CFO Roundtable: Opportunities and Challenges for Critical Access Hospitals Monday June 25th Session 3

Challenges

- Accessing capital is extremely difficult especially for Electronic Health Record
- Achieving meaningful use
- The organization is unable to fund new facilities and service lines
- The hospital cannot achieve operating margins of 1 to 3 percent
- Physician recruitment is increasingly difficult

Opportunities

- Improve Quality and Customer Satisfaction
- Once the CAH is financially stabilized, it's time to grow
- Look at new opportunities for needed services
- Look at opportunities to affiliate or collaborate

Opportunities

- Improve Revenue Cycle Management
- This is an area where outside experts can have an immediate impact by helping the CAH identify areas for improvement, such as clinical documentation, billing &
- coding, and case management. They can also provide training to strengthen hospital employees' skills. The result can be a dramatic drop in accounts receivable days and improved cash flow.

Opportunities

- Promote Physician/Hospital Alignment

- CAH board members should never underestimate the long-term strategic importance of physician/hospital alignment and joint ventures.
- It's prudent for the board to seek outside expertise on how to cultivate relationships with area physicians.

Strategies Used by High Performers

- 1.Educate and use the Board
- 2.Meet the needs of your physicians
- 3.Take strategic planning seriously
- 4.Don’t leave cash on the table
- 5.Look and look again for cost reduction opportunities

Strategies Used by High Performers

- 6.Provide services that the community needs and wants
- 7.Take advantage of network affiliations
- 8.Communicate and hold people accountable
- 9.Boards should hang on to good CEOs and CFOs

Widely Used, Good Results

- ***Widely Used, Good Results***
- 1.Acquired/replaced diagnostic equipment
- 2.Held down wage and salary increases
- 3.Improved billing and coding training
- 4.Increased/improved revenue cycle activities
- 5.Joined purchasing organization/network
- 6.Recruited allied health personnel
- 7.Recruited primary care physician(s)
- 8.Reduced amount of contract labor
- 9.Updated chargemaster

Widely Used, For Financial Results and Patient Satisfaction

- 1.Balanced scorecard / dashboard
- 2.Benchmarking activities
- 3.Implemented / improved EHR
- 4.Implemented / improved other IT
- 5.Modified charity care / bad debt policies
- 6.Patient satisfaction activities
- 7.Quality management activities

New Benchmarks 48 Profitability indicators:

- ***New Benchmarks*** 48 **Profitability indicators:**
- •Total margin >3%
- •Cash flow margin >5%
- •Return on equity >4.5%
- •Operating margin >2%

- **Liquidity indicators:**
- •Current ratio >2.3 times
- •Days cash on hand >60 days
- •Days revenue in accounts receivable <53 days

New Benchmarks

- **Capital structure indicators:**
- •Equity financing >60%
- •Debt service coverage >3 times
- •Long-term debt to capitalization <25%

- **Revenue indicator:**
- •Medicare outpatient cost to charge <0.55

- **Cost indicator:**
- •Average age of plant <10 years

Risk of Financial Distress

	Number (Percent) of CAHs	
Risk	MN	US
Low	66(86%)	813 (63%)
Mid-Low	10 (13%)	232 (18%)
Mid-High	1 (1%)	119 (9%)
High	0 (0%)	124 (10%)
Total	77	1288

- CAH Financial Indicators Report Team

Your 2009 Performance Compared to Benchmarks

- Percent of CAHs Meeting Benchmark

Indicator	Benchmark	MN	Nation
Cash Flow Margin (percent)	5	80.5%	53.5%
Days Cash on Hand (days)	60	61.0%	52.8%
Debt Service Coverage (times)	3	47.5%	42.3%
LT Debt to Capitalization (percent)	25	40.8%	47.4%
Medicare O/P Cost to Charge (times)	.55	76.9%	68.3%

Why Do Some CAHs Continue to Offer SNF Services?

- Two factors may account for the larger percentage of CAHs continuing to offer SNF services
- Community needs and sentiments may make it difficult for CAHs to close and/or downsize their SNF units
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Critical Access Hospital-based SNF Closures

- Financial disincentive SNF bed (PPS) vs. swing bed (cost-based)

- –Mitigation of community impact CAHs may work with other local LTC providers to facilitate a seamless transition and avoid undue hardship for patients
- LTC beds may not disappear from the community, but instead change hands

Shifting Financial Incentives

- The Balanced Budget Act of 1997 implemented Medicare prospective payment systems for SNF, home health, and other LTC services: Reversed the positive relationship between diversification and hospital financial performance
- Created economic disincentives for the continued operation of distinct part SNFs and home health care services by CAHs, which are reimbursed on a cost basis

Role of Rural Hospitals in LTC

- ***Role of Rural Hospitals in LTC***
- In the 1980s and early 1990s, diversification into LTC was a common strategy for rural hospitals Large elderly population
- Stagnant demand for inpatient services

- The number of rural hospitals offering LTC services-including skilled nursing facility (SNF), home care, swing bed, and hospice services-grew throughout the 1990s

Payer Mix

- Commercial payer use to pay 85-90 percent of charges now 80-85 percent of charges
- Patient payer
- Medicaid ? ACA huge jump
- Medicare Cost-based

Payer Mix

- Measuring Outcomes
- Leading to Capitated payments
- Shift of Risk from payer to provider

Examples of costs not allowed in calculations

- Advertising costs
- Bad debts (except Medicare bad debts)
- Lobbying
- Patient phone and television costs

Revenues that offset costs

- Grant Revenues (usually)
- Interest Income
- Medical Record Fees
- Miscellaneous Revenues

Cost Based Medicare Reimbursement Impact

- Inpatient and most outpatient hospital services
- Swing bed
- Provider-based Rural Health Clinics under 50 beds

Costs are not reimbursed at the same level

- Medicare reimburses costs on a department by department basis

- Medicare reimburses a higher percentage of costs in
- departments with higher Medicare utilization

Facilities must continue to implement annual increases to charges unless

- Facility is making too much money
- Facility costs are decreasing
- Proof charges are above market

- CAHs cannot increase spending to gain financial success
- Not all costs are allowable
- CMS is always changing the rules and interpretations
- Not all costs are allowed in the calculation and some revenues are used to offset costs
- 101% of costs does not equal profit