2025 Rural Hospital and Clinic

Revenue Optimization Virtual Conferences

WINTERGREEN

NOSORH

NOSORH and SORH:
Your Partners in Rural Health

National Organization of
State Offices of Rural Health

Chris Salyers, DHSc
Director of Programs & Evaluation

National Organization of State Offices of Rural Health

- Rural communities are wonderful places to live, work, and play!
- Rural communities are unique, requiring localized innovative solutions
- Rural is often underinvested by government and philanthropic programs
- Rural always does more with less by leaning into their neighbors (*partners)*

NOSORH
National Organization of
State Offices of Rural Health

National Organization of State Offices of Rural Health

Promotes the capacity of State Offices of Rural Health and *rural stakeholders* to improve health in rural America through leadership development, advocacy, education and **partnerships**.

National Organization of
State Offices of Rural Health

NOSORH
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State Offices of Rural Health

3 Core Functions:

- Information Dissemination
- Rural Health Coordination
- Technical Assistance

Other Funding:

- Small Hospital Improvement Program
- Rural Hospital Flexibility Program

A True Part of the State:

- **37** are in state government
- **10** are within academic institutions
- **3** are independent non-profits

Member Directory at nosorh.org

National Organization of
State Offices of Rural Health

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NOSORH Opportunities

- Grant Writing Courses
  - Foundational and Advanced
- Rural Health Leadership Institute
- Rural Health Capital Resources Masterclass
- Rural Health Clinic Mock Survey Masterclass
- Rural Primary Care Institute

NOSORH Institutes

National Organization of
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PowerOfRural.org

- Free Tools & Resources
- Community Star stories
- Key Messages
- Celebration Ideas

…and more!

National Rural Health Day®

Celebrating the **Power of Rural!**

Questions?

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Importance of Revenue Optimization for Operators

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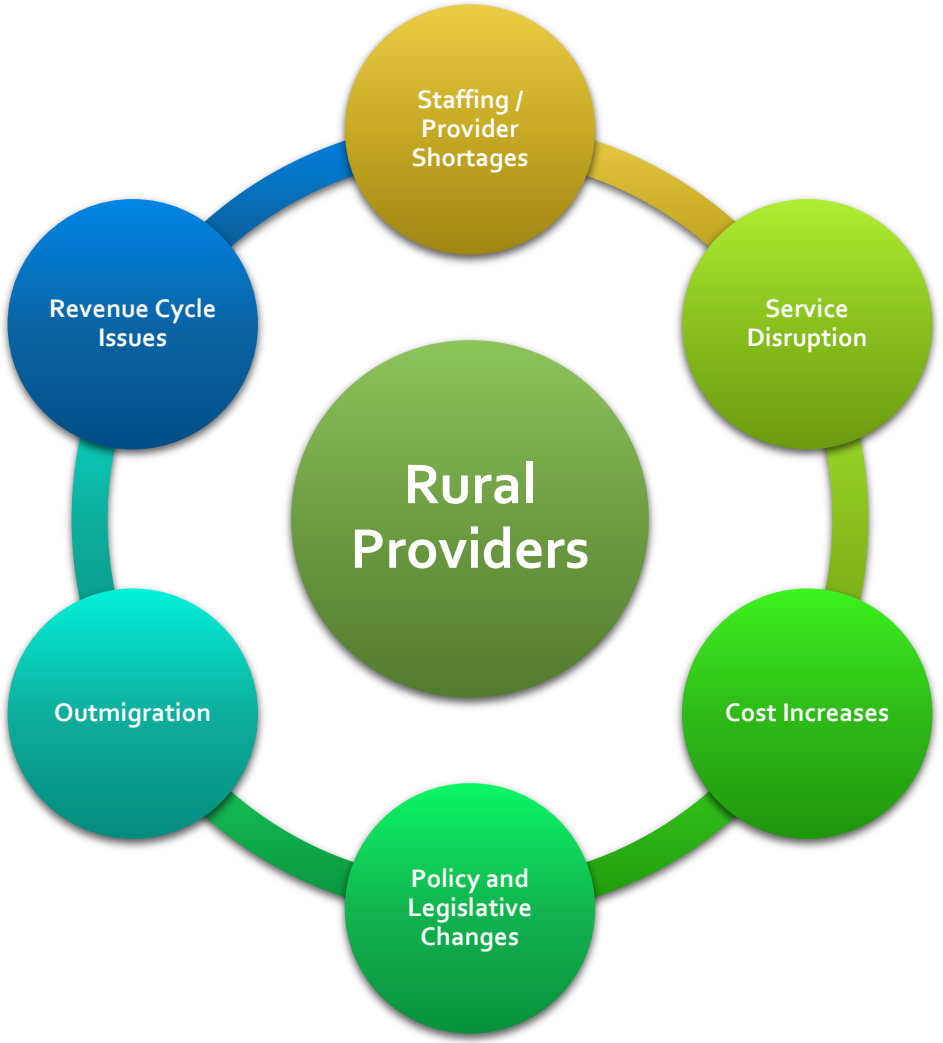
The Current Landscape

- 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



Changing the Dynamic

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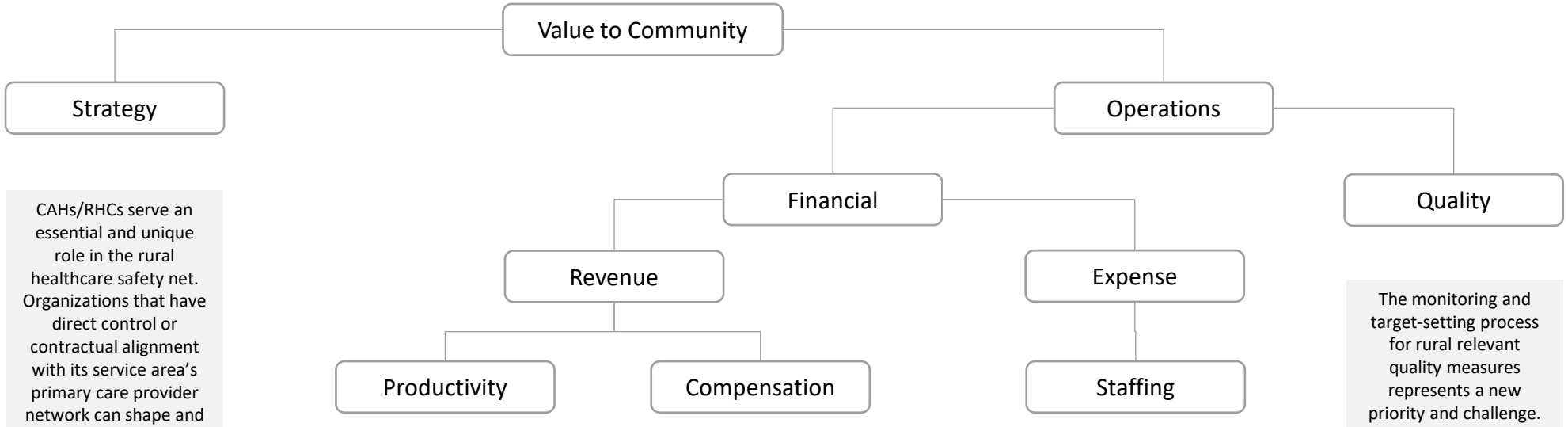
Revenue vs. **Expenses**

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.

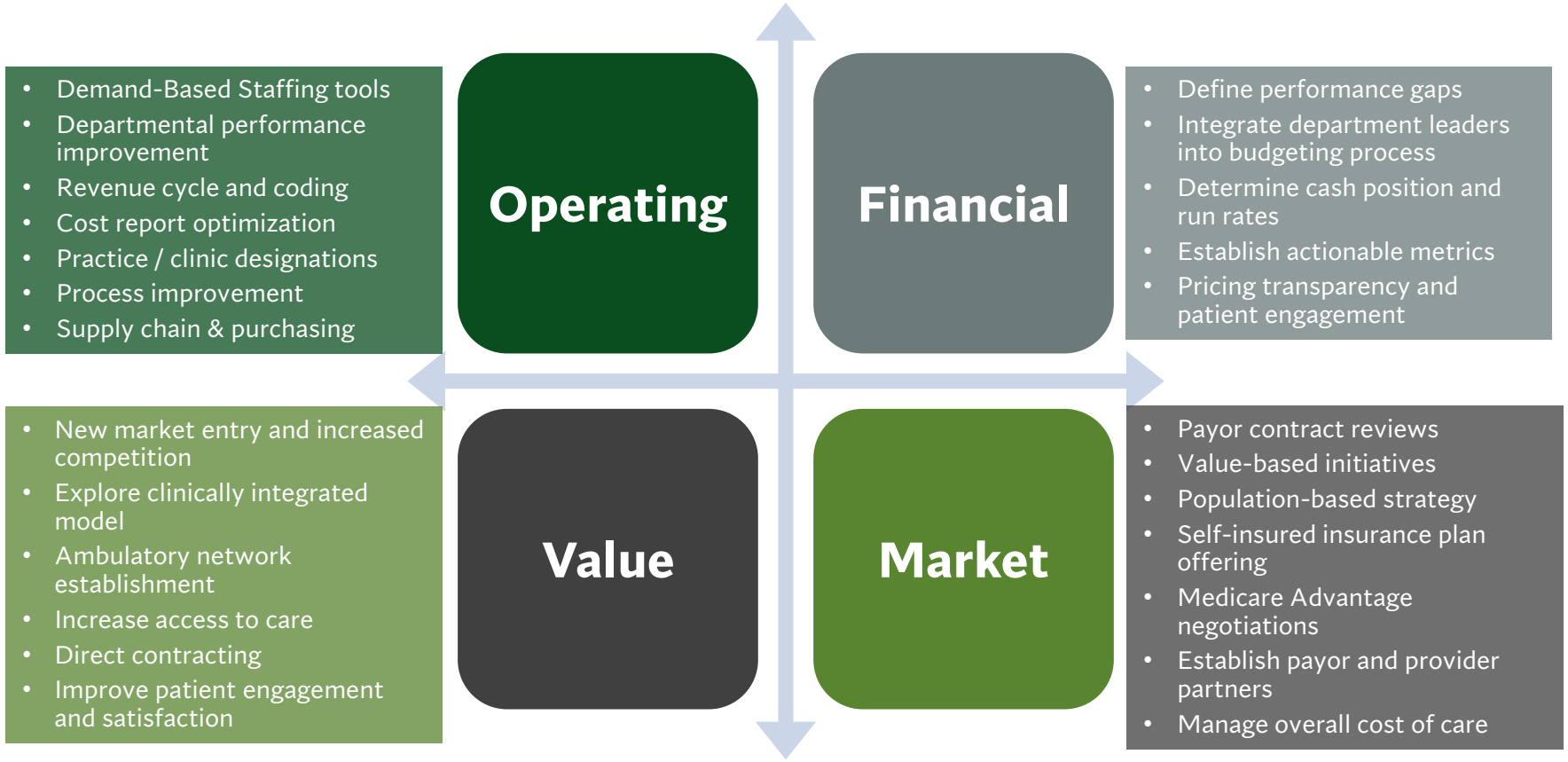
Compensation scale and design are key drivers of performance and satisfaction. How staff are paid can vary widely but compensation models should be tailored to your market realities.

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.

Revenue Optimization Opportunities

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



Optimize Revenue Cycle Tasks and Functions

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- **Revenue Cycle Administrative Functions**
  - Contract Negotiation
  - CDM Fee Schedule and Pricing
  - EDI Transactional Enrollment
  - Provider Enrollment and Credentialing
- **Pre- Registration**
  - Scheduling and Financial Clearance
  - Pre-Registration and Coordination of Benefit Review
  - Financial Counseling/Charity and Pre-Service Collections
  - Identification of Patient Health Outcome Delinquencies and need for services
  - Appointment Management and Care Management Enrollment Identification
- **Registration**
  - Patient Check In
  - Confirmation of Financial Counseling, Balance due assessment
  - Patient Check Out – Verification of Patient Services ordered, scheduled, referred.
  - Encounter Documentation and Charge Capture
  - Beneficiary Notice Identification
- **Coding**
  - Charge Reconciliation and Documentation review
  - Correct Hierarchal coding
  - Physician Query – Medical Necessity
  - Charge Entry as needed
- **Patient Accounting - Claims**
  - Claim Scrubbing
  - Error Correction
  - Claim Submission
- **Patient Accounting - Follow-up**
  - EDI management
  - Remittance Posting
  - Denials Management
  - Appeals and Recovery
  - Payor Credit Reconciliation
- **Collections**
  - Patient Statement management
  - Charity Care Management
  - Bad Debt Management
  - Patient Balance Management
- **Data and Analytics**
  - Benchmarking and Reports
  - Performance Improvement Activities
  - Strategy and Workflow focus and management

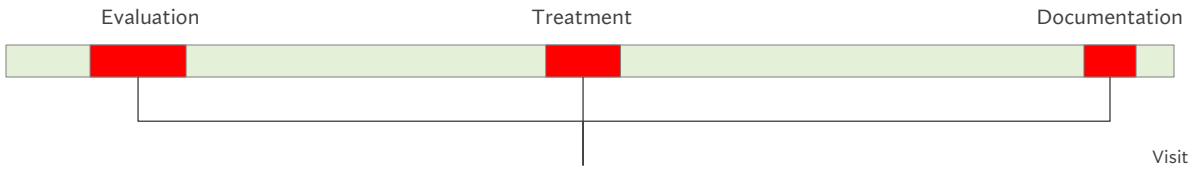
ED Provider Time Studies

To ensure that Critical Access Hospitals can provide emergency services 24/7, regardless of low patient volumes, CMS reimburses for Emergency Department provider stand-by time

What's included?

A critical access hospital (CAH) may be reimbursed through its cost report for the reasonable cost it incurs compensating a physician for the time the physician spends in the emergency room (ER) awaiting the arrival of patients and furnishing other services to the provider (provider component). Before this cost may be claimed, the CAH must determine the amount of time the ER physician spends with patients (professional component) vs. the time spent furnishing otherwise allowable services that do not directly relate to the care of one individual patient (provider component.)

Providers furnish services to patients during an ED visit but not for the entire duration

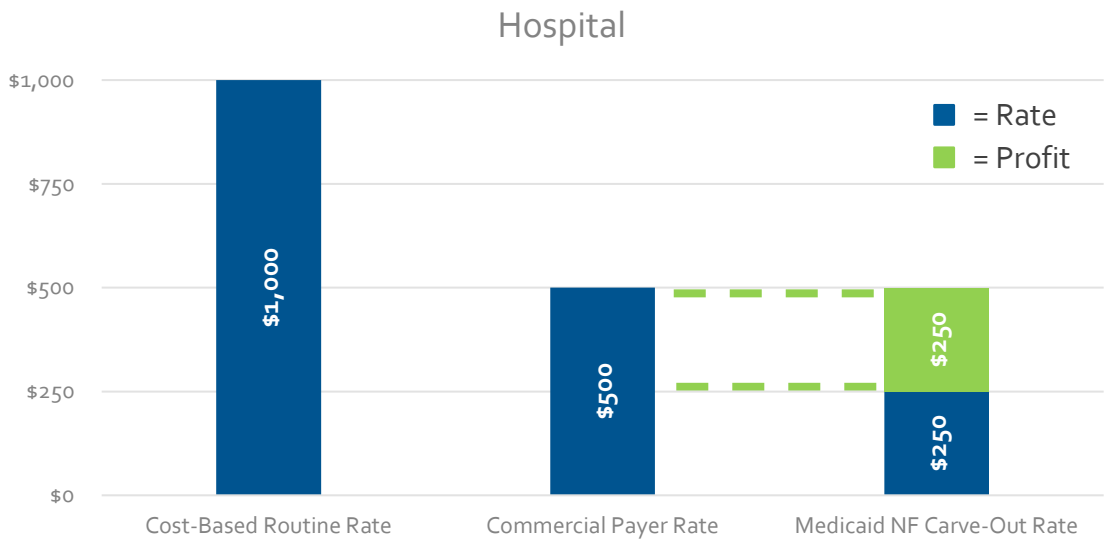


Target = 20 minutes per ED visit

	Current (30 Min/Visit)	Proposed (20 Min/Visit)	Variance
Total Cost	$ 2,776,769	$ 2,845,612	$ 68,843
Total Charges	$ 4,632,279	$ 4,632,279	$ -
RCC	0.599439	0.614301	0.014862
Medicare Charges	$ 1,459,434	$ 1,459,434	$ -
Medicare Reimb:	**$ 874,842**	**$ 896,531**	**$ 21,689**

Swing Bed NF Rate

- **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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Case Study on Health Benefits

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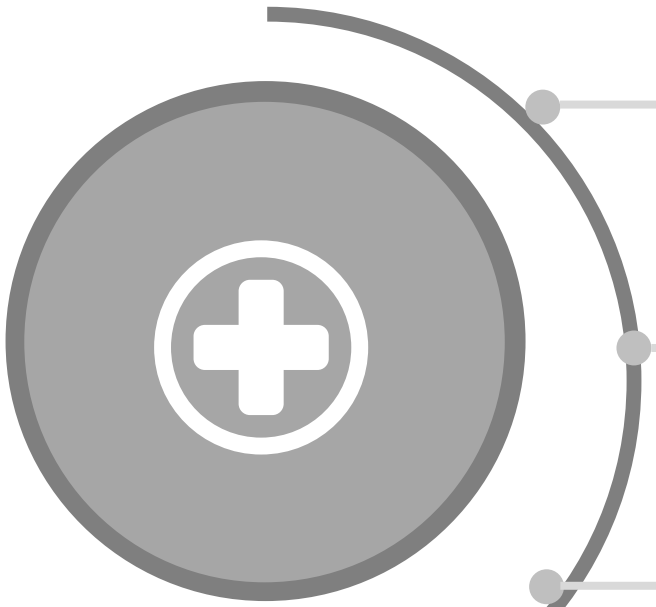
Recruitment and Retention Strategy

Recruitment and Retention Aren't Easy

- The largest expense on the income statement of rural hospitals is labor related.
- Less than 10% of US physicians practice in rural communities despite rural composing 20% of the US population.
- Labor costs continue to challenge economic viability and remains the biggest driver of margin pressure.
- Vacant positions generally mean something isn't getting accomplished under optimal conditions; from care to administrative tasks.
- Many employers are passing on healthcare cost increases to employees due to a perceived inability to control price.
- Benchmarking to other healthcare providers doesn't truly represent market position.
- **Hospitals must reevaluate their current employee benefit packages and make changes necessary to be competitive.**

People



Recruitment Challenges

Hospitals are facing personnel shortages across nearly all positions, not just clinical. This represents an increase in effort and complexity.

New Competitors

Competition is multi dimensional: regional, national, disruptors, and new industries all compete for rural resources.

Changing Workforce

Social evolution and communication platforms are changing the expectations of the existing and potential workforce.

Cost Constraints

Reimbursement pressures and unfunded mandates mean that the issue can't be solved by throwing money at the problem.

Checking the Box

Historically, most hospitals have a very similar menu of compensation and benefit options with little in the way of ingenuity.

Successful People = Successful Organizations

- **Compensation**: Cost control is not an effective strategy for people. To attract and retain top talent requires industry leading compensation packages.
- **Fulfillment**: Benefit plans should be structured to maximize employee value, not minimize cost or administrative effort. Stop measuring based on local markets.
- **Operational Excellence**: Top tier employees are required to optimize operational results in the current environment.
- **Strategic plan:** To achieve all of the above objectives, an HR strategy must be part of the organization's overall strategic plan to facilitate communication and execution.

Building a Winning Team

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Explicit Problem Statement: Recruiting and retention are ongoing challenges in rural settings that can be addressed through strategy

Agonizing Self-assessment

- Organizations think they compete with the local market
- Healthcare benefits are viewed as a necessary and expensive evil
- Compensation structure is rarely a part of strategic planning
- Offerings are vanilla
- Benefits are mostly comparative across healthcare competitors
- Benefits aren't driving recruiting efforts, salaries are

Why Doesn't Rural Change

- Entrenched incumbents
  - High margins
  - Investment in "education"
- Organizations compare themselves to competitors to evaluate parity
- HR theory taught by professional organizations that don't operate healthcare facilities
- Lack of effort

Strategy Requires Planning & Coordination

- **Seamless Communication**: Communication regarding major strategic initiatives cannot be assumed, it must be scheduled.
- **Leveraging Expertise**: While HR & Finance professionals work very closely in many areas, recognize and leverage individual subject matter experts.
- **Joint Problem Solving**: The best outcomes can be achieved when different skill sets come to the table to solve issues. Different perspectives are valuable tools when solving problems.
- **Growth:** Current reimbursement methodologies still reward growth. In order to both achieve and sustain larger volumes in an increasingly complex regulatory environment, organizations must reach higher levels of sophistication.
- **Innovation:** Innovation is more likely occur when all parties come together to solve problems by pooling knowledge. That's difficult when friction and fires exist.

Benchmarks

- All to often, organizations fail to evaluate their true competitive position in the market.
- As a general rule of thumb, voluntary benefits that do not achieve at least 70% enrollment are not considered competitive.
- Where are you?

Health Plan	70%
DC Plan	70%

Case Study

Methodology

A Critical Access Hospital in rural New York was reviewed for the cost savings of switching to a trust based Self-Insured Model. Year over year comparison health insurance per FTE was used. As much as 48% was saved per FTE with an average of 39% per FTE. In our case study, an over $600K savings versus prior year cost was saved on health insurance for a 25-bed critical access hospital.

It's important to consider the additional quantitative and qualitative factors which are not considered in the health insurance per FTE savings.

Qualitative

– ***Staff satisfaction***: A self insurance model leveraging a domestic network can allow employees to receive care for little to no out-of-pocket cost.

– ***Service line gaps***: A self insurance model inherently will feed data of the services which are lacking within the facility. These will show as adjudicated claims through the third-party administrator and allow for a simplified review of those services for which community demand is likely to mirror employee demand but are not offered currently.

– ***Cash flow control***: Selecting when and how to fund the trust allows for better cash flow control.

Quantitative

– ***Assessments***: In standard insurance cases even as employees receive services on campus cash flows out to the insurance company and then back into the facility. Though this seems like a $1 for $1 transaction it is not, cash receipt assessments and other transactional expenses must be paid on these received dollars thereby disguising expenses attributable to health insurance costs.

Methodology

While savings over the base year are an important point of measure, the actual cost savings are better measured against the cost of fully insured renewals. For this case study, the cost increase for 2021 was know as the hospital quoted maintaining the existing platform. For 2022, 2023, 2024 and 2025 Wintergreen partnered with United Professional Benefits to obtain the median cost increase experienced by hospitals in the central New York corridor and projected the 2021 fully insured cost forward utilizing these increases.

Annual fully insured increases, both known and assumed are below:

- 2021: 20% increase
- 2022: 18.5% increase (assumed)
- 2023: 23% increase (assumed)
- 2024: 14% increase (assumed)
- 2025: 19.5% increase (assumed)

Wintergreen adjusted annual costs to January 2021 FTE levels to eliminate any bias caused by changes in employee level for both the fully insured and self-insured costs for 2021, 2022, and 2023.

2023 costs for the fully insured platform are assumed to be at maximum potential liability. Wintergreen will update this study once actual savings are known.

Results

The three-year savings achieve by this critical access hospital are expected to total nearly $5.6 million by the end of 2025. Upon investigation, it was discovered that the decline in savings in 2022 resulted from a change in Pharmacy Benefit Manager (PBM) that resulted in significant cost increases. For the 2023 plan year, the hospital reverted to the PBM used in 2021 and expects cost to return to normalized rates.

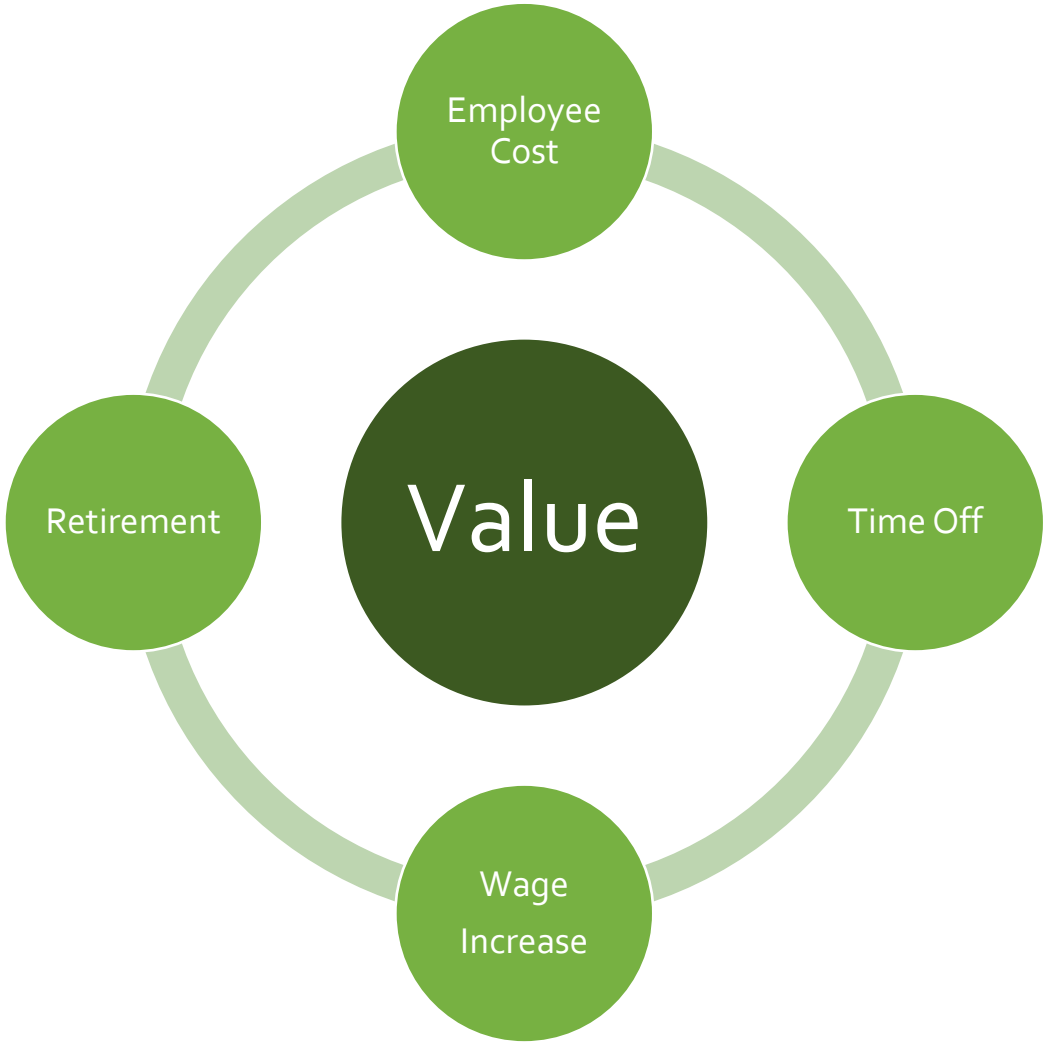
	2021	2022	2023	2024	2025
Fully Insured Cost	$ 1,906,906	$ 2,259,684	$ 2,779,411	$ 3,168,528.54	$ 3,786,395.61
Self Insured Cost	$ 985,686	$ 1,804,570	$ 1,692,717	$ 1,785,694	$ 2,039,231
Savings	**$ 921,221**	**$ 455,114**	**$ 1,086,693**	**$ 1,382,833**	**$ 1,747,163**
Percent Saved	**48%**	**20%**	**39%**	**44%**	**46%**

As can be seen in the table above, the lowest savings realized by the hospital over the three-year period was 20%. The reduction in savings in 2022 was primarily driven by a change in PBMs, highlighting the importance of active management.

If the funding of the trust results in the average of the prior four years surplus levels, 2025 self-insurance actual costs will be reduced by an additional $550,000

Reinvestment Opportunity

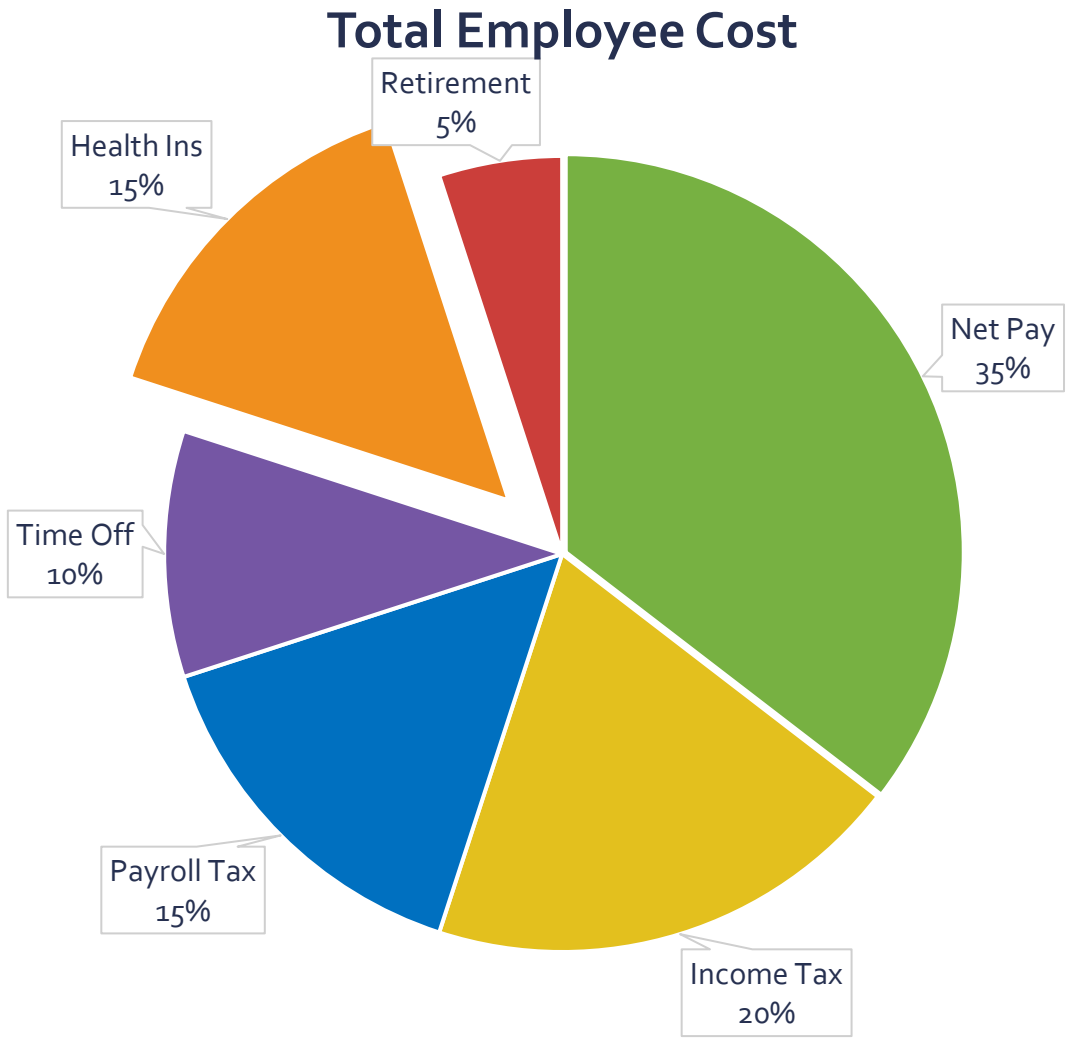
- **Employee Cost**: Savings were reinvested into the workforce by eliminating employee contributions toward health insurance.
- **Time Off**: Significant increases to paid time off are now part of the overall compensation package to improve employee satisfaction and reduce burnout. This includes the addition of more observed holidays.
- **Wage increase**: The hospital introduced a new incentive-based wage increase aimed at top 20% performers with some of the dollars.
- **Retirement**: The hospital introduced a novel employer retirement benefit for managers, providers, and executives to overcome many of the limitations of ERISA based plans.
- **Value:** This all culminates in execution of the organization's overall goal of becoming the employer of choice and curbing the bidding war for talent.



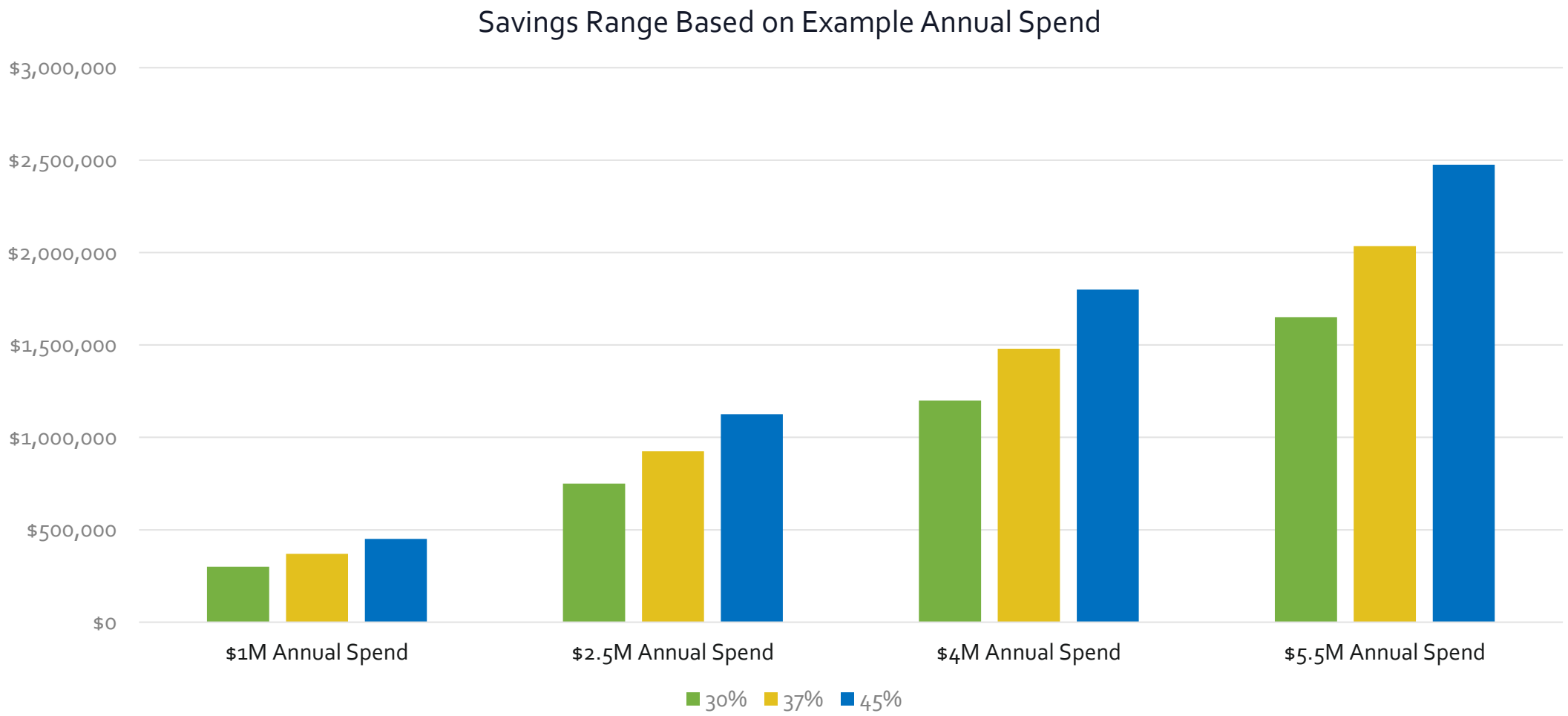
Keeping Bites of the Pie

Health Insurance

- Most hospitals have an opportunity to save between 30% and 45% on current healthcare spend.
- Variation in savings potential is a function of:
  - Current plan structure and strategy
  - Level of active management
  - Utilization of Domestic Network
- In almost all cases, employees receive a better overall benefit.
- The creation of a second-tier domestic network through partnerships represents an opportunity for increased savings.

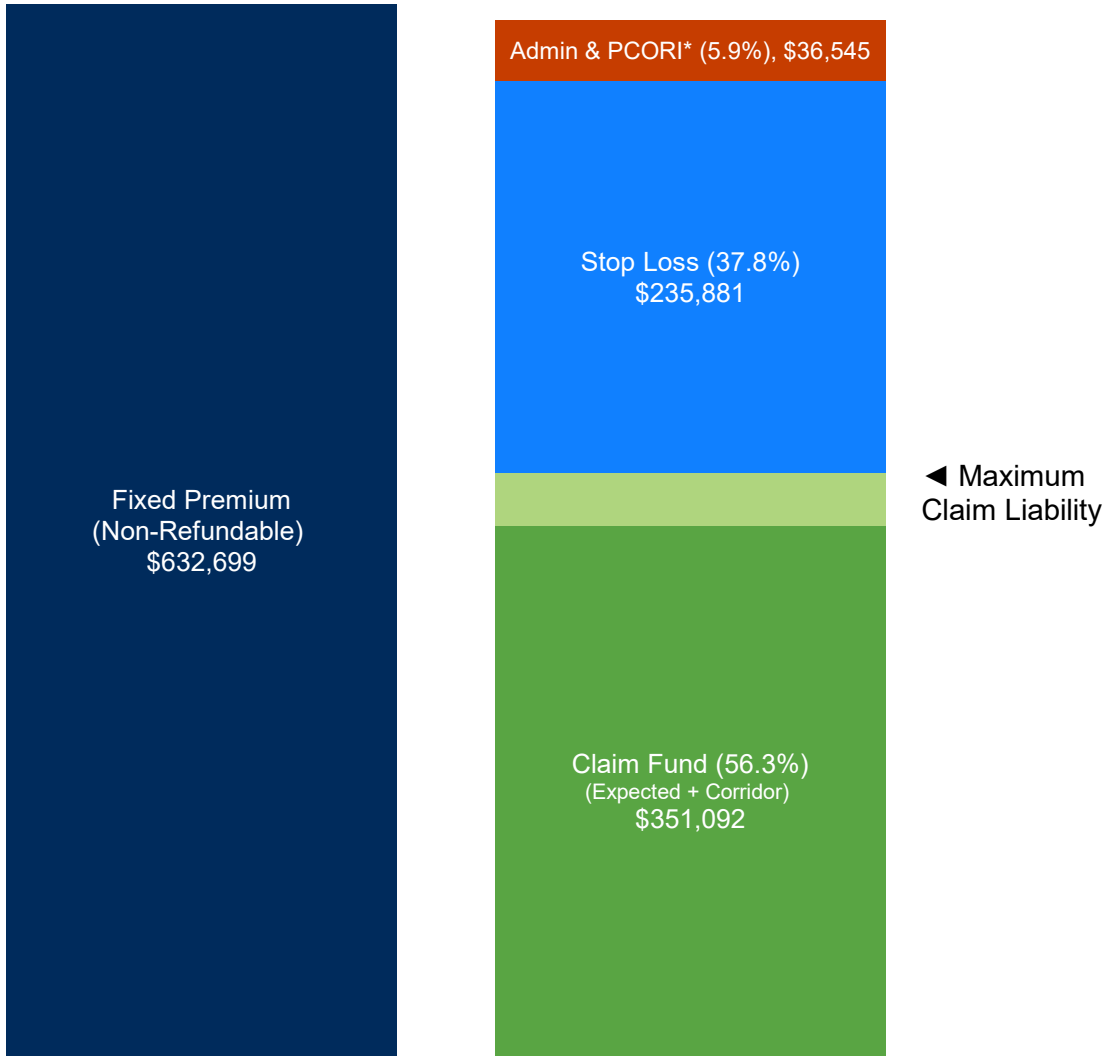


The Potential is Significant



Take Control of Costs

- Typical Rural strategies around employee benefits center around fixed costs.
- Variable cost strategies allow for cost containment and significant savings.
- Utilize a vehicle to create savings at worst case scenario and allow for higher savings based on strategy.
- *Example: 56.3 percent of total spend is impacted by hospital capabilities.



Risk Management

- **Network Affiliation**: By establishing a domestic network, hospitals and employers can negotiate favorable rates for medical services, reducing costs for both the institution and its employees, while improving hospital utilization and revenue.
- **Steerage Programs**: Implementing steerage programs encourages employees and patients to use the domestic network for their healthcare needs. This not only streamlines care coordination but also helps in maximizing the benefits and lowering healthcare costs, thereby improving financial outcomes for both the hospital and its employees.
- **Wellness Program**: Utilizing the domestic network, hospitals can develop specialized programs targeting prevalent conditions within the employee population. By providing accessible and coordinated care for diseases such as diabetes, hypertension, and obesity, hospitals can mitigate long-term healthcare costs, enhance employee wellbeing, and reduce insurance premiums.
- **Reinsurance:** Self-funded health insurance with the protection of set maximum liabilities, diverse risk pools and large numbers without a capital buy in.

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Innovative Recruitment and Retention Strategies for Rural Healthcare Facilities

In today's challenging healthcare landscape, building and maintaining strong medical teams in rural settings requires innovative approaches. Our strategic solutions address the unique challenges of rural healthcare staffing while creating sustainable, thriving medical communities that serve local populations effectively.

B **by Brett Shippee**

The Rural Healthcare Challenge

Staffing Shortages

Rural hospitals face chronic understaffing, with critical positions remaining unfilled for months or years, impacting quality of care and staff burnout rates.

Salary Gap

Rural healthcare professionals earn 10-15% less than urban counterparts, making recruitment and retention especially challenging in competitive markets.

Resource Constraints

Limited access to advanced medical equipment and specialized support services creates additional operational challenges for rural facilities.

Why Rural Healthcare Matters

Essential Services

Rural hospitals serve as lifelines, providing critical emergency care, primary healthcare, and specialized services to communities that would otherwise face hours of travel for medical attention. These facilities are often the only source of immediate healthcare for miles around.

Community Well-being

Beyond medical care, rural hospitals are vital economic engines, typically ranking among the largest local employers. Their presence attracts other businesses, retains young families, and ensures communities can provide comprehensive care for aging populations, creating a foundation for sustainable rural development.

Understanding Employee Motivations

Work-Life Balance

Rural healthcare settings offer manageable patient loads and flexible scheduling, allowing professionals to truly disconnect when off duty.

Professional Growth

Rural practitioners gain broad clinical experience and leadership opportunities, with strong support for specialized training and skill development.

Community Connection

Healthcare providers become respected community leaders, forming lasting relationships with patients and making visible impact on local health outcomes.

Lower Cost of Living

Rural communities offer affordable housing, reduced commute times, and better value for money, helping healthcare professionals build long-term financial stability.

Attracting Talent to Rural Communities

Educational Partnerships

Build partnerships with medical schools for rural clinical rotations and hands-on training experiences.

Student Loan Relief

Implement competitive loan repayment programs for healthcare professionals choosing rural practice.

Lifestyle Benefits

Provide comprehensive relocation packages and housing assistance to ease the transition to rural living.

Enhanced Retirement

Leverage Critical Access Hospital funding to offer innovative retirement benefits and long-term financial incentives.

Keeping Your Team Engaged and Fulfilled

1

Positive Culture

Create an environment where team members thrive through monthly recognition programs, peer-nominated awards, and dedicated time for team building activities. Implement a "voices heard" program where staff suggestions directly influence workplace improvements, and celebrate both clinical victories and personal milestones.

2

Professional Development

Invest in your team's growth through individualized development plans, offering rotations at partner urban facilities for specialized training, and providing dedicated time for online learning and certification courses. Create clear advancement pathways with defined milestones and mentorship opportunities to help staff visualize their long-term future in rural healthcare.

3

Mentorship and Support

Combat professional isolation through structured peer support programs, connecting rural practitioners with both local and virtual mentors. Establish regular case review sessions where experienced providers share insights, and create leadership shadowing opportunities that prepare the next generation of rural healthcare leaders.

4

Leadership Commitment

Demonstrate unwavering support for engagement initiatives through visible leadership participation, transparent resource allocation, and regular "town hall" meetings where leaders actively listen to staff concerns. Establish accountability metrics for engagement initiatives and make them part of leadership performance evaluations.

Enhancing Work Through Innovation

1

Telehealth

Revolutionize patient care through secure video consultations, remote monitoring, and digital health assessments, enabling providers to serve more patients while reducing travel burden.

2

Electronic Health Records

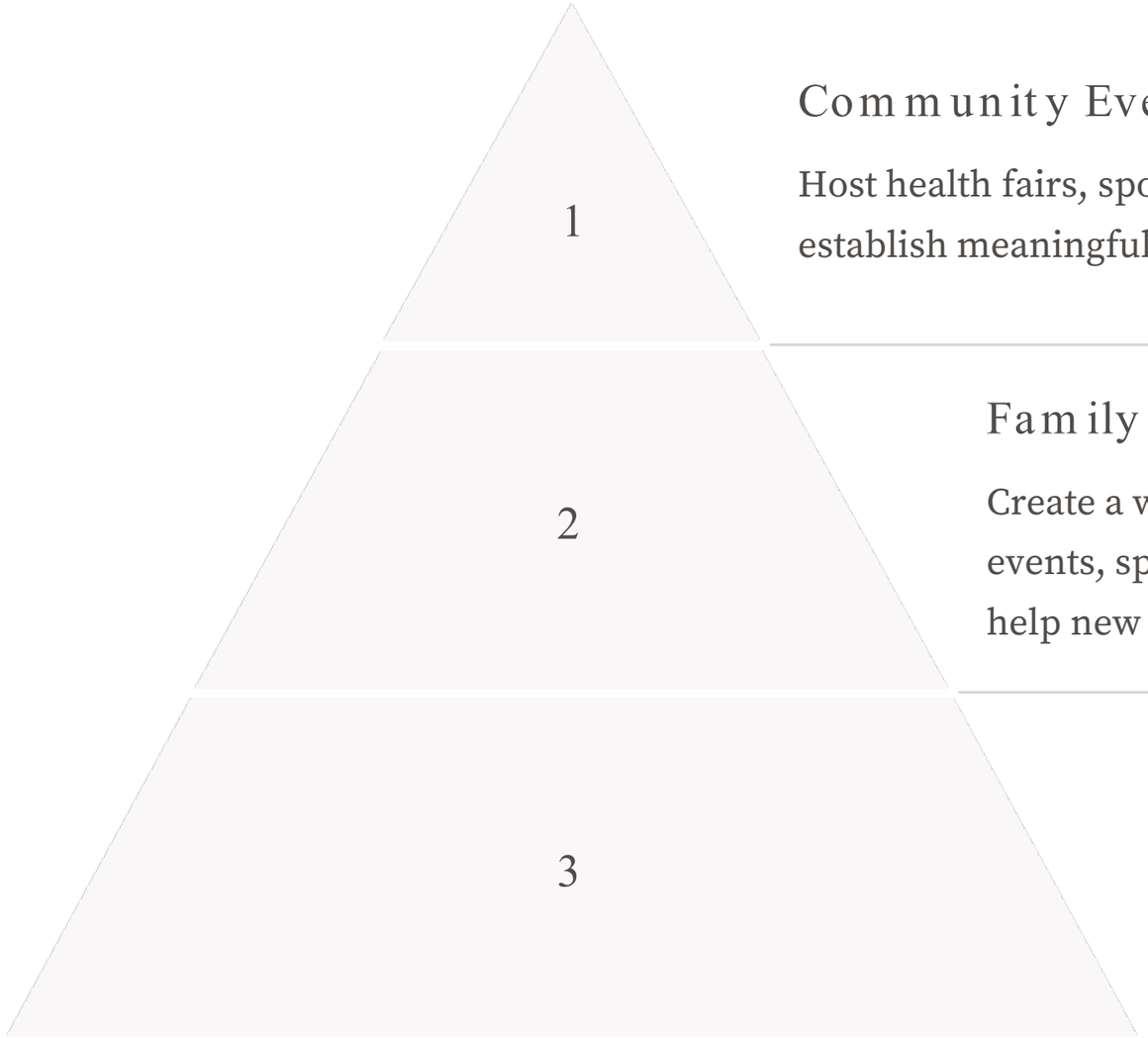
Transform clinical workflows with integrated digital systems that enable instant access to patient histories, automated documentation, and seamless care coordination between providers.

3

Remote Support

Leverage partnerships with leading medical centers to access specialist consultations, continuing education, and emergency support, ensuring high-quality care in rural settings.

Building Strong Community Connections



Community Events

Host health fairs, sponsor local sports teams, and lead wellness workshops to establish meaningful connections within the community.

Family Integration

Create a welcoming environment through monthly family networking events, spouse career assistance programs, and children's activities that help new healthcare families thrive.

Local Scholarships

Invest in tomorrow's healthcare heroes by offering mentorship programs and educational funding for local high school students pursuing medical careers.

Lessons from the Field

1

Successful Models

Learn from rural healthcare facilities that have achieved 90%+ staff retention through innovative workplace cultures, competitive benefits, and creative scheduling solutions.

2

Program Examples

Discover proven initiatives like "Grow Your Own" training programs, mentorship partnerships, and housing assistance that have transformed rural recruitment challenges into opportunities.

3

Employee Testimonials

Gain insights from healthcare professionals who have built rewarding careers in rural settings, finding greater autonomy, deeper community connections, and enhanced work-life balance.

Next Steps for Your Facility

1

Develop a Strategy

Design a targeted workforce plan that addresses your facility's unique challenges, leveraging data-driven recruitment channels and proven retention incentives.

2

Invest in Resources

Allocate strategic funding for professional development, market-competitive compensation, and quality-of-life enhancements that make rural healthcare careers more attractive.

3

Build Partnerships

Foster strategic alliances with educational institutions and community organizations to establish reliable talent pipelines and comprehensive support systems.

—

Elevate Standards

Look beyond traditional rural healthcare benchmarks to adopt best practices from high-performing organizations across all sectors, setting ambitious goals that drive meaningful improvement.

Building a Resilient Rural Healthcare Workforce

Implement Proven Strategies

Apply research-backed approaches to attract, develop, and retain skilled healthcare professionals in rural settings through competitive benefits, mentorship programs, and quality of life initiatives.

Foster Innovation and Growth

Create an environment where creative solutions thrive, encouraging teams to adapt to changing healthcare needs while developing new approaches to rural care delivery.

Strengthen Team Excellence

Build a culture of support and recognition that empowers healthcare professionals to excel, while providing opportunities for leadership development and career advancement.

Your Role in Transforming Rural Healthcare

The time to strengthen our rural healthcare workforce is now. Take the first step today by accessing our Implementation Toolkit, which includes ready-to-use templates, recruitment guides, and mentorship programs. Together, we can build resilient healthcare teams that will serve our rural communities for generations to come.

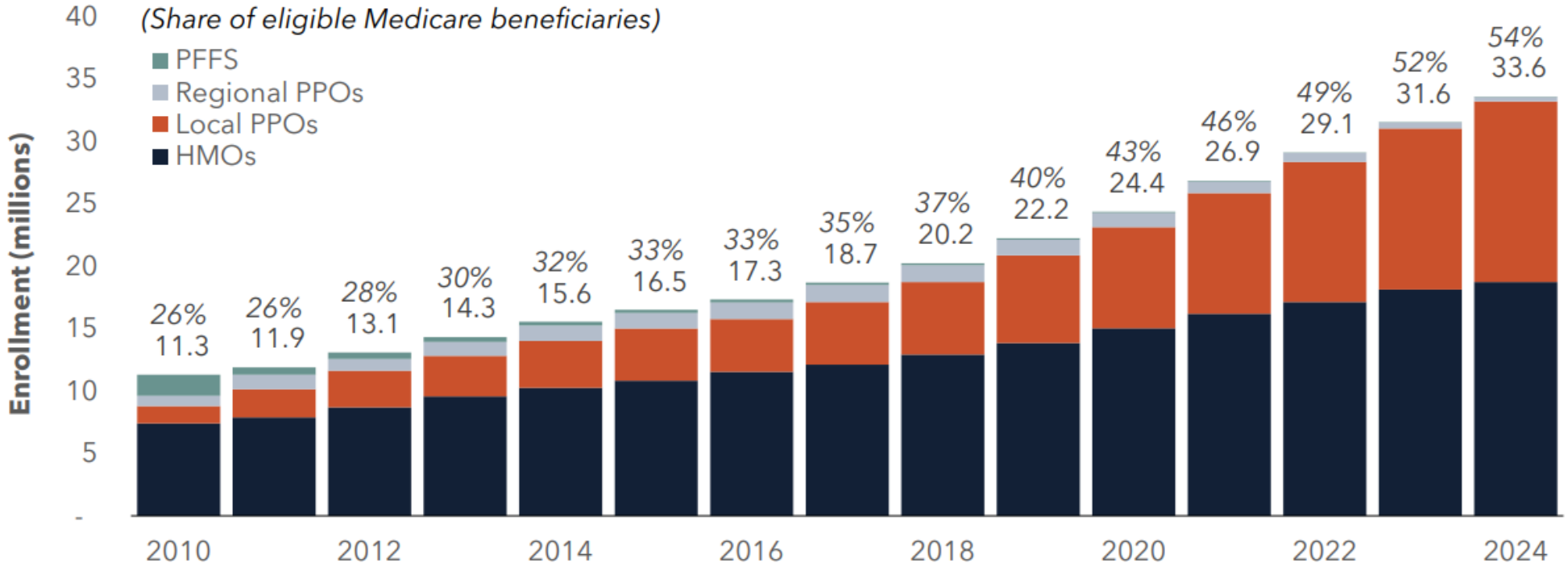
Visit https://www.3rnet.org/ to download these resources and join our network of rural healthcare champions. Every action you take today brings us closer to our shared vision of accessible, high-quality healthcare for all rural communities.

NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

Impact of Medicare Advantage on RHCs

Nathan Baugh
Executive Director
National Association of Rural Health Clinics

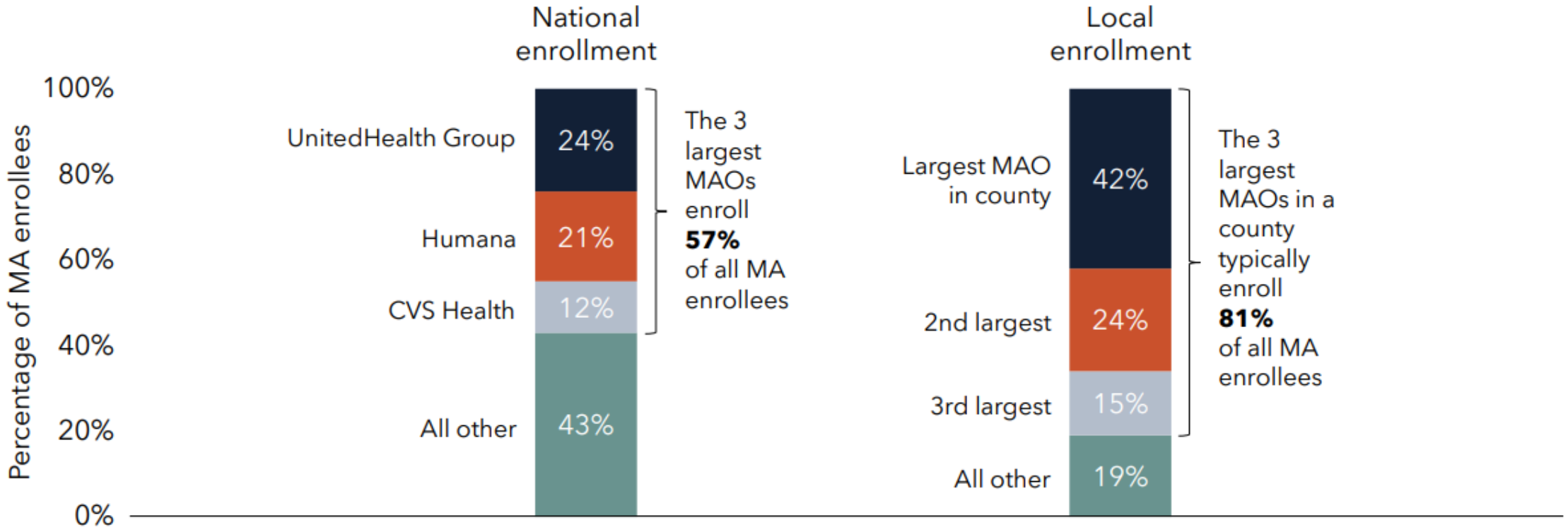
In 2024, 54% of eligible beneficiaries enrolled in MA plans



Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files, July 2010–2024.

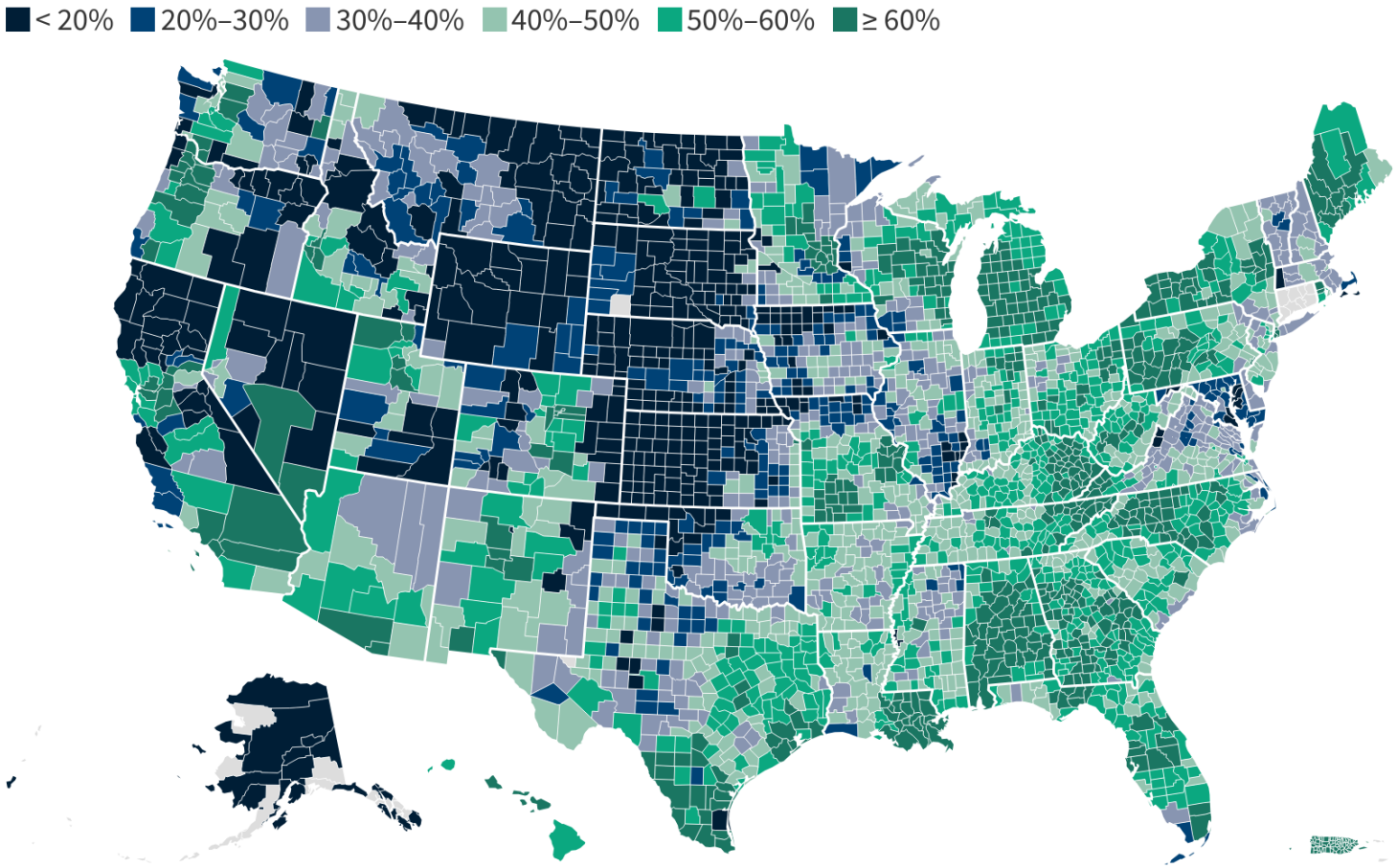
MA enrollment is highly concentrated at the national and local level



Note: MAO (Medicare Advantage organization). Employer plans and special-needs plans are excluded.
Source: MedPAC analysis of CMS July 2024 enrollment data.

Figure 7

Medicare Advantage Penetration, by County, 2024



https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

Note: Includes only Medicare beneficiaries with Part A and B coverage. Counties in gray cannot be displayed due to cell suppression standards - see methods for more details. Data on Connecticut is not included due to differences in FIPS codes in the CMS Medicare Advantage Enrollment Files and CMS Medicare Enrollment Dashboard.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2024 and March Medicare Enrollment Dashboard, 2024.

KFF

Medicare Advantage

Widespread Issues

- Prior authorization timelines/decisions
  - Claims denials / timelines
  - Administrative burden
- Inaccurate marketing / lack of patient understanding

RHC / Other Rural Provider Niche Issue

- Lower/significantly lower reimbursement than enhanced traditional Medicare reimbursement

A Few Positive Steps Forward

- CMS published a final Medicare Advantage rule in mid-January with some prior authorization reforms (beginning in 2026):
  - Require standard, non-urgent decisions within 7 days
  - Require urgent decisions within 72 hours
  - Payers must submit a specific reason for denying coverage if prior authorization is denied

- Prior legislation that aimed to reform MA prior authorization but had too high of a cost was recently re-scored by the Congressional Budget Office as a $0 cost

Medicare Advantage Issues

For RHCs, each MA plan is like another commercial contract

- While some RHCs are able to negotiate for comparable reimbursement, there is **no requirement** that MA plans treat RHCs differently than any other provider (despite the RHC role in the health care safety net)
- FQHCs receive quarterly wrap payments to make up the difference between contracted rates and traditional Medicare reimbursement rates

NARHC Policy Survey MA Contract Structure

MA Contract Structure

- **35.0% of responses** agreed with "Our Medicare Advantage contracts are structured on a **fee-for-service basis** where we are paid differing amounts based on CPT codes and other billing codes."
- **46.3% of responses** agreed with "Our Medicare Advantage contracts are structured on an **encounter basis**, similar to our Traditional Medicare and Medicaid payments where we are paid a specific rate per encounter."
- **15.5% of responses** agreed with "We **do not have Medicare Advantage** contracts."
- **3.9% of responses** agreed with "Our Medicare Advantage contracts have an **alternative payment structure.**"

NARHC Policy Survey – MA Payment

MA Reimbursement Rates

- **3.4% of responses** agreed with "**significantly more (20% +)** than our traditional Medicare reimbursement."
- **9.1% of responses** agreed with "**slightly more (5-20%)** more than our traditional Medicare reimbursement."
- **31.1% of responses** agreed with "**roughly the same (+/- 5%)** as our traditional Medicare reimbursement."
- **18.4% of responses** agreed with "**slightly less (5-20%)** than our traditional Medicare reimbursement."
- **29.5% of responses** agreed with "**significantly less (20% +)** than our traditional Medicare reimbursement."

2025 NARHC Policy Survey

- Responses are due by February 26th, 2025
- One response per organization
- Survey and video walk through
- With any questions, please contact Mo.Sullivan@narhc.org

All submissions are entered into a drawing to win a $500 stipend for the 2025 NARHC Policy Summit!

Medicare Advantage Advocacy

- **We cannot let Medicare Advantage plans diminish our rural safety-net**

- **Legislatively, NARHC is pursuing a floor payment (minimum) that MA plans must pay RHCs**
  - Different options for structuring and financing the floor

Medicare Advantage is still largely popular amongst Members of Congress, although this is shifting in certain ways. This is a potentially costly priority that will require RHC advocacy once text is introduced hopefully later this year.

Legislative Options

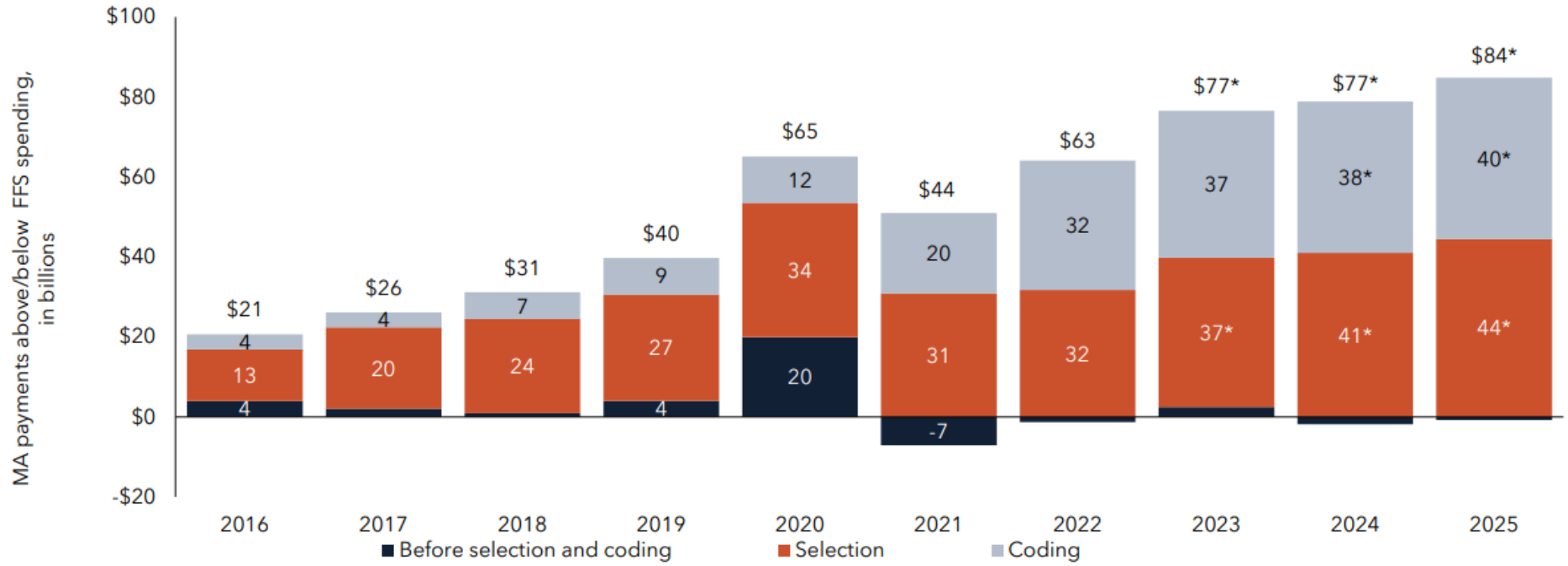
"Wrap" Payment from Part B	Establishing a "Floor" MA Plans Must Pay
Pros: • Established policy for FQHCs **Cons:** • Paid by the Medicare Part B Trust Fund	**Pros:** • Doesn't impact Medicare Part B Trust Fund **Cons:** • Challenges/limitations to Congress requiring certain practices/reimbursement from MA plans

Medicare Advantage Trends

- Medicare Advantage For All Can Save Our Health-Care System
  - Dr. Mehmet Oz
  - https://www.forbes.com/sites/steveforbes/2020/06/11/medicare-advantage-for-all-can-save-our-health-care-system/
- Project 2025 proposed making MA the default option for Medicare enrollees

Medicare Advantage Trends

Coding and selection have driven MA payments substantially above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Components may not sum to totals due to rounding. Estimates from 2016 through 2022 use actual MA and FFS data. Unidentified values indicate less than $3 billion.
* Specified values used projected data.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

MEDPAC Report June 2025

Evaluating effects of MA on rural providers

Provider concerns about MA expressed during site visits:

- Difficulty getting prior authorization for admission and discharge to post-acute care
- Lower payment rates for MA patients than for FFS patients
  - Providers don't always receive full cost-based payments for MA CAH patients
  - Providers don't always receive full RHC rates for MA patients
- Extra administrative time in billing
  - Delayed payments
- Analyze effect on rural closures
  - Hospitals suggest MA increases financial risk
  - Henke (2023) suggests there are lower closure rates in areas with MA growth

Note: MA (Medicare Advantage), FFS (fee-for-service), CAH (critical access hospital).
Source: MedPAC site visits and interviews with rural providers.

MEDPAC *Preliminary and subject to change* 16

NARHC Overview

"To educate and advocate for Rural Health Clinics, enhancing their ability to deliver cost-effective, quality health care to patients in rural, underserved communities."

Education:

NARHC ACADEMY
EDUCATING RHC PROFESSIONALS ACROSS THE US

Technical Assistance Webinars

- Mobile Units and Your RHC – Is this a good fit?
- RHC Billing 101

Conferences

Legislative & Regulatory Advocacy:

NARHC Advocacy Letters and Comments

NARHC often communicates with Congress and the Administration on issues of importance to the Rural Health Clinic community. The following is an archive of official communications we have sent advocating on behalf of the Rural Health Clinic Program. We have also included some communications and letters that NARHC has signed but were not authored by NARHC.

June 26, 2024 - Statement for the Record CMMI Hearing

June 18, 2024 - Statement for the Record 340B Oversight Hearing

May 30, 2024 - Joint Letter to Energy and Commerce Leadership

May 30, 2024 - Statement for the Record, Senate Finance Committee Rural Health Hearing

May 29, 2024 - CMS Medicare Advantage Data Request for Information Response

May 28, 2024 - RFI Response - Rural Definition Proposed Changes - FORHP Grants

April 25, 2024 - MedPAC April Public Meeting Statement for the Record

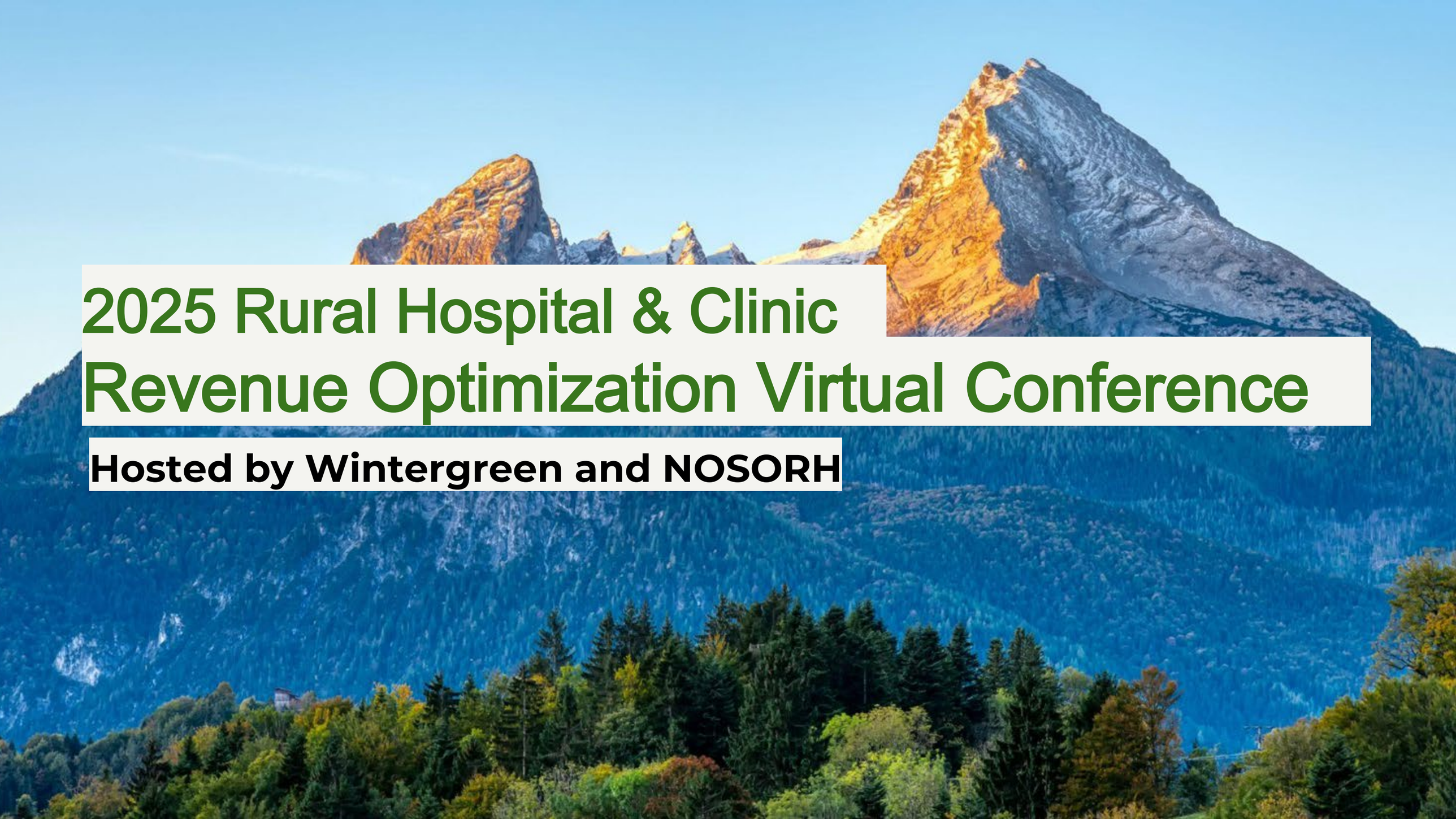
March 28, 2024 - CPT Category II ~ Letter to the Administrator

Join the fight for rural health and make your voice heard here!

2 E. Main St, Fremont, MI 49412 | 866-306-1961 | NARHC.org

Thank You!

Nathan.Baugh@narhc.org



2025 Rural Hospital & Clinic Revenue Optimization Virtual Conference

Hosted by Wintergreen and NOSORH

HUNTER AMBROSE INT.

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hunterambrose.com

Strategies to Attract Providers and Staff

Presented by Nicole Barbano,
Founder & Principal of Hunter Ambrose
615-953-9479 - ext. 2
Nashville, Tennessee
nicole@hunterambrose.com

January 23, 2025

The Recruitment Challenge in Rural America

- **Recruiting healthcare providers and staff in rural areas is a challenge**
- **High demand but limited talent pool**
- **Organizations must adopt innovative strategies to attract top professionals**

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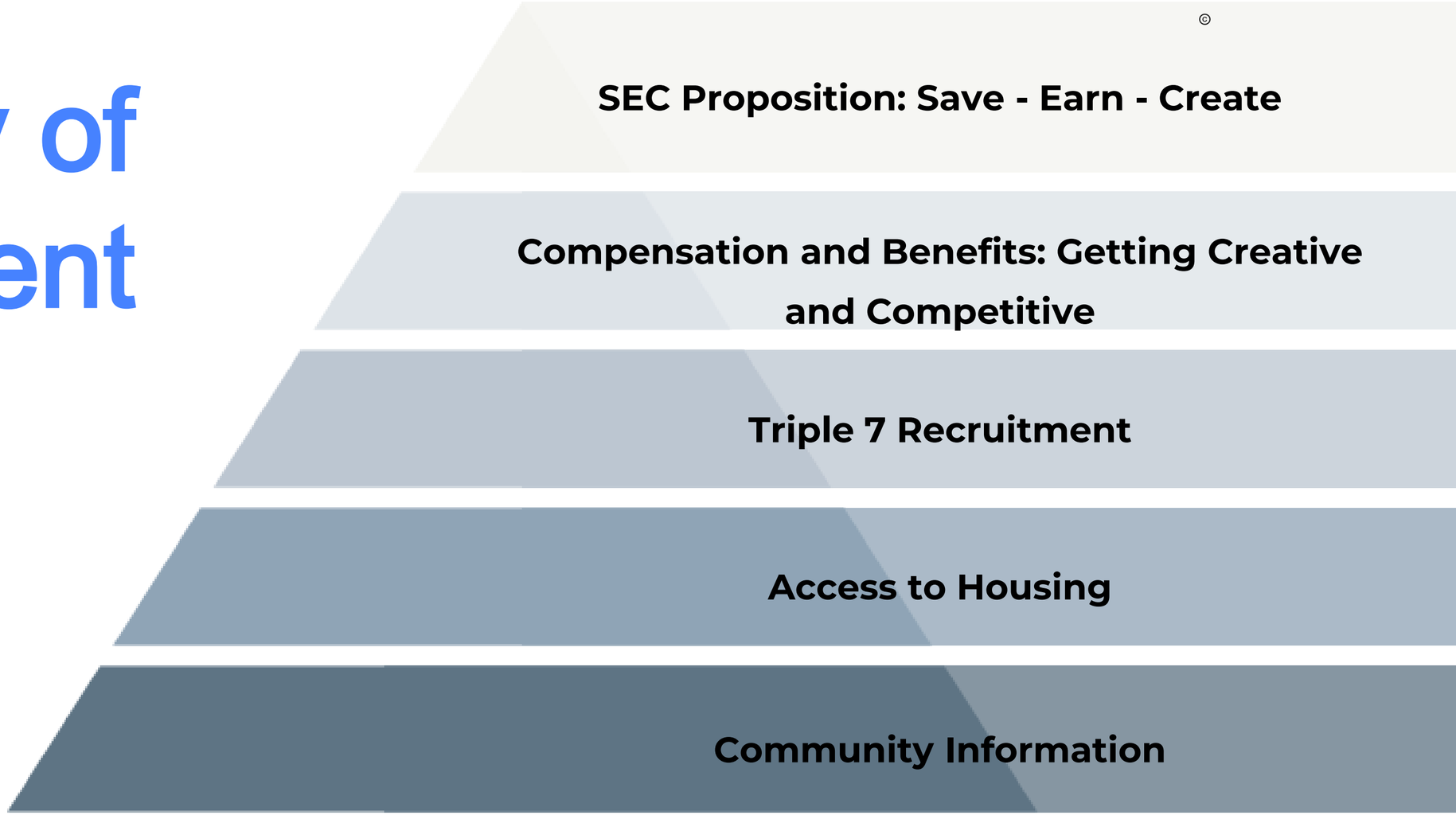
Hierarchy of Recruitment in Rural America



Community Information

Building a Strong Recruitment Foundation

- **Candidates don’t just choose a job—they choose a community**
- **Organizations should highlight:**
  - **Schools, grocery stores, gyms, places of worship, outdoor activities, etc.**
  - **Local culture and lifestyle benefits**
- **Providing visually appealing online resources simplifies decision-making**

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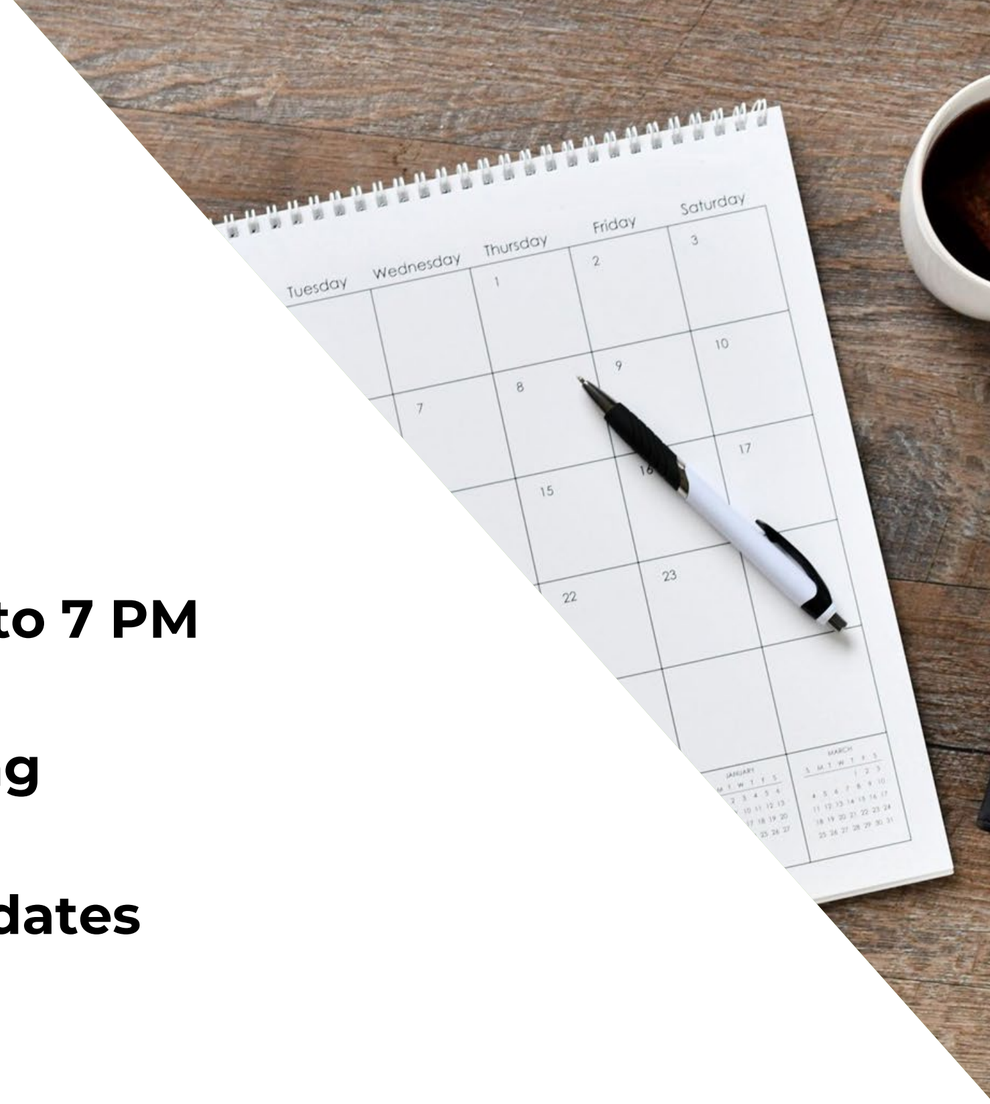
Access to Housing

- **Housing is a major factor in attracting and retaining staff**
- **Focus on affordable rentals, home prices, and temporary housing - Dont’ force home ownership**
- **Provide resources and relocation assistance to make the move easier**

Triple 7 Recruitment Strategy



- **Recruitment Works - 7 days a week, from 7 AM to 7 PM**
- **Know your numbers - strong KPIs and metrics**
- **Use automation, scheduling tools, and marketing strategies**
- **Removing barriers = faster hiring + better candidates**

Compensation and Benefits

Getting Creative and Competitive

- **Employer-covered healthcare for employees & families**
- **Retirement benefits beyond competitors**
- **Flexible schedules and hybrid when needed**
- **Embrace the Super Commute Candidate**
- **Modern Day Paid Time Off- *Hint?* It's not 20 days a year.**

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SEC Proposition
Save, Earn, Create

- **Save: Provide financial incentives and stability for professionals**
- **Earn: Competitive salaries, professional growth opportunities, tuition reimbursement for continued learning**
- **Create: Foster leadership and innovation in the workplace. Top tier leaders once obtaining job satisfaction need a professional and creative outlet or project outlet to ensure engagement.**

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Next Steps to Success- *Be First. Be Fast. Be Kind.*

1. Implement Triple 7 Recruitment: 7am - 7pm, 7 days a week.
2. Designate a Recruitment Ambassador: Appoint a leader to drive recruitment initiatives.
3. Engage the Community: Invite the community to participate as part of the "Hierarchy of Recruitment."
4. Executive Connection: Ensure provider candidates meet with the CEO within 24 hours.
5. Expand and Strengthen Partnerships: Avoid operating in an echo chamber. Find partners and resources for new ideas.
6. Outpace the Competition: Know your Recruitment Numbers- Create KPI's - Measure what matters.
7. Nicole's most suggested reading / playlist?

- **The Revenge of the Tipping Point by Malcolm Gladwell**
- **The 48 Laws of Power by Robert Green**
- **Building a StoryBrand by Donald Miller**
- **In Good Company with Nicolai Tangen (Podcast)**

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Nicole Barbano,
Founder & Principal

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Nashville, Tennessee
nicole@hunterambrose.com

CLARA VITA

Find Your Career and Your Community in Rural America
claravita.com

HUNTER AMBROSE
LEADERSHIP PODCAST

How Clinical Operations Link to Revenue Cycle

Nicole Thorell RN, MSN, FNP-C
Jennifer Cooper CPB, CPCO

WINTERGREEN

Objectives

WINTERGREEN

Key connections between clinical operations and revenue cycle

Challenges caused by siloed approaches

Strategies to foster collaboration and measurable outcomes

Sarah’s Journey

Admission and Insurance Verification

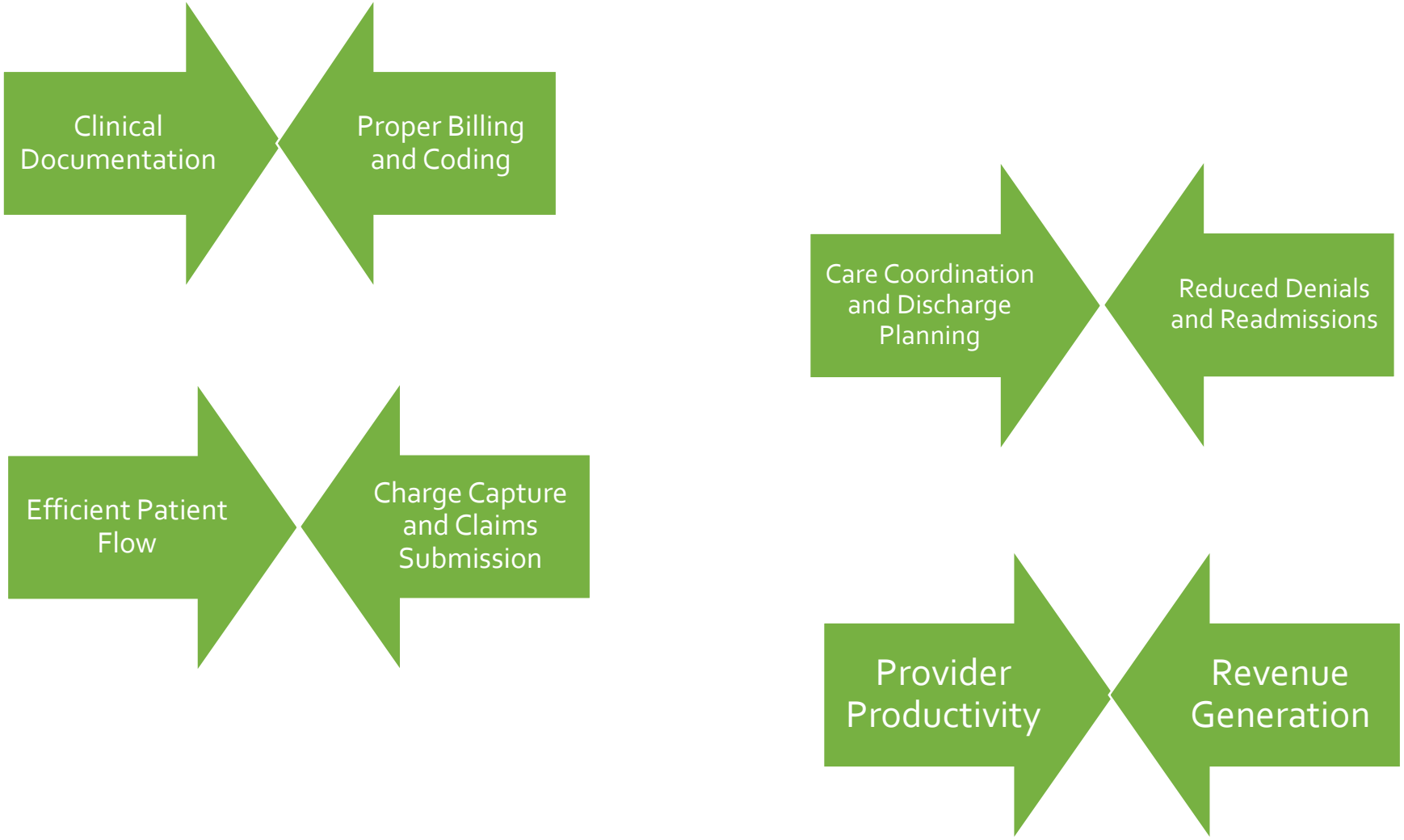
Diagnosis and Treatment

Care Transition to Swing Bed

Discharge and Billing

Patient Statements

Key Points of Interdependence



Challenges of a Siloed Approach

Operational Impacts

WINTERGREEN

LACK OF COMMUNICATION

MISALIGNED GOALS

LACK OF SHARED KNOWLEDGE AND TERMINOLOGY

DUPLICATION OF EFFORTS LEADING TO INEFFICIENCY

FRAGMENTED WORKFLOWS CAUSING DELAYS

Revenue Cycle Impacts

WINTERGREEN

Increased Claims denials due to incomplete or inaccurate documentation

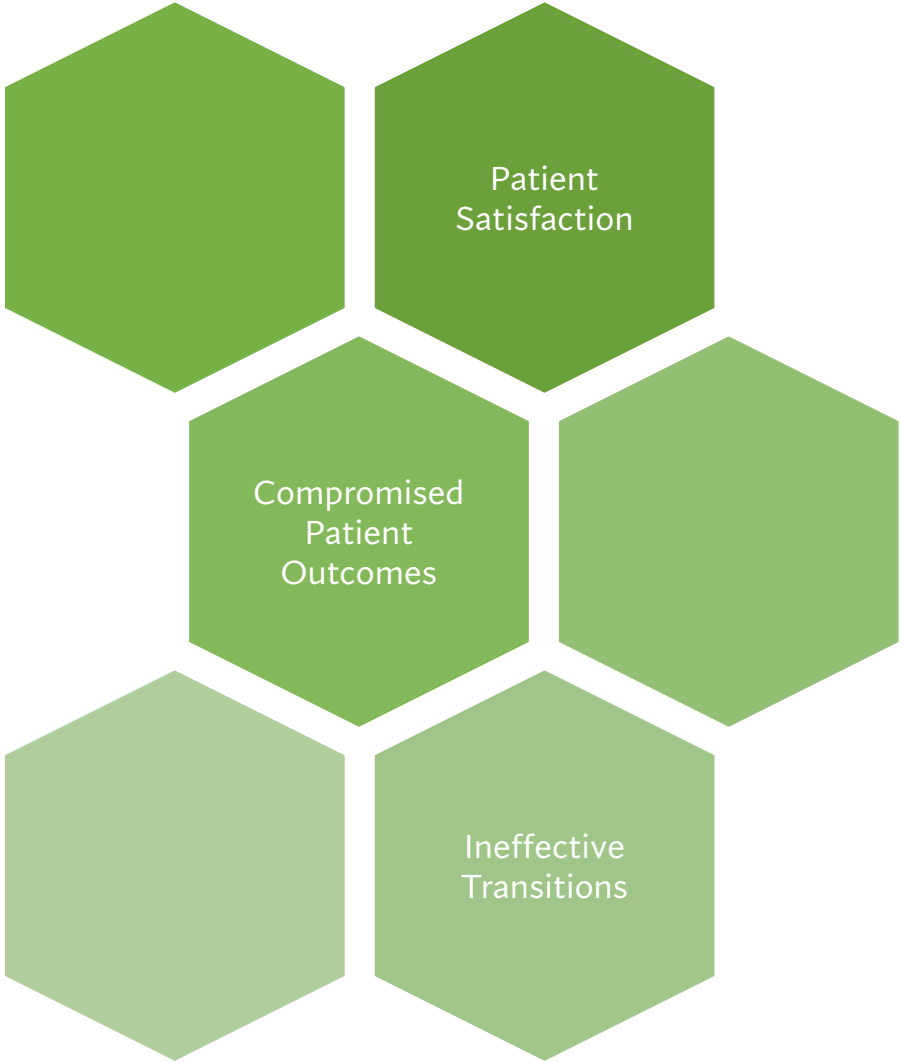
Missed revenue opportunities

Financial Instability

Higher rates of accounts receivable aging due to operational inefficacies

Coding and billing errors

Quality of Care Impacts



Strategies to Foster Collaboration

Build Cross-Functional Teams

- Build meetings with interdisciplinary representation
- Foster open communication
- Define shared goals and metrics
- Encourage collaborative problem solving
- Promote accountability and ownership
- Celebrate success together!

Education and Training

Train clinical staff on revenue cycle basics (e.g., the impact of documentation on billing).

Train revenue cycle staff on clinical workflows to understand operational pressures.

Shared Goals and Metrics

Metric	Target	Current Performance	Status
Observation to Inpatient Conversion Rate	20%	18%	Below Target
Average Length of Stay (ALOS)	4.0 Days	4.2 Days	Below Target
Readmission Rate (30 Days)	10%	12%	Above Target
Patient Satisfaction Score	90%	88%	Below Target
Accounts Receivable (AR) Days	40 Days	45 Days	Above Target
Net Operating Margin	10%	8%	Below Target
Revenue Per Adjusted Patient Day	$2,000	$1,900	Below Target
Billing Accuracy Rate	98%	96%	Below Target
Denial Rate	5%	7%	Above Target
Staff Turnover Rate	12%	15%	Above Target
Cost Per Patient Day	$1,200	$1,250	Above Target
Quality Measure Compliance Rate	95%	93%	Below Target

Call to Action: Moving Breaking Down Silos

Next Steps

WINTERGREEN

1. Identify gaps in collaboration
2. Identify key champions for revenue cycle and clinical operations
3. Educate on the interconnectedness
4. Commit to creating shared goals and fostering communication across departments

Questions

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308-325-0201
www.linkedin.com/in/nicole-thorell-wintergreen

USE OF TECHNOLOGY FOR MANAGERIAL DECISION MAKING

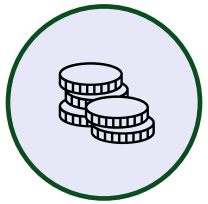
JED HANSEN & BEN RUBACHA

LEVERAGING DATA IN RURAL HEALTH

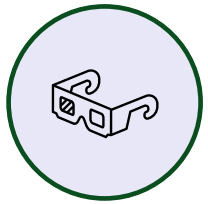
The HL7® FHIR® (**Fast Healthcare Interoperability Resources**) standard defines how healthcare information can be exchanged between different computer systems regardless of how it is stored in those systems. It allows healthcare information, including clinical and administrative data, to be available securely to those who have a need to access it, and to those who have the right to do so for the benefit of a patient receiving care.

WHY IT MATTERS

Patient Care
Use data to drive clinical decision making



VBP
Simplify data collection and reporting



Optics and Analytics
Track patient care and 3rd party payments

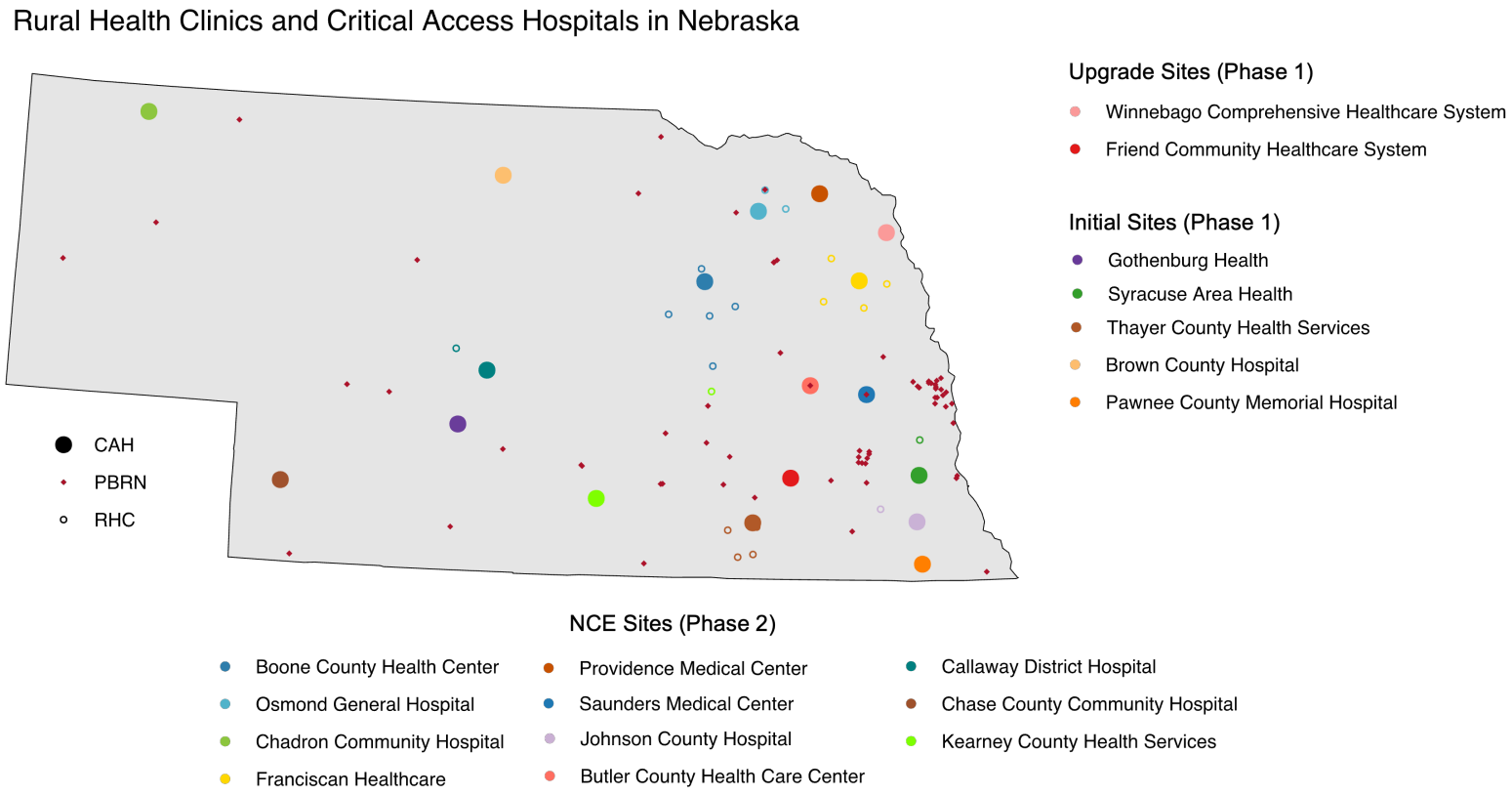
Checkbox
Meet the CMS/ONC regulatory mandates

Future-Proofing
Prepare for collaboration opportunities

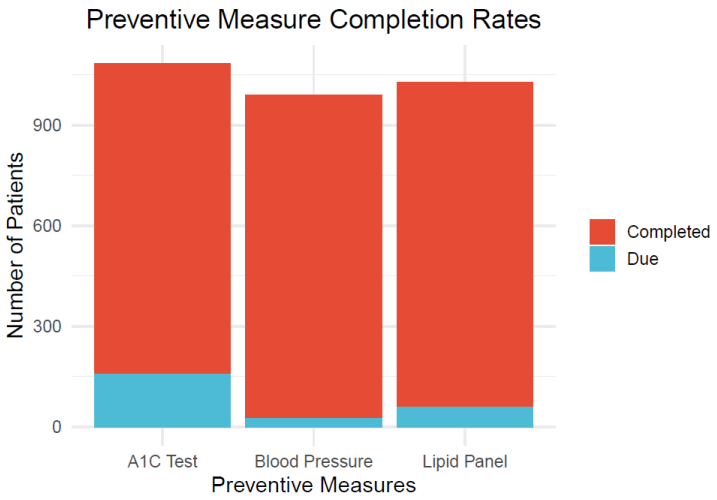
SETTING DATA ON FHIR

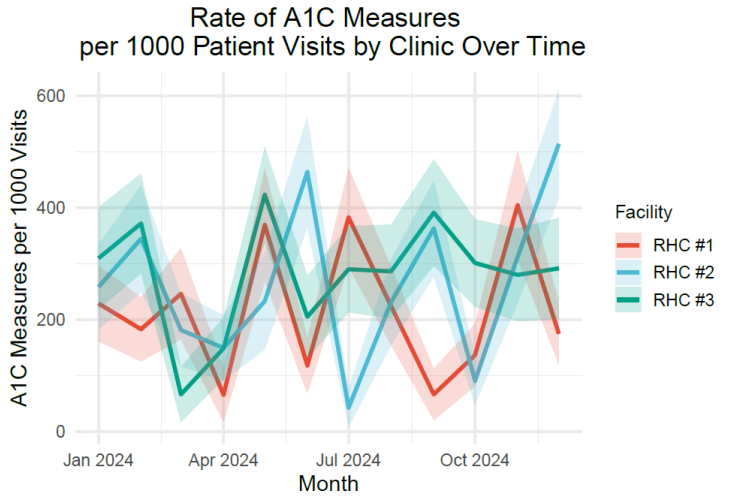
Objectives

- Implement FHIR standards in rural settings
- Bolster data capabilities for RHCs
- Create a rural dedicated landing pad for research, care, and operational activities



CLINICAL APPLICATIONS





FUTURE APPLICATIONS

Rural Research

- Rural research network
- Populations eligibility searches
- Seamless clinical participation

Operations

- RHC Quality Measures
- Clinically Integrated Networks
- Revenue Cycle optimization

WHAT IS HL7

- Standard for Data Exchange Between Systems
- Complex, Structured Data
- Pipe (|) Delimited or XML
- Specific in Nature
  - ADT – Admit Discharge Transfer
  - ORU - Observation Result
  - And More

EXAMPLE OF HL7 V2 MESSAGE

```
MSH|^~\&|||||20111215114509.682+0100||ORU^R01^ORU_R01|88c3|P|2.6.1|||NE|AL|||||
PID|||005.132264889546 51^^^&1.2.40.0.10.1.6.1.0.1.100.1.1&ISO||Testpatient^Hage
nberg||19310320000000+0100|M|||
OBR|
OBX||NM|150021^MDC_PRESS_BLD_NONINV_SYS^MDC|1.0.1.1|125|266016^MDC_DIM_MMHG^MCD
|||||F|||||||20111215114505.824+0100
OBX||NM|150022^MDC_PRESS_BLD_NONINV_DIA^MDC|1.0.1.2|85|266016^MDC_DIM_MMHG^MCD|
||||F|||||||20111215114505.824+0100
```

WHAT IS FHIR

- FHIR is Next-Gen HL7
- Modern Data Exchange Standard
- RESTful API
  - **Re**presentational **S**tate **T**ransfer
  - Application Programming Interface
- Highly Flexible, Web-Based
- Covers All Common Healthcare Use Cases

EXAMPLE OF FHIR MESSAGE


```
{
  "code": {
    "coding": [
      {
        "system": "http://loinc.org",
        "code": "8462-4",
        "display": "Diastolic Blood Pressure"
      }
    ],
    "text": "Diastolic Blood Pressure"
  },
  "valueQuantity": {
    "unit": "mm[Hg]",
    "system": "http://unitsofmeasure.org",
    "code": "mm[Hg]",
    "value": 82
  }
}
```

```
{
  "code": {
    "coding": [
      {
        "system": "http://loinc.org",
        "code": "8480-6",
        "display": "Systolic Blood Pressure"
      }
    ],
    "text": "Systolic Blood Pressure"
  },
  "valueQuantity": {
    "unit": "mm[Hg]",
    "system": "http://unitsofmeasure.org",
    "code": "mm[Hg]",
    "value": 109
  }
}
```

Swing Bed Quality Certification Program

Because every patient deserves exemplary care.

The ComplianceTeam™ Accreditation Organization | 30 YEARS 1994-2024

Learning Objectives

Why Swing Bed Certification?

Swing Bed Quality Standards

Operational & Financial Benefits

WHY?
Swing Bed Certification

The ComplianceTeam Accreditation Organization 30 YEARS 1994-2024

The Big Picture

- **With uncertainty around several significant provisions, such as payment, insurance, and delivery-system reforms, the healthcare industry must address future market changes.**

- **Swing Bed services provide an important care resource for rural patients and a volume growth opportunity for the hospital.**
  - However, concerns continue to be raised about the cost of Swing Bed care.

- **An effective Swing Bed Strategy and process will have a significant impact on the number of patients in your Swing Bed program.**
  - Swing Beds have not been included in national efforts to address comparability of post-acute quality measures (e.g. IMPACT Act and NQF).

Background

- **Swing Bed programs in rural Prospective Payment System hospitals and Skilled Nursing Facilities must submit Minimum Data Set patient data to CMS.**
  - CAHs are exempt
- **CAHs are not uniformly demonstrating the quality of care provided to their Swing Bed patients.**
  - In fact, broad differences exist in the quality of services received at one CAH when compared to another.
- **Inability to demonstrate Swing Bed quality potentially limits CAH's ability to participate in alternative payment models.**

Why Swing Bed Certification

Organizations who want to level the playing field must quantify and qualify the services they provide.

- Third party validation of your quality.
- Differentiate yourself from other Post-Acute Care Providers.
- Provide transparency about your program.
- Make you Swing Bed program stronger.
- Decrease out migration.
- Demonstrate bigger is not always better.
- Quantify and qualify the value of your swing bed program.
- Set yourself up for success.
- CAHs are exempt from Quality reporting of their swing bed program.

The ComplianceTeam Accreditation Organization 30 YEARS 1994-2024

Swing Bed Value

$$\text{Value} = \frac{\text{Co\$t}}{\text{Quality}}$$

The ComplianceTeam Accreditation Organization 30 YEARS 1994-2024

Risk Adjusted Metrics

$$\frac{\text{Co\$t}}{\text{Quality}} =$$

Discharge disposition

- To home
- Transferred to a NH/LTC facility
- Transferred to a higher level of care

30-day follow-up status

- Readmitted to CAH
- Readmitted to other hospital
- ED visit at CAH
- ED visit at other hospital

Functional status

- Change in self-care score between Swing Bed admission/discharge
- Change in mobility score between Swing Bed admission/discharge

The ComplianceTeam Accreditation Organization 30 YEARS 1994-2024

Testimonial

“An effective Swing Bed strategy and process will have a significant impact on the number of patients in your Swing Bed program.

The Swing Bed Certification Program ensures and validates that CAH’s are meeting all required policies and procedures and implementing best practices for transitional care.”

- **Leslie Marsh,** CEO, Lexington Regional Health Center
  Current President of NRHA

The ComplianceTeam Accreditation Organization 30 YEARS 1994-2024

Thoughts

- With a limited number of Swing Bed patients, hospitals need to actively pursue patients to increase swing bed volumes.
- Hospitals must establish relationships with larger hospitals and actively pursue Swing Bed patients whenever beds are available.
- The goal is to establish relationships with other hospitals, so you're the first hospital called when they have a patient needing Swing Bed services.
- When transferring patients for Acute services elsewhere, work to ensure they return to your facility if the patient needs Swing Bed services.

SWING BED
Quality Standards

The ComplianceTeam Accreditation Organization 30 YEARS 1994-2024

Swing Bed Quality Standards & EOC

Transparency Standards

- Medical Oversight
- Patient/Family Rights
- Staffing Types & Amounts

Care & Services Standards

- Patient/Family Expectations Met
- Patient/Family Engagement & Education
- Cleanliness/Environment
- Team Approach & Coordination
- Medication Management
- Infection Prevention
- Quality of Life
- Transitional Management
- Rehabilitative Services

Safety & Security

- Fall Prevention
- Surroundings & Belongings Secure

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Swing Bed Quality Standard: Transparency

TP 1.0 The Swing Bed Quality Program ensures all patients receive care and treatment as ordered upon admission and throughout the stay.

TP 2.0 The Swing Bed Quality Program protects patient and family rights and responsibilities.

TP 3.0 The facility ensures the healthcare staff is sufficient to provide the services essential for the operation of the Swing Bed program.

Swing Bed Quality Standard: Care & Services

CS 1.0 The Swing Bed Quality Program meets patient and family expectations.

CS 2.0 The Swing Bed Quality Program provides Patient Education and Self-Management tools to patients and their family/caregivers.

CS 3.0 The premises of the Swing Bed Quality Program are clean and orderly.

CS 4.0 The Swing Bed Quality Program uses a team-based approach for services, care and treatment it provides.

CS 5.0 Medication Management is sufficient to meet the needs of the patient and the prescribing physician's order.

CS 6.0 The organization follows infection control techniques that relate to the type of patient served, service provided, staff risk for exposure, and to protect the patient and staff from the spread of infection.

CS 7.0 Quality of life is enhanced in the Swing Bed Quality Program.

CS 8.0 The Swing Bed Quality Program provides continuity of medical oversight through transition of care provided at multiple health care settings (i.e., Acute Care admission to Swing Bed and then to Home Health or Outpatient Services).

CS 9.0 Rehabilitative Services (i.e., PT,OT, and/or Speech Language Pathology), if applicable, are provided by qualified individuals under an established plan of care.

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Swing Bed Quality Standard: Care & Services

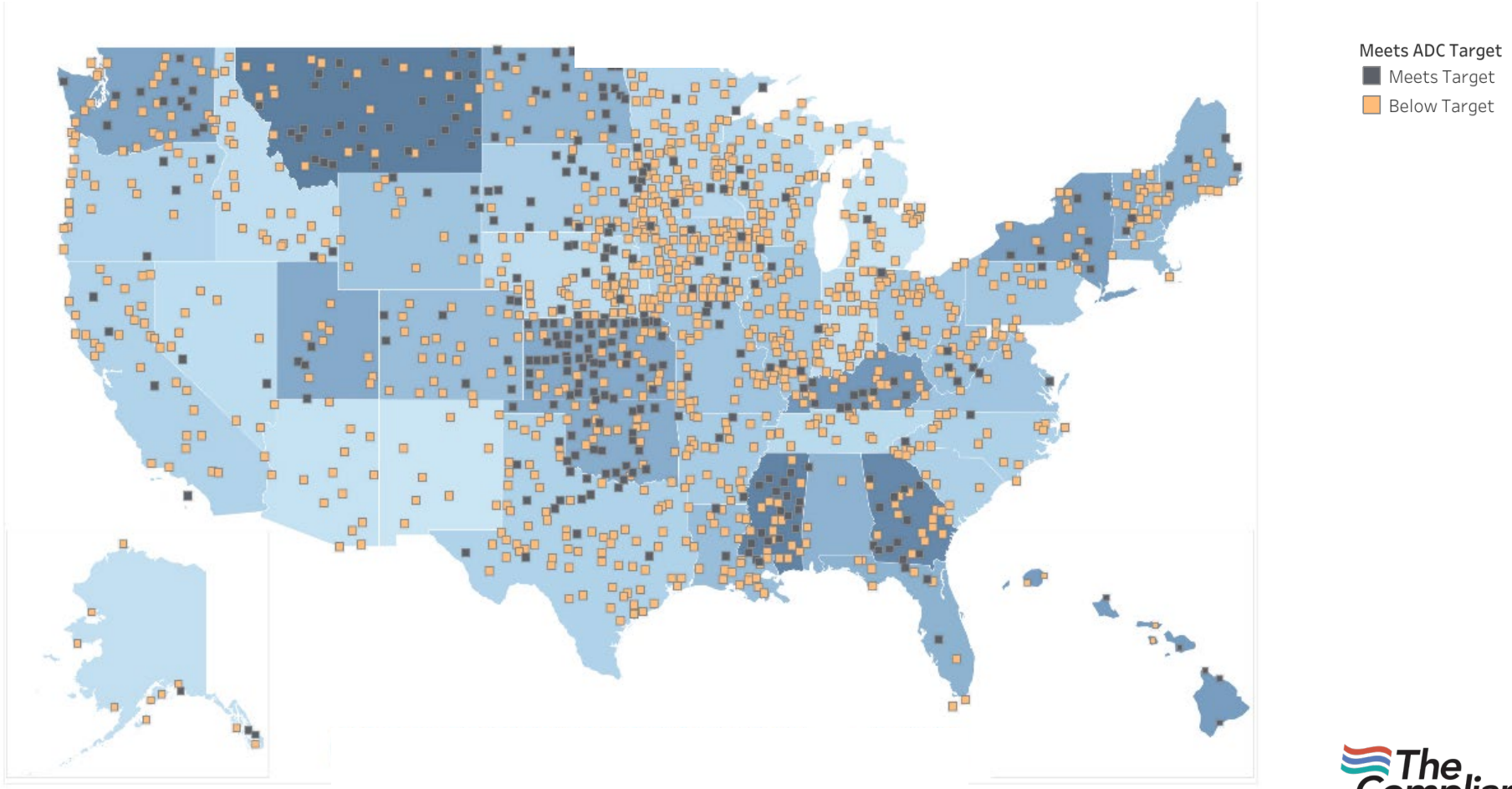
SS 1.0 The Swing Bed Quality Program conducts a fall-risk assessment on all patients.

SS 2.0 The Swing Bed Quality Program provides a safe and secure environment.

The ComplianceTeam Accreditation Organization 30 YEARS 1994-2024

Swing Bed Utilization

Best practice CAHs achieve a Swing Bed ADC at a minimum of 4.0 per 10,000 people in service area.



The ComplianceTeam Accreditation Organization 30 YEARS 1994-2024

VALIDATION
Swing Bed Program

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TCT: Patient Satisfaction Survey

Admin -- Create a Swing Bed Survey

Customer

Survey Method ○ U.S. Mail ○ In Store ○ Phone

Patient's Name First Name: Last Name:

New or Existing Patient ○ New ○ Existing

Equipment Category

Model and Serial #

Date Of Service (mm/dd/yyyy format)

Survey Conducted By First Name: Last Name:

Survey Conducted On 05/04/2022 (mm/dd/yyyy format)

Delivery and Instruction Tech Names

	Access, Delivery and Service	Yes	No	N/A
1	Were the purpose and goals of the Swing Bed program explained to you prior to admission?	○	○	○
2	Throughout your stay, were you and your family provided updates regarding your care and treatment?	○	○	○
3	Are the instructions from your care team given clearly so that you understand and always know what to expect?	○	○	○
4	Was there an activities program(i.e., bingo, card playing, crafts) available to you?	○	○	○
5	Did you feel that the staff answered your questions and concerns?	○	○	○
6	Did you always have a call button within your reach?	○	○	○
7	Were your calls for assistance (i.e., call bell) answered in a timely fashion?	○	○	○
8	Were you 100% satisfied with your swing bed stay?	○	○	○
9	Would you recommend this facility to family and friends?	○	○	○

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Validating Quality of Swing Bed Program

Quality of life is enhanced in the Swing Bed Quality Program.

Transitions

- The patient and/or caregivers are involved in all transition of care.
- Provide a safe and seamless transition thru multiple healthcare settings.

Patient Satisfaction

- Develop a process, with clear goals to measure patient/family satisfaction. Includes interviews, one-on-one conversations with patients and family about their care and treatment provided.

How do you improve when you're already providing quality care?

Ask your patients!

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Validation

In the end we're validating these…and then some:

- A comprehensive patient assessment
- A comprehensive care plan
- A discharge summary
- Medication management at all transition points
- A patient activity plan
- Safety and security for the patients
- Team-based care

Where to Begin

Remember this is a team project, but you need a provider champion.

- Look at workflow.
- Educate all providers and staff on quality performance measures.
- Use huddles to scrub the schedule for issues. Delegate what you can.
- Involve your pharmacists. 50% of all prescriptions will either not be used or used improperly. One study shows people who received MTM services from a pharmacist were three times more likely to remain out of the hospital after 60 days.

Reminder

Start asking your patients today!

BENEFITS
Financial & Operational

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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 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.

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Fixed vs Variable Costs

VS

Costs exist irrespective of volume.

Unit staffing, medical direction, medical equipment, par levels of supplies.

Costs 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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Leveraging the Swing Bed Program

Cost-based reimbursement will only allow a hospital to break even.

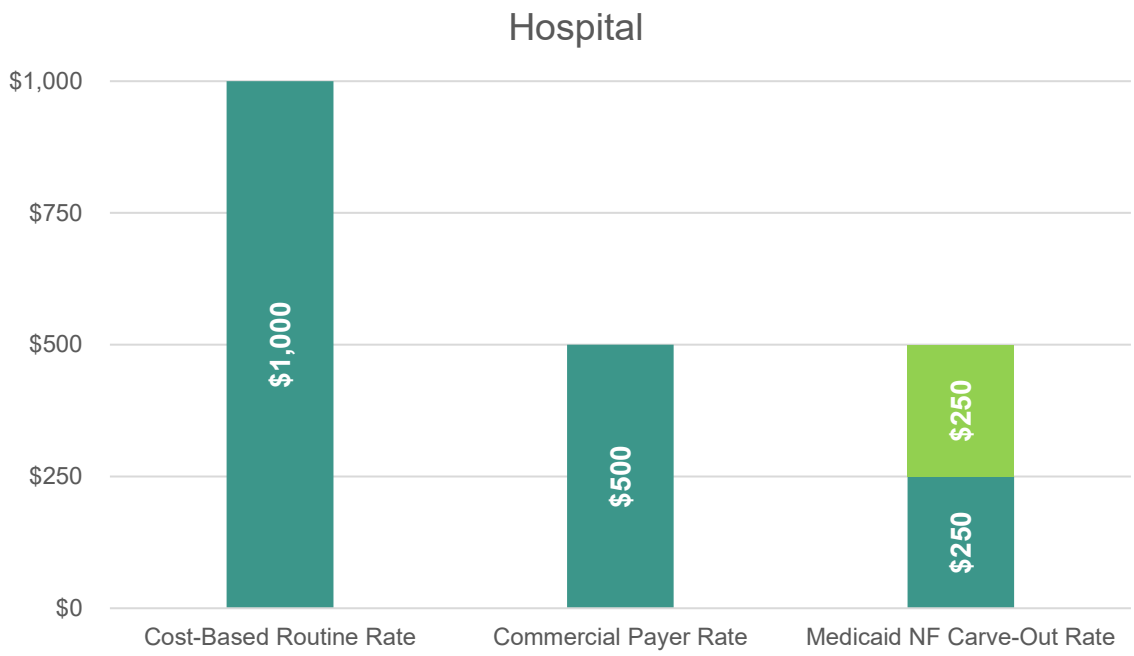
Opportunity: Non-Medicare or Medicare Advantage (Swing Bed NF) patient days.

- 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 Growth

Care Spectrum

- Organizations must evaluate the services provided and continue efforts to expand service delivery to increase reliance on the hospital for post-acute care services.

Active Pursuit

- With a limited number of Swing Bed patients, hospitals need to actively pursue patients to increase volumes.

Best Practice

Rural hospitals establish relationships with larger hospitals and actively pursue Swing Bed patients whenever beds are available.

- One primary concern of a PPS hospital looking for Swing Bed placement is to free up the bed for a future Acute admission.
- Goal of the rural hospital is to establish a relationship with the other hospital, so you are the first hospital called when they have a patient needing Swing Bed services.
- Ensure patients who are transferred for Acute services elsewhere, return to the hospital when needing Swing Bed services.

Admissions Process

Hospitals operating a Swing Bed program should implement a defined process to pursue Swing Bed patients and increase overall IP volumes.

Best practice admissions process for Swing Bed volume growth

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Final Takeaways

- **Important to build a high-quality Swing Bed program and use it to differentiate your services from others offering post-acute care.**
  - Swing Bed Quality Certification and tracking Swing Bed outcomes.

- **High-quality Swing Bed services provide a tailwind for Swing Bed program growth.**
  - Develop a Care Spectrum and use Active Solicitation techniques.

- **Improves financial position of the hospital through volume growth, which drives revenue growth and dilutes fixed costs resulting in service efficiency.**

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Questions

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