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Margin Improvement for Rural (any) Hospitals

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Introductions



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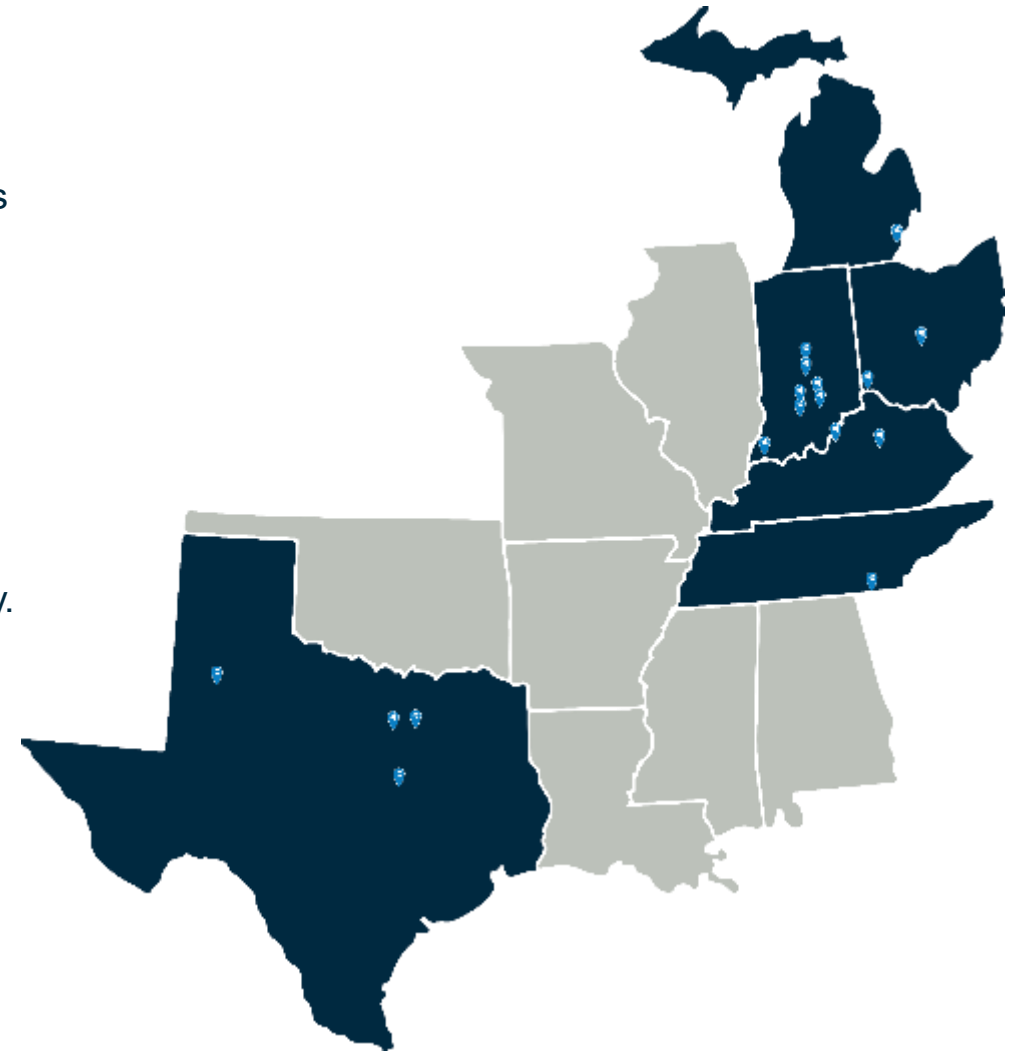
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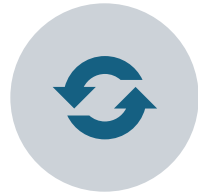
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Learning Objectives



Discuss revenue cycle strategies to optimize performance for rural organizations.



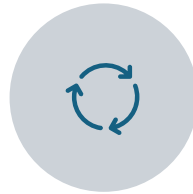
Explore common pitfalls seen with productivity in rural hospitals.



Review opportunities related to pharmacy strategy for rural hospitals.



Discuss outpatient clinic strategies and reimbursement optimization.



Explore charge capture, revenue integrity, and continuous revenue cycle process improvement.



Margin Improvement

What is Margin?

$$\text{Operating Margin} = \frac{\text{Operating Revenue} - \text{Operating Expenses}}{\text{Operating Revenue}}$$

Two fundamental levers to improve margin:

- Increase revenue
- Decrease expenses

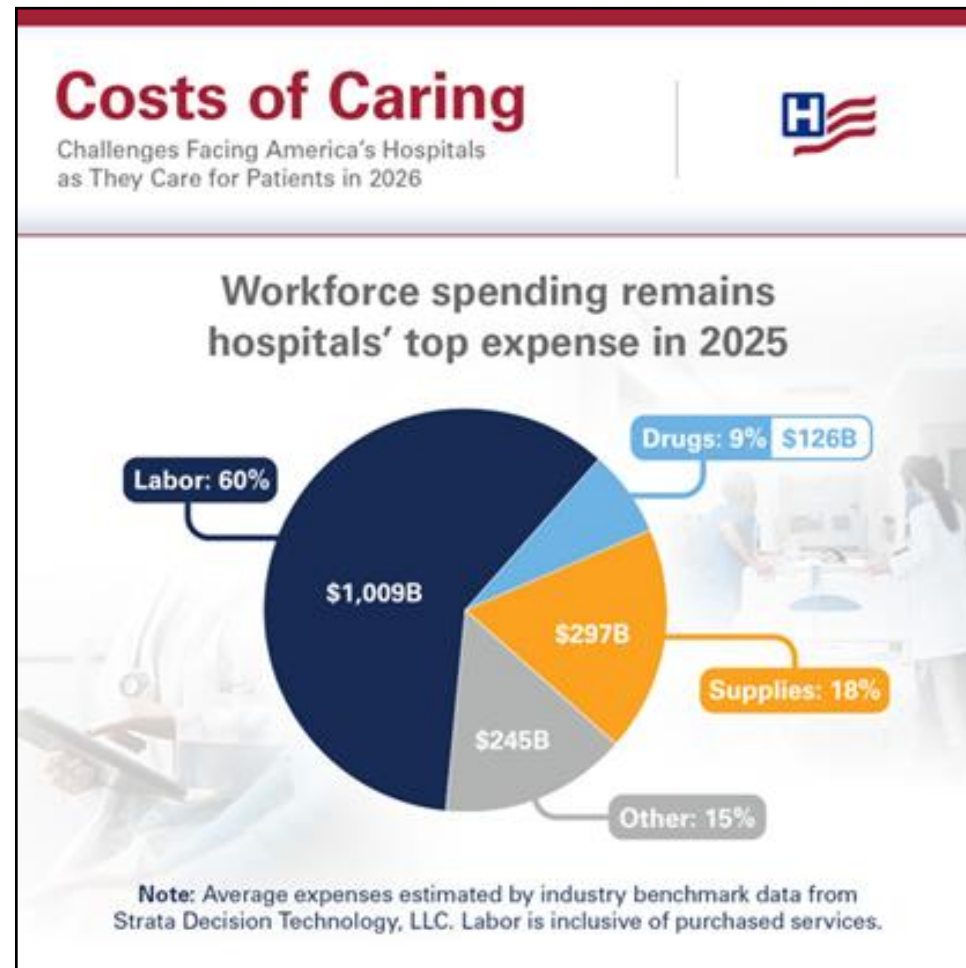


Labor Costs & Productivity Opportunities

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What are top hospital expenses?



Source: American Hospital Association Costs of Care Report.

From AHA Costs of Caring Report. [https://www.aha.org/costsofcaring#:~:text=Workforce%20remains%20hospitals'%20largest%20expense,workers%20\(see%20Figure%201\).](https://www.aha.org/costsofcaring#:~:text=Workforce%20remains%20hospitals'%20largest%20expense,workers%20(see%20Figure%201).)



Labor Costs- How is Ohio?

Labor Percent of Net Patient Revenue						
Nationally						
Year	All	CAH	< 25	25-100	100-300	300+
2022	47.3%	52.2%	49.6%	49.0%	45.0%	44.7%
2023	46.8%	52.0%	51.0%	48.3%	43.9%	42.8%
2024	45.4%	51.2%	50.4%	46.9%	42.4%	40.9%
2025	44.7%	50.2%	50.8%	45.8%	41.8%	39.5%
Ohio						
Year	All	CAH	< 25	25-100	100-300	300+
2022	43.5%	44.8%	37.6%	47.4%	41.3%	41.6%
2023	40.8%	41.4%	35.5%	43.4%	40.0%	38.6%
2024	39.6%	40.3%	35.8%	41.6%	39.2%	37.3%
2025	37.9%	38.3%	39.3%	36.3%	40.0%	37.3%

- Data set limited to general, short-term acute care hospitals
- 2025 data set remains limited in size
- Excluded hospitals with labor costs exceeding net patient revenue
- Ohio labor costs are below national comparison groups
- Consistent trend of improvement since COVID-19



Labor Costs

Identifying opportunities:

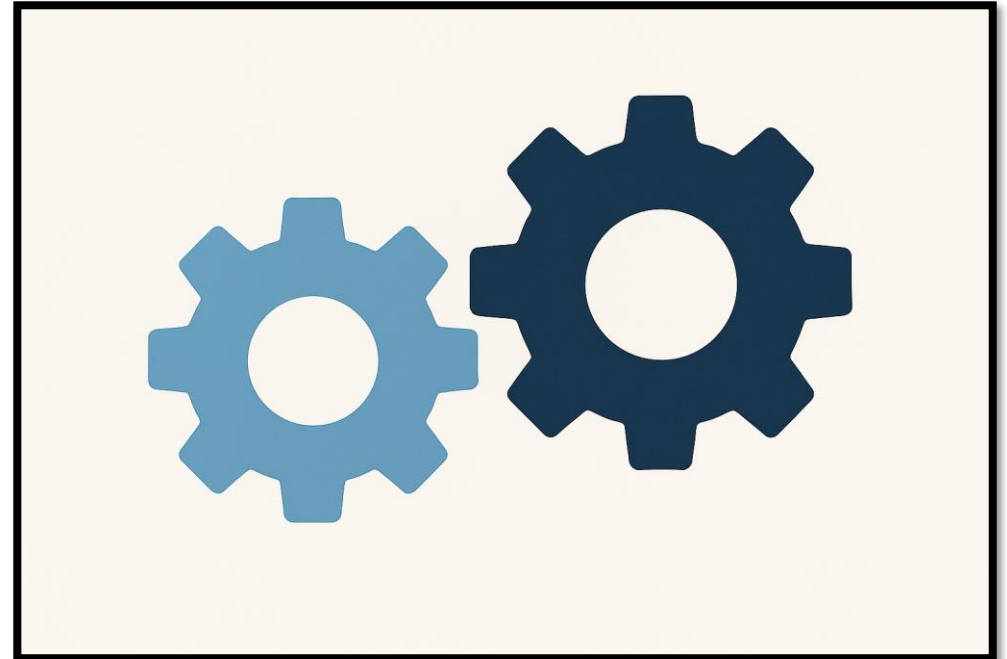
- Benchmark your hospital against national and Ohio data
- Has your hospital seen a decline in labor costs as a percentage of net patient revenue since COVID-19?
- Most opportunity exists at the department level
- Do you speak WHPUOS?



Labor Costs

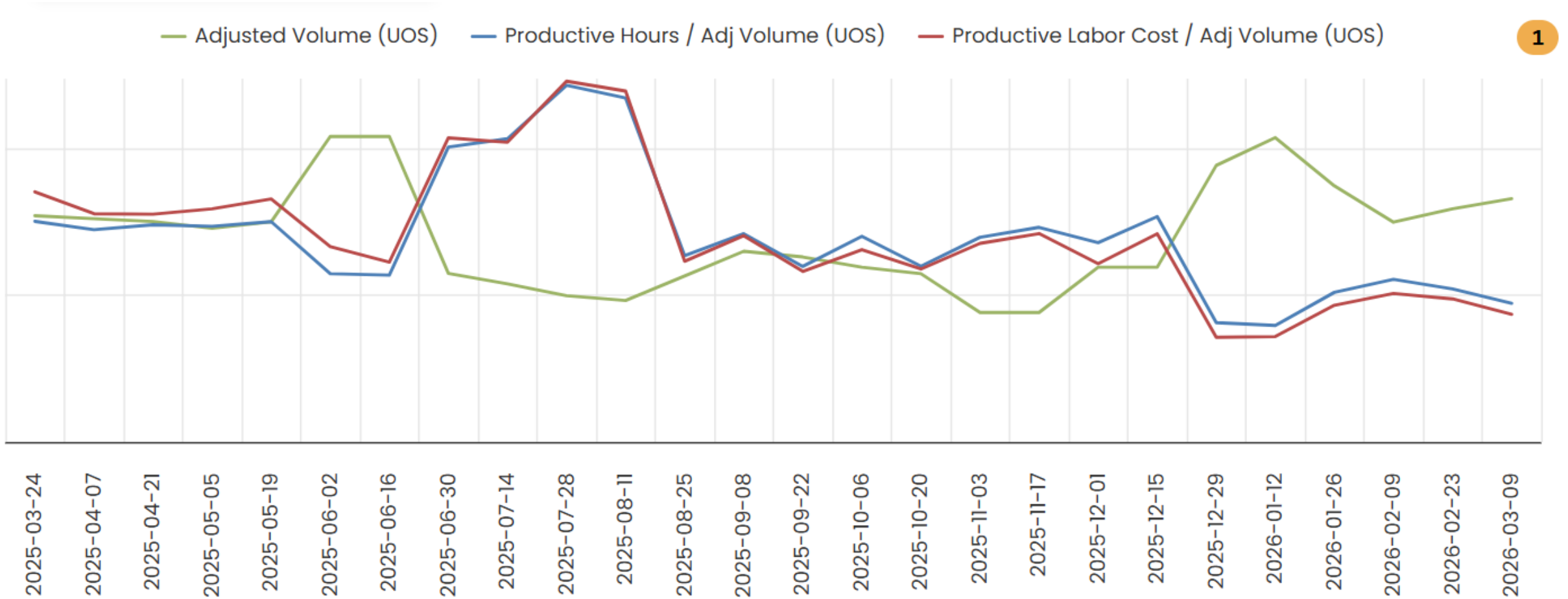
Productivity:

- Typically measured in WHPUOS (Worked Hours Per Unit of Service)
- Calculated as total worked hours divided by total units of service (volume)
- Enables benchmarking and comparisons across similar departments
- Track and review every pay period; establish processes to flex staffing daily, or every four hours for high-variability units



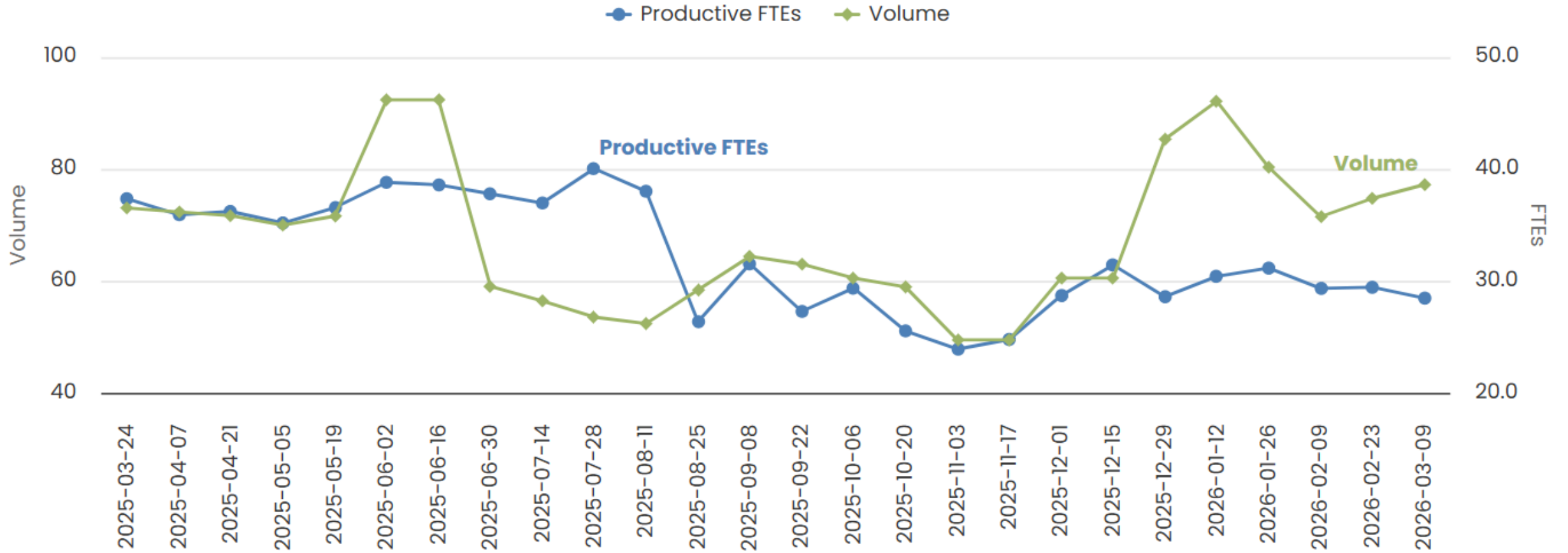
Labor Costs – Example Data

(Critical Access Hospital Medical/Surgical Unit)



Labor Costs – Example Data

(Critical Access Hospital Medical/Surgical Unit)

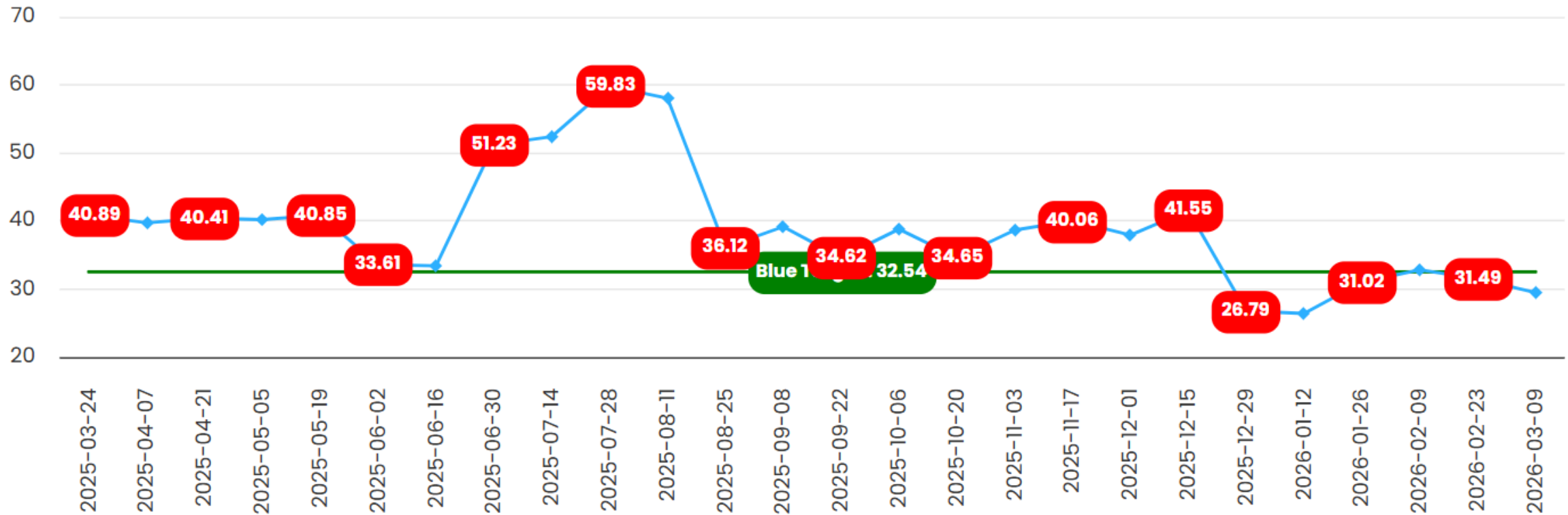


Labor Costs – Example Data

(Critical Access Hospital Medical/Surgical Unit)

Performance History Productive Hours / Patient Days

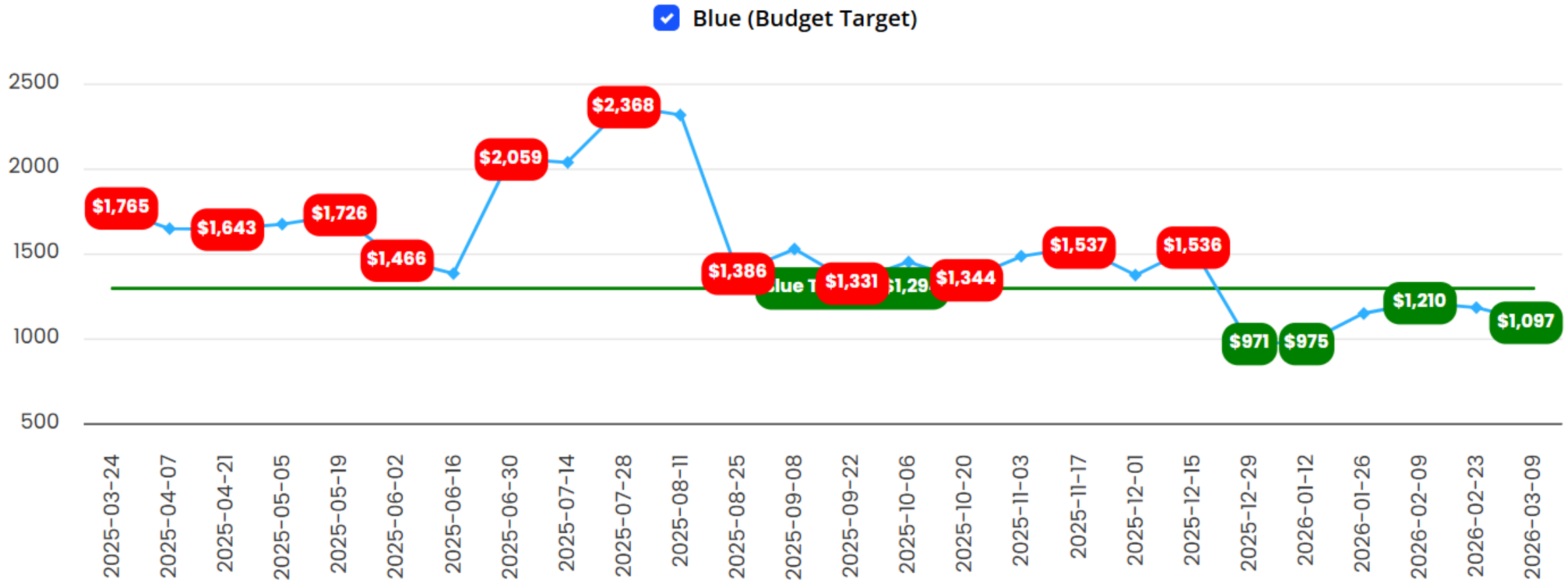
Blue (Budget Target)



Labor Costs – Example Data

(Critical Access Hospital Medical/Surgical Unit)

Performance History Labor Cost / Patient Days



Labor Costs – Key Opportunities

- Establish a labor committee and monthly operating review process – make productivity tangible and actionable
- Deploy a reliable productivity measuring system and clear targets
- Validate targets against external benchmarks
- Transition from retrospective review to concurrent staffing and productivity oversight (daily, or every 4–6 hours).
- Secure executive sponsorship to reinforce the productivity strategy and protect processes from being bypassed
- Approach productivity as a sustained discipline, a marathon, not a sprint
- Explore creative alternatives before engaging or continuing agency labor (e.g., unit consolidation, OR block utilization review)



Specialty Pharmacy Opportunities

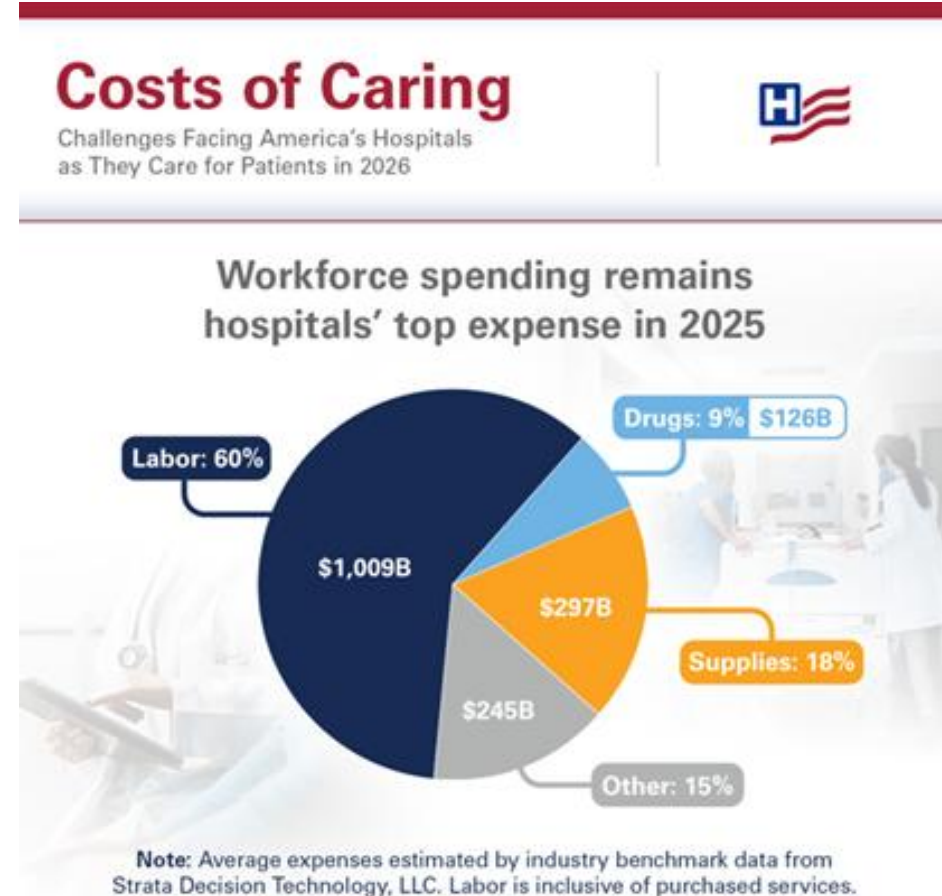
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Specialty Pharmacy Opportunities

Pharmaceuticals represent approximately 9% of total hospital expenses

Is reducing medication expense always the right objective?



Specialty Pharmacy Opportunities

What is a specialty drug?

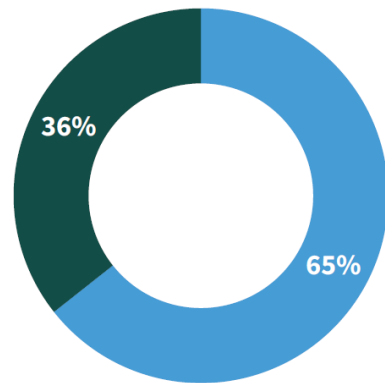
- Expensive, generally over \$800 per month or used to treat a rare condition
- Requires special handling or enhanced safety monitoring
- Subject to limited distribution



Specialty Pharmacy - Background

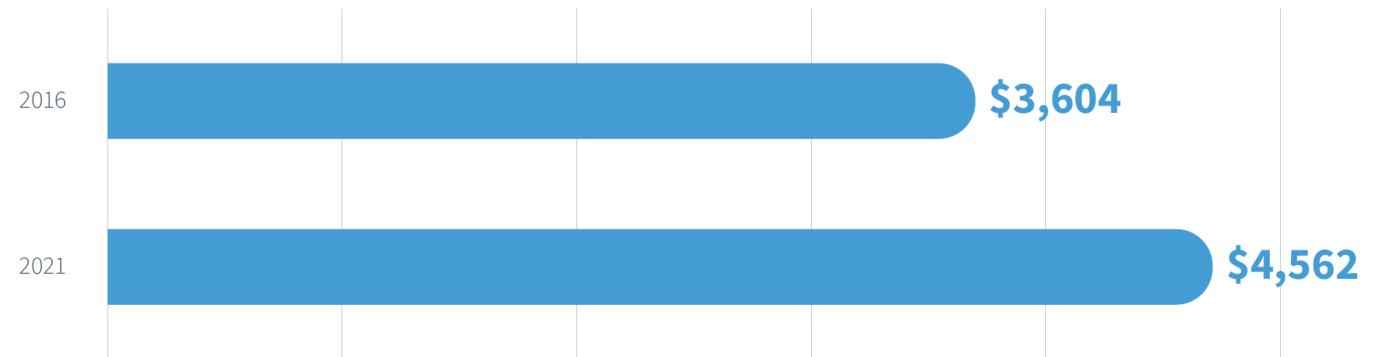
Key Statistics:

- In 2022, specialty medications accounted for 51% of total U.S. drug spending
- Approximately 5.5% of the US population uses a specialty medicine (up from 4.8%, 2019)
- Specialty medicines account for over 75% of the 7,000+ new drugs in development
- White bagging vs brown bagging vs clear bagging
- Not every drug is subject to limited distribution



● Pharmacy Benefit ● Medical Benefit

Pharmaceutical Strategies Group. 2022 Artemetrx State of Specialty Spend and Trend Report. Dallas, TX: PSG.



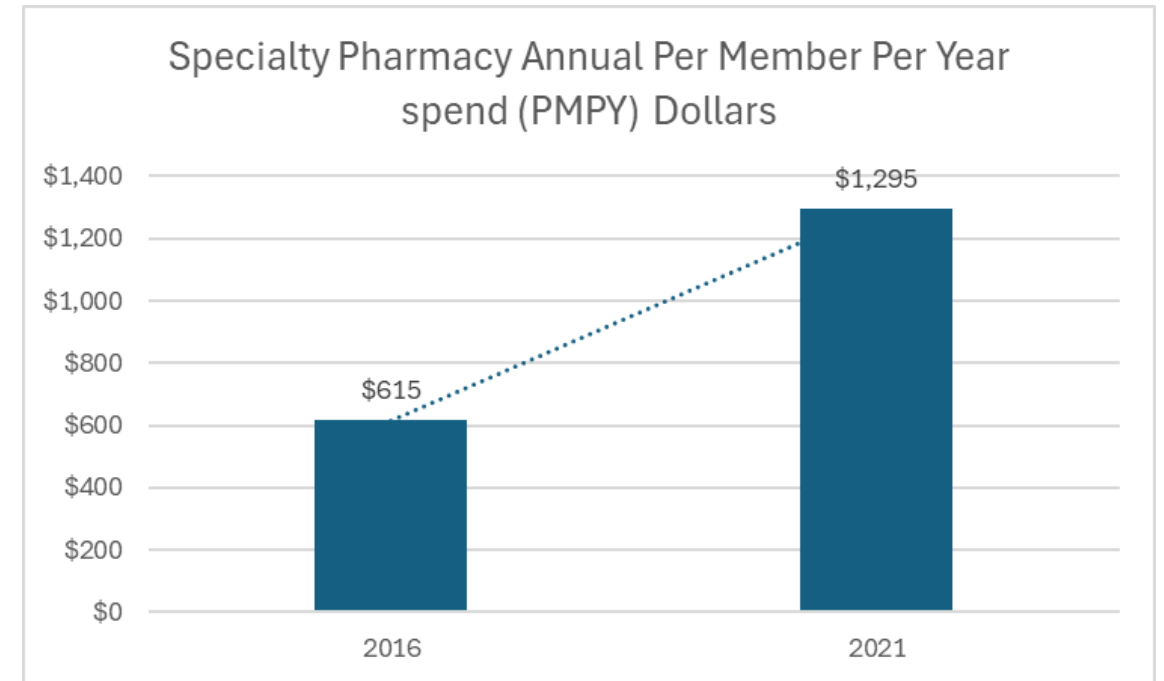
The average cost of a specialty drug on the pharmacy benefit has grown from \$3,604 (2016) to \$4,562 (2021).



Specialty Pharmacy – Market Estimation

Are there any specialty pharmacy patients near you?

- Specialty medications are used by roughly 5% of the population
- How many patients does your organization serve? 100K?
- A market of 100,000 patients equates to \$129.5 million of annual specialty drug spend
- Per-patient specialty drug spend rose to \$1,641 in 2024
- Trend slowed to 10% increase/yr



Specialty Pharmacy – Necessity?

- Specialty pharmacy represents >50% of medication costs
- Hospitals do not refer lab or radiology patients to random providers — the same principle applies here
- Hospital owned specialty pharmacies represent quality difference (EMR integration) for our highest-risk patients
- Operating margins of 2-5% on substantial revenue and can be meaningfully higher for eligible 340B entities
 - 3% of \$20,000 = \$600



Specialty Pharmacy – Strategic Opportunity

3 scenarios for Hospital Pharmacies:

1. No specialty pharmacy – start one!
2. Limited specialty pharmacy (resource constrained) – quantify the opportunity and make an appropriate investment
3. Fully accredited and mature specialty pharmacy– periodically assess for leakage and additional optimization opportunities

The revenue opportunity is significant for critical access hospitals and larger organizations alike.



Outpatient Clinic Reimbursement Opportunities

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Clinic Designations – Time for Review

Due to various regulatory and reimbursement changes, now is the opportune time to review your outpatient clinic strategy.

Designation Types:

- 1) Provider-Based Clinic
- 2) Rural Health Clinic
- 3) Physician Office



Provider-Based Clinics

Definition: Clinics that are operating and billing as hospital outpatient departments.

These clinics are:

- Enrolled on the hospital CMS-855A
- Reported in a reimbursable department on the Medicare Cost Report
- Billed with Place of Service (POS) 19 or 22
- Able to be on-campus (within 250-yards) or off-campus
- Required to meet provider-based regulations per 42 CFR 413.65



Provider-Based Clinics

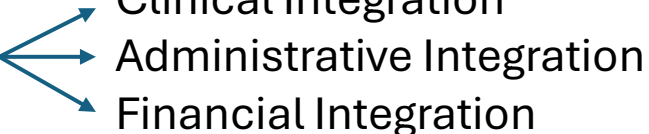
Reimbursement:

- **PPS Hospitals:**
 - On Campus = 100% OPPS
 - Off-Campus =
 - PO Modifier: 40% OPPS for E&M and 100% OPPS for other services
 - PN Modifier: 40% OPPS
- **Critical Access Hospitals**
 - 101% of Cost
- 340B eligible if parent hospital participates in the program



Provider-Based Clinics

Challenges/Considerations:

- Must meet provider-based requirements 
 - Clinical Integration
 - Administrative Integration
 - Financial Integration
- Split-billing pushback
- Critical Access Hospital distance requirements
 - Do NOT want to jeopardize CAH designation
- New Off-Campus Reporting requirements effective 12/31/2027
 - Separate NPI number for each location
 - Provider-Based Attestation for each location



Rural Health Clinics

Definition: A special Medicare designation for clinics designed to increase primary care services in rural and underserved areas.

These clinics are:

- Located in Rural (non-urbanized) areas
- Located in Medically Underserved Areas (MUA) or Health Professional Shortage Areas (HPSA)
- Enrolled on a CMS-855A
- Billed on a UB-04 for RHC Services



Rural Health Clinics

Reimbursement: Paid at an all-inclusive rate (AIR), up to a cap.

- Cap for 2026 = \$165 per eligible visit
- Can be provider-based or independent
 - Provider-based may be 340B eligible, if parent hospital participates



Rural Health Clinics

- **Challenges/Considerations:**
 - Must be certified and go through the survey process
 - The Compliance Team, QUAD A, The Joint Commission
 - Can be a balance to hit the “Sweet Spot” for reimbursement
 - Must meet certain requirements:
 - Staffing (NP, PA, or CNM available 50% of the time the clinic is open)
 - Policy & Procedure Manual
 - Lab Tests, emergency preparedness requirements, and more
 - Required to file a Medicare Cost Report
 - Part of the hospital’s if provider-based



Physician Offices

Definition: A clinic/group practice that is NOT part of a hospital.

These clinics are:

- Enrolled on a CMS-855B
- Billed on a CMS-1500 form using POS 11
- Reported as non-reimbursable on the hospital cost report**

Reimbursement:

- Medicare Physician Fee Schedule



Physician Offices

More straightforward, but still some strategy involved if part of your hospital or health system, in particular:

- Tax ID Number:
 - Under the hospital?
 - Under a separate Medical Group?

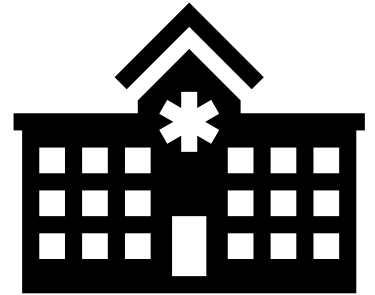
This could have implications on your Medicare Cost Report, especially if you are a Critical Access Hospital.



Outpatient Clinic Strategy Steps

Review the following for each outpatient site:

- 1) Eligibility criteria for various designations
- 2) Compliance capabilities
- 3) Operational resources
- 4) Financial Impact



Charge Capture & Revenue Integrity Opportunities

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Charge Capture & Revenue Integrity


- What is it?
- Why this cannot be overlooked
- Why does the entire Revenue Cycle matter?
- Common Opportunities & Countermeasures
- CAH Example
- Leadership, Accountability, Governance
- Conclusion

What is it?

Charge capture and reconciliation ensures the organization captures services and items accurately and completely.



Revenue integrity ensures the charges remain compliant, defensible, and consistent.



Revenue cycle continuous improvement uses that integrity to reduce rework, leakage, and risk over time.



Why this cannot be overlooked

- **Reimbursement uncertainty is increasing** due to federal and state budget pressure, with more audits and payment controls—making year-end Medicare settlements and cost-to-charge ratios critical.
- **Missed charges can reduce reimbursement** and cannot be recovered later; charge capture and revenue integrity are largely within the hospital's control.
- **Strong daily charge capture and documentation reduce audit risk**, protect reimbursement, and support long-term financial stability without increasing volume.



Why the Entire Revenue Cycle Matters

- **Front End:** Registration accuracy, patient status, valid orders, and medical necessity set the foundation for correct billing
- **Middle Cycle:** Documentation and coding alignment pose the highest risk for silent charge leakage, especially where nursing documentation and CDM alignment drive outpatient revenue
- **Back End:** Clean claims, timely billing, denial management, and underpayment follow-up are critical in low-volume services where every claim has impact



Common Opportunities + Solutions

Issue	Countermeasure	What This Fixes	Key Stakeholders
Fragmented workflows and siloed teams	Establish a closed-loop improvement cycle: Identify → Correct → Measure → Standardize → Monitor	Prevents small errors from repeating and compounding into revenue loss	Clinical leaders, Revenue Cycle, Finance, IT, Managed Care, Compliance
Missing charges and unclear workflows	Implement daily reconciliation routines and standardized documentation templates	Catches missing, late, or duplicate charges early	Nursing, Providers, Revenue Integrity, Coding
Lack of ownership and accountability	Define clear roles and accountability across handoffs	Reduces ambiguity and rework	Clinical Ops, Revenue Cycle Teams
Misalignment between documentation, coding, and charging	Regular interdisciplinary reviews and feedback loops	Ensures services documented are translated into compliant charges	Clinical Teams, Coding, CDM, Compliance
Reactive fixes instead of sustainable improvement	Elevate revenue integrity as a strategic priority	Creates consistent, defensible charge capture over time	Leadership, All Departments



Charge Reconciliation Protected Revenue and Compliance in a CAH

AREA IDENTIFIED	ISSUE FOUND	IMPACT
Laboratory & Imaging	Documented services not billed	~\$100K annual missed reimbursement
Respiratory Therapy	Charges continued after therapy stopped	Compliance and audit risk reduced
Cost-Based Reimbursement	Incomplete charge data feeding cost report	Improved cost settlement accuracy
Operations	Manual workflows without validation	Reduced rework and late charges



Leadership, Accountability & Governance

- Executive Sponsorship
- Clear Governance
- Education
- KPI Monitoring (Oversight)
- Sustained Reinforcement



Conclusion



**Revenue
Protection**



Compliance



Transparency



Questions? *Contact us:*



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Thank You

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