

Critical Access Hospital Finance 101 Manual

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PURPOSE

This manual was developed for use by state Medicare Rural Hospital Flexibility (Flex) Program personnel as well as staff and boards of critical access hospitals (CAHs). The content is designed to be as non-technical as possible and to provide answers to frequently asked questions regarding CAH finance and financial performance.

WHAT IS MEDICARE?

The Medicare program, an amendment to Social Security legislation known as Title XVIII, provides medical coverage to all Americans 65 years of age and older. The bill was signed into law by President Lyndon B. Johnson in 1965, and took effect in July, 1966. The enactment of the Medicare program was significant because it was the beginning of the federal government's role as a major financer of health care. In 2010, there were 46.6 million enrollees in the Medicare program, or approximately 15% of the total U.S. population. Approximately 21% of Medicare beneficiaries live in rural counties, meaning rural hospitals tend to have a higher percentage of Medicare recipients than their urban counterparts.

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease. Medicare is funded by both Social Security payroll taxes and insurance premiums, with coverage categories divided into "Parts." Medicare Part A is the hospital insurance portion of the program, and includes acute hospital inpatient care and inpatient skilled nursing care. Medicare Part B is the medical insurance component, and includes coverage for doctor visits and outpatient care. Medicare Part C, known as Medicare Advantage, covers both Part A and Part B options. And, Medicare Part D is the prescription drug coverage component of the program, which went into effect on January 1, 2006.

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home health care.
- Most people do not have to pay a premium for Medicare Part A because they, or a spouse, paid Medicare taxes while working in the United States. If they do not automatically get premium-free Part A, they may still be able to enroll, and pay a premium.

Medicare Part B (Medical Insurance)

- Helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment and home health care.
- Helps cover some preventive services.
- Most people pay up to the standard monthly Medicare Part B premium.

Some Medicare recipients buy coverage that fills gaps in Medicare coverage, such as Medicare Supplemental Insurance (Medigap).

Medicare Part C (also known as Medicare Advantage)

- Offers health plan options run by Medicare-approved private insurance companies. Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B. Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D).
- Some Medicare Advantage Plans may include additional benefits for an additional cost.

Medicare Part D (Medicare Prescription Drug Coverage)

- Helps cover the cost of prescription drugs.
- May help lower your prescription drug costs and help protect against higher costs.
- Run by Medicare-approved private insurance companies.
- Costs and benefits vary by plan.

WHAT IS MEDICAID?

Medicaid is health coverage available to people and families who have limited income and resources. It is funded both by the federal government and state governments, but is managed at the state level. The program was enacted in 1965 as Title XIX of the Social Security Act. The funding of Medicaid is a major component of state spending, on average comprising 25% of the total

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state budget. Nationally, 60% of Medicaid spending goes toward acute care services and over a third goes toward long-term care services.¹

Medicaid recipients who are disabled or elderly may also receive coverage for services such as nursing home care or home and community-based services. Depending on the state's rules, individuals may also be asked to pay a small part of the cost (copayment) for some medical services. If an individual qualifies for both Medicare and Medicaid, most of their health care costs will be covered, including prescription drug coverage.

Frequently, nursing home residents run out of financial resources during their stay, at which point they become eligible for Medicaid coverage. States attempt to control the costs by ensuring that those receiving Medicaid benefits are truly eligible, and at times adopt payment methodologies of the Medicare program. Because Medicaid programs are managed at the state level, there is state-to-state variation in eligibility requirements, coverage and reimbursement.

Medicaid reimbursement, in general, is lower than both Medicare and private insurance reimbursement. Thus, the proportion of Medicaid business for any health care organization is particularly relevant to its financial performance. Moreover, because Medicaid programs place stress on state budgets, state regulators often carry out cost containment measures to reduce Medicaid spending. State cost containment activities include the reduction of payments to providers, reduction in covered services and reduced pharmacy benefits. Over half of CAHs receive cost based reimbursement from their state Medicaid program. For information on state-specific Medicaid reimbursement rates for CAHs, please visit <http://www.ruralcenter.org/node/159>

WHAT IS CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)?

The Children's Health Insurance Program (CHIP) provides access to low cost health insurance coverage for children in families who earn too much to qualify for Medicaid but not enough to be able to buy private health insurance. These families are eligible for free or low-cost health insurance that pays for doctor and dental visits as well as prescription drugs, hospitalizations and more.

¹ **Medicaid Spending by Service and Medicaid Spending on Long-Term Care:** Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Centers for Medicare and Medicaid Services-64 reports, March 2009.

WHAT IS THE PROSPECTIVE PAYMENT SYSTEM?

In 1983, the payment methodology for inpatient acute hospital care (Medicare Part A) changed from cost-based reimbursement to a prospective payment reimbursement system (PPS). In this new payment system, all of the various clinical diagnoses were classified into groups, called "Diagnosis Related Groups" or DRGs. With the establishment of DRG categories, of which there are more than 500, hospitals were then paid a fixed amount to treat each patient based on age, sex, International Classification of Diseases (ICD) diagnoses, procedures, discharge status and the presence of comorbidities or complications. Upon admission, each patient is assigned a DRG based on their primary diagnosis, for example, "pneumonia". The hospital is then paid a specific dollar amount for that pneumonia patient, based on the DRG code they were assigned. Some patients need more anticipated services to treat their specific ailment(s), while other cases require fewer services. Regardless, the hospital is still paid the same amount for that DRG code. Naturally, some diagnoses, and their corresponding DRGs, have very high levels of complexity and thus are more costly to treat. For example, a heart transplant is vastly more complicated and requires more resources than a normal newborn birth. Consequently, DRG reimbursement for heart transplants is higher than for the normal newborn DRG.

Base DRG rates can be adjusted for several reasons, including a hospital's location. Just as the cost of living in the United States varies by location, the cost of providing health care varies by location as well. A heart transplant performed in San Francisco, California, would likely cost more than one performed in Omaha, Nebraska, due to wage differences, supply costs differences, etc. The DRG system adjusts for this by varying DRG payments according to market forces across the country.

Inherent in the DRG reimbursement system is the incentive for hospitals to treat and discharge patients as quickly as possible. Because this reimbursement program pays hospitals on a "per patient" basis, there is a financial incentive for hospitals to treat as many patients as possible, as efficiently as possible. By discharging patients in a timely manner, it frees more bed space which can be used to treat more incoming patients. Additionally, the reduced number of days spent in the hospital for a given patient reduces the required resources and associated costs of caring for that patient. In this way, for any DRG, a shorter length of stay is more profitable for the hospital than a longer length of stay. Because of this direct impact on profitability, the "Average Length of Stay" metric is used by hospitals to assess the efficiency of their organization.

WHAT IS THE MEDICARE SWING BED PROGRAM?

As discussed earlier, hospitals are reimbursed on a DRG basis for inpatient acute care. Often, patients who require acute inpatient services require inpatient rehabilitative aftercare or skilled nursing care. DRG acute payment rates are set based upon the resources required to treat the acute condition only, and not those expended on the subsequent rehabilitation. Therefore, the Medicare program created a separate reimbursement system to compensate providers for the extended care service they provide. The amount of extended care required by patients for any condition is highly variable because of differences in age, overall health and other factors that determine the speed of recovery. Due to this length of stay variation, hospitals receive reimbursement based on the overall assessed condition of the patient, the amount of which is determined by the assigned Resource Utilization Group (RUG).

The RUG system classifies patients into one of 66 RUG levels, based on the expected amount of provider resources to be expended. RUG payments are larger for most severe conditions that require a great deal of attention and service. In cases where extended care is required, hospitals receive two payments for a patient: DRG payment for the treatment of the acute condition, and the RUG payment for care offered to patients after the acute treatment.

The Medicare swing bed program allows hospitals with 100 beds or less to provide both acute care treatment and skilled nursing treatment to patients without having to physically move the patient to another bed. The hospital receives both forms of reimbursement described above, simply by discharging patients from acute care beds and admitting them to skilled nursing beds when the patient meets the coverage guidelines for skilled care. The skilled nursing bed is sometimes referred to as a "swing" bed, because the hospital swings a bed from an acute care designation to a skilled nursing designation. Patients must be in the medically necessary acute care bed for at least 72 hours before they can be discharged to a swing bed.

WHAT IS CAH COST-BASED REIMBURSEMENT?

During the 1980s and 1990s, almost 400 hospitals closed across the U.S. because of financial losses from the PPS system. In 1997, the Balanced Budget Act created the Medicare Rural Hospital Flexibility (Flex) Program and CAH provider type.

Medicare pays for the same services from CAHs as for other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests and post-acute skilled nursing days). However, CAH payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients).

CAHs receive cost based reimbursement for inpatient and outpatient services provided to Medicare patients (and Medicaid patients depending on policy of the state in which they are located). Cost based reimbursement provides significant financial advantage to CAHs by allowing them to get paid at 101% of costs on all of their hospital Medicare business. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports.

WHAT IS CAH MEDICARE AMBULANCE REIMBURSEMENT?

Under Medicare ambulance reimbursement, if a CAH or an entity that is owned and operated by the CAH is the only provider or supplier of ambulance service located within a 35-mile drive of that CAH, the CAH or the CAH-owned and operated entity is paid 101% of the reasonable costs of the CAH or entity in furnishing ambulance services. Additionally, if there is no other provider or supplier of ambulance services within a 35-mile drive of the CAH but there is a CAH-owned and operated entity furnishing ambulance services that is more than a 35-mile drive from the CAH, that CAH-owned and operated entity can be paid 101% of reasonable costs for its ambulance services as long as it is the closest provider or supplier of ambulance services to the CAH.

WHAT ARE ALLOWABLE COSTS FOR 101% COST-BASED REIMBURSEMENT FROM MEDICARE?

Medicare pays CAHs for most inpatient, outpatient and swing bed services to Medicare beneficiaries on the basis of reasonable cost. Reasonable cost is the cost that was actually incurred in order to provide a medical service, to the

extent that cost is necessary in order to efficiently deliver that service. Expenses must be prudent and reasonable, as well as related to patient care. For a condensed list of allowable vs. non allowable expenses, please refer to Table A. below.

Table A. Allowable Costs in CAH

Type of Expense	Allowable	Not Allowable
Public education	X	
Employee recruitment	X	
Taxes based on income		X
Sales tax	X	
Property taxes	X	
Entertainment		X
Civic organizations	X	
Legal fees	Depends on activity	
Collection agency fees	X	
Political/lobbying costs		X

WHAT IS THE DIFFERENCE BETWEEN PPS AND COST-BASED REIMBURSEMENT?

PPS is a system where payment levels are set ahead of time or “prospectively” before health care services are delivered, as opposed to after the diagnosis and treatment. Because rates are set prior to services, each service has a pre-determined rate associated with it. These rates are based on estimates of the resources that must be expended for any particular service, e.g. physician time and effort, supplies, etc. In this way, this reimbursement system attempts to appropriately match payments to the acuity of patient illnesses. For example, hospitals are paid a fixed amount for performing a hip replacement, and a different fixed amount for treating a patient with heart failure. This type of reimbursement methodology controls for costs because providers are paid a fixed rate per service, regardless of the costs they incur.

WHAT IS OPTIONAL (METHOD II) BILLING?

A CAH may elect the Optional (or Method II) Payment Method under which it bills the fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) for both facility services and professional services to its outpatients on a

single claim. Eligible medical professionals affiliated with CAHs can elect the Optional (Method II) Payment Method whereby the CAH bills on behalf of these professionals for their outpatient services. These services would include where a CAH physician would reassign outpatient billing services to the CAH, for example in pathology, radiology, emergency room, outpatient surgery and outpatient clinics. This payment does not include services provided at a rural health clinic and only applies to the CAH outpatient services.

It is important to note that Optional (Method II) Payment Method billing is setting-specific, not provider-specific. If a provider works in a rural health clinic, they cannot use Optional (Method II) Payment Method for those clinic services. However, if that same provider also provides outpatient services in the CAH, that provider could use Optional (Method II) Payment Method for those outpatient CAH services under the Optional (Method II) Payment Method based on the sum of:

- For facility services: 101% of reasonable costs, after applicable deductions, regardless of whether the physician or practitioner has reassigned his or her billing rights to the CAH; and
- For physician professional services: 115% of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule. Payment for non-physician practitioner services is 115% of the amount that otherwise would be paid for the practitioner's professional services under the Medicare Physician Fee Schedule.

Physicians reassign their billing to the hospital, and the hospital must do the billing. All providers of the CAH do not need to use Optional (Method II) Payment Method, but can individually elect to do so. Overall, it is beneficial for the CAH to elect the Optional (or Method II) Payment Method, in that it results in higher reimbursement.

Previously, if a CAH chose to be paid under the Optional (or Method II) Payment Method, it was required to make that election on an annual basis. However, in the Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS) Final Rule, CMS changed the regulations for the optional method election. Effective for cost reporting periods beginning on or after October 1, 2010:

- If a CAH elects the optional method in its most recent cost reporting period beginning before October 1, 2010, that election remains in place until the CAH submits a termination request to its FI/MAC. CAHs will no longer be required to make an annual election.

- If a CAH chooses to make a change or terminate its optional method election, the CAH will need to notify its FI/MAC in writing at least 30 days prior to the start of the next cost reporting period.

WHAT IS A MEDICARE ADMINISTRATIVE CONTRACTOR (MAC)?

Section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) established the Medicare Contracting Reform (MCR). This statute required the Department of Health and Human Services (HHS) to replace Medicare's 48 carriers and fiscal intermediaries who process Medicare Part A and B Fee for Service claims with the new Medicare Administrative Contractor (MAC) authority. The primary reasons for instituting this change were to increase the contractor's efficiency in the receipt, processing and payment of Fee-For-Service claims. When all states are transitioned, there will be 15 new MACs processing Part A and Part B claims.

IF CAHS ARE REIMBURSED AT 101%, WHY MIGHT THEY NOT MAKE A PROFIT?

Some CAH expenses, such as recruiting and bad debts, are not included in the cost-based reimbursement formula. Therefore, CAHs generally earn less than 101% of cost for care of their Medicare patients. Consequently, profitability of CAHs is dependent on private insurance business, both inpatient and increasingly for outpatient services. Private insurance payors do not reimburse CAHs on a cost basis, but rather follow a PPS system or reimburse on a percent of charges. In fact, the profitability of commercial business is enhanced because of the cost based reimbursement received for Medicare/Medicaid business.

Suppose a CAH administrator decides to purchase and install a CT scanner for \$1 million, and assume 40% of patient care at the CAH in the CT department is Medicare business. The CAH will receive \$400,000 in cost reimbursement over the useful life of the scanner ($\$1 \text{ million} * 40\% = \$400,000$) from Medicare for their portion of this scanner used to serve patients. This reduces the hospital's remaining costs for the CT scanner to \$600,000. The use of the scanner from other patients would need to be available in order to offset the remaining costs based on overall demand.

It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers. When performing financial assessments of CAHs, it is essential to evaluate both the proportion of private insurance business, as well as the DRG rates negotiated with the private payor.

WHAT IS A HOSPITAL COST REPORT?

The Medicare Cost Report is a financial document filed annually by all Medicare providers participating in the program, including: hospitals, skilled nursing facilities, home health agencies, rural health clinics (RHC), federally qualified health centers (FQHC), hospice, renal and home office. The Medicare Cost Report is submitted annually to CMS for settlement of costs relating to health care services rendered to Medicare beneficiaries. The Medicare Cost Report records each institution's total costs and charges associated with providing services to all patients, the portion of those costs and charges allocated to Medicare patients, and the Medicare payments received.

The Medicare Cost Report must be filed with the FI/MAC within five months of fiscal year end of the CAH in order to achieve settlement of costs for health care services. Final settlement will equal the total reimbursable costs incurred by or on behalf of the CAH for furnishing covered care to the CAH's Medicare enrollees (less applicable deductible and coinsurance). Throughout the course of the year, the hospital receives interim payments from Medicare for its services. These payments are based on historical costs as claims are processed. At the end of the hospital's fiscal year, if the final settlement determination is greater than payments already made to the CAH through interim settlement, an underpayment will be declared, and CMS will make a lump-sum payment to the CAH. Conversely, if the final settlement determination is less than the total payment made, the CAH has been overpaid, and CMS must recover the overpayment. This is similar to the filling of individual taxes each year, where it is likely a person will either owe tax money to or be paid a refund from the state or Federal government based on estimated tax payments throughout the previous year. The above payment methodology illustrates the importance of up-to-date charges, billing and coding methodologies for the hospital to ensure accuracy and maximize allowable payment.

IF A CAH HAS A RURAL HEALTH CLINIC ATTACHED, HOW DO THEY BILL FOR THOSE SERVICES AND FILE THEIR EXPENSES?

The primary benefit of rural health clinic (RHC) status is enhanced reimbursement from Medicare and Medicaid. Medicare reimburses RHCs based on allowable and reasonable costs. There are two types of RHCs: independent RHCs and provider based RHCs. Provider based RHCs work as a department of another provider, such as a CAH, providing health care services to the same population. Independent RHCs, on the other hand, are not affiliated with other providers. There can be significant reimbursement implications associated with each type of designation; for example, independent RHCs are subject to a payment cap, whereas provider based RHCs are not. However, if the main provider has fewer than 50 available acute care beds (not licensed beds), the RHC's reimbursement rate is uncapped. Provider based RHCs are reported on the main provider's cost report as a department of that provider. As a result, overhead is allocated to the RHC through the step-down overhead allocation process in the same manner that impacts all of the provider's patient care service departments.

WHAT ARE THE MOST IMPORTANT CAH FINANCIAL INDICATORS OF PERFORMANCE?

Financial indicators closely aligned with financial strength can be used to determine the financial status of a CAH. Financial indicators, often ratios, combine line items from the balance sheet, statement of operations and/or statement of cash flows in a meaningful way to help interpret strengths or weaknesses in operations or financing activities. Examining these ratios over time can help determine an organization's future trajectory or momentum.

In June 2012, a group of CAH financial experts met in Minneapolis, Minnesota at a CAH Financial Leadership Summit. Of the many identified financial ratios proven useful for assessing organizations' financial conditions, the Summit participants identified the 10 most important indicators for evaluating CAH financial performance. These indicators are listed below with associated definitions, formulas and benchmarks from the *2012 CAH Financial Indicators Report* distributed by the Flex Monitoring Team. The tables are meant to be used as a reference when calculating these ratios for a specific CAH. A series of financial statements (balance sheet, statement of operations and statement of cash flows) are presented in the Appendix and are used to illustrate where ratio inputs are located and how to calculate the ratios

discussed. Table B displays each of the indicators with the 2010 CAH U.S. medians. Each indicator has an arrow pointing up or down, displaying if favorable values are above or below the median.

Table B. CAH Financial Indicator Medians, 2010

CAH Financial Indicator	2010 U.S. Median	
Days in Accounts Receivable	52.24	▼
Days Cash on Hand	68.43	▲
Total Margin	1.94%	▲
Operating Margin	0.75%	▲
Debt Service Coverage	2.58	▲
Salaries to Net Patient Revenue	44.78%	▼
Medicare Inpatient Payor Mix*	72.59%	▼
Average Age of Plant (years)	9.87	▼
Long Term Debt to Capitalization	26.37%	▼

* Summit participants agreed Overall Payor Mix was a more comprehensive indicator of financial performance than Medicare Inpatient Payor Mix alone.

Source: Flex Monitoring Team Data Summary Report No. 10: CAH Financial Indicators Report: Summary of Indicator Medians by State, August 2012.

1. Days in Net Accounts Receivable

Days in Net Accounts Receivable measures the number of days it takes an organization to collect its payments.

Table C. Example Calculation: Days in Net Accounts Receivable

	2009	2010	2011
Days in Net Accounts Receivable			
Net Accounts Receivable [B-C]	771,000	802,000	778,000
Net Patient Revenue [Q]	5,195,000	5,330,000	5,388,000
Days in Net Accounts Receivable $[(B-C)/(Q/365)]$	54	55	53

High values reflect a long collection period and indicate problems in the organization's business office with regards to billing or collecting payments. The ability to collect payments for services is increasingly difficult, but extremely important. Improvement in days in accounts receivable can mean hundreds of thousands of dollars in improvement in cash on hand. Common problems include out of date chargemasters, poor registration processes and bad communication. "Days in Accounts Receivable" is a good measure of how the billing process is working and efficiency, but it does not indicate the overall financial strength of the hospital. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **52.24 days**. Reductions to accounts receivable will improve cash on hand.

2. Days in Gross Accounts Receivable

Days in Gross Accounts Receivable tests the net days in accounts receivable with a goal of being the same amount of time as net days in accounts receivable.

Table D. Example Calculation: Days in Gross Accounts Receivable

	2009	2010	2011
Days in Gross Accounts Receivable			
Gross Accounts Receivable [B]	1,001,000	1,012,000	993,000
Gross Revenue [P]	6,395,000	6,460,000	6,503,000
Days in Gross Accounts Receivable $[B/(P/365)]$	57	57	56

Days in gross accounts receivable is important to track and compare to net accounts receivable to assess the revenue cycle performance. Gross and net days are close in value in highly functioning business offices. Gross accounts receivable does not include any accounting adjustments which makes it a good measure of overall performance when compared to net days in accounts receivable. For example, if gross days are higher than net days, the organization's allowances (e.g. write offs) may require further analysis. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **52.24 days**.

3. Days Cash on Hand

Days Cash on Hand measures the number of days an organization could operate if no additional cash was collected or received. This reflects the organization's "safety net" relative to the size of the hospital's expenses.

Table E. Example Calculation: Days Cash on Hand

	2009	2010	2011
Days Cash on Hand			
Cash and Investments [A]	1,120,000	1,280,000	1,831,000
Operating Expenses [X]	5,688,000	5,747,000	5,817,000
Depreciation Expense [U]	229,000	218,000	211,000
Bad Debt Expense [W]*	102,000	107,000	126,000
Total [X-U-W]	5,357,000	5,422,000	5,480,000
Days Cash on Hand [A/[(X-U-W)/365]]	76	86	122
<i>* Only if classified as operating expense on income statement</i>			

Lending organizations view this ratio as critical in the assessment of a project's feasibility, as it represents the amount of dollars readily available to meet short term obligations and make debt payments should an organization experience short term financial distress. Favorable values are **above** the median, and the 2010 CAH U.S. Median = **68.43 days**.

4. Total Margin

Total Margin measures the control of expenses relative to revenues.

Table F. Example Calculation: Total Margin

	2009	2010	2011
Total Margin			
Change in Net Assets [Z]	64,000	87,000	159,000
Total Revenue [S]	5,752,000	5,834,000	5,976,000
Total Margin [Z/S]	1.1%	1.5%	2.7%

Total margin indicates the organization's overall profit. It is important to note that organizations need at least a small measure of profit to reinvest in their facilities, staff and infrastructure. Consistently negative total margins may eventually lead to hospital closure. While total margin is a good indicator of financial strength, it is important to look at operating margin as well. An organization might have a high total margin ratio if, for example, it is the recipient of non-operating sources of revenue, such as a county subsidy to provide quality health care to indigent residents. Margin driven by supplemental funding sources may be at risk with more pressure on local and county governmental budgets, for example. Favorable values are **above** the median, and the 2010 CAH U.S. Median = **1.94%**.

5. Operating Margin

Operating Margin measures the control of operating expenses relative to operating revenues related to patient care. Operating expenses are all expenses incurred from the hospital in delivering services. Examples are salaries and benefits, purchased services, professional fees, supplies, interest expense, depreciation and amortization and bad debt expense.

Table G. Example Calculation: Operating Margin

	2009	2010	2011
Operating Margin			
Net Operating Income [R-X]	(7,000)	10,000	63,000
Total Operating Income [R]	5,681,000	5,757,000	5,880,000
Operating Margin [(R-X)/R]	-0.1%	0.2%	1.1%

This measure reflects the overall performance on the CAH's core business: providing patient care. It is important to note that it takes into account the deductions from revenue, such as contractual allowances, bad debt and charity care. Favorable values are **above** the median, and the 2010 CAH U.S. Median = **0.75%**.

6. Debt Service Coverage Ratio

Debt Service Coverage Ratio measures the ability to pay obligations related to long-term debt.

Table H. Example Calculation: Debt Service Coverage Ratio

	2009	2010	2011
Debt Service Coverage Ratio			
Change in Net Assets [Z]	64,000	87,000	159,000
Interest Expense [V]	28,000	17,000	13,000
Depreciation Expense [U]	229,000	218,000	211,000
Total [Z+V+U]	321,000	322,000	383,000
Principal Payments [AA]	169,000	145,000	90,000
Interest Payments [BB]	28,000	17,000	10,000
Total [AA+BB]	197,000	162,000	100,000
Debt Service Coverage Ratio [(Z+V+U)/(AA+BB)]	1.6	2.0	3.8

The measure reflects the availability of capital after debt obligations have been satisfied. The debt service coverage represents a key ratio in determining the ability of an organization to take on additional debt, whether for IT, equipment or a building project. The higher the value of the debt service coverage ratio, the greater the "cushion" to repay outstanding debt or take on additional obligations. Favorable values are **above** the median, and the 2010 CAH U.S. Median = **2.58**.

7. Salaries to Net Patient Revenue

Salaries to Net Patient Revenue measures labor costs relative to the generation of operating revenue from patient care.

Table I. Example Calculation: Salaries to Net Patient Revenue

	2009	2010	2011
Salaries to Net Patient Revenue			
Salaries [T]	2,895,000	2,908,000	2,958,000
Net Patient Revenue [Q]	5,195,000	5,330,000	5,388,000
Salaries to Net Patient Revenue [T/Q]	56%	55%	55%

Salaries are a major part of the expense structure and require close management. Reviewing the costs can help a CAH assess its staffing efficiency. Overstaffing can reduce overall hospital profitability. Closely monitoring salaries to net patient revenue and improving efficiencies can improve financial performance. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **44.78%**.

8. Payor Mix Percentage

Payor Mix Percentage is the proportion of patients represented by each payor type. As displayed below, inpatient and outpatient payor mix are calculated differently. **Inpatient Payor Mix** measures the percentage of total inpatient days that are provided to patients of each payor type. The 2010 CAH U.S. Median for Medicare inpatient payor mix was 72.59%. Favorable values are **below** the median.

$$\frac{\text{Inpatient Days for Payor}}{\text{Total Inpatient Days} - \text{Nursery Bed Days} - \text{Nursing Facility Swing Bed Days}}$$

Outpatient Payor Mix measures the percentage of total outpatient charges that are for patients of each payor type.

$$\frac{\text{Outpatient Charges for Payor}}{\text{Total Outpatient Charges}}$$

Payor mix percentages are particularly important in estimating provider revenue, because the final reimbursement amount for any patient ultimately depends on the payment source. For CAHs, reimbursement for Medicare is 101% of costs. Real costs for Medicare patients are already below 100% since some cost, such as physician recruiting, are not reimbursed by Medicare. The only alternative source of profits is providing services to privately insured patients. It is often the challenge of rural health care

providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers.

9. Average Age of Plant

Average Age of Plant measures the average age in years of the buildings and equipment of an organization.

Table J. Example Calculation: Average Age of Plant

	2009	2010	2011
Average Age of Plant			
Accumulated Depreciation [E]	1,874,000	1,755,000	1,896,000
Depreciation Expense [U]	229,000	218,000	211,000
Average Age of Plant [E/U]	8.2	8.1	9.0

CAHs often fail to improve or rebuild their facilities. The status of newer facilities has been shown to have a positive effect on financial performance and on the recruitment and retention of physicians and staff. Average age of plant is a good indicator of distress with older hospitals having greater problems. Lower, decreasing values indicate a newer facility or more frequent reinvestments in buildings or equipment over time. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **9.87 years**.

10. Long Term Debt to Capitalization

Long Term Debt to Capitalization measures the percentage of net assets (or equity) that is debt.

Table K. Example Calculation: Long Term Debt to Capitalization

	2009	2010	2011
Long Term Debt to Capitalization			
Long Term Capital Liabilities [K]	186,000	183,000	178,000
Net Assets [M]	1,835,000	2,173,000	2,694,000
Long Term Debt to Capitalization [K/[K+M]]	9.2%	7.8%	6.2%

This ratio measures the amount of capital that is financed with debt, which is important to lenders for long term viability. Higher values signify a riskier situation and indicate that a hospital may have a harder time sustaining debt payments in the future and/or getting financing from lenders. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **26.37%**.

IS THERE A MODEL FOR PREDICTING CAH FINANCIAL DISTRESS?

The CAH Financial Distress Model was developed by researchers from the North Carolina Rural Health Research and Policy Analysis Center at University of North Carolina at Chapel Hill.² A well-functioning prediction model, such as this, can be used as an early warning system to identify hospitals at increased risk of facing financial distress. State Medicare Flex Programs, CAH CEOs and boards reviewing the model could identify areas of particular distress and develop strategies, or interventions, to improve financial performance.

Today's characteristics (recent financial performance and measures of a market in which a hospital operates) are used to assign CAHs to one of four "risk levels" that predict whether a CAH will be in financial distress two years later. Many financial performance and market characteristics were considered for inclusion. The final model was selected due to its ability to predict performance in a straightforward manner. Variables used in the model are noted below in Table L.

² Mark Holmes, PhD and George H. Pink, PhD; North Carolina Rural Health Research and Policy Analysis Center, University of North Carolina at Chapel Hill
National Rural Health Resource Center

Table L. Descriptive Measures of Variables Included in CAH Financial Distress Model

Financial Performance	
Variable	Description
Profitability	Earnings before interest and taxes divided by total assets, operating margin and the 2-year change in operating margin
Reinvestment	Retained earnings divided by total assets
Hospital Size	Net patient revenue
Market Characteristics	
Variable	Description
Competition	Distance to the nearest hospital with at least 100 beds and percent market share, if less than 25 percent
Economic Status	Percent unemployment in the market area
Market Size	Population in the market area
Financial Distress Signals	
Variable	Description
Equity Decline	Whether the fund balance declined more than 25% and whether the fund balance was negative
Unprofitability	Indicator variables for a negative cash flow margin and three consecutive years of negative operating margin
Closure	Whether the hospital closed

The model separates hospitals into risk of financial distress categories; hospitals in the highest risk category had up to 15 times the rate of financial distress events as hospitals in the lowest category. Financial distress events include:

- Closure;
- Negative fund balance;
- Declining (>25%) fund balance;
- 3 years negative operating margin; and,
- Negative cash flow margin.

Accurate assignment of hospitals to categories that reflect low, mid-low, mid-high and high risk of financial distress can provide an effective early warning

system to CAHs, allowing CAH Administrators and state Medicare Flex Program Coordinators to target efforts to those at higher risk.

WHERE CAN I FIND INFORMATION ABOUT THE FINANCIAL PERFORMANCE OF CAHS IN MY STATE?

A “Financial Indicators Report” is provided to individual CAHs late each summer with a summary report for the state provided to the state Flex Programs. These reports include a variety of metrics, and will now include the Financial Distress Model. For more information, visit:

<http://flexmonitoring.org/indicators.html>.

WHAT INTERVENTIONS CAN CAHS USE TO IMPROVE THEIR FINANCIAL PERFORMANCE?

The 2012 CAH Financial Leadership Summit identified a number of important financial interventions that historically have been associated with improved financial performance. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician 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 CFO networks
- Benchmarking financial indicators

WHY IS A REVIEW OF THE COST REPORT IMPORTANT?

A review of the cost report can be completed by an outside party to look for common errors in preparation. Because it drives Medicare payments, errors on the cost report directly affect the bottom line, sometimes as much as hundreds of thousands of dollars. Errors include incorrect allocations of expenses and inaccurate statistics, for example. Most cost reports are “outsourced,” but understanding direct and indirect costs and how cost reports work is a critical input to making sound decisions for CEOs, CFOs and board members.

WHAT IS A CHARGEMASTER AND HOW OFTEN SHOULD IT BE REVIEWED?

The Charge Description Master (CDM) is primarily a list of services and procedures, room accommodations, supplies, drugs/biologics, and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim. It is integral to the CAH's revenue cycle and provides many of the necessary data elements for compliant claims submission for reimbursement. It is recommended to have an outside source perform a comprehensive chargemaster and revenue cycle review annually. Ongoing education is also crucial to having business office staff remain current with information necessary to appropriately bill for services rendered. Code changes and description changes must be communicated to the departments who will be generating the charges and may need to be altered or added to the system. Similarly, charge tickets may need to be updated. Billing and coding workshops are available in many locations throughout the country. For information on upcoming workshops and trainings, please visit: http://www.ruralcenter.org/search/apachesolr_search?filters=tid%3A2%20type%3Aeducation_gateway&solrsort=created%20desc&retain-filters=1.

WHAT ARE STRATEGIC, FINANCIAL AND OPERATIONAL ASSESSMENTS?

Strategic, financial and operational assessments provide a broad-based analysis of hospital performance and help identify specific opportunities for CAH improvement. These studies provide an objective review of the areas where many CAHs need help, including:

- Matching services to community needs;
- Staffing to benchmarks;
- Clinic management;
- Medical staff planning; and,
- Organizational culture.

Assessments are recommended periodically to determine areas of focus for follow-up improvement work.

WHAT IS REVENUE CYCLE MANAGEMENT?

Revenue cycle management is a means to improve hospital revenue and reimbursement by streamlining workflow, processes and education throughout all financial components of the hospital. A holistic revenue cycle management includes a multi-disciplinary approach focusing on culture change with comprehensive, dramatic and permanent results. Specific areas of focus may include:

- Comprehensive chargemaster and revenue cycle review
- Business office and patient financial services review
- Development of training protocols for revenue capture
- Implementation of an effective revenue control process
- Pricing analysis
- Recovery audit contractor (RAC) preparedness and revenue cycle process improvement
- Revenue process capture audits

These assessments should result in identifying opportunities for improvement and specific, actionable recommendations.

WHY ARE PHYSICIAN PRACTICE MANAGEMENT ASSESSMENTS USEFUL?

As more and more physicians align and become employees of CAHs, it is critically important to contract with physicians and operate the clinics according to best practices. A practice management assessment looks at physician and mid-level provider productivity, scheduling, staffing, billing and collection practices specific to this area. These assessments should result in specific recommendations and action plans that have the potential to bring in additional revenue and improve clinic efficiency.

WHAT IS LEAN AND HOW CAN IT IMPACT CAH FINANCES?

Lean focuses on increasing efficiency and eliminating waste. This creates greater value for customers and uses fewer resources. In the health care setting, Lean processes can result in substantial cost savings, fewer delays and increased patient and staff satisfaction. Lean education, Lean networks and shared Lean expertise have all been successfully used by individual CAHs and networks of rural hospitals.

WHY IS EDUCATION ON FINANCES IMPORTANT FOR CAH DEPARTMENT MANAGERS AND BOARD MEMBERS?

Financial education for CAH department managers can enhance budgeting, planning and financial skills in department heads, whose background may be clinical rather than business or administrative. CAH Board members similarly lack basic CAH financial knowledge. Financial education for CAH Boards provides a fundamental grounding on cost-based reimbursement and CAH financial strategies. Hospital financial management is complex and rural hospital boards need a basic understanding of CAH finances to provide needed oversight. This type of education has been done successfully with rural hospitals using both on-site workshops and web-based presentations, which are often stored and accessible online.

WHY IS COLLABORATION IMPORTANT FOR IMPROVING FINANCES IN CAHS?

Two minds are better than one. Collaboration allows CAH staff to share ideas, lessons learned, best practices and funds with one another. Many state Flex Programs have provided support to develop CFO networks. CFO networks have proven to be a popular method of education, peer learning and peer support. In more than a dozen states, rural hospital CFOs meet periodically, either in person or virtually, to discuss common issues, gain new skills and share experiences and techniques.

Benchmarking financial outcomes among groups of hospitals is a common means of measuring performance and comparing results. By collaboratively comparing results, CAHs identify areas of strengths and weaknesses and measure progress toward strategic goals. This collective benchmarking also provides an opportunity for the hospitals to share common issues, best practices and lessons learned. The University of North Carolina-Chapel Hill's distribution of an annual *CAH Financial Indicators Report* is a useful source for benchmarking, but other information sources are also available.

Aside from the value of bringing collective minds together, using various funding sources to achieve an end goal can be strategic. Pooling SHIP dollars among a group of CAHs has provided an effective means of providing financial or Lean education to hospital staff and boards. Economies of scale, shared expertise, access to speakers and resources, peer learning and support have all been reported as benefits of pooling resources.

APPENDIX

**EXAMPLE CRITICAL ACCESS HOSPITAL
BALANCE SHEET**

	2009	2010	2011
ASSETS			
Current Assets:			
A Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
B Patient Accounts Receivable, Gross	1,001,000	1,012,000	993,000
C Less: Provision for Doubtful Accounts	(230,000)	(210,000)	(215,000)
Other Accounts Receivable	-	24,000	24,000
Supplies	162,000	169,000	169,000
Other Current Assets	68,000	57,000	57,000
D Total Current Assets	2,121,000	2,332,000	2,859,000
Property, Plant and Equipment:			
E Less: Accumulated Depreciation	(1,874,000)	(1,755,000)	(1,896,000)
Net Fixed Assets	789,000	857,000	816,000
F TOTAL ASSETS	2,910,000	3,189,000	3,675,000
LIABILITIES AND NET ASSETS			
Current Liabilities:			
G Current Portion of Long Term Debt	144,000	89,000	49,000
H Accounts Payable and Accrued Liabilities	115,000	148,000	158,000
Estimated Amounts Due to Third Party	260,000	226,000	226,000
I Other Current Liabilities	370,000	370,000	370,000
J Total Current Liabilities	889,000	833,000	803,000
K Long Term Debt, Net of Current Portion	186,000	183,000	178,000
L TOTAL LIABILITIES	1,075,000	1,016,000	981,000
NET ASSETS			
M Accumulated Earnings (Deficit)	1,835,000	2,173,000	2,694,000
TOTAL LIABILITIES AND NET ASSETS	2,910,000	3,189,000	3,675,000

**EXAMPLE CRITICAL ACCESS HOSPITAL
STATEMENT OF OPERATIONS**

	2009	2010	2011
REVENUE			
N Total Inpatient Revenue	2,402,000	2,445,000	2,471,000
O Total Outpatient Revenue	3,993,000	4,015,000	4,032,000
P Total Gross Revenue	6,395,000	6,460,000	6,503,000
Less: Contractual Allowances	(1,200,000)	(1,130,000)	(1,115,000)
Q Net Patient Revenue	5,195,000	5,330,000	5,388,000
Other Operating Revenue	486,000	427,000	492,000
R Total Operating Revenue	5,681,000	5,757,000	5,880,000
Gain (Loss) on PP&E Disposal	(2,000)	(3,000)	-
Contributions/Grants	65,000	69,000	77,000
Investment Income	8,000	11,000	19,000
S Total Revenue	5,752,000	5,834,000	5,976,000
EXPENSES			
T Salaries	2,895,000	2,908,000	2,958,000
Benefits, Supplies, & Other	2,434,000	2,497,000	2,509,000
U Depreciation and Amortization	229,000	218,000	211,000
V Interest	28,000	17,000	13,000
W Provision for Doubtful Accounts/Bad Debt	102,000	107,000	126,000
X Total Expenses	5,688,000	5,747,000	5,817,000
Y EXCESS OF REVENUES OVER EXPENSES	64,000	87,000	159,000
Restricted Contributions		-	-
Z CHANGE IN NET ASSETS	64,000	87,000	159,000

**EXAMPLE CRITICAL ACCESS HOSPITAL
STATEMENT OF CASH FLOWS**

	2009	2010	2011
CASH FLOWS FROM OPERATING ACTIVITIES			
Change in Net Assets	522,000	547,000	542,000
Adjustments to reconcile change in net cash provided by operating activities:			
Purchase of Other Assets	246,000	459,000	(210,000)
Other Current Liabilities	(3,000)	(6,000)	-
	34,000	-	-
Net Cash Provided by Operating Activities	<u>799,000</u>	<u>1,000,000</u>	<u>332,000</u>
CASH FLOWS FROM FINANCING ACTIVITIES			
AA Repayment of Debt	(169,000)	(145,000)	(90,000)
Purchases of PP&E	(63,000)	(189,000)	(100,000)
BB Interest Paid on Long Term Debt	(28,000)	(17,000)	(10,000)
Gifts to Purchase Capital Assets	46,000	-	-
Net Cash Used by Investing Activities	<u>(214,000)</u>	<u>(351,000)</u>	<u>(200,000)</u>
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest and Dividends on Investments	8,000	11,000	19,000
Net Cash Used by Investing Activities	<u>8,000</u>	<u>11,000</u>	<u>19,000</u>
NET INCREASE (DECREASE) IN CASH	<u>593,000</u>	<u>660,000</u>	<u>151,000</u>
CASH, BEGINNING OF YEAR	<u>527,000</u>	<u>1,120,000</u>	<u>1,780,000</u>
CASH, END OF YEAR	<u><u>1,120,000</u></u>	<u><u>1,780,000</u></u>	<u><u>1,931,000</u></u>