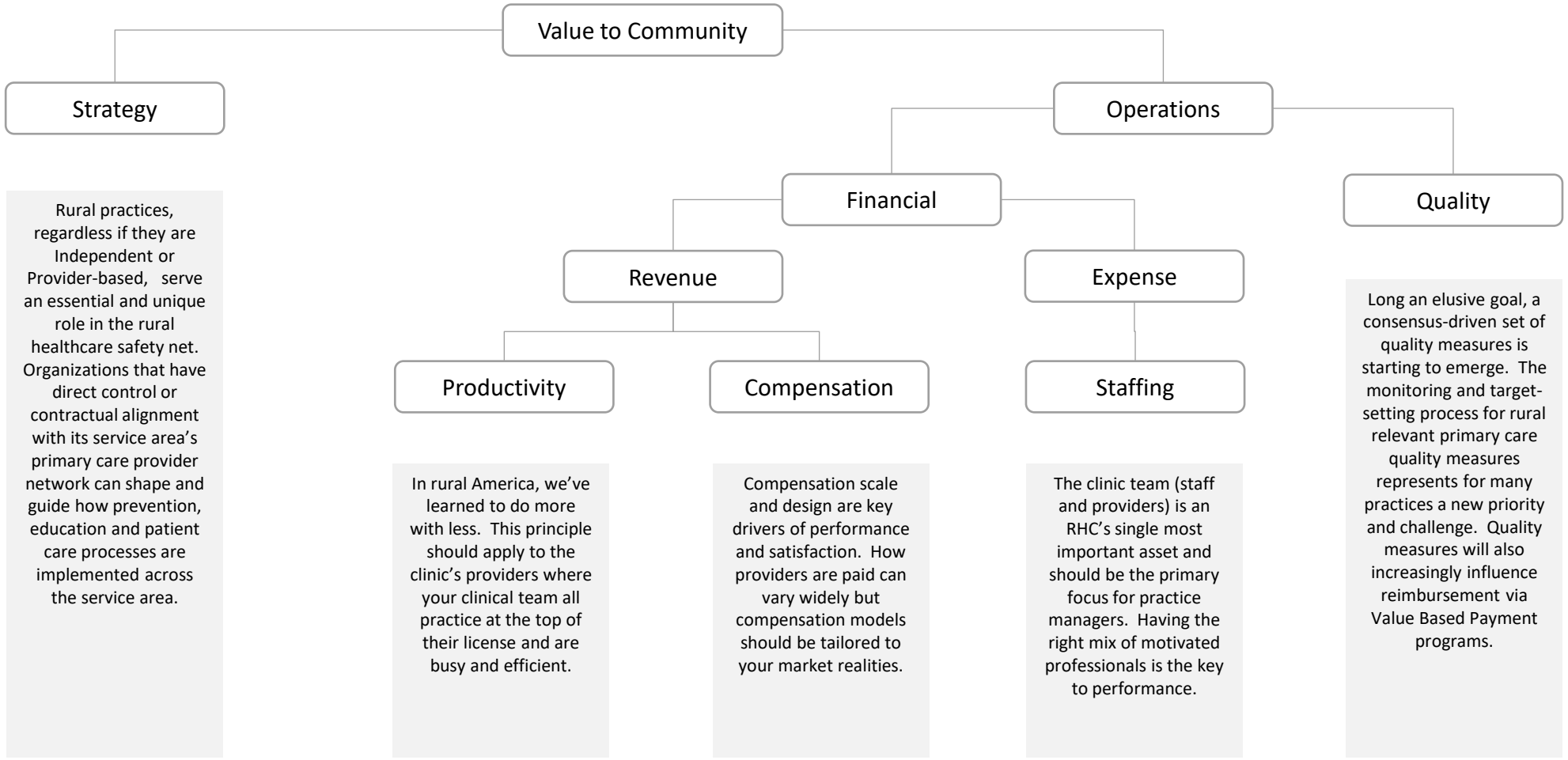
- Rural providers continue to experience cost increases, while having to address staffing shortages, outmigration, and significant policy/legislative changes

- The past few years have fundamentally changed how many patients receive healthcare services
  - Organizations must take a proactive approach to address these changes

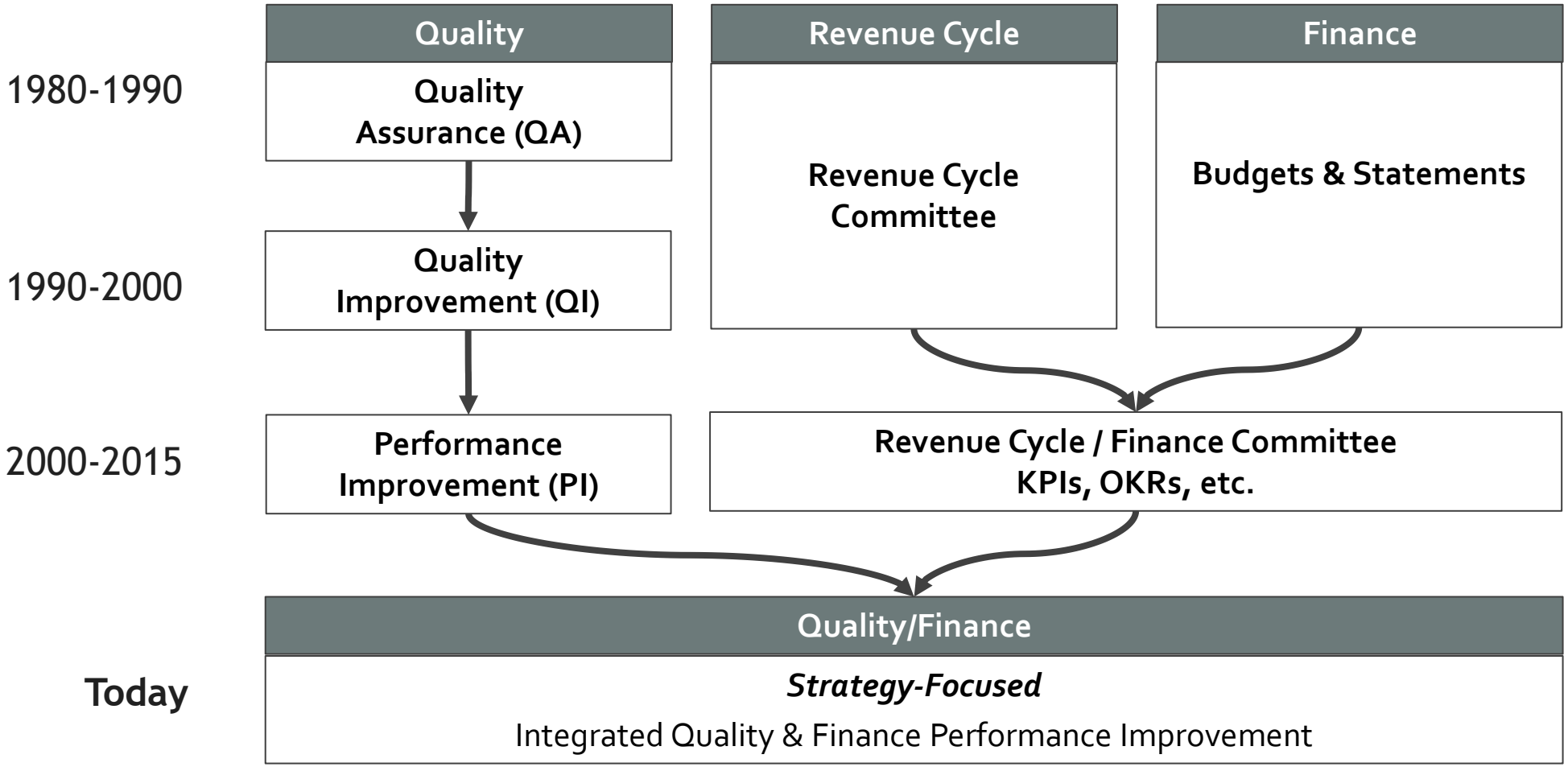


Performance Improvement Opportunities

Performance Improvement Model

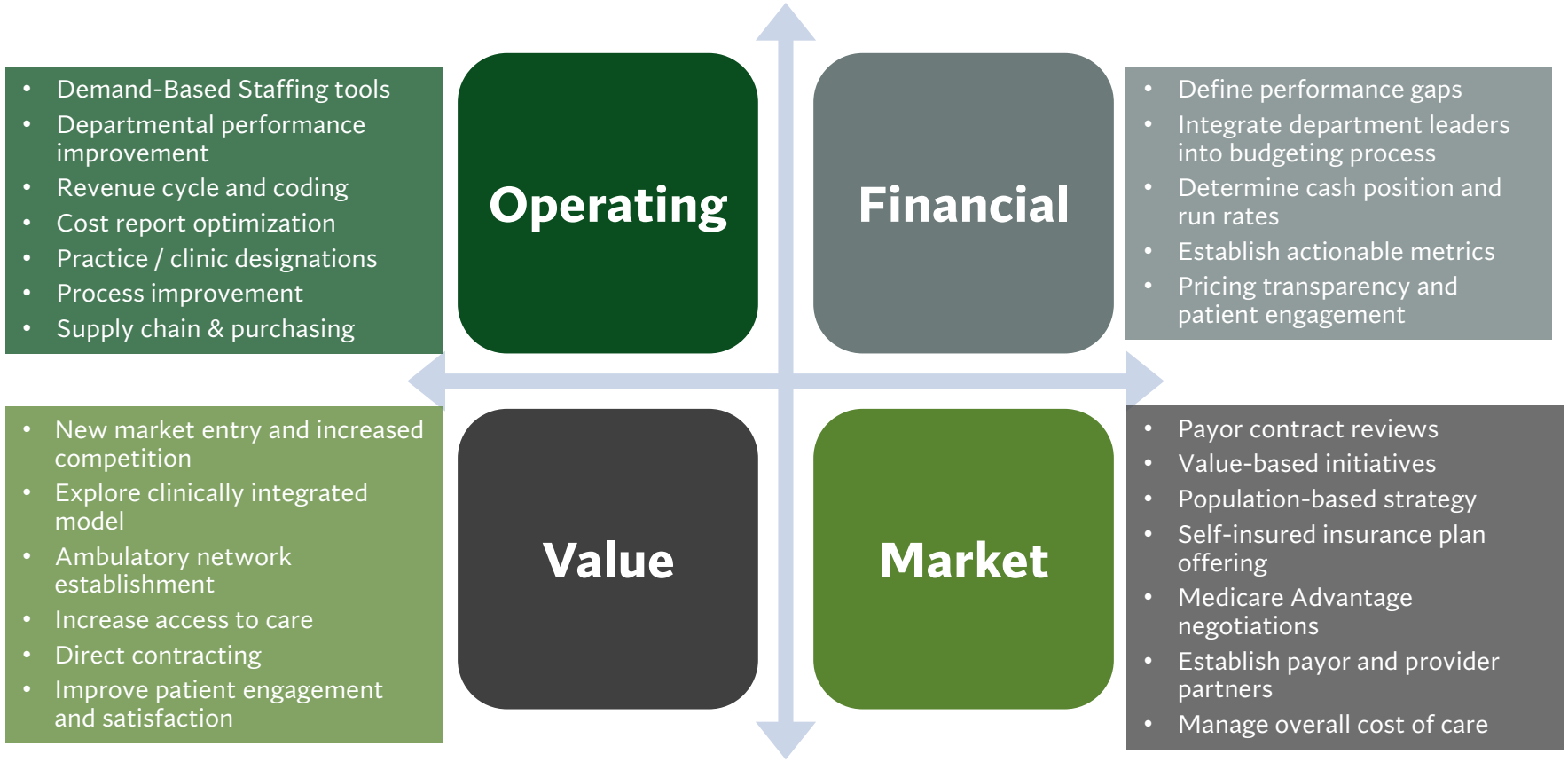


Evolution of Improvement Model



Performance Improvement Opportunities

Organizations must focus and establish plans for each of the four identified areas to improve the organizational position



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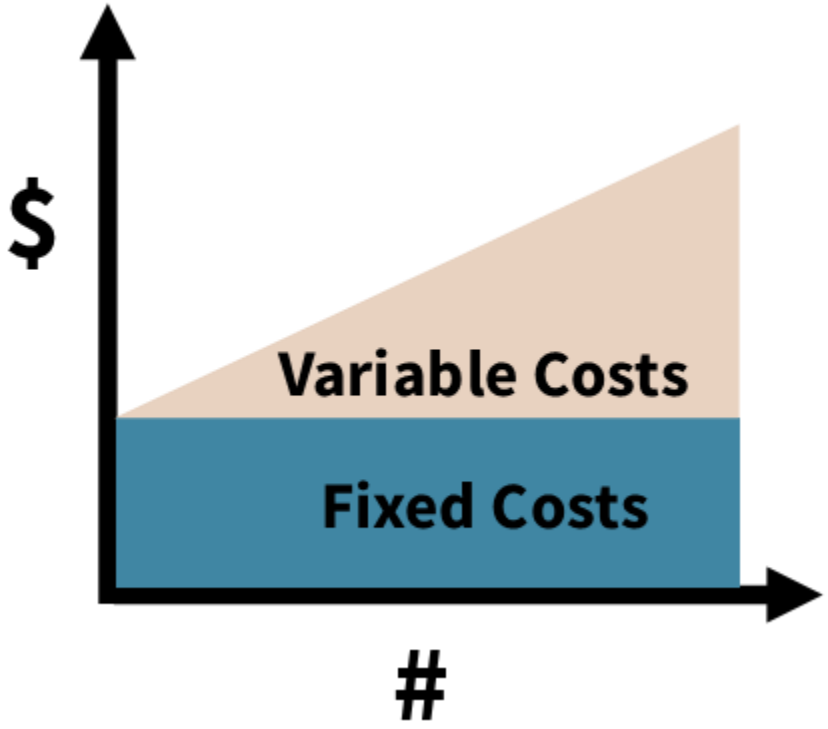
- Fixed costs are those which exist irrespective of volume
  - Unit staffing, medical direction, medical equipment, par levels of supplies
- Variable costs are those which would be incurred with each additional IP day
  - Incremental medical supplies, pharmaceuticals, food for patient meals
- In comparison to fixed costs, variable costs represent only a fraction of IP costs
  - As volume grows, fixed costs are diluted faster than variable costs grow



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- **Scope of Practice/Care**
  - Organizations must evaluate the services provided and continue efforts to expand service delivery to increase reliance on the hospital for post-acute care services
  - **Best practice** rural hospitals define the Scope of Practice (those patients able to receive care at your facility) across applicable departments (Med/Surg, ED, Rehab, etc.) as a collaborative, multi-disciplinary group inclusive of the following categories:
    - Medical Staff, Nursing, Pharmacy, Medical Equipment, Rehabilitation, and Business Office

Example: Wound Care Program

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- **Provider Complement**
  - Maintain a catalog of all primary and specialty care providers within the service area to ensure strategies consider market competition and saturation
    - Include telehealth providers in catalog which are often overlooked
  - At least annually, evaluate the alignment and designation of practices to leverage reimbursement advantages
  - If not already, transition provider contracts to include wRVUs, panel sizes, patient satisfaction scores, and quality scores
  - Leverage the Medical Group Management Association (MGMA) provider benchmarks to assess provider efficiency levels, service growth, and contract production incentives
    - Review established productivity goals with providers monthly
  - Implement the Patient Centered Medical Home (PCMH) or other initiatives to improve patient outcomes

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- **Practice Alignment and Designation**
  - Due to the changing healthcare landscape, healthcare entities must leverage additional revenue opportunities, including reimbursement methodologies, to drive improved financial performance
  - Healthcare entities can leverage the following to improve reimbursements when those practices can meet certain eligibility requirements:
    1. Periodically evaluate and convert practices to a designation that will improve the net financial position of that practice
    2. Establish system strategy and realign practices, when possible, to leverage alternative designation types
    3. Consolidate practices by integrating specialty practices and providers, when possible, within a PBC or RHC to realize operational efficiencies and leverage alternative reimbursement methodologies
    4. Pursue acquisition of independent practices to leverage reimbursement and revenue opportunities afforded to rural hospital providers
       - *Note: An RHC owned and operated by a hospital that qualifies for 340B does not have to meet the provider-based rules at 42 CFR 413.65 to be registered as a child site for 340B purposes*

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- **Practice Alignment and Designation**
  - The following table shows the net financial impact of different designations on a hospital:

			Before Change		After Change
Summary Data	**Scenario #1 PBC**	**After 2019 OPPS Final Rule (PBC)**	**Scenario #2 PB-RHC >50 Beds**	**Scenario #3 PB-RHC <50 Beds**	**Scenario #4 RHC Post 4/1/21**
Medicare / Medicaid Average	$ 149.06	$ 136.86	$ 86.32	$ 187.82	$ 127.92
Annual Visits	28,294	28,294	28,294	28,294	28,294
Reimbursements Received	$ 4,217,643	$ 3,872,319	$ 2,442,338	$ 5,314,296	$ 3,619,368
340B Benefit	n/a	n/a	n/a	n/a	n/a
Variance w/ Before 2019 PBC (Scenario #1)		$ (345,324)	$ (1,775,305)	$ 1,096,653	$ (598,275)
Variance w/ After 2019 PBC (Scenario #1)			$ (1,429,981)	$ 1,441,977	$ (252,951)

  - Outcomes:
    - Prior to the change in the RHC reimbursement methodology, the PB-RHC would have been the most advantageous designation; however, under the new reimbursement methodology, the practices would be better served to remain as a PBC until the RHC UPL surpasses the average PBC rate
    - Since the practices were already PBCs, there was no additional 340B benefit by converting the practices to RHCs

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- **Acute Inpatient Services**
  - Ensure the appropriate placement of patients based on medical necessity
    - Leverage InterQual, Milliman Care Guidelines (MCG), or other solutions to reduce variation among providers
  - Define the Scope of Care (those patients able to receive care at your facility) across applicable departments (Med/Surg, ED, Rehab, etc.) as a collaborative, multi-disciplinary group inclusive of the following categories:
    - Medical Staff, Nursing, Pharmacy, Medical Equipment, Rehabilitation, and Business Office
  - Integrate alternative providers (tele-intensivist, e-hospitalist, or APP) as necessary to expand the number of providers available for inpatient coverage
    - Explore addition of specialty providers also to expand the Scope of Practice
  - Establish evidence-based standards for acute care services
    - The goal is to bring together all individuals of the care delivery team to improve patient outcomes

CAH Financial and Operational Best Practices

- **Acute Inpatient Services**
  - Establish a multidisciplinary approach for bedside handoff and hourly rounding among the nurses and providers to improve communication and patient outcomes
    - Increase the linkages between the providers and nurses
  - Integrate Pharmacist into the inpatient care delivery model
    - The pharmacist must be available to meet with patients, as necessary and or requested, upon discharge or to discuss medication questions
  - Implement systems to track and monitor Nurse/Patient ratios against industry standards
    - Flex staffing levels to accommodate service utilization
    - Staffing levels must consider both volume, patient acuity, and staff competencies

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- **Swing Bed Services**
  - Identify a specific individual responsible for and who prioritizes the pursuit of swing bed patients
    - Often, CAHs will assign the responsibility to several individuals
  - Evaluate the specific services they can provided as a swing bed provider, often referred to as the Scope of Practice
    - After identifying services, CAHs should look to reduce the barriers preventing them from expanding the services provided
  - Take a proactive approach in the pursuit of swing bed patients instead of predominantly waiting for patient referrals: referred to as Proactive Pursuit
    - Establish relationships with larger hospitals and actively pursue patients based on care spectrum
    - Education providers and staff on the importance of swing bed services
  - Engage payors to reduce barriers regarding prior authorizations and denials due to medical necessity
    - Leverage the swing bed NF rate as a competitive advantage when negotiating with commercial payors

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- **Swing Bed Services**
  - Target and pursue 4.0 swing bed patients per 10,000 people in the primary service area
    - High-performing CAHs able to secure in excess of 4 per 10,000 through proactive pursuit and relationships
  - Implement and follow a defined admissions process to reduce barriers to admission
    - The admissions process should take no longer than 2 to decide on an admission

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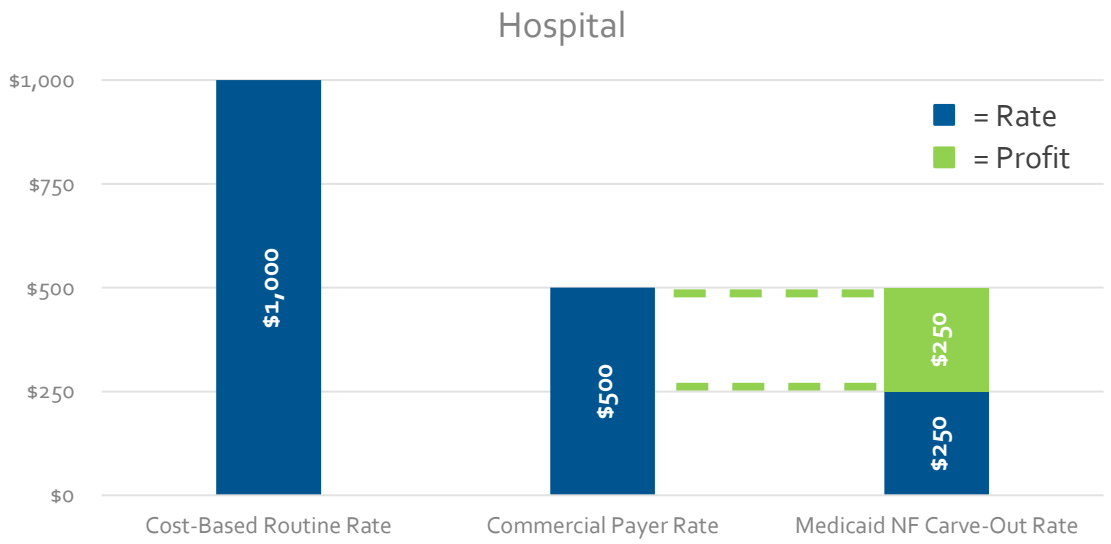
- **Non-Cost Based Swing Bed Days**
  - Cost-based reimbursement will only ever allow a hospital to break even
  - The opportunity: Non-Medicare or Medicare Advantage (Swing Bed NF) patient days
  - Common misconception: If contracted reimbursement rate is less than cost-based rate, negative financial impact
    - Medicaid NF carve-out rate
      - Carved out of routine costs at statewide
      - Do not negatively impact cost-based rates
  - If contracted reimbursement rates exceed statewide NF carve-out rate, **the hospital makes profit**



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- **Emergency Services**
  - Implement systems to ensure non-emergent patients who present to the ED are redirected to urgent care centers or primary care practices
    - A medical screening is required before redirecting a patient
    - Communities that do not have adequate access to primary/urgent care services will often rely on the ED for non-emergent care
  - Institute multidisciplinary team to review transfer appropriateness to reduce unnecessary transfers and increase utilization when medically appropriate
    - Review patient transfers for potential missed opportunities
  - Track and monitor key metrics related to the ED :
    - ED admissions
    - Transfer rates as a percentage of ED visits to below 5% of all ED visits
    - Door to provider times
    - ED provider stand-by time
      - The ED provider stand-by time can have a material impact on the net financial performance of a CAH

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- **Revenue Cycle**
  - Reorient the overall managerial focus on the revenue cycle process to the “front end” of the value chain (e.g. pre-authorizations, scheduling, registration, etc.) and a measurement culture
    - Organization should have the appropriate workflows to pre-register patients, accept copayments, review contracts, etc.
    - Ensure all outpatient services are scheduled and prior authorizations received before the patient presents for services
  - Implement and maintain a performance measurement system that evaluates key areas throughout revenue cycle
    - Metrics selected should evaluate both the macro and micro processes
  - Establish a price list (charge description master) and review at least annually to ensure the price list is accurate and defensible
    - Organizations must also address the public reporting requirements regarding their price list
  - Prioritize point of service (POS) collections to improve cash flow and reduce the patient responsibility portion
    - Staff must be held accountable for achieving POS goals

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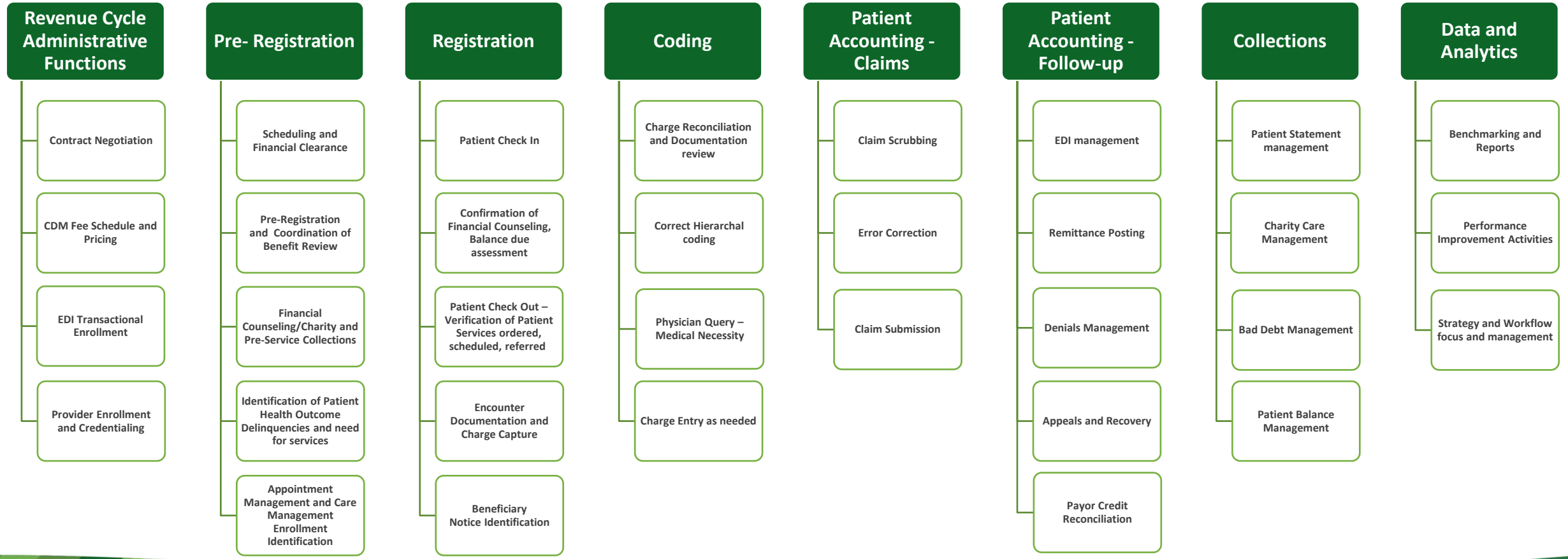
- **Revenue Cycle**
  - Evaluate and improve revenue cycle functions by ensuring a fair distribution of work, clearly defined roles and task automation or improvement



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- **Cost Report Opportunities**
  - Establish a bad debt process (policies and procedures) that determines when to send claims to collections and for pulling back claims from collections to deem as worthless
    - The CAH must pull a claim back from collections and deem worthless prior to inclusion on the Cost Report
  - Evaluate all A-8-2 adjustments to ensure the CAH is not unnecessarily reducing the amount of provider cost
    - Emergency Room standby time
    - RHC providers when not working in the RHC
    - Providers performing medical directorships or other administrative support
  - Monitor the ratio of cost-to-charges (RCC) on Worksheet C
    - The RCCs often highlight pricing issues or improper allocation of expenses

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- **Cost Report Opportunities**
  - Evaluate the methodology and stats used to allocate overhead costs on Worksheet B-1 particularly in the following areas:
    - Medical Records
    - Buildings and Fixtures (square footage)
    - Nursing Administration
  - Monitor the allocation of Medicare outpatient beneficiary costs (coinsurance/deductible) on Worksheet E Part B
    - Since the Medicare beneficiary patient portion is 20% of charges, CAHs must evaluate the costs passed on to patients to ensure an adequate pricing methodology
  - Engage cost report preparer, and if possible, establish a board-designated funded depreciation account to reduce the interest income offset
    - Most CAHs experience an interest income offset by not leveraging a board-designated funded depreciation account

Questions

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