FY 2019 Application – Use of CAHMPAS

To: State Flex Coordinators

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This memorandum outlines Federal Office of Rural Health Policy's plan to incorporate the use of CAHMPAS in the FY 2019 application process. State Flex coordinators are required to use data from the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS), or justified alternative data sources, to include financial data in their *Needs Assessment* section of the FY 2019 Medicare Rural Hospital Flexibility Program application.

Introduction: The Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS) is a web-based data query tool that uses CAH-level financial, state-level quality, and county-level community data. The University of North Carolina (UNC), under The Flex Monitoring Team (FMT) cooperative agreement, created this online tool so that users can compare CAH performance for various measures and indicators. Within the past year, there have been additional enhancements in CAHMPAS's functionality in response to users' feedback and requests. UNC and FMT continually work to update CAHMPAS so that it provides the most value to State Flex Programs and CAHs.

Users are able to:

- Compare reporting and performance for quality and community measures among CAHs in one or more states to those in a state or states of their choice, as well as pre-defined peer groups;
- Filter quality measure results to display only measures for which CAHs within a state or states had significantly better and/or worse performance;
- Filter quality measure results to display only measures included as required or optional measures for MBQIP;
- Visualize trends in performance and/or reporting rates over time, both by measure and by condition

The FMT will actively solicit feedback from State Flex Coordinators and CAHs during the development period of these new quality and community data portals while UNC/FMT will continue to improve upon the existing system by refining the financial dashboard and updating CAH-level financial data quarterly.

Incorporating CAHMPAS Financial Data into Flex NOFO: For the FY 2019 Medicare Rural Flexibility Program application, FORHP will **require** state Flex coordinators (SFCs) to provide CAHMPAS data (or a justified alternative such as a state-specific database that collects more timely financial data from hospitals) in their needs assessment, and use these data to inform the work plan. Some states may have more recent and robust data for their hospitals, in which case these data can be used to augment CAHMPAS. However CAHMPAS can also be used to inform the interpretation of state-specific data sources and to put state needs and data in the context of national standardized data and benchmarks.

CAHMPAS will be used to:

1. Identify specific CAHs that are most in need of financial and/or operational improvement interventions (Table 1).
2. Identify specific financial indicators that are suggestive of common intervention needs across CAHs in the state (Table 2).

In both scenarios, the SFC will identify potential interventions to generate improvements.

Table 1. Hospitals at risk of financial distress.

Hospital Name	Risk Level in Previous Year	Risk Level in Most Current Year	Interventions (in Work plan)
Example CAH A	High	High	Will receive focused technical assistance via Contract X
Example CAH B	Medium-High	High	Part of a cohort that focuses on Revenue Cycle Management (RCM) via Contract Y
Example CAH C	Low	Low	CAH will have access to recorded webinars produced by contract Z.

Financial Distress Index data can be used to identify troubled hospitals to which resources can be targeted. Technical assistance (TA) could be in the form of on-site consulting, helping to identify affiliation opportunities, or identifying potential alternative models of care. SFCs may be most concerned about hospitals at the highest risk of financial distress, but they may also be concerned about hospitals for which this measure is trending in the wrong direction. To help inform the work plan, SFCs should also explore the performance of individual hospitals on the distressed list using the hospital dashboard in CAHMPAS.

Table 2. Financial indicators where hospitals' performance lags behind the benchmark and/or US median in the current year.

Indicator	Benchmark Value[1]	2016 CAH U.S. Median	% of Hospitals in state Worse than Benchmark (where available) or Worse than U.S. median (where benchmark not available)
Profitability			
Total margin	>3.0%	2.74%	
Operating margin	>2.0%	0.93%	
Liquidity			
Days in net accounts receivable	<53 days	53.34	

Revenue			
Outpatient revenue to total revenue (generally higher is better)	N/A	77.74%	
Medicare outpatient cost to charge	<0.55%	0.45%	
Medicare acute inpatient cost per day (generally higher is better)	N/A	2592	
Cost			
Salaries to net patient revenue (generally lower is better)	N/A	44.90%	
Average age of plant	<10 years	10.48 years	
Utilization			
Swing-Skilled Nursing Facility ADC (generally higher is better)	N/A	1.53	
Acute ADC (generally higher is better)	N/A	2.70	
1. CAH financial benchmarks were developed by FMT and printed in the CAH Financial Indicators Reports. The benchmark values are now incorporated in CAHMPAS. See FMT Policy Brief #11, November 2009, and Developing Financial Benchmarks for Critical Access Hospitals, Health Care Finance Review, 2009, for more details on the development of CAH financial benchmark values.			

SFCs can use CAHMPAS to calculate the percent of hospitals in their state with performance lagging behind the benchmark (where available) or U.S. median on each of the indicators (where benchmark not available) in Table 2.

SFCs routinely work with CAHs by funding cohort trainings, educational sessions, and facilitating learning collaboratives. By considering the percentage with performance lagging behind a benchmark or median, SFCs will have a more informed approach towards cohort interventions.

Below are a few examples of how these data points can point to the correct intervention.

Indicator that is worse than benchmark / U.S. Median	***Example Intervention***
Days in net accounts receivable	*Revenue Cycle Management training*
Operating margin	*Lean training*
Medicare outpatient cost to charge	*Cost report or chargemaster support*
Total margin	*Service line analysis*

To support identification of appropriate interventions, SFCs should ask hospitals for underlying utilization and operational data to identify the drivers of lagging performance in order to best target interventions.

By the end of FY 2018 (September 01, 2018 – August 31, 2019), separate portals will be used to access quality and community data, with one CAHMPAS landing page. Login credentials will not be required to access quality and community data, as they will be aggregated at the state level (as they are in FMT current state-level reports) or represent publicly available data (e.g., County Health Rankings data).

Communication Strategy:
Significant updates to CAHMPAS and newly available supporting materials will be promoted in cooperation with TASC through blast emails via the FMT listserv. Additionally, new resources related to CAHMPAS use/demos and data interpretation will be uploaded to the CAHMPAS landing page and advertised to state Flex coordinators by FMT. The Reverse Site Visit is also an opportunity for FMT to present on the enhanced features of the quality and community components of CAHMPAS. Throughout FY 18 (September 01, 2018 – August 31, 2019), FMT will host focused webinars for user feedback and to answer specific questions.

FMT will also continue to work with TASC and RQITA to promote the enhancements through existing outreach efforts to CAHs and State Flex Coordinators. FMT will seek additional opportunities to engage with low CAHMPAS users and promote the improved capabilities to all users. If there are immediate questions and/or feedback, please email Owmy Bouloute (obouloute@hrsa.gov).