Critical Access Hospital Financial Sustainability Guide

National Rural Health Resource Center

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Purpose

This guide is intended for use by state Medicare Rural Hospital Flexibility (Flex) Program personnel, leaders of critical access hospitals (CAHs), and other individuals and/or teams that provide guidance and assistance to these providers in managing their long-term financial stability. While CAH finance can be complex, this guide is designed to be as non-technical as possible while providing guidance and strategies regarding various potential interventions CAHs may employ to address ongoing and systemic financial challenges in the rural health care setting. Successful adoption and implementation of the interventions will assist CAHs in improving overall performance over the long term to enhance financial stability.

Background

Of the many identified financial ratios proven useful for assessing organizations financial conditions there are 10 which are most referenced and utilized in the Flex Program. These ten indicators and favorable direction for trending the financial data in relation to the median are shown below.

Critical Access Hospital Indicators

Favorable Upward Trends

- Days Cash on Hand
- Total Margin
- Operating Margin
- Debt Service Coverage

Favorable Downward Trends

- Days in Net Accounts Receivable
- Days in Gross Accounts Receivable
- Salaries to Net Patient Revenue
- Medicare Inpatient Payer Mix
- Average Age of Plant (years)
- Long-Term Debt to Capitalization

Additional details about these financial indicators and most recent US Medians can be found in the Small Rural Hospital and Clinic Finance 101 guide.[1]

Several important financial interventions that have been associated with improved financial performance include:

- Strategic, financial, and operational assessments
- Cost report review and strategy
- Revenue cycle management
- Clinic practice management assessments
- Lean process improvement training
- Financial education for CAH department managers
- Financial education for CAH boards
- Pooling Small Rural Hospital Improvement Program (SHIP) dollars
- Developing chief financial officer (CFO) networks
- Benchmarking financial indicators
- Strategic planning
- Service line assessments
- Marketing plan assessments
- Rural Emergency Hospital (REH) conversions

This guide addresses interventions and activities that can be carried out and supported by Flex program dollars to improve the financial well-being of a CAH. These include interventions that can be implemented on every level of the CAH including executive leadership, administrative staff, and clinic providers. Opportunities for projects with short-, medium-, and long-term outcomes are presented and separately identified. State Flex Programs and hospital staff should consider reviewing the Strategies for Critical Access Hospitals To Address Outmigration for additional information and resources related to CAH market share.

1 National Rural Health Resource Center, Small Rural Hospital and Clinic Finance 101 Guide. September 2024. Accessed October 21, 2024. http//ruralcenter.org

Interventions

- Strategic, Financial, and Operational Assessments
- Revenue Cycle Management
- Process Improvement
- Financial Education for Boards
- Developing Chief Financial Officer (CFO) Networks
- Strategic Planning
- Marketing Plan Assessments
- Medicare Cost Report Review, Strategy, and Education
- Clinic Practice Management Assessments
- Financial Education for CAH Department Managers
- Pooling of Small Rural Hospital Improvement Program (SHIP) Funds
- Benchmarking Financial Indicators
- Service Line Analysis
- Rural Emergency Hospital (REH)

Strategic, Financial, and Operational Assessments

This intervention has the potential to positively impact Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, and Long-Term Debt Capitalization.

Strategic, financial, and operational assessments may be the most comprehensive level of intervention for a CAH depending on how the intervention scope is determined. A strategic, financial, and operational assessment may include any or all of the following components:

- Benchmarking financial indicators
- Financial reporting processes and format
- Debt capacity assessment
- Review of organizational structure
- Assessment of governance structure
- Market assessment
- Review of current strategic plan and process
- Medicare cost report assessment
- Revenue cycle assessment
- Productivity / lean process training
- Quality engagement
- Telehealth engagement

This type of assessment requires a significant level of engagement by facility management due to the amount of internal data that must be gathered and submitted to the team performing the assessment. Several components identified above can be performed as stand-alone interventions and will be explained in further detail in this document.

A review of financial reporting processes and formats focuses on methodologies engaged in the preparation and delivery of financial statements within the organization. It includes the determination of financial estimates and the format of the documents provided to management and the board monthly to communicate the financial and operational condition of the organization. A debt capacity calculation may be included as a part of this assessment to assist management and the board in better understanding the potential level of additional debt the organization could manage financially.

An assessment of organizational structure concentrates on the size and composition of the core management team, overall span of control of upper management, and the appropriateness of reporting relationships. An assessment of the backgrounds and demographics of board members, years of tenure, term limits, board knowledge and ongoing board education processes is commonly a part of the board governance structure assessment. A quality assessment includes the level of engagement in and results for reporting quality metrics as well as a review of the current quality program structure in the organization.

Telehealth is a continuously expanding area of opportunity and risk for critical access hospitals. A telehealth assessment is concentrated on the potential opportunities for deploying telehealth services in a given market, the state specific coverage and reimbursement opportunities for telehealth, and the technology required to meet coverage and reimbursement requirements. In addition to assessing the opportunity, the telehealth assessment explores the potential risk of lost volumes and market share to the organization if it fails to adopt this growing delivery model.

As noted, this strategic, financial, and operational level of intervention does require the gathering and reporting of a significant amount of data to be submitted to the assessment team.

Timeline

While is it is possible for the information to be gathered, submitted, and the assessment be completed in 3 months, it is more reasonable to expect a 3–6-month timeline for this process. Due to the size of the intervention, it is expected that implementation based on assessment findings would start in months 6-9 and could continue for more than a year. The timing for initial results to be realized would typically be in the 6–12-month timeline.

Medicare Cost Report Review, Strategy, and Education

This intervention has the potential to positively impact Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, and Long-Term Debt to Capitalization.

For a CAH, the Medicare cost report is one of the most important revenue related items as this determines the hospital's reimbursement for services provided to Medicare and Medicare Advantage beneficiaries. At a high level, it is similar to an income tax return. It includes a significant amount of financial and volume information related to the organization and is utilized to determine how much payment Medicare should have provided during the reporting period for CAH services compared to the actual payments received to determine a settlement receivable or payable. Much like an income tax return, the goal is to ensure accurate reporting while capturing all necessary data points and making filing elections that are most advantageous to the organization.

A thorough cost report review will analyze items such as revenue and expense matching to determine whether accurate cost-to-charge ratios are used to determine Medicare cost. It will also look at current allocation of overhead costs to revenue producing departments to ensure accuracy and for the possibility of utilizing alternate methodologies within Medicare rules and regulations to enhance reimbursement. Most reviews also aim to provide the facility with some education on allowable versus non-allowable expenses for cost reimbursement and strategies regarding handling of practitioner expenses for emergency room, rural health clinics and provider-based clinics.

Although Medicare Advantage payers don't reimburse directly through the cost report like traditional Medicare does, they typically utilize the cost-based interim payment rates that Medicare establishes from the cost report to reimburse CAHs. In some situations, the CAH may have separately contracted with Medicare Advantage to accept fee schedule payments versus the cost-based payment rates. These negotiated fee schedule rates would normally be lower than the established cost-based rates. Combined, Medicare and Medicare Advantage represent anywhere from 25 to 60% of the

revenue for most CAHs. In addition, in some states the cost report is also utilized by State Medicaid programs to determine reimbursement. Given this, it is imperative to ensure the cost report is prepared accurately to ensure the CAH is obtaining proper reimbursement.

Timeline

Findings from the review and education provided as a part of the assessment can be used to create short-, medium- and long-term strategies for the organization.

- Short-term – Identification of inaccuracies in previous filings that can be amended for quick infusions of revenue and cash collection.
- Intermediate– Identification of opportunities to improve the quality of data collection/reporting and/or to request approval for changes in reporting methodologies to improve revenue and cash collection. The approval process and timelines for implementation will take a longer period of time than correcting inaccuracies.
- Long-term – Identification of opportunities to engage in changes in organizational structure, like change in hospital designation, converting a clinic to a Certified RHC, or changes to service offerings to improve revenue and cash collections. Organizational changes will typically take a longer period of time to plan and implement.

A proper cost report review may generate additional Medicare reimbursement of a range of $10,000 to $100,000 on an annual basis.

Revenue Cycle Management

These revenue cycle interventions have the potential to positively impact Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, and Long-Term Debt to Capitalization.

Revenue Cycle Management encompasses a large body of activity as it essentially includes all processes that impact revenue from the point a patient begins their journey to access care through finalization of any financial account balances. For this reason, there are a variety of interventions that may be appropriate and considered by a CAH. These interventions range from higher level and more broad interventions to very focused activities that are more in-depth in nature. The following are descriptions of various interventions and activities that may be considered and how they can impact the organization.

Revenue Cycle Assessment & Improvement Analysis

The goal of an RCA is to identify the areas of opportunity that contribute to high accounts receivable days or lost reimbursement, with the recommendations outlined to improve performance.

A healthy revenue cycle contributes to the organization's financial stability as all claims for patient care are processed through the various components within the revenue cycle. The revenue cycle refers to the following activities that take place for all patients that receive services at the organization.

- Front end revenue cycle is where patient information is collected upon scheduling, registration, or check-in is often referred to as "patient access." This includes demographic information, health insurance coverage, the determination of medical necessity for the services ordered by the provider, the need for prior authorization from the payer source and financial counseling if necessary.
- The middle revenue cycle includes the provider documentation in the medical record for the services provided to the patient, the capture of charges and codes that reflect the services, the workflows surrounding these processes and efficiencies of properly documenting and capturing this information. Over time this will include a readiness assessment for the eventual conversion to ICD-11 coding. Social Determinants of Health (SDOH) screening and reporting as required by the Medicare Beneficiary Quality Improvement Project (MBQIP) program in 2025 also occurs in this portion of the revenue cycle.
- The back end of the revenue cycle consists of the processing or submission of the claim to the payer. Medicare, Medicaid, worker's compensation, and commercial insurance companies all fall under the category of a 'payer'. Each payer has different rules and policies that outline how to bill and what they will reimburse for the services provided. Any errors or missing information will result in a denial or a failure of the claim to process, which then requires billing staff to re-work the claims. In some cases, claims require appeal which entails collecting medical record documentation and, in some cases, including the clinician to assist in appealing to the payer.

The electronic medical record (EMR), practice management systems, billing systems, and clearinghouse (claims processing vendor) contain the ability to monitor metrics and statistics that reflect best practice for health care

organizations. Various reports can be pulled from these systems and, when analyzed, can lead to the identification of opportunities for improvements.

A revenue cycle assessment (RCA) consists of the following:

- Front, middle and back-end process analysis;
- Operations workflow and process assessment;
- Review of claims data, detailed accounts receivable data, claim denials, and productivity statistics to compare to benchmarks including the Critical Access Hospital Measurement & Performance Assessment System (CAHMPAS)[2] and Key Performance Indicators (KPIs);
- Denials assessment to assist with root-cause analysis;
- A report of detailed findings, recommendations, and action plan; and
- Post-RCA project management and implementation.

Timeline

The time it takes to realize these improvements is dependent on the current state of the revenue cycle along with the ability to implement the recommendations. Some organizations see improvement within 3 months and others may take up to a year to see significant improvement.

Claim Denial Management Reviews

Denials in payment from payers is a growing challenge for most health care providers. Increased complexity in rules as well as payer strategies to minimize payments increased the amount of time, effort and resources that must be committed to managing these denials. A denial review focuses on the denials data of the organization and various assessment tools to highlight the areas with the most risk and opportunity for the organization. This intervention typically consists of:

- Collection of the 835 files from the organization. These are standardized electronic files that the organization receives from all payers that includes the reason for the denial.
- Various tools are utilized to analyze these 835 files and produce a dashboard (stand-alone or interactive) that allows the organization to view the types of denials and most prominent payers that are contributing to their denial issues. These tools are typically designed with drill-down capabilities to provide the needed root cause analysis.

2 Flex Monitoring Team. Critical Access Hospital Measurement & Performance Assessment System (CAHMPAS). May 2024. Accessed October 21, 2024. http//CAHMPAS.sirs.unc.edu.

The goal is that once the root causes are identified, corrections and improvements are put in place to prevent these types of denials from occurring. With the root cause addressed, denials will be reduced, which results in increased revenue for the organization through correct and complete claims sent to payers, less re-work of claims by staff and higher reimbursement.

Timeline

A denials assessment is often a lower-cost way to identify easily achievable improvements, and if attention is directed towards the root cause, improvements can be seen in as little as 3 months with ongoing long-term impacts to the organization.

Point of Service/Sale Collections Review

There is no better time to review a patient's account than when they arrive at the facility for an appointment. Registration or front desk staff will be viewing the patient's eligibility information during this process and will be able to see if a co-pay is due or if the patient is uninsured. This is the ideal moment to collect a co-pay or self-pay balance rather than sending statements and attempting to collect after services are rendered. Asking the patient to pay their bill during the registration process also results in an increase in cash collections. If patients are self-pay or voice a concern or inability to pay, referring them to visit with a financial counselor is the proper next step to assist the patient as well as improve cash collections. An intervention in this area of the revenue cycle focuses on the existence and adherence to best practice processes to improve short and long-term cash collections.

Timeline

In most situations implementing these practices as part of the registration and check-in process will significantly increase cash and reduce accounts receivable days. Following this process consistently could provide improvements within 3 months with ongoing long-term impacts.

Coding and Documentation / Charge Capture Reviews

Accurate and comprehensive code assignment and capture of charges are vital to accurate reimbursement and maintaining compliance. The charge capture process drives 100% of revenue generation in an organization. Diagnosis and procedure coding for both professional and hospital claims support the medical necessity for the services provided while also driving reimbursement from the payers. The documentation in the medical record is vital to support the codes assigned.

A coding review will typically focus on the codes assigned for professional services and codes assigned by the hospital coders for the facility (technical) services. A properly designed charge capture review will also look at the codes assigned by coding, but also validate that each charge line on the claim form is correct (for example, supply charges, ancillary services charged through the chargemaster, or medication charges/units). While frequently included as part of a larger intervention, a coding or a charge capture review can be conducted independently to address focused areas of concern.

A coding and/or charge capture review consists of reviewing the documentation for the patient visit against the codes assigned and the charges applied. Following a charge for patient services from point of origin to bill generation allows for a comprehensive picture of the relationship between the documentation, code assignment, and charge capture. Coding/Charge capture reviews include:

- Review of coding and charge capture processes
- Gap analysis (e.g. review manual entries, outdated charge slips/superbills)
- Review of CAH staff training needs
- Findings/Recommendations report

Timeline

Improvements are typically noted within 6-9 months depending on the types of issues noted in the reviews, the billing system updates required, and the training and education needs.

Prior Authorization Review

Prior authorization is a process many payers require before a service is approved for coverage and payment. It is an obligation placed upon the health care organization to assist payers in limiting payment for services they have determined are unnecessary and assist providers in ensuring payment will be received for services rendered. There are a couple of different ways that prior authorization issues can be discovered and addressed. During a revenue cycle assessment, the prior authorization process is typically reviewed, and recommendations shared if gaps or deficiencies are found. The denials assessment process can also alert health care organizations to any issues related to obtaining prior authorizations. An intervention solely on the prior authorization process can address specific concern/issues focused on prior authorizations. Once the issues are identified and a resolution in place, the improvements in this area would be immediate, resulting in a lower denials rate, decrease in accounts receivable, and increase in margins.

Chargemaster Review

The chargemaster has one of the most important functions in a hospital. Quite often, a chargemaster is one of the last items on which departmental managers and Business Office staff focus because of its extensive amount of detail and the time necessary to maintain it. However, because the chargemaster is also responsible for 100% of the gross revenue of a facility all departments throughout the hospital need to be aware of its impact on the financial status of the hospital.

The goal of a chargemaster (CDM) review is to ensure the CDM itself is current with the services provided at the organization. The charge capture component is critical in that the CDM file may be set up appropriately but if there is no process or mechanism in place to capture the charges, revenue will be lost. An efficient and well-maintained CDM will impact accounts receivable, cash on hand, and total and operating margins.

Due to the wide variety of third-party reimbursement programs, a single billing approach is not appropriate for all departments and cannot be used throughout the hospital. Different reimbursement methodologies (such as fee schedule reimbursement, cost report reimbursement, and billed charge reimbursement) all play a significant role in the various intricacies of proper reimbursement for the services provided.

A separate charge capture review with a small sample of outpatient claims is frequently a part of this type of intervention. As a component of the chargemaster review, the charge capture review assists in identifying risks and opportunities in the way the organization is utilizing the chargemaster. This is an important component as a perfectly designed chargemaster does not guarantee there are processes in place for its proper use. While not always included as a component of the chargemaster review, a review of pricing levels and strategy can also be included. An onsite chargemaster review usually provides optimal results and value for the organization as it provides an opportunity to better understand the organization through an onsite observation, allow for more extensive staff conversation, and provide staff education, however remote options for these reviews can be effective when properly designed.

As an intervention, the chargemaster review process should include an analysis of the facility chargemaster (CDM) file, associated historic revenue and usage reports, and meetings with revenue cycle, finance, reimbursement, and the revenue producing department leaders. A comprehensive chargemaster review will include a review of the following:

- Current Procedural Terminology (CPT) Code Assignments;
- Revenue Cycle Assignments;
- Modifiers;
- Billing processes;
- Charge capture processes;
- Compliance with payer rules and regulations; and
- Discussions and education with revenue generating department leaders.

Upon completion, a report of findings and recommendations is typically provided along with templates or listings to assist with prioritization of the recommendations.

Timeline

Depending on the findings, resolution can take anywhere from 3 months to 12 months to implement. Compliance issues and straightforward changes are prioritized with more extensive project-based recommendations take a longer period of time to resolve.

HIM Operations, Coding Quality and CDI

Health Information Management (HIM) is the collection, reporting, analysis, storage and protection of patient health information. Clinical Documentation Improvement (CDI) is the process of assessing medical record documentation for accuracy and completeness.

The operations and workflows within the HIM, coding, and CDI areas are interconnected and will impact other areas of revenue cycle should there be a breakdown in the processes. Oftentimes, it is found that these processes are impacted by both internal and external workflows, staffing, and/or the systems in place.

The goal of a coding, HIM, and CDI operational assessment is to identify opportunities in workflows, improve the quality of documentation, and remove barriers that delay the coding process. An operational assessment of the coding/HIM areas (to include CDI) would include the review of policies and procedures, job shadowing, and interviews with staff to determine that their workflows follow the stated processes and the identification of opportunities to improve. In some cases, a staffing or productivity analysis may be performed to determine if the department is staffed appropriately and if there are any billing system or knowledge factors that impact productivity.

A review of the quality of the documentation is a critical component to determining barriers to the coding process as well as to assess the impact of the CDI program. When coders are unable to assign codes in a timely manner or the documentation prohibits the coder from assigning the most specific codes, claims processing and reimbursement rates are impacted.

Billing and EMR system set-up and optimization will play a role in this form of an operational assessment. If these systems are not being utilized to their full potential or if features of the systems are not working properly, it requires staff to develop workarounds and manual processes. This form of operational assessment helps bring these issues to light.

Clinic Practice Management Assessments

This intervention has the potential to positively impact Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, and Long-Term Debt to Capitalization.

The need for critical access hospitals to employ and/or contract for physician and provider services has been growing over the past several decades. Increasing costs, inadequate reimbursement, and increasing regulatory requirements have led many practitioners to opt out of private ownership of clinic practices and larger health systems to pull their clinic services out of smaller rural markets. This has left CAHs to establish or acquire clinic practices and absorb the financial and regulatory challenges. The result is a large number of rural clinic practices that are underperforming financially and potentially placing the complete health care delivery model at financial risk.

Clinic practice management assessments are interventions that assess the risks and opportunities in the clinic setting. While focused in the area to be assessed, the scope of the assessment can vary greatly based on the specifics of each clinic. At a high level, an assessment may address the following areas based on individual need:

- Reimbursement
- Demand
- Staffing
- Operational processes

The reimbursement component of an assessment includes accuracy of reimbursement in the current payment model as well as an evaluation of various payment models. In the area of accuracy, there should be a review of documentation, coding, billing, and payment to assist in ensuring that the clinic processes allow for receiving the appropriate reimbursement for services rendered to patients. This typically involves reviewing a sample of claims for each provider and specialty. An assessment of the various payment models is focused on the comparisons of reimbursement available in the freestanding, provider-based hospital clinic, and provider-based rural health clinic settings to determine the most advantageous reimbursement model for the specific situation.

The demand component of an assessment is focused on determining the estimated demand and need for providers based on population size and demographics as well as by area of specialty. The goal of the market demand analysis is to determine the number of total full-time-equivalent providers that are needed in the market to appropriately care for the patient population. The use of data creates documented support for the number of providers needed versus staffing based on past levels, public requests, and/or internal perceptions.

A review of staffing includes several components. This includes physician/advance practice providers, provider compensation, and ancillary staffing. The staffing levels for providers is supported by the completed market demand assessment and also includes consideration for minimum staffing needs to cover any emergency room call coverage or other duties. The review of provider staffing also includes a review of current visit volumes to determine the overall productivity of the existing provider mix. This

can identify understaffing, overstaffing, or opportunities to expand volumes without increasing staffing levels.

Provider compensation and the structure of provider contracts is an ongoing challenge for rural health care facilities. It requires a balance of compensation demands by providers in a challenging market, financial viability, and fair market value limitations. An assessment that includes a compensation review will provide findings and recommendations to support the appropriateness of compensation in a specific market based on individual circumstances that is supported with compensation survey data as well as potential opportunities to build incentives into contracts to promote increased volumes, improved efficiencies, and engagement in quality initiatives.

The appropriate number of ancillary support staff in the clinic setting is critical in being able to adequately support the number of providers while still demonstrating good financial stewardship. Operating with too few staff may appear to be fiscally responsible but may limit the ability for providers to see more patients in a day. At the same time, operating with excessive levels of staffing risks the financial viability of the clinic operations. The assessment of staffing levels accounts for the volume of visits and providers in determining the needed number of staff.

Finally, a clinic assessment may include a review of operational processes. This focuses on the efficiency of processes in the clinic setting to allow the providers and staff to operate in the most efficient manner. It will typically include an assessment of bottlenecks and variability in processes that lead to inefficiencies. This includes hours of operation, scheduling protocols, variation between provider processes, etc. with a goal to identify opportunities to reduce rework, standardize processes, and increase throughput with equal or lessor effort.

Timeline

The completion of this level of assessment is quite dependent on the ability of the facility to provide the necessary data to the team completing the assessment. The assessment could be completed in 3 months, with implementation of findings and results being demonstrated in 6-9 months of initiating the assessment.

Process Improvement

This intervention has the potential to positively impact Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, and Long-Term Debt to Capitalization.

Process improvement focuses on enhancing efficiencies and reducing waste in health care delivery. Focused efforts can streamline processes, improve patient care, and optimize resources.

One key element of process improvement for hospitals is productivity management and benchmarking. Since salary expense is typically one of the largest expenditures of health care facilities, it is essential organizations prioritize and focus efforts to optimize staffing. Productivity management calculates staff hours in comparison to volumes and compares this to industry benchmarks to identify potential opportunities for staffing and workflow optimization. A productivity intervention will usually involve meeting with departmental leaders to discuss current performance compared to benchmarks along with current processes and obstacles. This allows for the identification of opportunities to be implemented. Potential opportunities may include the redesign of processes utilizing lean concepts, sharing of staff across departments, utilization of technology, implementation of staffing acuity tools, interdepartmental collaboration, and staffing adjustments.

Ongoing productivity management is crucial to future success. To achieve this, it is important to ensure departmental leaders receive pertinent information to understand their current performance. This may include payroll data and productivity information each pay period that includes current pay period performance along with year-to-date information.

Factors of success include creating a culture of accountability which includes an "owner" of productivity and process management that is responsible for creating a plan, the prioritization of necessary changes, and monitoring future performance. These interventions frequently include recommendations to implement enhanced hiring and rehiring approval processes that include assessing workflow and productivity performance. While productivity management can assist in process improvement, it is also important for hospitals to recognize current obstacles staff face on a regular basis and work to improve these processes. Often this involves the acknowledgement of "silos" across departments that can prevent efficiency.

The benefits of process improvement have widespread impact to most parts of an organization that include patient and staff satisfaction, ability to recruit and retain staff, and profitability.

Timeline

The timeline for process improvement is ongoing with some results documented in the short-term, while other outcomes may take longer to be realized.

Financial Education for CAH Department Managers

This intervention has the potential to positively impact Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, Age of Plant, and Long-Term Debt to Capitalization.

Financial education for hospital department managers is crucial for effective management and decision making. Key components and topics that should be included in financial education for management include basic financial concepts, revenue cycle management, and financial planning.

Basic Financial Concepts

It is important department managers have a basic understanding and familiarity of financial statements to include balance sheets, income statements, and cash flow statements. They should also play an integral role in the capital and operating budget process by being involved early and often. This early involvement should include management expertise and knowledge on volume forecasting to drive budgeted revenues and expenses. Managers should receive regular financial and budgeting reporting information pertinent to the organization and their respective departments to aid in accountability and understanding.

Revenue Cycle Management

Department managers should also be provided education on the foundational elements of the revenue cycle and how their department impacts the revenue cycle. This includes clinical and non-clinical managers. Clinical managers should have a role in their departmental chargemaster to include an understanding of charges and CPT codes. The revenue cycle team should provide support of details and provide education related to annual and ongoing coding and billing changes. Clinical management should understand the mechanisms of reimbursement and be provided information specific to denials for their respective departments.

Financial Planning

Managers need education and data regarding service line performance and profitability. This allows them to assist in the analysis of profitability trends specific to their responsible departments and aid in improving performance. This information can also be valuable to duplicate as potential new service lines are explored. Management's ability to understand the importance of enhancing quality and its impact on reimbursement is also essential.

In summary, financial education for hospital department managers encompasses a wide range of topics, from basic financial literacy to the complexities of understanding the revenue cycle and financial planning. Providing managers with the necessary financial knowledge and skills is essential for optimizing departmental performance and contributing to the overall success of the hospital. While the implementation of training can occur quickly, the positive impact from this education can take time as managers begin to put their newly learned skills to use in their daily work.

Timeline

Implementation of the education provided for CAH department managers may occur over 6-9 months with results observed from 9-12 months or more.

Financial Education for Boards

This intervention has the potential to positively impact Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, Age of Plant, and Long-Term Debt to Capitalization.

Financial education for the board of directors of a CAH is essential to ensure informed decision-making and effective governance. The board must understand the unique financial challenges and opportunities that CAHs face. Below are key components and topics to include in a financial education for CAH board members:

Introduction to Health Care Finance

Board members should be provided with an overview of the health care industry's financial landscape, including key trends and challenges. This should also include specific financial issues faced by CAHs, such as reliance on Medicare and Medicaid, rural health care funding, financial sustainability, the financial and operational impacts of the transition to value, the effects of shifts in care from the inpatient to outpatient setting, and the effect technology advancements are having on the industry. With an ever-changing industry, it is important to prepare Board members to act in a proactive versus reactive manner.

Understanding Financial Statements

Financial education needs to include training on the understanding of financial statements to include the elements of a balance sheet, income statement, and cash flow statement.

Budgeting and Financial Planning

Hospital board members need to receive education specific to the process of creating and approving the organization's budget. This should also include predicting future financial performance and understanding the assumptions behind forecasts. Capital budgeting education should be incorporated to discuss the planning for significant expenditures on building, equipment, and technology.

Revenue Cycle Management

Board members need to understand the basic elements of the hospitals reimbursement processes and the understanding the critical roles Medicare and Medicaid program play in CAH funding.

Governance and Fiduciary Responsibilities

The board should be provided information regarding their role in the financial oversight and fiduciary duties as a board member of the organization. This should include processes for making informed financial decisions, including evaluating investment opportunities and major expenditures. The board should also play a role in strategic financial management by aligning financial strategies with the hospital's long-term goals and mission.

Timeline

Implementation of the education provided for boards may occur over 6-9 months with results observed from 9-12 months or more.

Opportunities to Educate Board Members

Board education can be delivered by attending workshops and seminars and utilizing interactive sessions with financial experts and health care consultants. Online courses and programs have also proven to be an effective educational tool for board members. Many hospital boards also find success in board retreats that allow for dedicated time for in-depth financial training and strategic planning. Overall, the regular reporting of financial reports will provide ongoing education through detailed financial reports and presentations at board meetings that will likely be the most beneficial.

Financial education for the board of directors of a hospital is essential for effective governance and strategic oversight. By equipping board members with the necessary financial knowledge and skills, they can make more informed and strategic decisions that benefit the hospital's financial health and patient care. They can better navigate the unique challenges of rural health care and ensure the hospital's long-term success and sustainability. While the implementation of training can occur quickly, the positive impact from this education can take time as board members begin to put their newly learned skills to use in their board activities.

CAHs often don't send their staff or Board Trustees to educational opportunities. This may be due to financial, operational or distance issues that prevent their attendance. By bringing the education to multiple CAHs this allows

them to take advantage of sharing ideas, lessons learned, and financial best practices. These sessions can be geared towards department leaders and/or Board Trustees of multiple CAHs. An industry expert often facilitates the educational opportunities to ensure the CAHs receive the necessary education surrounding financial improvement. This format can allow the conversation to take a deeper dive into how to improve operations than most conferences due to its size and the familiarity of the attendees. As noted previously, the education would be geared towards financial improvement with topics such as financial benchmarking, productivity benchmarking, revenue cycle improvements, marketing, and service line analysis.

Pooling of Small Rural Hospital Improvement Program (SHIP) Funds

This intervention has the potential to positively impact Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, Age of Plant, and Long-Term Debt to Capitalization.

As there are ever increasing needs of CAHs for education and financial improvement, it becomes difficult to determine what projects would be the best utilization of SHIP funds. The pooling of SHIP funds among a group of CAHs has provided an effective means to fund educational opportunities to two or more CAHs (or SHIP-eligible small rural hospitals).

The ability to provide education to multiple CAHs at one time using limited SHIP funds can make a lasting short-term and long-term impact on the organizations. The provision of the training can occur in the short-term, but the impacts will take more time as individuals implement the new skills they have learned into their daily practices.

Timeline

Implementation of activities to poll SHIP funds may occur over 3-9 months with results observed from 9-12 months or more.

Developing Chief Financial Officer (CFO) Networks

This intervention has the potential to positively impact Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, Age of Plant, and Long-Term Debt to Capitalization.

The importance of and potential impact of networks cannot be overstated. Historically, successful individuals and organizations have relied on networks to share best practices, obtain advice from colleagues in a similar industry or situation, learn about new trends, bounce ideas off each other, etc.

Many health care entities have limited travel budgets and are interested in remote learning. Travel restrictions can diminish the opportunity for peer-to-peer relationships to grow and learn from each other, especially with CAH CFOs. This can lead to health care professionals living on an island when it comes to sharing of experiences and learning from others.

The creation of CFO networks can provide the necessary structure to allow CAH CFOs the venue to share critical knowledge and experiences amongst a team of colleagues. In order to promote long term success, a network would consist of the following:

- Development of structured leadership for the network. While this leadership may be a CAH CFO, it may be more beneficial to identify a designated leader with health care industry operational and financial knowledge to provide the leadership and structure. This is important in markets where there is a high level of CAH CFO turnover, as consistency of leadership and direction is important to long term success. The leader of the network assists with promotion of the network, scheduling and agenda development, and facilitation of discussion. Agenda development and facilitation of discussion are critical as participation in meetings will quickly dwindle if there is a perception of limited value to the time invested by participating CFOs.
- Well-developed agendas focused on current and emerging topics help spark interest in meetings, allow for needed preparation by participants for the discussion, and allow scheduling for outside topic experts to provide education.
- Participation by CFOs with varying lengths of tenure and backgrounds. This variety creates a greater value to all attendees as longer tenured CFOs bring a vast amount of history and experience to the conversation while those with less experience may provide fresh ideas and new approaches to issues and challenges in the industry. This mix helps create a learning opportunity for all CFOs.
- A mixture of in-person and virtual meetings. It is hard to replace the impact of an in-person event. However, the reality of distance, competing priorities and limited budgets limit the ability for CFOs to commit significant amounts of time away from their organizations. Monthly or quarterly meetings that encompass a mixture of meeting styles help promote the maximum benefit of a network to the individual CFO and participation over time.

Timeline

The initial creation of a CFO network can occur quickly if there is adequate interest and necessary financial resources to support the network. The improvements in financial metrics will take time as participating CFOs begin to attend network events, obtain new knowledge from the network, and begin to implement what is learned within their organizations.

Benchmarking Financial Indicators

This intervention has the potential to positively impact Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, Age of Plant, and Long-Term Debt to Capitalization.

Benchmarking of financial indicators can provide CAHs with comparatives to industry benchmarks as well as their peers. Industry experts have identified the 10 most important indicators for evaluating CAH financial performance.[3] The mere development and implementation of a process for benchmarking and reporting of financial indicators can assist facilities in identifying areas for potential improvement and lead organizations to engage in focused activities to promote improvements in financial performance. It is important to not only monitor the current performance level for each indicator,

but how their performance is trending. This allows for a more proactive approach to managing the organization. When looking for opportunities it is best to look for both high and low performers for each indicator. While the identification of low performers highlights those that may benefit more from a financial and/or operational intervention, it is important to also identify high performers in each area. These high performers can be a source of valuable information in the development of cohorts as they can share best practices they have deployed in their organizations.

3 National Rural Health Resource Center, Small Rural Hospital and Clinic Finance 101 Guide. September 2024. Accessed October 21, 2024. http//ruralcenter.org

Benchmarking and reporting against financial indicators can be completed at the statewide or national level. Statewide comparisons may often rely on data from the CAHMPAS database that is obtained via the required submission of Medicare cost reports. Cost reports are not required to be submitted until 5 months after the end of the organization's fiscal year. Extensions to the filing requirements have been historically limited but were very common during the Covid Public Health Emergency. Once received by Medicare, the release of the information to the public is delayed until Medicare completes its acceptance of the reports. This can be several months. This results in the reporting of information that is more dated than desired, but it is inclusive of all CAH in the state. State Flex Programs have access to facility specific as well as state and national data via CAHMPAS to allow for statewide and facility specific comparisons. In some states, more current data has been captured through more timely and frequent reporting of financial information to groups such as state Hospital Associations. These state specific repositories are a great resource and may provide timelier data but may not include all CAHs in the state as there is not a binding requirement for submission. The greater the engagement at the state specific level the more valuable the information that is gathered can be. When statewide comparisons are made, facilities are deidentified to allow for anonymity while still demonstrating opportunities and variability.

One key component in the benchmarking process is determining the source of data for the benchmarking. There are multiple sources CAHs may choose to utilize and benchmark for comparison. Potential sources include:

- CAHMPAS;
- American Hospital Association Hospital Statistics;
- State hospital associations;
- Hospital system specific benchmarks; and
- Proprietary sources.

As noted, organizations may elect to compare their performance against multiple sources of data to assist in better understanding their current situation and the areas for potential improvement.

Timeline

The development and reporting of initial benchmark comparison can be accomplished in a 3-6 month timeline depending on the span of the reporting (i.e. local, state, or national). Opportunities may be identified in the 6-9 month timeline with results being realized in the 9-12 month timeline.

Strategic Planning

This intervention has the potential to positively impact Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, Age of Plant, and Long-Term Debt to Capitalization.

A strategic planning engagement is recommended for organizations looking to develop a strategic direction for the next 1-3 years. This engagement is helpful for organizations seeking direction on where to prioritize time and resources to best serve the mission, vision, and values.

The frequency of a strategic plan engagement is generally every 3 years unless there has been a significant change in the region resulting in the current strategic plan becoming obsolete (change in competitive landscape, demographics, etc.).

A robust strategic planning process is recommended for all health care organizations. This includes the gathering of necessary data including market assessment, a strengths/weaknesses/opportunities/threats (SWOT) assessment, financial information, and industry trends. Active participants would include board members, management, providers, staff, and other local key partners. Surveys as often utilized to gather input from participants throughout the process. Strategic planning sessions/retreats usually are a day or two in length and are often most effective when completed offsite to minimize interruptions.

Timeline

By completing strategic planning, an organization will develop specific goals and work plans for the organization to use over the next 1-3 years to work towards and accomplish the strategic priorities identified. It is very common for strategic planning engagements to include goals and expectations around financial health and quality of care. This means that successfully implemented strategies and goals from strategic planning should improve overall financial health over a long-term view of the organization (including, but not limited to, improved operating margins, cash flow position, and overall liquidity and profitability). However, it is very possible that there could be strategies implemented that would require investments that may show a short-term deterioration of financial position as well.

For example, a major capital project might require a large cash investment and increased debt. In the short-term financial ratios related to liquidity, profitability, and debt may fall to show improved overall financial position and ability to maintain services in the long-term.

Service Line Analysis

This intervention has the potential to positively impact Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, and Long-Term Debt to Capitalization.

Service line analysis interventions are intended for organizations seeking to evaluate and/or optimize the performance of a current or potential service line (or department).

The key benefits of any analysis would include:

- Evaluation of financial performance on existing service (if applicable).
- High-level review of resources needed to enhance or launch a new service (or inversely measure the financial impact of discontinuing a service).
- Evaluation of current and future market need and ability to capture that market.

Overall, a service line analysis helps an organization determine how to best enhance the operational efficiency and financial health while maintaining quality patient care. Financial health is improved through the identification of profitable service lines, cost reductions, reimbursement impacts, and the optimization of resource allocations. Ultimately, the goal would be to improve profitability indicators (total margin, operating margin, cash flow, etc.).

Service line analysis implementation will vary widely based on the resources needed to launch or expand a service. For example, a hospital launching a new radiology service within the organization may require significant construction resulting in a much longer implementation timeline than an organization evaluating the optimization of an already existing inpatient unit through review of inpatient and swing bed stays. Optimization of current space generally results in a much shorter implementation timeline than any implementation requiring the expansion of space through construction, purchase of equipment, or recruitment of staff.

Timeline

The frequency of a service line analysis varies widely based on the size of the organization and the complexity of services offered. However, organizations should consider service line analysis annually to ensure that services provided are adequate and sustainable for the patients within the service area.

In addition, all service lines should be subject to monthly monitoring of KPIs and financial metrics to monitor and react to any unanticipated changes or trends impacting performance. Continued unanticipated performance may also result in a need for a service line analysis.

Marketing Plan Assessments

This intervention has the potential to positively impact Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, Medicare Inpatient Payor Mix, and Long-Term Debt to Capitalization.

Market "leakage" and "pass-by" rates can have a significant impact on CAHs as they can represent a significant amount of volume of care that could have been provided to the constituents within a market. Rural providers frequently lack the local resources to gather the data to understand market share trends as well as to develop robust marketing plans to assist in driving increased volumes/market share for current as well as new service line offerings. A marketing plan assessment can be an intervention that creates significant value to the CAH as well as the community it serves. The process and tools are included in the Strategies for Critical Access Hospitals To Address Outmigration guide released for the Flex Program and CAHs.[4]

Timeline

Implementation of the results of a marketing plan assessment may occur over 6-9 months with results observed from 9-12 months or more.

Rural Emergency Hospital (REH)

This intervention has the potential to positively impact Days Cash on Hand, Total Margin, Operating Margin, Debt Service Coverage, Salaries to Net Patient Revenue, and Long-Term Debt to Capitalization.

The Rural Emergency Hospital (REH)[5] designation is available to rural hospitals with not more than 50 beds or a CAH enrolled in the Medicare program as of December 27, 2020. This designation was created by Congress as an alternative operating and reimbursement model under the Medicare program to assist small rural hospitals to maintain access to essential services. Beginning January 1, 2023, eligible hospitals could be licensed as an REH under the Medicare program Many state health departments were ready to license those eligible to become an REH while other states had to create the license for this new type of hospital. Under this designation a REH is eligible to provide outpatient services, such as emergency department services and observation care, along with ancillary services such as laboratory, radiology, and physical therapy. There is not a limit on the number of outpatient service lines an REH can provide. However, an REH is not eligible to care for inpatients or swing bed patients. The conditions of participation of a REH follow closely with those of a CAH. A REH must have a transfer agreement with a Level I or II trauma center and must also have a clinician on-call at all

4 Flex Monitoring Team. Critical Access Hospital Measurement & Performance Assessment System (CAHMPAS), Accessed May 2024. https://cahmpas.flexmonitoring.org

5 Centers for Medicare and Medicaid Services, Medicare Learning Network, Accessed November 2024. https://www.cms.gov/files/document/mln2259384-rural-emergency-hospitals.pdf

times and available on-site within 30 or 60 minutes depending upon location. It must also have an emergency department that is staffed at all times by an individual that has the skills needed to address emergency medical care. Although a REH can't have swing bed patients, it may have a distinct part skilled nursing facility that would be paid prospectively under the Medicare program a daily rate. This differs from a swing bed patient in a CAH that would be paid allowable cost by Medicare.

Under the Medicare program, a REH would be paid under the Medicare outpatient prospective payment system with a 5% add-on for eligible services delivered to Medicare beneficiaries. There are some services such as laboratory and therapy services provided to Medicare beneficiaries that would be paid under a fee schedule by Medicare and would not be eligible for the five percent additional payment. Also under this program, a REH would receive an alternative payment arrangement from Medicare. In calendar year 2024, this payment amount is $276,233.58 per month, after sequestration deduction. This fixed payment is to provide the REH with stable cashflow to support the provision of outpatient services to the communities they serve.

Some facilities that may benefit from the REH designation are qualifying entities that are struggling financially and also have low census for inpatients and swing beds. A financial assessment to determine if this program would benefit a facility is recommended before conversion to the REH designation. The Health Resources Services Administration, Federal Office of Rural Health Policy supports the REH Technical Assistance Center, services provided by the Rural Health Redesign Center, which provide financial assessments, education, communication and stakeholder engagement tools, strategic planning, a helpful FAQs document, and ongoing technical assistance post conversion for hospitals all at no cost.[6]

Timeline

Implementation of REH assessments, education, communication, and community and stakeholder engagement may occur over 6-12 months or more with results observed from 6-12 months or more as well.

6 Rural Emergency Hospital Technical Assistance Center, Accessed October 21, 2024. https://www.rhrco.org/

Summary

This guide provides a variety of interventions that may be utilized to assist state Medicare Rural Hospital Flexibility (Flex) Program personnel, leaders of CAHs, and others in improving the overall financial and operational performance of CAHs. Successful selection and implementation of interventions focused on the specific needs of each CAH can position the organization for long term improvement and stabilization.

Appendix A: Estimated Timelines for Assessment, Implementation, Impact

Intervention	3 months	6 months	9 months	12 months >
Strategic, Financial, and Operational Assessments	Assessment	Assessment Implementation Results	Implementation Results	Implementation Results
Medicare Cost Report Review, Strategy, and Education	Assessment	Implementation	Implementation Results	Results
Revenue Cycle Assessment & Improvement Analysis	Assessment Implementation Results	Assessment Implementation Results	Results	
Denials Management Review	Assessment Implementation Results			

Intervention	3 months	6 months	9 months	12 months >
Point of Service / Sale Collections Review	Assessment Implementation Results			
Coding and Documentation / Charge Capture Review	Assessment Implementation	Implementation Results	Results	
Prior Authorization Review	Assessment Implementation Results	Implementation Results		
Chargemaster Review	Assessment	Assessment Implementation Results	Implementation Results	Results
Pricing of Services in the Chargemaster	Assessment	Assessment Implementation Results	Implementation Results	Results

Intervention	3 months	6 months	9 months	12 months >
HIM Operations, Coding Quality, and CDI	Assessment	Assessment Implementation Results	Implementation Results	Results
Clinic Practice Management Assessment	Assessment	Implementation Results	Implementation Results	
Process Improvement	Assessment	Assessment Implementation Results	Implementation Results	Results
Financial Education for CAH Department Managers	Education	Implementation	Implementation Results	Results
Financial Education for Boards	Education	Implementation	Implementation Results	Results

Intervention	3 months	6 months	9 months	12 months >
Pooling of Small Rural Hospital Improvement Program (SHIP) Funds	Planning Implementation	Planning Implementation	Implementation Results	Results
Developing Chief Financial Officer (CFO) Network	Planning Implementation	Planning Implementation	Implementation Results	Results
Benchmarking Financial Indicators	Assessment Implementation	Implementation Results	Implementation Results	Results
Market Assessment	Assessment	Implementation	Implementation Results	Results
Strategic Planning	Planning	Planning Implementation	Implementation Results	Results
Service Line Analysis	Assessment	Assessment Implementation	Implementation Results	Results

Intervention	3 months	6 months	9 months	12 months >
Marketing Plan Assessment	Assessment	Implementation	Implementation Results	Implementation Results
Rural Emergency Hospital (REH) Assessment	Assessment	Implementation Results	Implementation Results	Implementation Results

Appendix B: Areas of Potential Impact

Intervention	Days in Net A/R	Days in Gross A/R	Days Cash in Hand	Total Margin	Operating Margin	Debt Service Coverage	Salaries to Net Patient Revenue	Medicare Inpatient Patient Mix	Average Age of Plant	Long-Term Debt to Capitalization
Strategic, Financial, Operational Assessment	X	X	X	X	X	X	X	X		X
Medicare Cost Report Review, Strategy, and Education			X	X	X	X	X			X
Revenue Cycle Management	X	X	X	X	X	X	X			X
Clinic Practice Management Assessment			X	X	X	X	X			X
Process Improvement	X	X	X	X	X	X	X			X

Intervention	Days in Net A/R	Days in Gross A/R	Days Cash in Hand	Total Margin	Operating Margin	Debt Service Coverage	Salaries to Net Patient Revenue	Medicare Inpatient Patient Mix	Average Age of Plant	Long-Term Debt to Capitalization
Financial Education for CAH Department Managers	X	X	X	X	X	X	X	X	X	X
Financial Education for Boards	X	X	X	X	X	X	X	X	X	X
Pooling of Small Rural Hospital Improvement Program (SHIP) Funds	X	X	X	X	X	X	X	X	X	X
Developing Chief Financial Officer (CFO) Network	X	X	X	X	X	X	X	X	X	X

Intervention	Days in Net A/R	Days in Gross A/R	Days Cash in Hand	Total Margin	Operating Margin	Debt Service Coverage	Salaries to Net Patient Revenue	Medicare Inpatient Patient Mix	Average Age of Plant	Long-Term Debt to Capitalization
Benchmarking Financial Indicators	X	X	X	X	X	X	X	X	X	X
Market Assessment			X	X	X	X	X	X		X
Strategic Planning			X	X	X	X	X	X		X
Service Line Analysis			X	X	X	X	X			X
Marketing Plan Assessments			X	X	X	X	X	X		X
Rural Emergency Hospital Assessment			X	X	X	X	X			X

Appendix C: Definitions

Benchmarking Financial Indicators

Benchmarking of financial indicators can provide CAHs with comparatives to industry benchmarks as well as their peers. Industry experts have identified the 10 most important indicators for evaluating CAH financial performance.[7] The mere development and implementation of a process for benchmarking and reporting of financial indicators can assist facilities in identifying areas for potential improvement and lead organizations to engage in focused activities to promote improvements in financial performance. It is important to not only monitor the current performance level for each indicator, but how their performance is trending. This allows for a more proactive approach to managing the organization. When looking for opportunities it is best to look for both high and low performers for each indicator. While the identification of low performers highlights those that may benefit more from a financial and/or operational intervention, it is important to also identify high performers in each area. These high performers can be a source of valuable information in the development of cohorts as they can share best practices they have deployed in their organizations.

Assessment of governance structure: An assessment of the backgrounds and demographics of board members, years of tenure, term limits, board knowledge and ongoing board education processes is commonly a part of the board governance structure assessment.

Debt capacity assessment: A debt capacity calculation may be included as a part of this assessment to assist management and the board in better understanding the potential level of additional debt the organization could manage financially.

Financial reporting processes and format: A review of financial reporting processes and formats focuses on methodologies engaged in the preparation and delivery of financial statements within the organization. It includes the determination of financial estimates and the format of the documents provided to management and the board monthly to communicate the financial and operational condition of the organization. A debt capacity calculation may be included as a part of this assessment to assist management and the board in better understanding the potential level of additional debt the organization could manage financially.

Market assessment: A strengths/weaknesses/opportunities/threats (SWOT) assessment, financial information, and industry trends.

Medicare cost report assessment: The Medicare cost report is one of the most important revenue related items as this determines the hospital's reimbursement for services provided to Medicare and Medicare Advantage beneficiaries. At a high level, it is similar to an income tax return. It includes a significant amount of financial and volume information related to the organization and is utilized to determine how much payment Medicare should have provided during the reporting period for CAH services compared to the actual payments received to determine a settlement receivable or payable.

Productivity / lean process training: Process improvement focuses on enhancing efficiencies and reducing waste in health care delivery. Focused efforts can streamline processes, improve patient care, and optimize resources. One key element of process improvement for hospitals is productivity management and benchmarking. Since salary expense is typically one of the largest expenditures of health care facilities, it is essential organizations prioritize and focus efforts to optimize staffing. Productivity management calculates staff hours in comparison to volumes and compares this to industry benchmarks to identify potential opportunities for staffing and workflow optimization. A productivity intervention will usually involve meeting with departmental leaders to discuss current performance compared to benchmarks along

with current processes and obstacles. This allows for the identification of opportunities to be implemented. Potential opportunities may include the redesign of processes utilizing lean concepts, sharing of staff across departments, utilization of technology, implementation of staffing acuity tools, interdepartmental collaboration, and staffing adjustments.

Revenue cycle assessment: The goal of a revenue cycle assessment is to identify the areas of opportunity that contribute to high accounts receivable days or lost reimbursement, with the recommendations outlined to improve performance.

Review of current strategic plan and process: A robust strategic planning process is recommended for all health care organizations. This includes the gathering of necessary data including market assessment, a strengths/weaknesses/opportunities/threats (SWOT) assessment, financial information, and industry trends. Active participants would include board members, management, providers, staff, and other local key partners. Surveys as often utilized to gather input from participants throughout the process.

Review of organizational structure: An assessment of organizational structure concentrates on the size and composition of the core management team, overall span of control of upper management, and the appropriateness of reporting relationships. An assessment of the backgrounds and demographics of board members, years of tenure, term limits, board knowledge and ongoing board education processes is commonly a part of the board governance structure assessment.

Quality engagement: A quality assessment includes the level of engagement in and results for reporting quality metrics as well as a review of the current quality program structure in the organization.

Telehealth engagement: Telehealth is a continuously expanding area of opportunity and risk for critical access hospitals. A telehealth assessment is concentrated on the potential opportunities for deploying telehealth services in a given market, the state specific coverage and reimbursement opportunities for telehealth, and the technology required to meet coverage and reimbursement requirements. In addition to assessing the opportunity, the telehealth assessment explores the potential risk of lost volumes and market share to the organization if it fails to adopt this growing delivery model.

7 National Rural Health Resource Center, Small Rural Hospital and Clinic Finance 101 Guide. September 2024. Accessed October 21, 2024. http//ruralcenter.org