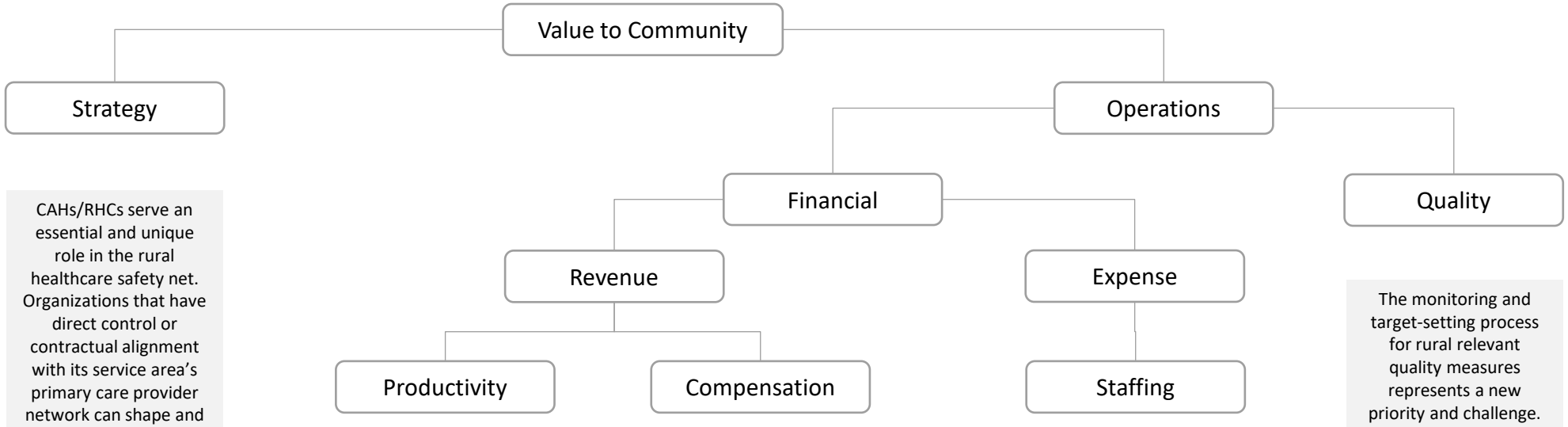
CAH Financial & Operational Best Practices

March 8, 2023

WINTERGREEN

Performance Model



CAHs/RHCs serve an essential and unique role in the rural healthcare safety net. Organizations that have direct control or contractual alignment with its service area's primary care provider network can shape and guide how prevention, education and patient care processes are implemented across the service area.

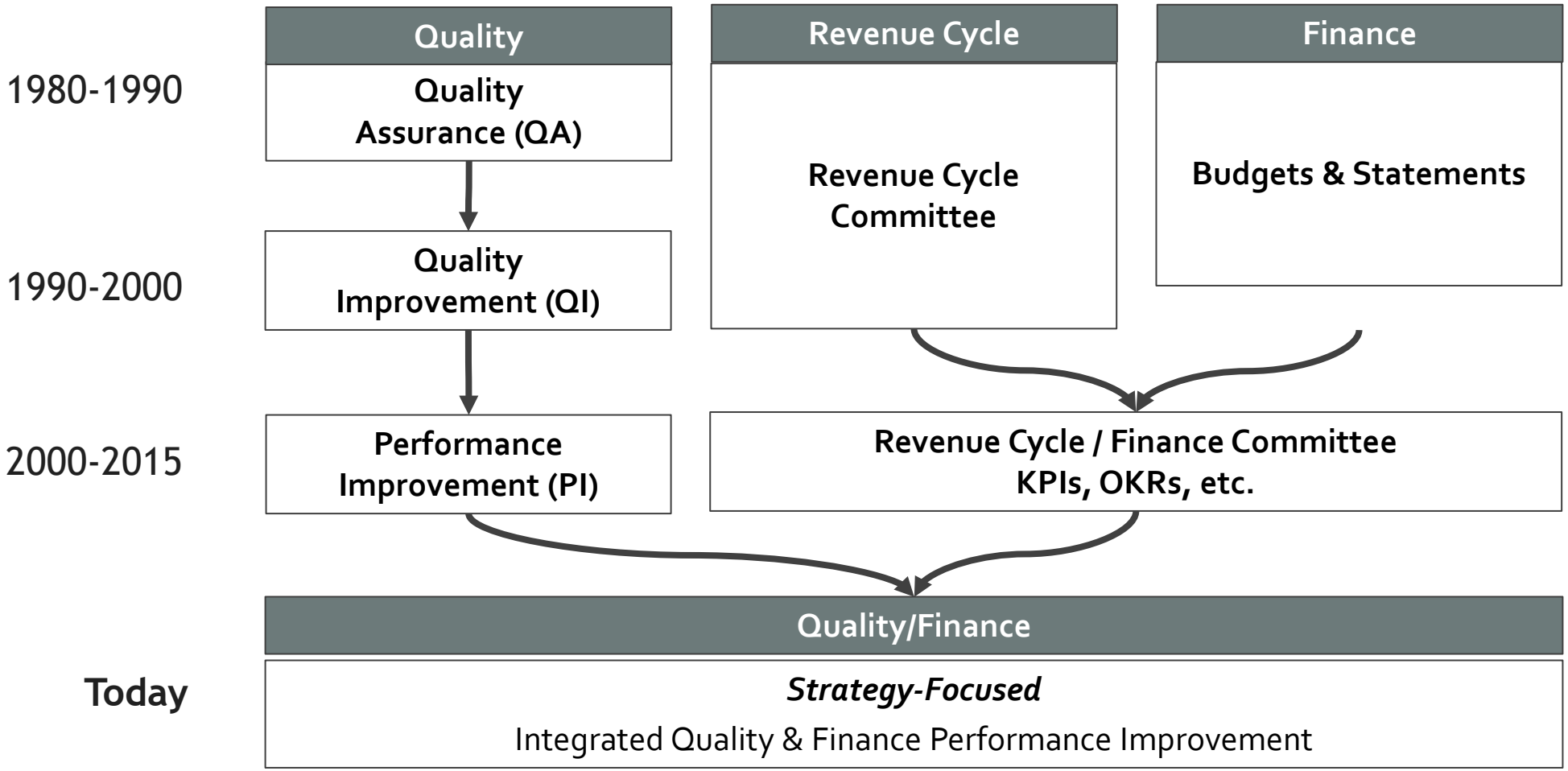
In rural America, we've learned to do more with less. This principle should apply to all service areas, when appropriate, by working with staff to work at the top of their license.

Compensation scale and design are key drivers of performance and satisfaction. How staff are paid can vary widely but compensation models should be tailored to your market realities.

Staff are the single most important asset and should be the primary focus for leaders. Having the right mix of motivated professionals is the key to performance.

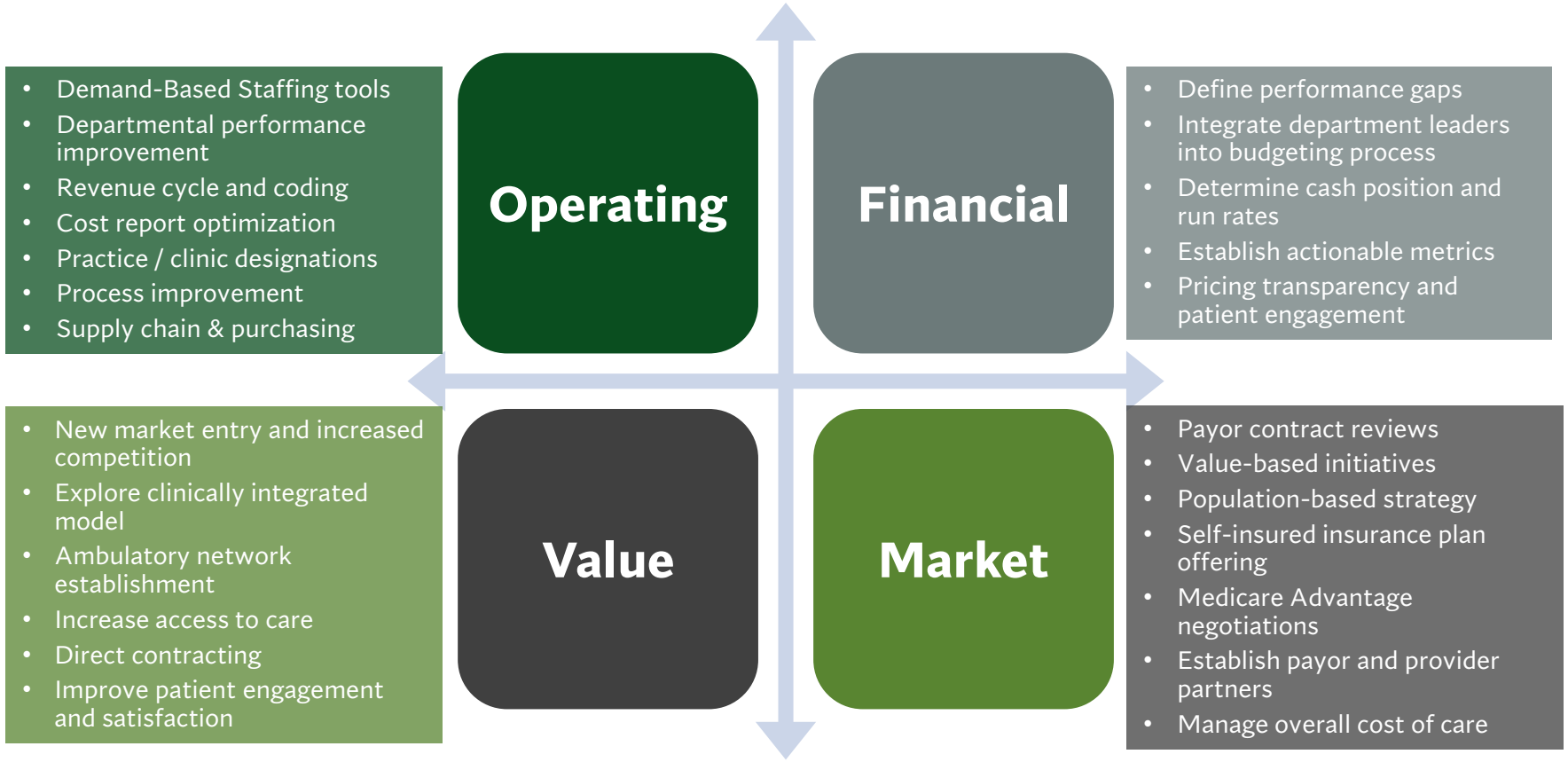
The monitoring and target-setting process for rural relevant quality measures represents a new priority and challenge. Quality measures will also increasingly influence reimbursement via Value Based Payment programs.

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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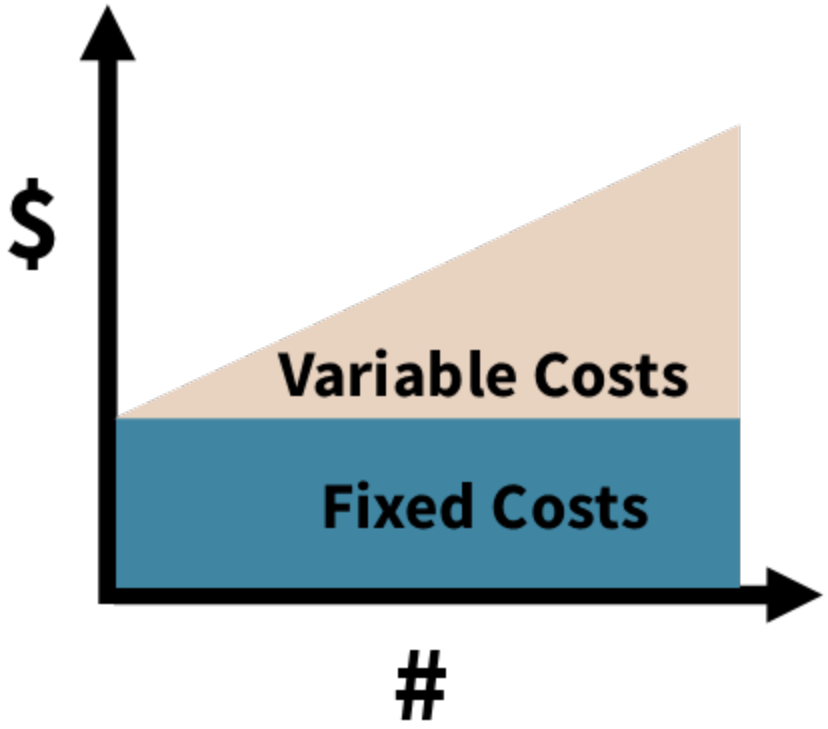
- Fixed costs are those which exist irrespective of volume
  - Unit staffing, medical direction, medical equipment, par levels of supplies
- Variable costs are those which would be incurred with each additional IP day
  - Incremental medical supplies, pharmaceuticals, food for patient meals
- In comparison 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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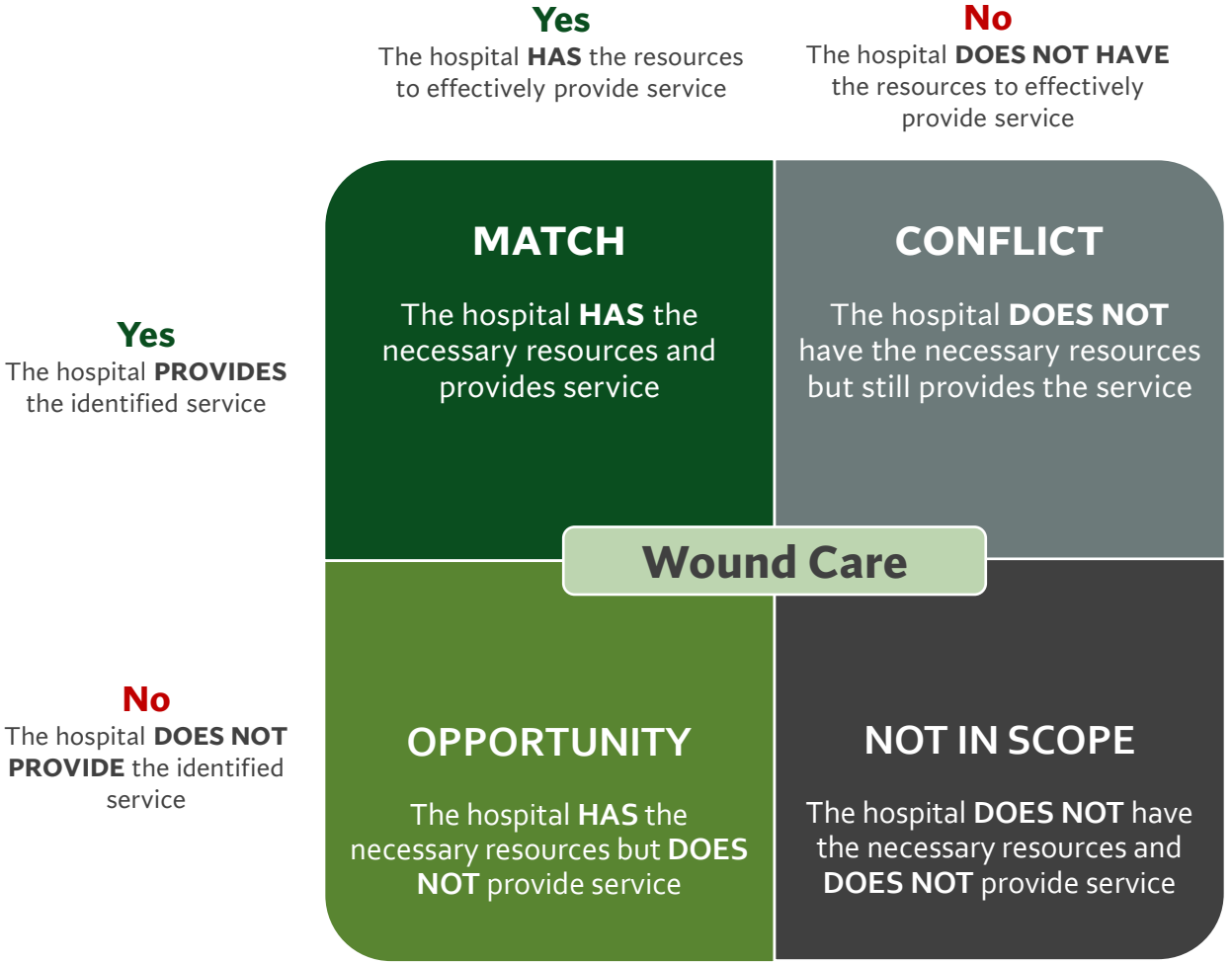
- **Scope of Practice/Care**
  - Organizations must evaluate the services provided and continue efforts to expand service delivery to increase reliance on the hospital for post-acute care services
  - **Best practice** rural hospitals define the Scope of Practice (those patients able to receive care 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 on a monthly basis
  - Implement the Patient Centered Medical Home (PCMH) or other initiatives to improve patient outcomes

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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

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- **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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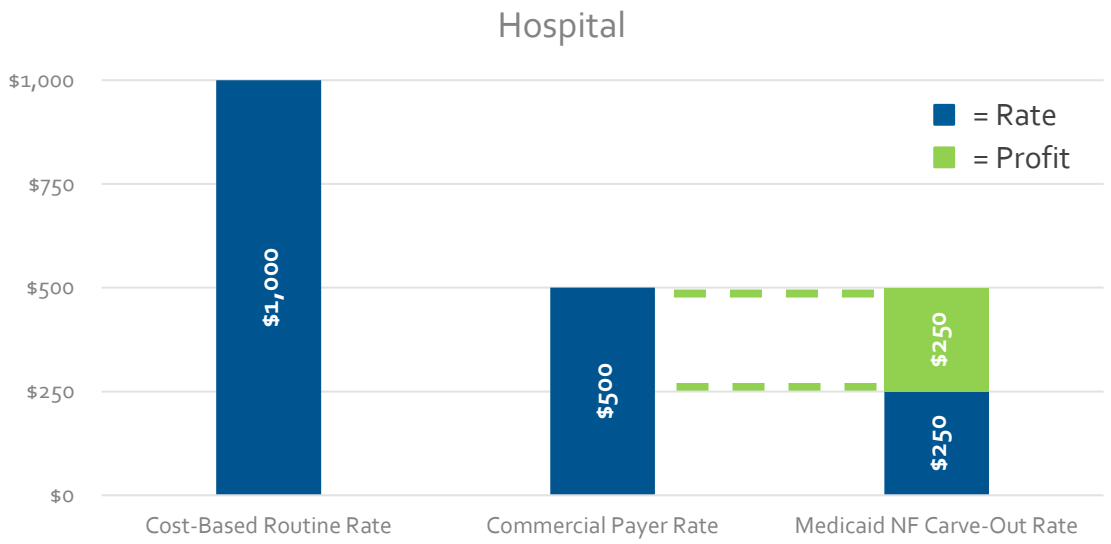
- **Non-Cost Based Swing Bed Days**
  - Cost-based reimbursement will only ever allow a hospital to break even
  - The opportunity: Non-Medicare or Medicare Advantage (Swing Bed NF) patient days
  - Common misconception: If contracted reimbursement rate is less than cost-based rate, negative financial 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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- **Swing Bed Economics**
  - Deliver additional inpatient (IP) rehabilitation services to the community
  - Provide increased reimbursement while assisting in length-of-stay management
  - Help to dilute fixed and step-fixed costs in the nursing unit
  - Financial benefit occurs by increasing the proportion of IP costs that are reimbursed on a cost basis
    - Reduces overall unit costs by diluting fixed costs related to IP services

Base Case

	ADC	Total Days	Cost-Based Mix	Cost-Based Days	Non-Cost-Based Days	Payment Per Day	Non-Cost-Based Payment
Acute (includes ICU)	5.9	2,154	83%	1,787	366	$ 1,750	$ 640,666
Observation	2.7	986	27%	266	719	1,250	899,269
Swing Bed - SNF	3.2	1,168	96%	1,121	47	1,250	58,400
Swing Bed - NF	0.1	37	0%	-	37	250	9,125
Total Days	11.9	4,344		3,175	1,169		$ 1,607,460
Total Acute, SB SNF, Obs		4,307	73%				
Inpatient Fixed Costs		$6,765,480					
Inpatient Variable Costs		1,096,825 [1]					
Swing Bed - NF Carve Out		(6,908)					
Total Inpatient Costs		$7,862,305					
Inpatient Costs Per Day				$ 1,825.47			
Cost-Based Payment				$5,795,451			$ 5,795,451
Total Payment							$ 7,402,911
Inpatient Costs Per Day							7,862,305
Net Margin							**$ (459,393)**

Swing Bed ADC Increase of 2.0

	ADC	Total Days	Cost-Based Mix	Cost-Based Days	Non-Cost-Based Days	Payment Per Day	Non-Cost-Based Payment
Acute (includes ICU)	5.9	2,154	83%	1,787	366	$ 1,750	$ 640,666
Observation	2.7	986	27%	266	719	1,250	899,269
Swing Bed - SNF	5.2	1,898	96%	1,822	76	1,250	94,900
Swing Bed - NF	0.1	37	0%	-	37	250	9,125
Total Days	13.9	5,074		3,876	1,198		$ 1,643,960
Total Acute, SB SNF, Obs		5,037	73%				
Inpatient Fixed Costs		$6,765,480					
Inpatient Variable Costs		1,242,825 [1]					
Swing Bed - NF Carve Out		(6,908)					
Total Inpatient Costs		$8,001,396					
Inpatient Costs Per Day				$ 1,588.52			
Cost-Based Payment				$6,156,437			$ 6,156,437
Total Payment							$ 7,800,397
Inpatient Costs Per Day							8,001,396
Net Margin							**$ (201,000)**
						Difference:	**$ 258,394**

1- Assumes $275/day marginal Acute/Obs costs and $200/day marginal swing bed SNF and NF costs

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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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- **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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