Small Rural Hospital and Clinic Finance 101

Updated September 2021

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This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $1,205,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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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), small rural prospective payment system (PPS) hospitals, and provider based rural health clinics (RHC). The content is designed to be as non-technical as possible and to provide answers to frequently asked questions regarding CAH, PPS, and RHC finance and financial performance.

Government Insurance Programs

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

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. As of April 2014, 13 states receive cost-based reimbursement for inpatient services. In addition, as of July 2016, 16 states receive cost-based reimbursement for outpatient service. Visit the website for information on state-specific Medicaid reimbursement rates for CAHs.

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.

Government Health Care Reimbursement

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 system (PPS). In this new payment system, all the various clinical diagnoses were classified into groups called Diagnosis Related Groups (DRGs). With the establishment of DRG categories, of which there were more than 500, hospitals were 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. Subsequently in 2007, Medicare updated this methodology to Medicare Severity-Diagnosis Related Groups (MS-DRG) of which there are approximately 1,000 categories. Upon admission, each patient is assigned a MS-DRG based on his or her primary diagnosis, for example, pneumonia. The hospital is then paid a specific dollar amount for that pneumonia patient based on the MS-DRG code 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 MS-DRG code. Naturally, some diagnoses, and their corresponding MS-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, MS-DRG reimbursement for heart transplants is higher than for the normal newborn MS-DRG.

Base MS-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 MS-DRG system adjusts for this by varying MS-DRG payments according to market forces across the country.

Inherent in the MS-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 MS-DRG, a shorter length of stay can be more profitable for the hospital than a longer length of stay. However, it is important to note that Medicare has implemented some reductions in payment under the MS-DRG methodology when the Medicare beneficiary is discharged before the Medicare average length of stay with a discharge to a covered skilled nursing stay in a nursing home or to a home health agency. Because of this direct impact on profitability, the Average Length of Stay metric is used by hospitals to assess the efficiency of their organization.

Outpatient services are reimbursed prospectively under one of three methodologies. The first methodology is the Clinical Lab Fee Schedule. This fee schedule applies to outpatient lab services rendered by prospective payment hospitals. The second methodology is the Medicare Physician Fee Schedule which provides for the payment methodology for outpatient therapies (i.e., Physical Therapy, Occupational Therapy and Speech Therapy). Under these methodologies, the payment is based on a fee schedule that is assigned according to the Current Procedural Terminology (CPT) codes reported for the services. The final methodology is the Ambulatory Payment Classification (APC) methodology. Initially implemented by CMS in 2000, this methodology provides for payments of services by grouping a CPT code or group of CPT codes into an APC classification. Each APC classification then has a payment level assigned. This methodology provides for significant bundling of services.

What is the Medicare Swing Bed program?

As discussed earlier, hospitals are reimbursed on a MS-DRG basis for inpatient acute care. Often, patients who require acute inpatient services require inpatient rehabilitative aftercare or skilled nursing care. MS-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 in which extended care is required, PPS hospitals receive two payments for a patient: MS-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 fewer 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 unless a waiver has been granted by CMS to the provider as a participant in special Medicare programs (i.e., Tracks 1+ and 3 accountable care organizations (ACO)).

What is CAH cost-based reimbursement?

During the 1980s and 1990s, almost 400 hospitals closed across the US 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 the 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 percent of costs on all of their hospital Medicare revenue. 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 percent 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 percent 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 percent 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 incurred to provide a medical service, to the extent the cost is necessary 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 or Not Allowable
Public education	Allowable
Employee recruitment	Allowable
Taxes based on income	Not Allowable
Sales tax	Allowable
Property taxes	Allowable
Entertainment	Not Allowable
Civic organizations	Allowable
Legal fees	Depends on activity
Collection agency fees	Allowable
Political/lobbying costs	Not Allowable

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 (i.e., 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 (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 include when a CAH physician reassigns 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 RHC 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 an RHC, 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 percent 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 percent of the allowable amount, after applicable deductibles and coinsurance, under the Medicare Physician Fee Schedule. Payment for non-physician practitioner services is 115 percent 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 (Method II) Payment Method, as it results in higher reimbursement. However, software and other system limitations can make it difficult to impossible to implement this methodology.

In the past, if a CAH chose to be paid under the Optional (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. However, the

CAH must continue to submit 855R forms for any newly hired/contracted practitioners.

- 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 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 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. For more information on the MACs, please visit the CMS website.

If CAHs are reimbursed at 101 percent, 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. In addition, a two percent sequestration reduction applies to Medicare's portion of the reimbursement after deductibles and coinsurance has been calculated. Therefore, CAHs earn less than 101 percent of cost for care of their Medicare patients. Consequently, profitability of CAHs is dependent on private insurance business, for both inpatient and, increasingly, 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 revenue.

Suppose a CAH administrator decides to purchase and install a CT scanner for $1 million and assume 40 percent of patient care at the CAH in the CT department is Medicare revenue. The CAH will receive $400,000 in cost reimbursement over the useful life of the scanner ($1 million * 40 percent =

$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 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, RHCs, federally qualified health centers (FQHC), hospice, renal dialysis, 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 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 like the filing of individual taxes each year, where a person will either owe money or be paid a refund from the state or federal government, based on estimated tax payments from the previous year. The above payment methodology illustrates the importance of up-to-date charges, billing and coding

methodologies, and cost reporting strategies for the hospital to ensure accuracy and maximize allowable payment.

If a CAH or PPS hospital has an RHC attached, how do they bill for those services and file their expenses?

The primary benefit of 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 subject to a payment cap if the parent entity is a hospital with fewer than 50 available acute care beds (not licensed beds). 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. Throughout the year, the RHC receives interim per visit payments based on past Medicare cost reports or other relevant information provided to CMS. At the end of the fiscal year, Medicare calculates the actual payments to be made to the RHC per the Medicare Cost Report. These payments are compared to the actual payments previously made to the RHC to determine if a payable is due to, or a receivable due from, the RHC.

CAH Finances

What are the most important CAH financial indicators?

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. Table B displays each of these 10 indicators with the 2019 CAH US medians as listed in the *CAH Financial Indicators Report: Summary of Indicator Medians by State* updated by the Flex Monitoring Team in April 2020. Each indicator also notes if favorable values are trending above or below the median.

Table B. CAH Financial Indicator Medians, 2019

CAH Financial Indicator	2019 US Median	Favorable Trending
Days in Net Accounts Receivable	50.54	Down
Days in Gross Accounts Receivable	47.57	Down
Days Cash on Hand	71.23	Up
Total Margin	2.40%	Up
Operating Margin	0..72%	Up
Debt Service Coverage	3.95	Up
Salaries to Net Patient Revenue	45.39%	Down
Medicare Inpatient Payer Mix*	69.80%	Down
Average Age of Plant (years)	12.28	Down
Long Term Debt to Capitalization	29.97%	Down

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

Source: Source: CAH Financial Indicators Report: Summary of 2019 Indicator Medians by State, April 2021

A definition, formula, and benchmarks for each of the 10 most important indicators of CAH financial performance is provided below. Each indicator also includes an example data table, which is meant to be used as a reference when calculating these ratios for a specific CAH. Sample data corresponds with the financial statements in the Appendix, including a balance sheet, statement of operations, and statement of cash flows. Many of the line items on the financial statements have a letter designation under

the column titled "Row". These letters are referenced in the descriptions of the indicator calculations.

Days in Net Accounts Receivable

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

How values are calculated:

- Net Accounts Receivable: [Row B] – [Row C]
- Net Patient Revenue: [Row Q]
- Days in Net Accounts Receivable: ([Row B] - [Row C]) ÷ ([Row Q] ÷ 365)

Example data:

	2018	2019	2020
Net Accounts Receivable	771,000	802,000	778,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Days in Net Accounts Receivable	**54.17**	**54.92**	**52.70**

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 its efficiency, but it does not indicate the overall financial strength of the hospital. Favorable values are **below** the median and the 2019 CAH US Median = **50.54 days**. Reductions to accounts receivable will improve cash on hand.

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.

How values are calculated:

- Gross Accounts Receivable: [Row B]
- Gross Revenue: [Row P]
- Days in Gross Accounts Receivable: [Row B] ÷ ([Row P] ÷ 365)

Example data:

	2018	2019	2020
Gross Accounts Receivable	1,001,000	1,012,000	993,000
Gross Revenue	6,395,000	6,460,000	6,503,000
Days in Gross Accounts Receivable	**57.13**	**57.18**	**55.74**

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 (i.e., write offs) may require further analysis. Favorable values are **below** the median and the 2019 CAH US Median = **47.57 days**.

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.

How values are calculated:

- Cash and Temporary Investments: [Row A]
- Total Expenses: [Row X]
- Depreciation and Amortization: [Row U]
- Provision for Doubtful Accounts/Bad Debt: [Row W]
- Days Cash on Hand: [Row A] ÷ (([Row X] – [Row U] – [Row W]) ÷ 365)

Note: Provision for Doubtful Accounts/Bad Debt is only included in this equation if classified as an operating expense on the Income Statement.

Example data:

	2018	2019	2020
Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
Total Expenses	5,688,000	5,747,000	5,817,000
Depreciation and Amortization	229,000	218,000	211,000
Bad Debt	102,000	107,000	126,000
Days Cash on Hand	**76.31**	**86.17**	**121.96**

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 2019 CAH US Median = **71.23 days**.

Total Margin

Total Margin measures the control of expenses relative to revenues.

How values are calculated:

- Change in Net Assets: [Row Z]
- Total Revenue: [Row S]
- Total Margin: [Row Z] ÷ [Row S]

Example data:

	2018	2019	2020
Change in Net Assets	64,000	87,000	159,000
Total Revenue	5,752,000	5,834,000	5,976,000
Total Margin	**1.11%**	**1.49%**	**2.66%**

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 2019 CAH US Median = **2.40 percent**.

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, depreciation and amortization, supplies, interest expense, professional fees, and bad debt expense.

How values are calculated:

- Net Operating Income: [Row R] – [Row X]
- Total Operating Income: [Row R]
- Operating Margin: ([Row R] – [Row X]) ÷ [Row R]

Example data:

	2018	2019	2020
Net Operating Income	-7,000	10,000	63,000
Total Operating Income	5,681,000	5,757,000	5,880,000
Operating Margin	**-0.12%**	**0.17%**	**1.07%**

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 2019 CAH US Median = **0.72 percent**.

Debt Service Coverage Ratio

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

How values are calculated:

- Change in Net Assets: [Row Z]
- Interest: [Row V]
- Depreciation and Amortization: [Row U]
- Repayment of Debt (Principal Payments): [Row AA]
- Interest Paid on Long Term Debt (Interest Payments): [Row BB]
- Debt Service Coverage Ratio: ([Row Z] + [Row V] + [Row U]) ÷ ([Row AA] + [Row BB])

Example data:

	2018	2019	2020
Change in Net Assets	64,000	87,000	159,000
Interest	28,000	17,000	13,000
Depreciation and Amortization	229,000	218,000	211,000
Principal Payments	169,000	145,000	90,000
Interest Payments	28,000	17,000	10,000
Debt Service Coverage Ratio	**1.63**	**1.99**	**3.83**

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 information technology (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 2019 CAH US Median = **3.95**.

Salaries to Net Patient Revenue

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

How values are calculated:

- Salaries: [Row T]
- Net Patient Revenue: [Row Q]
- Salaries to Net Patient Revenue: [Row T] ÷ [Row Q]

Example data:

	2018	2019	2020
Salaries	2,895,000	2,908,000	2,958,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Salaries to Net Patient Revenue	**55.73%**	**54.56%**	**54.90%**

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 2019 CAH US Median = **45.39 percent**.

Payer Mix Percentage

Payer Mix Percentage is the proportion of patients represented by each payer type. As displayed below, inpatient and outpatient payer mix are calculated differently.

Inpatient Payer Mix

Inpatient Payer Mix measures the percentage of total inpatient days that are provided to patients of each payer type. The 2019 CAH US Median for Medicare inpatient payer mix was **69.80 percent**. Favorable values are **below** the median.

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

Outpatient Payer Mix

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

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

Payer 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 percent of costs. Real costs for Medicare patients are already below 100 percent since some costs, such as physician recruiting, are not reimbursed by Medicare (see Table A - "Allowable Costs in CAH"). 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.

Average Age of Plant

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

How values are calculated:

- Accumulated Depreciation: [Row E]

- Depreciation and Amortization: [Row U]
- Salaries to Net Patient Revenue: [Row E] ÷ [Row U]

Example data:

	2018	2019	2020
Accumulated Depreciation	1,874,000	1,755,000	1,896,000
Depreciation Expense	229,000	218,000	211,000
Average Age of Plant	**8.18**	**8.05**	**8.99**

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 2019 CAH US Median = **12.28 years**.

Long Term Debt to Capitalization

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

How values are calculated:

- Long Term Debt, Net of Current Portion: [Row K]
- Net Assets - Accumulated Earnings (Deficit): [Row M]
- Long Term Debt to Capitalization: [Row K] ÷ ([Row K] + [Row M])

Example data:

	2018	2019	2020
Long Term Debt	186,000	183,000	178,000
Net Assets	1,835,000	2,173,000	2,694,000
Long Term Debt to Capitalization	**9.20%**	**7.77%**	**6.20%**

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 2019 CAH US Median = **29.97 percent**.

Is there a model for predicting CAH financial distress?

The Financial Distress Index was developed by researchers from the North Carolina Rural Health Research and Policy Analysis Center at University of North Carolina at Chapel Hill. 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 Flex Programs, CAH CEOs, and boards reviewing the model could identify areas of particular distress and develop strategies, or interventions, to improve financial performance. To view more information about the prediction of financial distress among rural hospitals, please visit the Rural Health Research website.

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 Tables C, D, E, and F.

The model separates hospitals into risk of financial distress categories. Financial distress events include:

- Unprofitability
- Equity decline
- Insolvency
- Closure

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.

Table C. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Financial Performance

Variable	Description
Profitability	Total margin; two-year change in total margin
Reinvestment	Retained earnings as a percent of total assets
Benchmark performance	Percent of benchmarks met over two years

Table D. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Government Reimbursement

Variable	Description
Medicare	CAH status
Medicaid	Medicaid to Medicare fee index

Table E. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Hospital Characteristics

Variable	Description
Ownership	Government/not-for-profit, for-profit
Size	Net patient revenue (millions)

Table F. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Market Characteristics

Variable	Description
Competition	Log of miles to nearest hospital more than 100 beds; market share (<25%)
Economic Condition	Log of poverty rate in the market area
Market Size	Log of population in the market area

Where can I find information about the financial performance of CAHs in my state?

The Flex Monitoring Team has created a login protected online tool called the *Critical Access Hospital Measurement and Performance Assessment System* (CAHMPAS). CAHMPAS is available to CAH executives, state Flex Programs

and federal staff to explore the financial, quality, and community-benefit performance of CAHs. CAHMPAS provides graphs and data, which allows comparison of CAH performance for various measures across user-defined groups: by location, net patient revenue, or other factors. CAHMPAS includes a variety of metrics and allows CAHs to compare their financial performance to peer facilities. For more information visit the Flex Monitoring website.

The Flex Monitoring Team has also released primers, a presentation template and a calculator spreadsheet to support communication of the CAH financial data. The primer documents explain the measure calculations and offer insights regarding the roles each measure plays in assessing a hospital's financial health. The presentation temple is an editable PowerPoint file for CAHs to use in presenting their own CAH financial data to others. The calculator spreadsheet is an Excel file that enables CAHs to verify the Flex Monitoring Team's calculations and calculate more recent financial indicators using data on hand. Use the calculator spreadsheet on the Flex Monitoring Team website.

Improving CAH Financial Performance

What interventions can CAHs use to improve their financial performance?

The 2012 CAH Financial Leadership Summit identified several 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 chief financial officer (CFO) networks
- Benchmarking financial indicators

A subsequent CAH Financial Leadership Summit was held in 2016 to build upon the knowledge gained from the 2012 Summit. The resulting report, 2016 Financial Leadership Summit Report: Strategies for Rural Hospitals Transitioning to Value-based Purchasing and Population Health, is designed to help rural hospital leaders meet existing challenges by describing market forces impacting rural hospitals and providing key operational strategies that providers may deploy to overcome these challenges and be successful in alternative payment models. The report highlights success stories and lessons learned that were shared by the panelists during the summit.

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 chief executive officers (CEOs), chief financial officers (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.

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
- 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 clinics according to best practices. A practice management assessment looks at physician and mid-level provider productivity, scheduling, staffing, billing, and collection practices. 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 strength and weakness 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 annually updated financial indicator data through CAHMPAS 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.

Additional Performance Indicators and Strategies

CAH Finance Summit

In May 2018, a group of financial experts met in Minneapolis, Minnesota at a CAH Finance Summit. This summit produced additional indicators to be monitored and strategies to be implemented to assist CAHs in achieving operational and financial success.

Market Indicators

Understanding an organization's market share is vital in developing and updating strategic and marketing plans. Ultimately, a higher market share will be desirable and necessary to allow for operational and financial success. The challenge for providers is obtaining the market share data for their organization as this is based on claims data, typically unavailable publicly, and varies by region. Organizations that are looking to obtain market share data will need to explore available sources in their market area. This may include proprietary sources, state hospital associations, state governmental agencies, and marketing firms that specialize in the health care industry.

The level of detail available in market share data will drive the amount of analysis to be performed and the nature of the strategies that may be developed. In addition to understanding the overall market share, the ability to understand the nature of services, demographics, and unique patients associated with outmigration can assist the organization in developing network, service, and/or demographic marketing strategies. Organizations may find it necessary to employ a skilled health care data analyst or share the employment of a health care data analyst with other CAHs.

Over time, understanding potential patient attribution under a population health reimbursement model is crucial to be the dominate provider of primary health care services. This can be a difficult indicator to obtain for an entity that is not currently in or exploring to be in a population health model. However, for those in a population health model, this information can be a

good indicator of the level of primary care being provided as well as brand loyalty for patients in a specific financial class.

Financial Performance and Conditions (liquidity)

The summit identified the Current Ratio as an additional important indicator of liquidity.

Current Ratio measures the number of times short-term obligations can be paid using short-term assets.

How values are calculated:

- Current Assets: [Row D]
- Current Liabilities: [Row J]
- Current Ratio: [Row D] ÷ [Row J]

Example data:

	2018	2019	2020
Current Assets	2,121,000	2,332,000	2,859,000
Current Liabilities	889,000	833,000	803,000
Current Ratio	**2.39**	**2.80**	**3.56**

This ratio measures the amount of current assets that are available to pay off current liabilities. Lower values signify a riskier situation and indicate that a hospital may have a harder time sustaining payment on current liabilities in the future. Favorable values are **above** the median and the 2019 CAH US Median = **2.52**.

CAHs that are looking to maximize their financial performance must ensure they are leveraging the reimbursement and other advantages that are available to rural providers. This includes working with their cost report preparer to ensure the organization has elected the cost reporting strategies that are most beneficial to the organization. They should also work with its licensure and reimbursement specialists to ensure that they are utilizing the most beneficial licensure status for the individual services being offered. This includes the review of overhead allocation methodologies and the utilization of RHC, provider-based clinic, visit nurse, and other reimbursement/licensure opportunities.

High performing providers are also implementing revenue cycle committees to identify and address opportunities to improve the overall reimbursement for services being rendered. This includes the development of standardized processes, charge capture teams, and denial management programs as well as assigning and holding individuals accountable for their roles in the revenue cycle process. This includes holding patient care staff accountable in addition to the traditional assignment of business office and health information management accountability.

The ability to obtain timely reports from a management reporting system is crucial in being able to identify potential areas of concern early in the process. The availability of adequate management reporting is a product of system capabilities and the skill set of those responsible for managing the systems.

The provision of education to department heads as it relates to organizational finances and reimbursement is important in all CAHs. Many CAH leaders struggle with organization finances due the lack of education they have been provided in both their formal education as well as education provided in the provider setting. Health care finances are complicated and a failure to understand the financial ramifications of decisions can lead individuals to make decisions without the proper information. Sources for financial education to department heads can be the internal finance department, state hospital associations, and trustee seminars.

Operational Efficiency

Improving the efficiency and effectiveness of resource utilization is key in improving the operational and financial performance of the organization. The use of Lean process improvement and other improvement methodologies, as well as benchmarking, can provide for improvement in processes and total resource consumption. The use of Lean concepts is utilized by some CAHs, but many others could benefit from its use.

The use of staffing and other cost benchmarks is a challenge for most CAHs. This is usually due to the lack of access to the desired information for comparison purposes. This is not data that is publicly reported or otherwise available. Therefore, CAHs typically need to look to external proprietary products and/or utilize internally developed benchmarks based on past performance. However, some states have gathered groups of providers to

share their staffing and cost information to develop averages and benchmarks. This can be coordinated through a State Office of Rural Health, State Hospital Association, or another similar group.

Once benchmarking data is available, the organization must create a methodology to gather and report this information to organizational leadership on a timely basis. This reporting may be performed utilizing current systems or may require the use of business intelligence software and reporting systems. While once cost prohibitive, the cost of business intelligence software to gather and generate desired reports has become affordable for even the smallest of organizations.

The cost of and scarcity of some professional services and acceptance of remote technologies has led to the increased utilization of telemedicine services. These services can allow a CAH to provide much needed services in the rural setting at a much more affordable cost. In addition, more payors are allowing payment for these services. Currently, one of the biggest hurdles for providing telemedicine services is the low-level reimbursement for the service. In 2021 Medicare provides $27.02 in reimbursement for the originating site. This includes the CAH and RHCs. Many organizations are advocating for higher reimbursement for these services at the state and federal level.

Workforce

The adequacy and education of the rural workforce of a CAH has been a challenge for years. It is becoming more difficult due to the continued reported shortages of health care providers and the increased complexity of the health care environment.

While health care workforce adequacy is a national issue and one that will most likely not be solved for some time, CAHs need to develop strategies at the local level to address the challenges today. This includes understanding the local workforce, educating and identifying potential future employees, and understanding staff satisfaction. Organizations may need to work with national, state, and local government entities to obtain information regarding the make-up of health care professionals at the national, state, and local areas. This may include current data as well projected data to assist in identifying current and future shortage areas. This workforce data can be used to develop local education programs to educate individuals in

middle school and high school on the background and availability of future employment positions in information technology, clinical services, emergency department, emergency medical services, community paramedic, etc. Many schools provide health career courses in high school to introduce opportunities and to provide for job shadowing. The ability to generate interest by local students can help in the recruitment process as the organization provides encouragement and, potentially, financial support during their obtaining of the necessary education and licensure. Workforce analysis may also involve developing strategies to support unpaid family care-givers that are vital to the health care system.

Once staff have been employed, the next challenge is retaining them. Encouraging staff engagement and the provision of staff satisfaction tools can assist organizations to identify the overall health of their workforce pool and also areas of risk that must be addressed to improve overall satisfaction and performance.

Education of the workforce, boards, community members, other stakeholders, and legislators on the transition from volume to value is also important. This transition from volume to value is a foreign concept to many as it is no longer business as usual. The transition will require many individuals to rethink past strategies as they work to create new strategies to manage and succeed in this transition. Organizations will struggle if some leaders are developing strategies based on volume while others are pursuing strategies based on value without understanding the process of transition that is occurring.

Care Management

Understanding care management can be key in maintaining and/or increasing market share and part of understanding the transition from volume to value. The first step in implementing successful care management programs is to understand the transition from volume to value. As organizations continue to move forward in the transition, the importance of care management will increase. This is due to the fact that the reimbursement under a value methodology will focus more on earlier interventions and less on the provision of high dollar back-end services.

The transition to value-based strategies will result in some providers obtaining Patient Centered Medical Home (PCMH) certification and/or to join

accountable care organizations. Both models will encourage a focus on care management. Medicare and many other payors have developed payment methodologies for these services. This includes annual wellness visits, chronic care management, and transitional care management. Annual wellness visits are covered by Medicare and provide for an annual visit to address and plan for a patient's health care for the next year. This includes the provision of other preventive, screening and educational services designed to address, prevent, and/or to provide early detection of potential issues that can decrease the quality of life for the patient and drive up the overall cost of health care. Many of these services are provided at little or no cost to the beneficiary.

Chronic Care Management services are covered by Medicare and many other providers. Among the requirements for coverage are the existence of 2 or more chronic conditions. Unaddressed, these chronic conditions can lead to a decrease in the quality of life for the patient and higher long-term costs. Chronic Care Management allows for coverage and payment for monthly follow-up with the patient without a face-to-face visit to discuss adherence to care plans, upcoming appointments, challenges in affording necessary medications, etc. In addition to the potential improvement in health outcomes, these visits are often very popular with the patients as they appreciate the ongoing connection with their care providers.

Transitional Care Management is the management of a patient for the 30 days after discharge from an inpatient stay. Medicare and many other providers provide coverage and payment for this service. The focus of this service is to assist the patient with the transition from the inpatient setting to the home without a readmission to the hospital. This includes making sure all discharge orders are understood and being followed. Some organizations have seen a significant reduction in readmissions once a Transitional Care Management program has been implemented.

The implementation of these programs requires the development of care plans for patients and follow-up by the provider and patient. The ongoing communication between the provider and the patient can often be the encouragement to engage the patient. The success with improved patients' lives can be the encouragement providers need to engage in these programs. Full implementation of care management services can be a differentiator in the market as they have the potential to increase patient and provider engagement and improve overall satisfaction by the patient. In

addition, these services can increase other ancillary services that are often provided by the rural provider while decreasing the higher cost services that may have to be provided in larger organizations and with greater cost. In time, this can help lead to increased market share.

Quality Performance

Monitoring reported quality performance is increasing over time as the information is becoming more readily available to the public. Medicare's Care Compare is one example of publicly available data that patients and families are using to make comparisons and choices about health care. Information on individual hospitals can be found on the Care Compare website. While there are ongoing questions as to the validity of the data and potential challenges of reporting results for providers with smaller volumes, this information is being used by current and potential patients and must be monitored. Over time, it is anticipated that more quality data will be made available to the public. CAHs should develop a process for the long-term monitoring of these programs and strategies for improving any areas of concern that are noted in the reporting.

Increasingly, organizations are transitioning current compensation models with physicians towards a model that provides financial rewards for quality activities and performance with less focus on overall production. The transition is a balancing act as there is still a need for productivity but must include reportable quality results. The transition may take time, but it is expected that the portion of compensation for quality activities and performance will continue to increase. At the same time, organizations will be developing internal strategies to track the activities and performance.

Community Health

The ability to measure the health of a community is crucial in determining the overall success of health care providers efforts. This can be a challenge as much of the information on the factors of success are not being measured. The ability to track social determinants of health and county health rankings are key. Health care providers must strive to identify and measure social determinants of health. This can include:

- Availability of affordable housing and food
- Access to transportation

- Access to health care and community-based resources
- Accessibility and quality of education and job training
- Literacy rates
- Public safety

While facilities may not be able to track data for each determinant, organizations should start with the data that is available and continue to work with external organizations to develop strategies for capturing the necessary data to monitor these statistics. In addition, organizations should be working with their state and county to ensure adequate data and reporting exist on county health. Facilities can monitor trends and their rankings to help determine the level of success for the program as well as areas of opportunity for improvement.

Since the cost of care is an integral part of compensation under the value methodology, providers also need to address Hierarchical Condition Category (HCC) reporting. HCC reporting is based on ICD-10 coding and provides for a methodology to assess the level of medical risk for a patient. The resulting HCC risk score is utilized to determine the expected cost of a patient and to compare the difference in costs between providers for a normalized population. CAHs are at higher risk of under reporting their HCC risk since much of their reimbursement has not been reimbursed based on the completeness of coding since entering the CAH program. Strategies for increasing the accuracy of HCC reporting include initial assessment of coding as well as the development of strategies to improve provider documentation and health information management coding based on the results of the assessment.

For many years, the trend in physician contracts has been to increase the amount of compensation that is based on production. Frequently, these contracts have been successful in increasing the productivity of the physicians. However, under population health concepts there needs to be a balance between production and population health activities that may not be reflective of volumes. This has led to a transition in contracting models to reduce the emphasis on production with an increase in population health and other quality initiatives. While it may be difficult to obtain statistics regarding contract structure for all providers in their community, facilities can gather and track internal information to determine the percentage of contract with their primary care providers that include incentives for population health activities.

The reported costs of health care typically only include the direct costs associated with the services. This would include insurance premiums, copays, coinsurance, deductibles, medications, etc. However, it rarely tracks the full cost. This would include time, travel, lost wages, etc. Understanding the full cost of care to the patient is critical in managing costs as well as promoting access to care in the long run. Health care providers should be working with local and state resources to develop strategies to capture and monitor these costs over time.

Overarching Strategies

To be successful, providers need to understand their data. For some this will require organizations to develop new strategies to create or obtain the necessary data for analysis. Once the data is obtained, it needs to be converted into quality information that can be used to create actionable strategies. As previously noted, this will require some organizations to add health care data analysts. Once actionable strategies have been identified, responsibility and accountability will need to be assigned in the organization.

Many of the challenges in rural health care are caused by inadequate or inappropriate rural policies established by Congress, CMS, and state agencies. There is an ongoing need for advocacy for the establishment of rural health care policies that take into account the unique situations in the rural setting. This advocacy should come from more than just the rural providers, but should include rural patients, business leaders, and other stakeholders. Congressional and other state and local leaders need to hear from their constituents regarding the need for workable rural health care policies. Successful discussions will include proposed solutions in addition to the addressing of current problems and challenges with current policies.

How are small rural PPS hospitals reimbursed?

Small rural PPS hospitals have many of the same major issues and concerns with a few very specific differences. While they are typically in areas with a larger population base, they are not reimbursed based on cost from Medicare and may be in closer proximity to competitors.

PPS Finances

What are the most important financial indicators?

In general, the most important financial indicators for the small rural PPS hospital are the same as those that are important for CAHs. The biggest differences are the strategies employed to impact the indicators and improve performance. While there are CAH US Median's available for these indicators, there is not a central resource for this information for small rural PPS providers. The calculations for these indicators remain the same as previously indicated.

Days in Net Accounts Receivable

The same common issues as found in CAHs will result in poor reported performance in the PPS provider. This includes out of date chargemasters, poor registration processes, and bad communication. Lower levels that are stable or declining are favorable.

Days in Gross Accounts Receivable

Low numbers in this category can be an indicator of a highly functioning business office. Again, lower levels that are stable or declining are favorable.

Days Cash on Hand

As a safety net calculation, this indicator is used by lending organizations as a reflection of the amount of dollars that are readily available to meet short term expectations. As such, higher levels or levels that are trending upward are favorable.

Total Margin

The indicator performance in a given year, as well as the trend over time, is important to track as a measure of overall profitability. Ongoing poor performance in this area can have significant impact on other indicators and

eventually lead to closure. Higher levels or levels that are trending upward are favorable.

Operating Margin

As a measure of operating expenses in comparison to operating revenues, this indicator of how well an organization is operating in its core business area. As is the case in Total Margin, higher levels or levels that are increasing over time are favorable.

Debt Service Coverage Ratio

As previously noted, this ratio measures the ability of an organization to pay obligations related to long-term debt. A favorable value is one that is above the median and/or is trending upward.

Salaries to Net Patient Revenue

Just like in a CAH, the major expense in a PPS hospital is related to salaries. Profitability of the organization can often be impacted by overstaffing. A lower value and/or one that is declining is favorable.

Payor Mix Percentage

While Medicare does reimburse PPS hospitals under a different reimbursement methodology, the importance of this indicator remains. This is due to the fact that the profitability of Medicare revenue is still usually the lowest amongst payers in the PPS setting. The ability to generate higher long-term profitability is dependent on a higher percentage of non-Medicare payers. A lower and/or declining value for this indicator is favorable.

Average Age of Plant

As is the case in the CAH, the successful PPS hospital needs to continue its reinvestment in buildings and equipment to attract and retain physicians and staff as well as to keep up with the needs of the patient. Favorable values in this indicator are lower.

Long Term Debt to Capitalization

As a measure that indicates the amount of capital that is financed with debt, higher numbers will be an indication of higher risk for lenders. A lower number is an indication of less risk of sustaining debt payments and may improve the ability for an organization to acquire additional debt.

Improving PPS Financial Performance

What interventions can PPSs use to improve their financial performance?

Many of the same interventions that are effective for the CAH to improve their financial performance can be effective in improving the performance for the PPS hospital. However, the specifics for each intervention may be different. 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 PPS department managers
- Financial education for PPS boards
- Pooling Small Rural Hospital Improvement Program (SHIP) dollars
- Developing chief financial officer (CFO) networks
- Benchmarking financial indicators

Unless otherwise indicated below, the interventions in these areas are essentially similar to those in the PPS.

Why is a review of the cost report important?

While the PPS hospital is not reimbursed based on cost for the majority of its services, there are some areas where Medicare may reimburse for some costs through the cost report. The cost associated with Medicare bad debt can be a major area of opportunity during the review of the Medicare Cost Report. Reportable Medicare bad debt occurs when the Medicare beneficiary fails to pay the hospital for the applicable deductible and coinsurance that is applied on inpatient, swing bed, nursing home, distinct part unit, and RHC services. In addition, the bad debt related to outpatient services reimbursed under the outpatient perspective payment system are eligible. To be eligible, the facility must be able to demonstrate the amounts were uncollectible after following the normal collection processes for the organization. Unfortunately, many providers fail to properly capture all of this reimbursement opportunity. Other items related to the wage index, RHCs, and disproportionate share may be identified during such a review.

Revenue Cycle Management for the PPS Hospital

The focus of revenue cycle management in the PPS hospital is essentially the same as in a CAH. However, the importance of development of training protocols for revenue capture and revenue process capture audits is usually higher for the PPS hospital. Unlike the CAH, Medicare reimburses the PPS hospital based on revenue capture and coding versus cost, as identified in the Medicare Cost Report. Failure to properly capture and code services in the PPS hospital will impact reimbursement from both non-Medicare payors and Medicare.

Physician Practice Management Assessments

The potential benefits of physician practice management assessments may be greater in a PPS hospital than in the CAH. In a PPS hospital, one would expect to see a lower number of RHCs in relation to provider based or free-standing clinics. In addition, for those PPS hospitals with more than 50 beds,

the provider based RHC would be limited to the cost per visit limit. Due to these differences, a larger portion of any cost savings due to improved efficiencies and/or cost reductions, etc., will have a greater potential of improving the financial performance of the PPS organization.

How can Lean impact PPS finances?

Whereas a portion of any cost savings identified in the CAH are shared with Medicare, cost savings identified in the PPS hospital frequently allow for a 100% impact to the operating and total margin. This is due to the nature of the PPS reimbursement methodology. For this reason, the PPS hospital may be able to use Lean to find smaller cost savings that have a larger net financial impact than would be available under the CAH methodology.

Education on finances for PPS department managers and Board members?

PPS department managers can also enhance their budgeting, planning, and financial skills with the proper financial education. PPS Board members will also usually benefit. Unlike the financial education provided to CAH leaders, the education to PPS leaders should focus on prospective payment methodologies and strategies.

The Provider Based RHC in the CAH or PPS Hospital Setting

The challenges facing provider-based clinics that are part of a CAH or PPS hospital are unique to their licensure status. The nature of the enhanced reimbursement from Medicare and Medicaid, completion of a Medicare Cost Report, potential payment caps, and application of productivity standards can provide for opportunities and risks not seen in other provider types.

While the provider based RHC does file a Medicare Cost Report, this information is imbedded into its main provider's cost report and financial statements. Therefore, financial indicators relating to just the RHC are not available for the RHC in the same manner as the CAH. However, that does

not preclude the RHC from monitoring specific indicators and initiating interventions to improve financial performance.

The importance and impact of RHCs on hospital finances has continued to grow. Historically, the RHC program has provided for a methodology for RHCs in certain areas with Health Professional Shortage Area (HPSA) designation to receive cost-based reimbursement for professional services. This cost-based reimbursement methodology provides for a significant improvement in reimbursement by Medicare for these professional services. While this has been a popular reimbursement model since its inception in 1977, it has become more popular in recent years due to the growth in the number of rural hospitals employing physicians and the size of the clinics has grown.

Currently, approximately 20% of national health care expenditures occur in the clinic setting. However, this is expected to continue to grow as health care continues its movement from the inpatient hospital setting to the outpatient hospital setting as well as the move from the outpatient hospital to the clinic setting. Advances in technology, introduction of population health reimbursement methodologies, and expansion of reimbursement for care coordination services is expected to be a driver in continued growth for clinic-based services. The RHC reimbursement methodology allows the hospital-based clinic to provide these services in a manner that still provides for the enhanced reimbursement levels typically required in the rural setting. Without this reimbursement methodology, many providers would find it financially impossible to provide clinic-based services.

RHC Finances

What are the important RHC financial indicators?

As was previously noted, the Medicare Cost Report and financial statements do not provide for the same type of financial indicators as are available for the CAH. However, some indicators do exist that can be beneficial to RHC leadership.

Days in Accounts Receivable (Gross and Net)

While most of the financial indicators identified for CAHs and PPS cannot be calculated separately for the RHC, the gross and net days in accounts receivable is typically an indicator that can be separately calculated for the RHC. As such, this is a good indicator for monitoring the health of the revenue cycle in the RHC. Higher days in accounts receivable can be an indication of chargemaster, coding, charge capture, and communication issues. A lower value is favorable.

Cost per Visit

The Medicare Cost Report calculates an average cost per visit for services in the RHC. In 2014, this average cost was $176. While a higher cost per visit does provide for a higher level of reimbursement from Medicare and potentially Medicaid, it does make services rendered to non-Medicare patients less profitable. A lower cost per visit is favorable over the long run as it allows the facility to improve its financial performance for services rendered to non-Medicare payers.

Medicare Payer Mix

As is the case in the CAH and PPS hospital, a lower Medicare payer mix over time can assist the organization in improving financial performance. However, increasing the non-Medicare payer mix should not come from decreasing Medicare volumes, but rather from increasing the non-Medicare volume. At the same time, the organization needs to be managing its average cost per visit to allow for profitability from the services rendered to the non-Medicare patient.

Visits per Physician/Nurse Practitioner/Physician Assistant

The number of visits by provider is important for two reasons. First, is the application of productivity standard by Medicare on the Medicare Cost Report? If the providers as a whole are producing at a level below this standard, Medicare will calculate the cost per visit with the calculated

standard number of visits. This has the effect of reducing the calculated cost per visit and subsequent payment to the RHC. Second, a higher number of visits is an indicator of greater productivity and should reduce the calculated cost per visit over time. A lower cost per visit allows the RHC to improve its profitability with non-Medicare payors. A higher number of visits per provider is a favorable indicator.

Percentage of Nurse Practitioner/Physician Assistant FTEs to Total Provider FTEs

RHCs are required to have a minimum amount of coverage by a nurse practitioner or physician assistant. However, the percentage of the total provider FTEs that are nurse practitioners and/or physician assistants varies significantly. Some RHCs will just staff the minimum requirement of nurse practitioner or physician assistant while others will rely much heavier on these non-physician practitioners. The potential benefits of utilizing a higher percentage of these practitioners is the lower cost associated with these professionals as well as the lower productivity standard that is applied to each non-physician practitioner. A higher percentage of these non-physician practitioners is favorable as it can be an indicator of the ability to control cost and manage the productivity standards that can ultimately impact Medicare reimbursement.

Staffing Cost per Provider FTE

Compensation for practitioners can vary significantly between RHCs. While there may be significant variations by region, large variations can also exist between neighboring RHCs. For this reason, in addition to being able to manage the mix of overall practitioners in the RHC, the RHC needs to be able to manage the cost of each FTE. Facilities can calculate per FTE staffing costs for physicians, nurse practitioners, and physician assistants. A lower staffing cost per provider FTE is favorable as it may be an indication of RHCs ability to control the cost per visit and improve the profitability of non-Medicare and non-Medicaid volumes.

Average Charge per Billable Visit

While managing the number of visits is important, the average charge per visit is equally important. While Medicare and Medicaid reimburse based on a

cost per visit methodology, 20% of the reimbursement from Medicare is based on the charge submitted. In addition, this indicator may provide insight into the adequacy of pricing for other payers as well as the appropriateness of the coding and documentation processes. A higher average charge per billable visit may indicate that the provider has appropriately priced the services being rendered and/or that the RHC and its staff are appropriately documenting, coding, and capturing all reportable services. A lower average charge per billable visit may be an indication that pricing is below average for the services rendered, that there is opportunity to improve documentation, coding, and charge capture or that the RHC is seeing less complex patients. A higher average charge per billable visit is typically favorable.

Improving RHC Financial Performance

What interventions can RHCs use to improve their financial performance?

Many of the same interventions that are effective for the CAH and PPS hospital to improve their financial performance can be effective in improving the performance for the RHC. However, the specifics for each intervention may be different. They include:

- Cost report review and strategy
- Strategic, financial, and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Developing chief financial officer (CFO) networks
- Benchmarking operational indicators

Unless otherwise indicated below, the interventions in these areas are essentially similar to those in the PPS.

Why is a review of the cost report important?

For the RHC, a cost report review can identify opportunities for the RHC to develop strategies to improve financial performance. Average RHC visits by discipline, limitations of reimbursement due to the application of productivity standards, the impact of lower charges on coinsurance reimbursement, payer mix, cost per visit, etc., are examples of information the RHC may be able to pull from their Medicare Cost Report. The information identified in these areas may lead the provider to consider additional work in the area of operational assessment, revenue cycle management, physician practice management assessment, and lean process development.

The Chargemaster in the RHC

The CDM in the RHC is most times less complex than that of the CAH or PPS hospital. However, that does not diminish the importance of ongoing monitoring and maintenance of the chargemaster. The main focus for ongoing monitoring is to ensure annual updates to CPT codes are implemented, new CPT codes related to new physicians in different specialties are added, and that pricing is properly established. Any changes that are implemented should include an update to the forms used by the clinic providers to complete the procedures and diagnosis for process payment.

Revenue Cycle Management

In the RHC, the focus of revenue cycle management involves coding assessments, training for revenue capture, revenue process charge capture audits, and review of upfront collection efforts. Failure to properly capture and code services in the RHC can significantly impact reimbursement from non-Medicare payors.

Physician Practice Management Assessments

The potential benefits of physician practice management assessments in the RCH cannot be overstated. In the RHC, these assessments can include

reviews of physician contracts, development of compensation strategies, review of scheduling protocols, process flow assessments, and staffing reviews. These assessments can result in increased efficiencies, decreased costs, and/or improved patient access.

How can Lean impact RHC finances?

When included as part of the physician practice management assessment, Lean can help improve process flows while also reducing costs. For those RHCs that are subject to the cost per visit limits and are over these limits, any savings in cost over the limits will be reflected in the operating margin and total margin. For those RHCs already below the limits, a large portion of the savings will usually still end up as improvements in the operating margin and total margin.

Appendix

Example – Balance Sheet

[Row]		2018	2019	2020
	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 & Equipment:	2,663,000	2,612,000	2,712,000
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 & NET ASSETS			
	Current Liabilities:			
G	Current Portion of Long Term Debt	144,000	89,000	49,000
H	Accounts Payable & 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 & NET ASSETS	2,910,000	3,189,000	3,675,000

Example – Statement of Operations

[Row]		2018	2019	2020
	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 & 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 – Statement of Cash Flows

[Row]		2018	2019	2020
	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:	246,000	459,000	-210,000
	Purchase of Other Assets	-3,000	-6,000	-
	Other Current Liabilities	34,000	-	-
	Net Cash Provided by Operating Activities	799,000	1,000,000	332,000
	CASH FLOWS FROM FINANCING ACTIVITIES			
AA	Repayment of Debt	-169,000	-145,000	-90,000
	Purchase 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	-214,000	-351,000	-200,000
	CASH FLOWS FROM INVESTING ACTIVITIES			
	Interest and Dividends on Investments	8,000	11,000	19,000
	Net Cash Used by Investing Activities	8,000	11,000	19,000
	NET INCREASE (DECREASE) IN CASH	593,000	660,000	151,000
	CASH, BEGINNING OF YEAR	527,000	1,120,000	1,178,000
	CASH, END OF YEAR	1,120,000	1,780,000	1,931,000