TASC 90

CAH Finance Post-COVID

February 8, 2024

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued.

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/DEI

Your Participation is Critical For Success!

- Webinar Engagement from our Coordinators helps other Flex Programs Nationwide.
- Don't hesitate to share your stories!
- Closed captioning is available.
- When not speaking, please keep microphones muted.
- Use chat box, raise hand feature, or come off mute to ask questions.
- A copy of recording will be made available.
- Please take a moment to complete the polling questions on your screen.

Objectives

At the conclusion of today's webinar, be able to:

- Recognize key CAH financial indicators as they relate to hospital financial sustainability in a post COVID environment.
- Identify relevant financial data to better support your CAHs.
- Develop financial management strategies, to better support your state's CAH Operational and Financial Improvement.

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $1,350,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Today's Agenda

- Flex Partners Updates
- FMT / University of NC at Chapel Hill
- Stroudwater Associates
- Dallas County Medical Center
- Washington County Hospital and NH
- Q&A / Polling / Closing Comments

Federal Partners Updates

MBQIP 2025 Resources and Support

- Hot off the Press!
  - RQITA Quality Improvement Workbook
  - Telligen RQITA Quality Improvement Website host of QI tools related to MBQIP www.telligen.com/rqita
- Coming Soon!
  - Measure Submission Guides for MBQIP 2025 core measures
  - Recorded video overviewing MBQIP 2025 measures and reporting details
  - Quality Improvement Basics recorded series

TASC

- TASC is available to review one component of your cooperative agreement application prior to your final submission. (examples: work plan, narrative, budget, etc.)
  - If you would like a review, please choose one section for TASC to review and submit your request to tasc@ruralcenter.org by April 2nd for primary Flex funding and April 11th for the EMS supplement.
- Also consider posting NOFO or other questions in the Flex Program Forum. If you've got a question, someone else likely has the same question.
- Evaluation Webinar Series #5 - Designing Measurable Outcomes that Demonstrate Program Impact February 20th
- Flex Open Office Hours – Feb 26th & Mar 12th (2pm CST)
- Spring Flex Workshop participant request form now open.

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Monitoring CAH Financial Performance Post-COVID

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Flex Monitoring Team

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FUNDING: This work was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement # U27RH01080. The information, conclusions and opinions expressed in this presentation are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.

Agenda

01 CAH Financial Performance

Trends Pre-, During, and Post-COVID

02 The Post-COVID Environment

CAHMPAS data to support monitoring and planning

03 Discussion

Comments, Sharing and Q&A

01 CAH Financial Performance

Since January 2005, 67 CAHs Have Closed or Converted

Most rural hospitals that closed between 2017-2020 were more unprofitable and less liquid than those that remained open.[1]

38

Complete Closures

29

Converted Closures

Source: Cecil G. Sheps Center for Health Services Research https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

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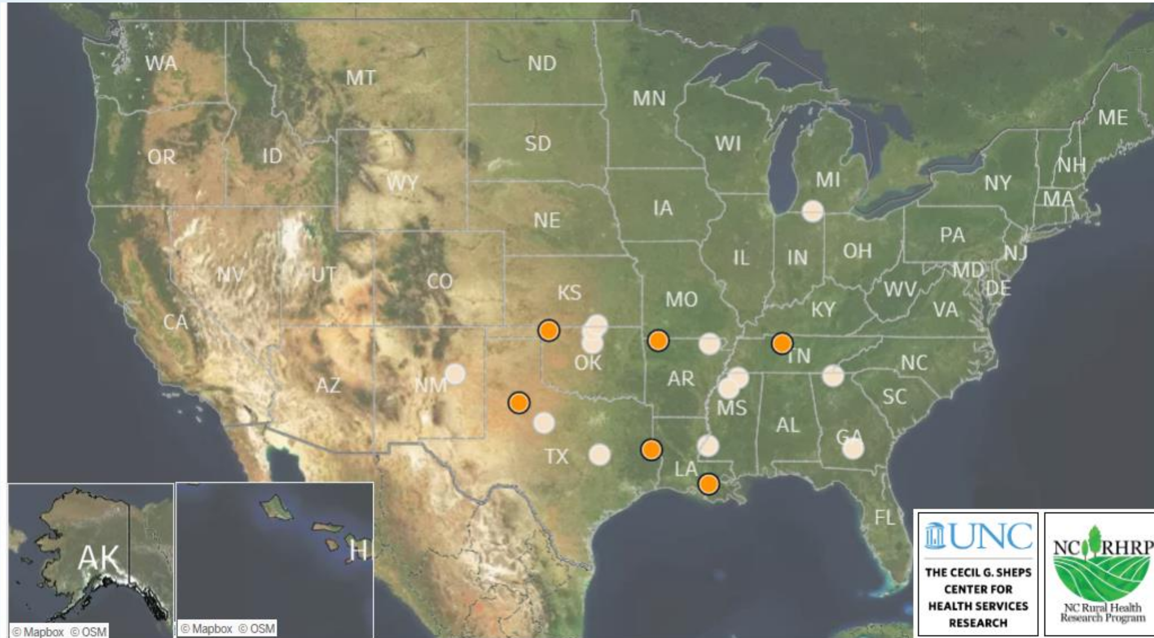
Six of 19 Hospitals that Converted to Rural Emergency Hospitals in 2023 were CAHs



Source: Cecil G. Sheps Center for Health Services Research https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

CAH	State
Eureka Springs Hospital	AR
Harper County Community Hospital	OK
Assumption Community Hospital	LA
Tristar Ashland City Medical Center	TN
St. Luke's Health - Memorial Hospital - San Augustine	TX
Crosbyton Clinic Hospital	TX

Operating Margin: A Key Measure of Profitability

Variable	Definition
Actual Operating Margin	Net patient revenue + operating income – total operating expenses Net patient revenue + other revenue
Simulated Operating margin	(Net patient revenue + operating income – total operating expenses) – COVID-19 PHE Funding (Net patient revenue + other revenue) – COVID-19 PHE Funding
COVID-19 PHE Funding	COVID-19 Public Health Emergency Funding

Interpretation: Measures the control of operating expenses relative to operating revenues

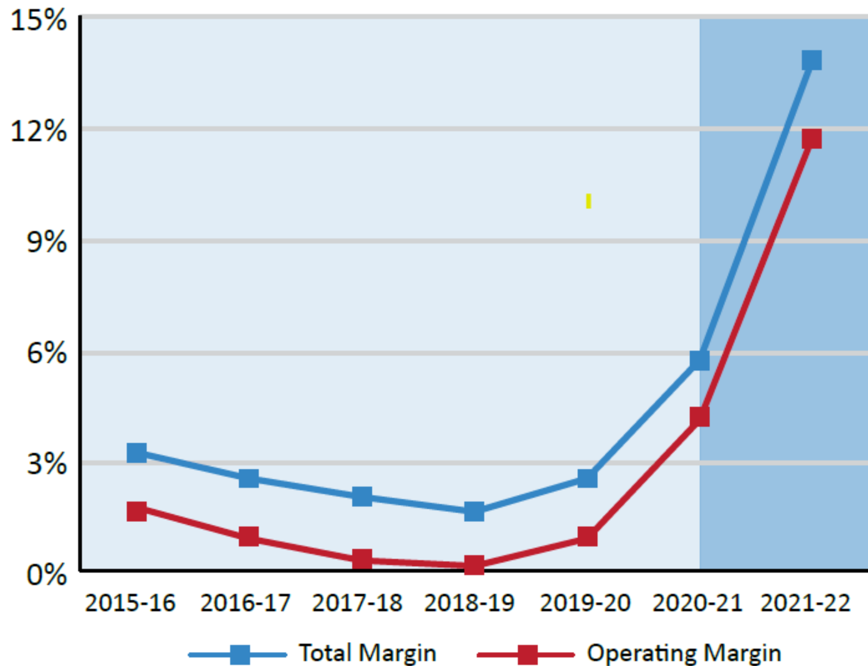
Total Margin: A Comprehensive Measure of Profitability

Variable	Definition
Actual Total Margin	$\frac{\text{Net income}}{\text{Total revenue}}$
Simulated Total Margin	$\frac{\text{Net income – COVID-19 PHE Funds}}{\text{Total revenue – COVID-19 PHE Funds}}$
COVID-19 PHE Funding	COVID-19 Public Health Emergency Funding

Interpretation: Measures the control of expenses relative to all sources of revenue

Public Health Emergency (PHE) Funding Likely Masked Financial Challenges

During April 2020-March 2022, CAH profitability increased sharply compared to pre-COVID trends.[2]



	With PHE Funds	Without PHE Funds
Median Operating Margin	7.3%	(0.3)%
Median Total Margin	9.4%	1.9%

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Public Health Emergency (PHE) Funding Does Not Sustain CAHs Long-Term

April 2022– March 2023 data portrays a sharp decline to around pre-pandemic levels

Median Actual CAH Operating and Total Margin, April 2015 - March 2023

16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-2.0%

2015-16 2016-17 2017-18 2018-19 2019-20 2020-21 2021-22 2022-23

Operating Margin Total Margin

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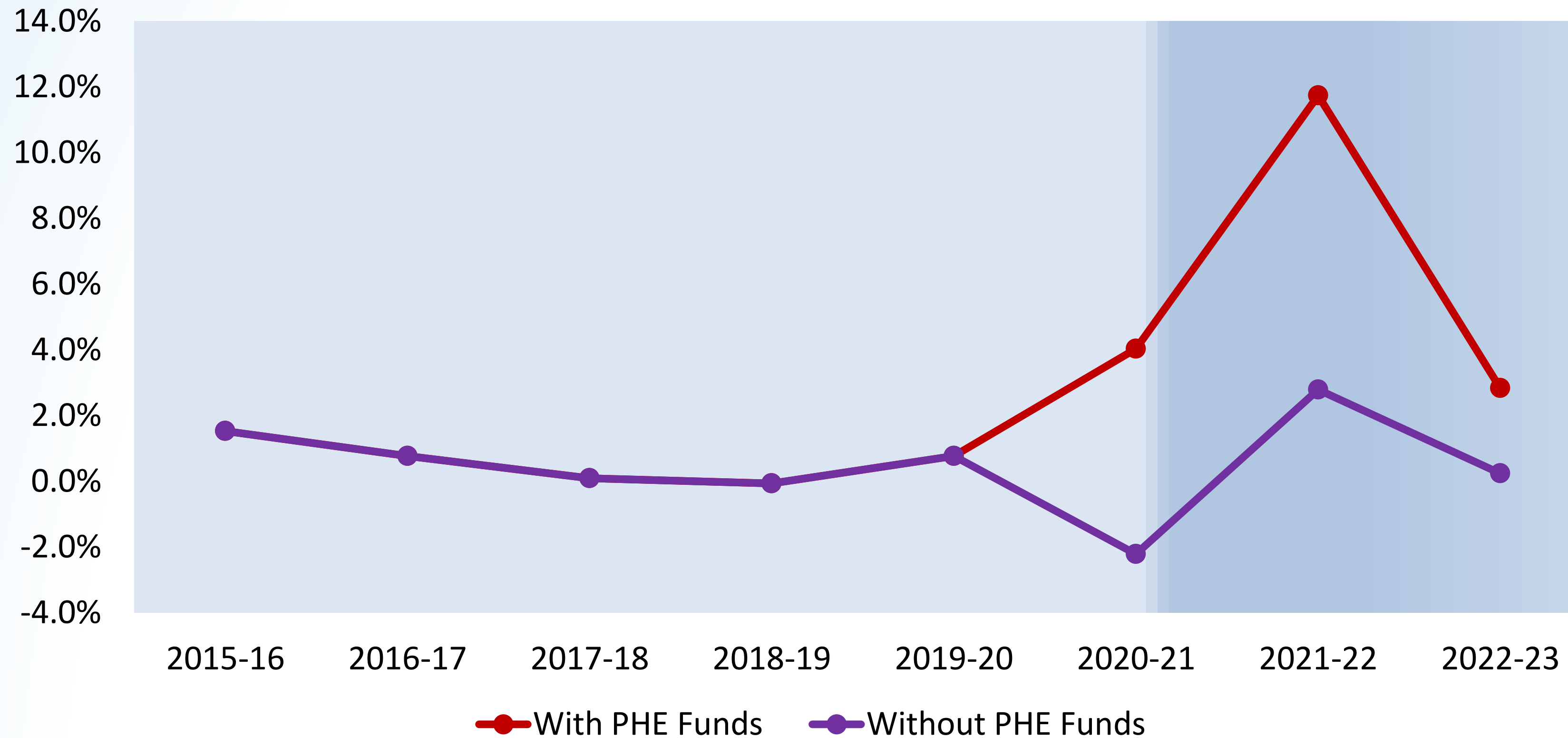
Without Public Health Emergency (PHE) Funding, CAH Operating Margins Would be Below Pre-Pandemic Levels



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02 The Post-COVID Environment

Hospitals Face Ongoing Challenges

Continued monitoring will be important

- Workforce
- Inflation
- Volume
- Liquidity

CAHMPAS is a Free Online Tool for Monitoring CAH Financial Performance

Login

Username

Password

Remember Me

Login FAQ Tutorial

https://cahmpas.sirs.unc.edu/login

CAHMPAS Data are Derived from the Medicare Cost Report

Updated September and March

Update Month/Year	Data Year
March 2023	Complete 2021; Partial 2022
September 2023	Partial 2022; Partial 2023
March 2024	Complete 2022; Partial 2023

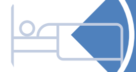
Peer Group Factors Allow For More Accurate Comparisons[4]

Geography

Net Patient Revenue (size)

Government Ownership

Operation of a Rural Health Clinic

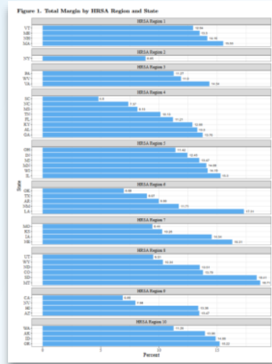


Provides Long-term Care

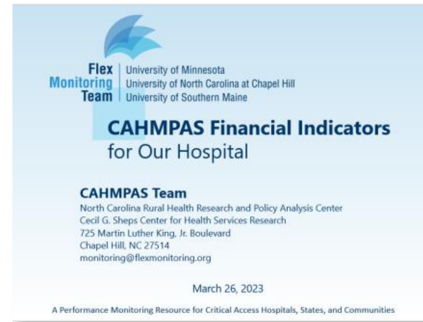
System Affiliation

Ancillary Products

Supplementary reports and presentations to understand and communicate financial performance and condition



Annual State Medians Report[5]



CAHMPAS Financial Indicators Presentations[6]

CAHMPAS Financial Indicators Calcul

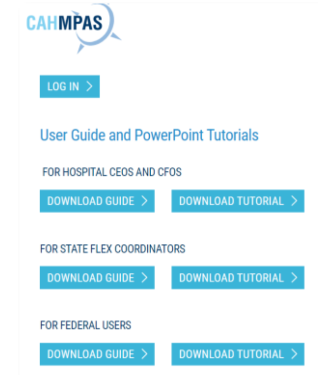
USING 2020 MEDICARE COST REPORT FORM DATA ELEMENTS

Cells where you input numbers from your Medicare cost report

Cells where your CAHMPAS financial indicator values are reported

Description	Worksheet	Part
Growth		
1- Year Change in Operating Revenue	#DIV/0!	
3- Year change in Operating Revenue	#DIV/0!	
1- Year Change in Operating Expense	#DIV/0!	
3- Year change in Operating Expense	#DIV/0!	
Labor		
FTE per Adjusted Occupied Bed	#DIV/0!	
Average Salary per FTE	#DIV/0!	
Salary to Net Patient Revenue	#DIV/0!	
Other		
Average Age of Plant	#DIV/0!	
Patient Deductions	#DIV/0!	
Medicaid Payer Mix	#DIV/0!	
Uncompensated Care	#DIV/0!	

CAHMPAS Financial Indicators Calculator[7]



CAHMPAS Tutorials[8]

Financial Performance Indicators

CAHMPAS data to support monitoring and planning

$

Profitability

Total Margin
Operating Margin
Cash Flow Margin
Return on Equity

$

Liquidity

Current Ratio
Days Cash on Hand
Days in Net A/R
Days in Gross A/R

$

Capital Structure

Equity Financing
Debt Service Coverage
Long-Term Debt to Capitalization

Bold indicates National Rural Health Resource Center "Top 10" indicators.[3]

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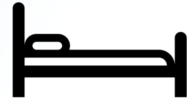
Service Line Indicators

CAHMPAS data to support monitoring and planning



Inpatient

Medicare Inpatient Payer Mix
Medicare Acute Inpatient Cost per Day
Average Daily Census - Acute
Average Daily Census – Swing SNF

Outpatient

Hospital Medicare Outpatient Payer Mix
Outpatient Revenue to Total Revenue
Hospital Medicare Outpatient Cost-to-Charge

Bold indicates National Rural Health Resource Center "Top 10" indicators.[3]

Operations Indicators

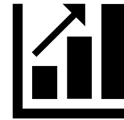
CAHMPAS data to support monitoring and planning

Labor

FTEs per Adjusted Occupied Bed

Average Salary per FTE

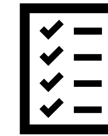
Salaries to Net Patient Revenue



Growth

1-year and 3-year change in operating revenue

1-year and 3-year change in operating expenses



Other

Average Age of Plant

Patient Deductions

Medicaid Payer Mix

Uncompensated Care

Bold indicates National Rural Health Resource Center "Top 10" indicators.[3]

03 Discussion, Sharing and Q&A

References and Resources

1. Osgood AS, Pink G. Rural Hospitals that Closed between 2017-20: Profitability and Liquidity in the Year Before Closure. NC Rural Health Research Program. UNC Sheps Center. January 2022. FB 170. https://www.shepscenter.unc.edu/download/23647/
2. McFadyen L, Pink G, Gurzenda S, Thompson K, Reiter K. The Impact of COVID-19 Funding on Profitability of Critical Access Hospitals. Flex Monitoring Team. June 2023. https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/Impact_of_COVID19_funding_on_Profitability_of_CAHs.pdf
3. Johnson J. Critical Access Hospitals Top 10 Key Financial Indicators. National Rural Health Research Center. August 2015. https://www.ruralcenter.org/sites/default/files/JJohnson%20Key%20Financial%20Indicators%20Final.pdf
4. Hawkins WL, Reiter K, Pink G. Reassessing Financial Peer Groups for CAHs. Flex Monitoring Team. November 2016. Policy Brief #44. https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/pb44.pdf
5. Reiter K. Summary of Indicator Medians by State. Flex Monitoring Team. April 2023. https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/statemediansreport_2023_natl.pdf
6. CAH Financial Indicators Presentation. April 2023. https://www.flexmonitoring.org/tool/cah-financial-indicators-primer-and-calculator-resources
7. CAH Financial Indicators Calculator. April 2023. https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/cahmpas-financial-indicators-calculator-3-19-2023.xlsx
8. CAHMPAS Tutorials. https://www.flexmonitoring.org/tool/cah-financial-indicators-primer-and-calculator-resources

Questions / Comments:

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TASC 90 WEBINAR - CAH FINANCE – POST COVID 19

Eric K. Shell, MBA

Lindsay Corcoran, MHA

RESPONSE TO FINANCIAL CHALLENGES

THE PREMISE

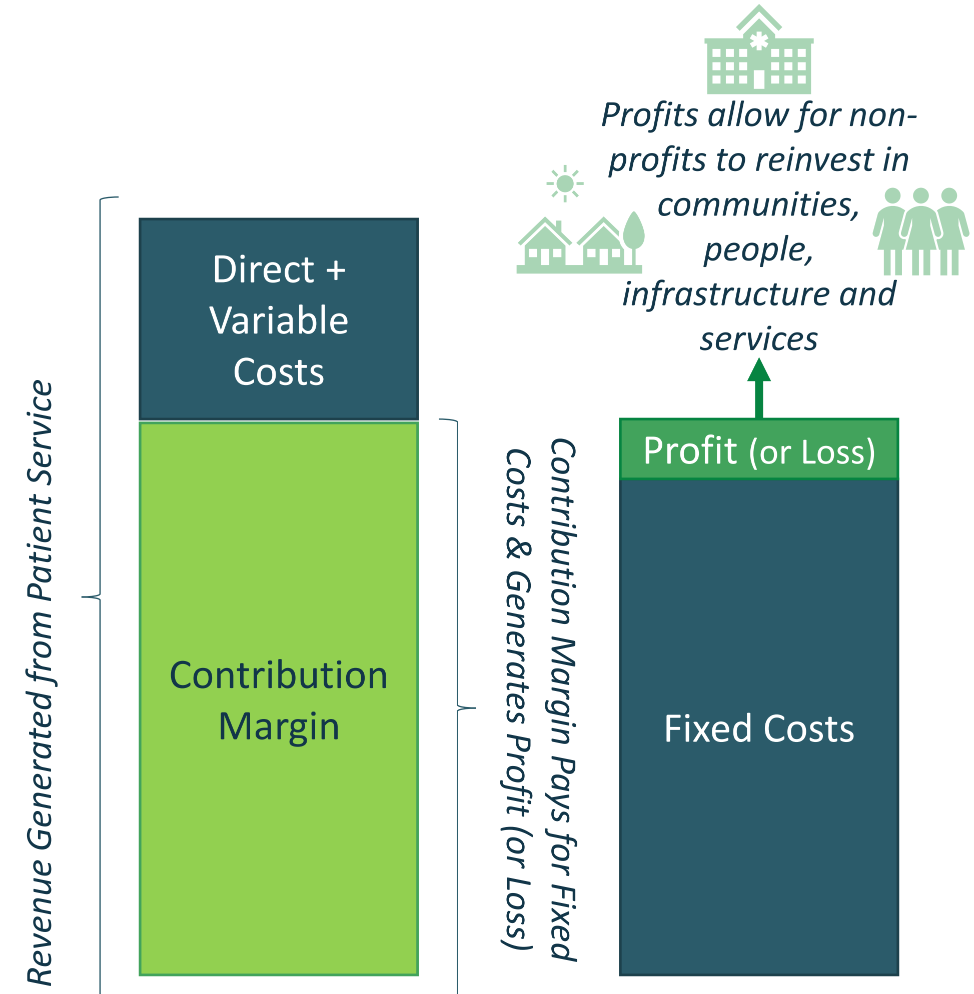
- Macro-economic payment system
  - Government payers changing from fee-for-service (FFS) to population-based payment system (PBPS)
  - CMMI is considering making value-based payment models mandatory
  - Private payers follow government payers

- Provider imperatives
  - Fee-for-service (FFS):
    - Maximization of price and utilization
    - Management of costs
  - Provider Based Payment System (PBPS):
    - Management of care of a defined population
    - Providers assume risk

- Provider organization evolution from:
  - Independent organizations competing with each other for market share →
  - Aligned organizations competing with other aligned organizations for covered lives based on quality and value
- Network and care management organization must develop new competencies:
  - Network development
  - Care management
  - Risk contracting & management

STROUDWATER'S IMPORTANT FRAME OF REFERENCE

- **In our experience, CAHs hospitals are successful when 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
  - Nearly all paying services create a positive contribution which is used to pay for fixed costs and create a profit (if applicable)
    - Those that do not should be examined closely, and may be deemed unviable
  - Economic imperative to develop thousands of "mini contribution margins" to cover all the fixed costs of the hospital
- **The inverse is true in a Value-Based Risk Contract**
  - Success in value-based risk contracts is often measured based on claims as a measure of cost
    - Claims are primarily composed of fixed costs versus variable costs confusing the issue
    - Generally, claims costs are 80%+ fixed



TRANSCENDING INDIVIDUAL AND ORGANIZATIONAL VALUES

- **IMPACT**
  - Leave better than before
- **INTERDEPENDENCE**
  - We before me
  - Small cog in a larger system
- **RESPECT**
  - For oneself, others, environment, etc.
  - Golden Rule
- **ABUNDANCE**
  - Stephen Covey coined the idea of abundance mentality or abundance mindset, a concept in which a person believes there are enough resources and successes to share with others.
  - This is contrasted with the scarcity mindset (i.e., destructive and unnecessary competition), which is founded on the idea that, if someone else wins or is successful in a situation, that means you lose; not considering the possibility of all parties winning (in some way or another) in a given situation (zero-sum game).

ECONOMIC PHILOSOPHY

- Understand difference between contribution margin and profit on fully allocated costs
  - Variable Cost
    - Definition: Expenses that change with changes in activity
    - E.g.: *Pharmaceuticals, reagents, film, food*
  - Fixed Cost
    - Definition: Expenses that do not change with changes in activity
    - E.g.: *Salaries and benefits (??), rent, utilities*
  - Hospitals have inordinately high fixed costs relative to revenue (E.g., ER Standby, acute care nursing costs, etc.)
  - Unit contribution margin
    - The amount from each unit of service available to cover fixed costs and provide operating profits
    - Example - If Department X's unit service price is $200 and its unit variable cost is $30, the unit contribution margin is $170 ($200 – $30)
    - A rural hospital is made up of 1000s of Unit Contribution Margins

RURAL HOSPITAL COST STRUCTURE

- Profits and Losses

Revenue

Dollars

Profit Zone

Cost

Loss Zone

Service Volumes

ORGANIZATIONAL DESIGN/MEASUREMENT

- Have an effective organizational design that drives accountability into the organization

Decision Rights	Performance Measurement	Compensation

• Drive decision rights down to clinical/operation level
• Education to department managers on business of healthcare
  • Avoid separation of clinical and financial functions
	• Department managers to be involved in developing annual budgets
	• Budget to actual reports to be sent to department managers monthly
	  • Variance analysis to be performed through regularly scheduled meetings between CFO/CEO and department managers
		• Recognize performance in line with organizational goals

FINANCIAL AND OPERATIONAL BEST PRACTICES

- The following best practice opportunities areas were derived from the 100+ Stroudwater CAH site visits conducted over the last five years

  - Strategy
  - Economic Philosophy
  - Inpatient Services
  - Emergency Services
  - Clinical Departments
  - Departmental Profitability
  - Quality Improvement
  - Information Technology
  - Cost Report Improvement
  - Revenue Cycle
  - Management Accounting
  - Staff Benchmark Analysis
  - Provider Complement/Practice Management
  - Provider Alignment
  - Service Area Rationalization
  - Alignment Strategy
  - Payment System Transformation
  - Population Health Management

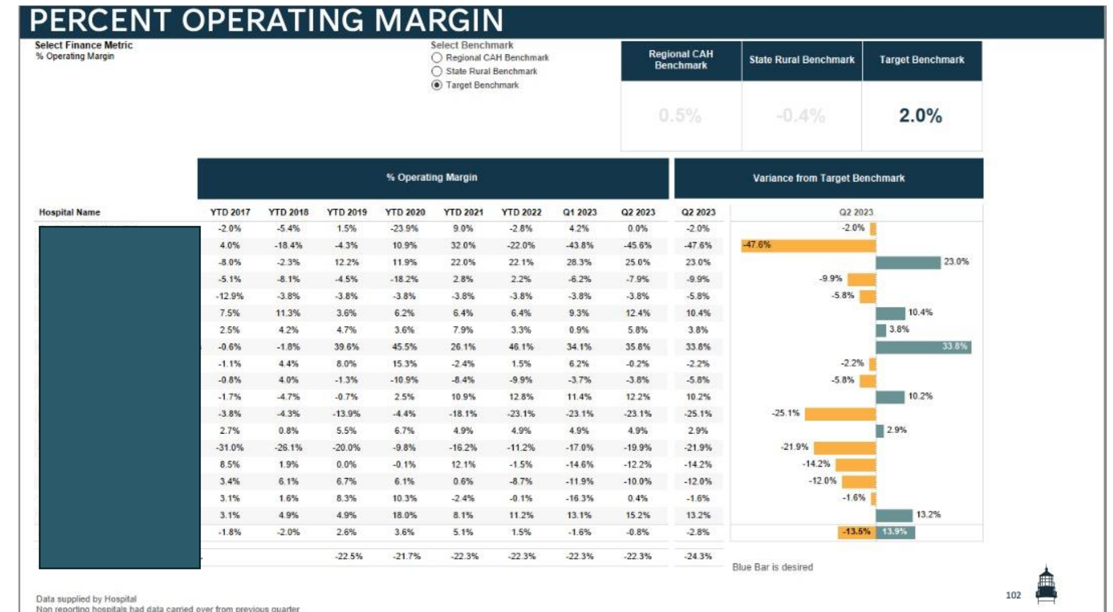
STRATEGIES TO SUPPORT CAH FINANCIAL AND OPERATIONAL IMPROVEMENT

KEY STRATEGIES

- CAH Specific Approaches
  - Strategic, Financial, Operational Assessment (SFOA): a rapid and focused analysis of targeted areas within the hospital that result in the identification of high-impact opportunities for operational and financial performance gains
  - RHC Performance Evaluation: focused assessment of the operations of the practices and recommendations for operational improvement and care optimization. Stroudwater will focus our assessment on the main components of physician practices that are often the key drivers for positive or negative performance
  - Service line assessments / ROI
    - Swing bed program evaluation
  - Cost report review and strategy
  - Chargemaster review and strategy
  - Value-based payment modeling
  - Market / service area assessment: a robust set of analyses based on curated data sources to highlight the various market factors that affect a hospital's current and future performance and the population it serves

KEY STRATEGIES

- Financial Education
  - Department manager training / education – finance 101, cost reporting, budget creation
  - Leader / manager performance assessment: measures organizational effectiveness, personal effectiveness, and balance to identify strengths and opportunity areas for improvement
- Performance Measurement
  - Needs assessment: leveraging CAHMPAS financial data reports, determine the financial status of state CAHs
- CAH Networks
  - Financial benchmarking network: facilitate CEO and CFO network meetings as a means of assessing statewide and CAH-specific needs, sharing industry/market updates, hospital best practices and benchmark data not available in the CAHMPAS program.
  - Revenue cycle improvement network: improving the revenue cycle management of each CAH/RHC through the network meetings, where participants will work on specific strategies and best practices through topics that impact revenue cycle management.



PERCENT OPERATING MARGIN

Select Finance Metric
% Operating Margin

Select Benchmark
Regional CAH Benchmark
State Rural Benchmark
Target Benchmark

Regional CAH Benchmark	State Rural Benchmark	Target Benchmark
0.5%	-0.4%	2.0%

Hospital Name	YTD 2017	YTD 2018	YTD 2019	YTD 2020	YTD 2021	YTD 2022	Q1 2023	Q2 2023	Variance from Target Benchmark Q2 2023
	-2.0%	-5.4%	1.5%	-23.9%	9.0%	-2.8%	4.2%	0.0%	-2.0%
	4.0%	-18.4%	-4.3%	10.9%	32.0%	-22.0%	-43.8%	-45.6%	-47.6%
	-8.0%	-2.3%	12.2%	11.9%	22.0%	22.1%	28.3%	25.0%	23.0%
	-5.1%	-8.1%	-4.5%	-18.2%	2.8%	2.2%	-6.2%	-7.9%	-9.9%
	-12.9%	-3.8%	-3.8%	-3.8%	-3.8%	-3.8%	-3.8%	-3.8%	-5.8%
	7.5%	11.3%	3.6%	6.2%	6.4%	6.4%	9.3%	12.4%	10.4%
	2.5%	4.2%	4.7%	3.6%	7.9%	3.3%	0.9%	5.8%	3.8%
	-0.6%	-1.8%	39.6%	45.5%	26.1%	46.1%	34.1%	35.8%	33.8%
	-1.1%	4.4%	8.0%	15.3%	-2.4%	1.5%	6.2%	-0.2%	-2.2%
	-0.8%	4.0%	-1.3%	-10.9%	-8.4%	-9.9%	-3.7%	-3.8%	-5.8%
	-1.7%	-4.7%	-0.7%	2.5%	10.9%	12.8%	11.4%	12.2%	10.2%
	-3.8%	-4.3%	-13.9%	-4.4%	-18.1%	-23.1%	-23.1%	-23.1%	-25.1%
	2.7%	0.8%	5.5%	6.7%	4.9%	4.9%	4.9%	4.9%	2.9%
	-31.0%	-26.1%	-20.0%	-9.8%	-16.2%	-11.2%	-17.0%	-19.9%	-21.9%
	8.5%	1.9%	0.0%	-0.1%	12.1%	-1.5%	-14.6%	-12.2%	-14.2%
	3.4%	6.1%	6.7%	6.1%	0.6%	-8.7%	-11.9%	-10.0%	-12.0%
	3.1%	1.6%	8.3%	10.3%	-2.4%	-0.1%	-16.3%	0.4%	-1.6%
	3.1%	4.9%	4.9%	18.0%	8.1%	11.2%	13.1%	15.2%	13.2%
	-1.8%	-2.0%	2.6%	3.6%	5.1%	1.5%	-1.6%	-0.8%	-2.8%
			-22.5%	-21.7%	-22.3%	-22.3%	-22.3%	-22.3%	-24.3%

Data supplied by Hospital
Non reporting hospitals had data carried over from previous quarter

CEO David Mantz

CEO Teresa Grimes

Program Area 2: CAH Financial & Operational Improvement

- This required program area focuses on improving CAH financial stability, operations, and efficiency. All State Flex Programs must assess the financial status of CAHs in the state, identify CAHs with greater needs, and implement interventions to address those needs. Work on the statewide needs assessment may range from intensive data collection and analysis for a systematic, in-depth statewide needs assessment to plan a new period of performance to a brief annual review of new data in the context of an existing assessment to ensure that planned activities are responsive to current CAH needs.

Program Area 2: CAH Financial & Operational Improvement

- Flex investments in this area must focus on CAHs. However, as appropriate to the specific interventions and supported by the needs assessment, Flex programs may assist CAHs that operate provider-based RHCs to improve their operations along with the main campus as it also helps improve the overall financial picture for the CAH.

Program Area 2: CAH Financial & Operational Improvement

- Projects should have short, intermediate, and long-term outcomes listed.
- FORHP does not expect that all hospitals in your state participate in every project. You should analyze which hospitals are most in need of the targeted interventions to efficiently use Flex resources.
- It is possible that the intervention of the project may only take place over one year, but it is expected that State Flex Programs review data for the participating hospitals in future years, to determine if the long-term outcomes are met after the project has been completed.

Program Area 2: CAH Financial & Operational Improvement

Workplan Investment Examples and Resources:

- FYs 24 - 28 Flex Program Structure Doc
- FYs 24 - 28 Flex Program Workplan Template
- FY 2024 NOFO Technical Assistance Webinar Playback
- Flex Program Grant Guidance

Q&A

Closing Comments

Thank you!

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