WASHINGTON WEBINAR SERIES

CAH FINANCIAL AND OPERATIONAL BEST PRACTICES

August 12, 2021

STROUDWATER

Financial and Operational Best Practices

- **Opportunities**
  - The following are the opportunities/recommendations from the 100+ Stroudwater CAH site visits conducted over the last three years
    - **<u>Economic Philosophy</u>**
      - The most important drive for a rural hospital is the overall mindset of the staff, management team and trustees where their commitment centers on abundance, growth and incremental contribution margin gains as opposed to a focus on expense management and cost reductions to the existing care model
        - Value is unlocked by the marginal revenue gain in a high fixed cost environment
        - Recognize that nearly all paying services create positive contribution
        - Economic imperative is the development of 1,000s of mini “contribution margins” to cover fixed costs of CAH
        - Cost-based reimbursement will only cover costs and not generate aggregate profit

Financial and Operational Best Practices

- **Provider Complement**
  - Create a catalog of all primary and specialty care providers within the primary and secondary service area to gain a better understanding of market competition and saturation
    - Ensure focus on increased competition through telehealth providers
  - Continue to evaluate the alignment and designation of each practice realizing that each designation type has certain financial/operational pros and cons
    - Evaluation must include both primary and specialty care providers
  - Continue to evaluate and explore relationships with specialty providers to increase both the access and number of services offered within the primary service area
  - Evaluate revising physician compensation contracts to include wRVUs, panel size, and quality scores
  - Utilize Medical Group Management Association (MGMA) provider benchmarks as guidelines for assessing provider efficiency levels, service growth, and contract production incentives
    - Establish productivity goals in conjunction with providers and review on a monthly basis

Financial and Operational Best Practices

- **Provider Complement**
  - Enhance alignment with the area primary care providers that strengthens clinic decisions rights, improves functional alignment and creates partnership opportunities
    - Engage all providers to ensure balanced participation
    - Review and revise Medical Staff By-Laws as needed to establish clear delineation of responsibilities and accountabilities
  - Conduct annual fair market value assessments and Stark Rule analyses for all employed physicians to comply with federal requirements
  - Implement OPPE (Ongoing Professional Practice Evaluation) and FPPE (Focused Professional Practice Evaluation) to ensure all providers meet hospital clinical performance standards necessary to maintain privileges
  - Evaluate opportunities to implement value-based initiatives such as the patient centered medical home (PCMH) model and/or team-based care to improve efficiency of practice and patient experience
    - Realize the continued push from volume- to value-based care

Financial and Operational Best Practices

- **Inpatient Services**
  - Target an admission rate (acute and observation status) of 10% of ED volume by partnering with medical staff to ensure appropriateness of care decisions, as well as to identify opportunities to reduce transfers
  - Implement systems to ensure all patients who are transferred to other hospitals for health care services are transferred back, when possible, for care delivery
  - Define the Care Spectrum (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
  - Develop an *Active Solicitation* swing bed marketing plan focused on offered services, targeting employed physicians, area providers, case managers, and *area hospitals*
    - Actively engage *area hospital* for swing bed opportunities that may be appropriate for the swing bed program at *hospital*
  - Investigate the use of Tele-Intensivist or e-Hospitalist programs and/or Advanced Practice Providers (NP/PA) to expand the number of options available for inpatient coverage

Financial and Operational Best Practices

- **Inpatient Services**
  - Elevate the development and promotion of the swing bed program as a strategic priority, targeting an ADC of 4 within 6 months
    - Implement Active Solicitation model to increase swing bed census
    - Educate the provider community on the benefits of cost-based reimbursement and the appropriate use of swing bed services
    - Develop focused swing bed marketing plan, targeting case managers within *hospital* as well as neighboring hospitals
    - Ensure that swing bed utilization is a priority with unit staff, case management staff and physician providers
  - Monitor required Swing Bed daily rate – an amount greater than the Medicaid Nursing Facility (NF) carve-out rate – required to generate a positive contribution margin by pursuing non-traditional arrangements, services, and patient types for care in Swing Beds
  - Streamline the post-acute care admissions process to ensure hospital does not lose out potential opportunities
    - For patient referrals, hospital should target a preliminary decision in less than 2 hours
  - Establish evidence-based standards for acute and post-acute care services
    - Ensure providers work with nursing staff to implement standards to improve patient outcomes

Financial and Operational Best Practices

- **Inpatient Services**
  - Reformat a distinct Intensive Care Unit (ICU) into a "High Observation" service and consolidate the ICU costs into the Med/Surg cost center
    - Evaluate the operational impact of consolidating the ICU into the Med/Surg department as a high acuity progressive care unit

Med/Surg, Swing Bed - SNF, and Observation	Current	Proposed (inc. ICU)	Variance
Routine Cost	$ 9,594,056	$ 11,918,076	$ 2,324,020
Total Days	3,174	3,595	421
Routine Rate:	$ 3,022.70	$ 3,315.18	$ 292.48
Medicare & Advantage Days	1,951	2,193	242
Medicare Routine Reimb:	$ 5,897,292	$ 7,270,192	$ 1,372,901
Intensive Care Unit			
Routine Cost	$ 2,324,020	$ -	$ (2,324,020)
Total Days	421	-	(421)
Routine Rate:	$ 5,520.24	$ -	$ (5,520.24)
Medicare & Advantage Days	242	-	(242)
Medicare Routine Reimb:	$ 1,335,897	$ -	$ (1,335,897)
Total Medicare Routine Reimb	**$ 7,233,189**	**$ 7,270,192**	**$ 37,003**

Financial and Operational Best Practices

- **Inpatient Services**
  - Utilize InterQual-like criteria resources to educate providers and enforce proper usage of observation admission criteria
  - Implement hourly rounding and bedside handoff models for nurses to optimize multidisciplinary communication
  - Integrate Pharmacist into the inpatient care delivery model to meet with patients, as necessary, to discuss medication questions and visits with patients upon discharge
  - Track and monitor Nurse/Patient ratios against industry standards and flex staffing levels based on the current patient complement
    - Staffing levels must take into account both volume and patient acuity
  - Target 15 – 25% of acute days as observation
    - Review and educate the medical staff on admission and observation status criteria

Financial and Operational Best Practices

- **Emergent Services**
  - Implement systems to ensure patients who present to the ED of a non-emergent nature are redirected to clinics, when open, to receive care
    - Recognize that if the CAH does not offer urgent care services, patients with high deductibles may leave rural community for care
  - Develop ED-hospitalist model coverage capability with ED provider and APP to improve care and admissions capability, and to reduce transfers
    - Include tele-specialist services to increase access to care and reduce potential transfers
  - Work with system partner to review appropriateness of transfers and leverage development of ED-hospitalist coverage model to enable patients to remain at *hospital* for care when medically appropriate
    - Review patient transfers for potential missed opportunities
  - Track ED standby time unless contracted Emergency Department providers/contractors bill for professional services; if so, the hospital does not need to track standby time (it is generally 100% of contracted time)

Financial and Operational Best Practices

- **Emergent Services**
  - Engage the hospitalists and ED providers to focus on improved collaboration that results in enhanced patient throughput
  - Track and monitor KPIs related to the ED, including:
    - ED admissions (acute/observation) as a percentage of ED visits to between 8% and 10%
    - Transfer rates as a percentage of ED visits to below 5% of all ED visits
    - Note: Track ED KPIs at the individual provider level

Financial and Operational Best Practices

- **Quality Improvement**
  - Report of public metrics to increase accountability and to compete regionally on quality scores through marketing of public quality and patient safety metrics
    - Emphasize importance of quality improvement to staff from the top down
    - Ensure that participation in quality metrics measurement and reporting includes MBQIP participation for CAHs
    - Consider dedicating additional staff resources to support quality improvement efforts if necessary
  - Convene a Patient Family Advisory Council with community member participation
  - Establish specific targets based on KPIs for the Quality Committee that focus on the entire care continuum then use those KPIs to drive outcomes and improve performance
  - Implement a Performance Improvement Executive Committee (PIEC) that integrates quality and revenue cycle into a single performance improvement initiative

Financial and Operational Best Practices

- **<u>Quality Improvement</u>**
  - Elevate quality as a strategic priority with the goal of being best in the region within 12 months
    - Continue to update the Board and Medical Staff on quality performance and initiative progress on a monthly basis
    - Develop an optimal portfolio of members of the Quality Improvement program to include CFO and EVS
    - Identify and partner with medical staff champions to drive improved performance
    - Drive accountability for care quality, outcomes, and patient satisfaction across all staff and providers
    - Leverage quality as a strategic driver of market share and widely promote performance results in outreach and marketing efforts

Financial and Operational Best Practices

- **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
  - Establish a KPI measurement system and set targets for all KPIs and strategies put in place to specifically address improving KPIs to targeted levels
  - Implement a revenue cycle task group as a subgroup that meets at least bi-weekly that includes representatives from clinical, financial, administrative, medical staff, health information management, and the business office to oversee and drive improvements regarding the revenue cycle process
    - Leverage data and technology to validate initiatives and drive improvement efforts
  - Establish workflow to pre-register all scheduled services including appointment verification, insurance verification, and a co-insurance discussion with patient
  - Ensure 100% of outpatient procedures are scheduled and pre-registered with proactive communication of patient co-payment expectations/estimated costs

Financial and Operational Best Practices

- **Revenue Cycle**
  - Implement a bad debt policy that establishes when claims will be deemed worthless and uncollectable for inclusion on the cost report
  - Prioritize improvement of POS cash collection amounts, with particular focus in all outpatient departments, and hold staff accountable through the creation of POS collection goals
    - Establish similar POS cash collections in hospital-owned physician practices
    - Use current revenues as the basis for establishing POS collection goals for each department
  - Implement a quick pay discount that matches the average commercial discount to increase cash flow and reduce bad debt
  - Conduct a comprehensive annual review of chargemaster (CDM) to ensure charge level appropriateness, targeting levels of 150-175% of Medicare pricing or at a level that is competitive within the market

Financial and Operational Best Practices

- **Cost Report Improvements**
  - Establish a bad debt policy that pulls claims back from the collection company, after a certain period of inactivity, for inclusion on the cost report
    - Target outpatient Bad Debt 10% of patient responsibility
  - Work with cost report preparer to determine if investment funds can be designated as funded depreciation to avoid significant offset
  - Implement a time study process and conduct medical record time studies to accurately capture true worked time by department for inclusion on the cost report
  - Monitor Worksheet E, Part B (Outpatient) to ensure the hospital is not passing on greater than 40% of the cost of care to the beneficiaries in the way of co-insurance and/or deductibles
  - Evaluate med/surg department square footage to incorporate the hallways to ensure accuracy of cost report; Minimum expectation is at least 300 square feet allocated for each inpatient bed

Financial and Operational Best Practices

- **Cost Report Improvements**
  - Utilize best practice time study methodology to ensure physician stand by time is accurate and fairly reflected on the cost report
    - Evaluate technology-based solutions that automate time tracking functions

	Current (@38 min)	Proposed (@20 min)	Variance
Total Cost	$ 3,048,843	$ 3,495,690	$ 446,847
Total Charges	$ 17,274,567	$ 17,274,567	$ -
RCC	0.176493	0.202361	0.025867
Medicare Charges	$ 6,035,289	$ 6,035,289	$ -
Medicare Reimb:	**$ 1,065,187**	**$ 1,221,304**	**$ 156,117**

  - Track Part A time for physicians via Time Studies for Medical Directorships, etc.

  - Monitor Ratio of Cost to Charge (RCC) levels to potentially indicate revenue cycle process improvement opportunities such as charge setting and/or charge capture improvement opportunities

Financial and Operational Best Practices

- **Cost Report Improvements**
  - Monitor appropriate assignment of non-Medicare or Medicare Advantage Swing Bed patients to Line 6 on Worksheet S-3-1 on the Medicare Cost Report

	Current	Proposed	Variance
Inpatient Routine Cost	$ 4,755,535	$ 4,755,535	$ -
NF Carve Out	$ 90,664	$ 104,482	$ 13,818
Total Cost:	$ 4,664,871	$ 4,651,053	
Total Days*	4,710	4,603	(107)
Routine Rate / Day:	$ 990.42	$ 1,010.44	$ 20.02
Medicare & Medicare Advantage Days*	3,777	3,777	-
Routine Reimb:	**$ 3,740,811**	**$ 3,816,430**	**$ 75,619**

* Days include Med/Surg, Swing Bed SNF, and Obsevation

  - Evaluate LDPR vs Med/Surg room usage based on observation status vs. active labor time status time studies to accurately allocate square footage
    - Ensure costs for LDRP include only the time assigned to “active” delivery otherwise these costs should be allocated to the Med/Surg cost center
  - Monitor departments with low charges relative to cost to ensure they are not missing charge opportunities, as this has a direct impact on ‘bottom line’

Financial and Operational Best Practices

- **Cost Report Improvements**
  - Evaluate the salaries included in Nursing Administration and ensure only the Chief Nursing Officer (CNO) and direct administrative support staff are included in this category
    - Ensure Nursing Administration costs are allocated only to departments that involve nursing functions – exclude departments such Imaging, Therapy, Laboratory, Pharmacy
  - Establish an internal threshold (such as a due from Medicare in excess of $500K) that would drive the completion and filing of an interim cost report
  - Consider consolidating RHCs for cost report purposes to remove reimbursement variances
    - The change in the RHC reimbursement methodology may impact the ability to consolidate RHC cost reports

	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Clinic 6	Clinic 7	Combined Totals	Consolidated Totals	Variance
RHC Allowable Cost	$ 397,089	$ 451,751	$ 309,335	$3,014,634	$4,326,832	$2,978,745	$ 349,383	$ 11,827,769	$ 11,827,769	$ -
Visits	1,432	1,883	1,761	15,845	23,906	8,967	1,731	55,525	55,038	(487)
Cost / Visit	$ 277.30	$ 239.91	$ 175.66	$ 190.26	$ 180.99	$ 332.19	$ 201.84	$ 193.61	$ 214.90	$ 21.29
Medicare Visits	395	498	512	4,061	6,260	315	249	12,290	12,290	-
Totals	$ 109,532	$ 119,475	$ 89,937	$ 772,637	$1,133,020	$ 104,640	$ 50,258	$ 2,379,499	$ 2,641,144	$ 261,645

  - The Proposed 2022 Payment Policies under the Physician Fee Schedule states Medicare will no longer allow new RHCs to file consolidated costs reports beginning with RHCs enrolled in Medicare as of January 1, 2021

Financial and Operational Best Practices

- **Management Accounting**
  - Engage managers in the process of developing operating and capital budgets to foster ownership and accountability
    - Educate all managers on the budget process and basic financial management principles
    - Industry best practice uses the zero-based budget methodology
  - Consistently hold managers accountable for monthly variance reporting by requiring rationale and actions related to positive/negative budget variances
- **Staffing Benchmark Analysis**
  - Use volume-based staffing benchmarks to evaluate departmental staffing levels for possible inefficiencies
    - Continue to monitor departments/units, recognizing that staffing maybe already be at a minimum threshold
  - Ensure balanced effort on managing staff and growing services

Financial and Operational Best Practices

- **Affiliation Strategy**
  - Evaluate strategic partnership options using the Affiliation Value Curve to guide the determination of mutual opportunities with an emphasis on the following priorities:
    - Development of primary care and sustainable specialty care resources in the region
    - Expansion of outpatient services, as well as clinical integration with regional partners to enable seamless coordination of care
    - Negotiating leverage with third party payers

- **Provider Alignment**
  - Pursue increased alignment with regional primary care providers in the service area through *functional*, *contractual* and *governance alignment strategies* given the future importance of primary care network development to developing payment systems

  - Given the future importance of primary care network development to developing payment systems, pursue increased interdependence with employed and other primary care providers in the service area through functional, contractual and governance alignment strategies

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