The CAH Financial Indicators Report and Other Financial Resources

AZ Webinar
December 11, 2012

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CAH Financial Indicators Report Team
Outline

- CAH Financial Indicators Report
- CAH-specific benchmarks
- Medicare outpatient indicators
- Financial distress
- What do CEOs and CFOs think really works to improve financial performance?
- What strategies are used by financial high performers?
CAHFIR

• 21 indicators of financial performance and condition developed with expert advice
• Profitability, liquidity, capital structure, revenue, cost, and utilization
• Peer groups
• Financial distress model
CAHFIR Resources available to CAHs

• **State level**
  - State Summary
  - State Graphs
  - State Medians

• **Hospital level**
  - Hospital Summary
  - Hospital Report
  - Hospital Graphs
  - Hospital Cover Letters

• **Other resources**
  - Presentation
  - Calculator
  - Primer
  - FMT Reports and Data
What’s New in 2012?

• **New year of data.** The most recent Medicare Cost Report data from CMS have been added.
• **Seven new CAH-specific benchmarks**…
• **Medicare outpatient indicators**…
CAH-specific benchmarks
CAH-specific benchmarks

- Financial benchmarks for <50 bed hospitals exist, but not the right metric for CAHs
- Decided to create CAH-specific benchmarks of “high but attainable financial performance”
- Established by a large sample of informed practitioners versus academic black box or arbitrary rankings
- Focus on absolute vs. relative performance
- Provide CAHs with ongoing management tool
CAH-specific benchmarks

• A 2011 online survey of CAH CEOs and CFOs was used to create benchmarks for seven more of the CAHFIR indicators.

• There are now benchmarks for twelve of the 21 indicators.
CAH-specific benchmarks

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
CAH-specific 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
Medicare outpatient indicators
What is the purpose of the proposed report?

- Managing outpatient services is becoming increasingly important for the financial strength of CAHs. CAHs are primarily outpatient facilities – on average, 70% of CAH revenue is for outpatients and the proportion is growing. On average, Medicare beneficiaries represent 36% of total outpatient revenue – probably the largest single payer group for most CAHs. The purpose of this report is to provide CAHs with management information about their Medicare outpatient business.
Medicare outpatient indicators

- Who developed the report?
  - The CAHFIR team worked with an advisory group consisting of the Flex Coordinator and a group of CAHs in AZ to select the indicators. Several iterations of hospital-specific indicators were produced and reviewed by the CAHs for face validity and usefulness for management purposes.
• How are outpatients grouped?
  – Outpatients are grouped by primary diagnosis. The Clinical Classifications Software (CCS) collapses ICD-9-CM's 14,000 diagnosis codes and 3,900 procedure codes into a smaller number of clinically meaningful categories that are more useful for presenting descriptive statistics than are individual ICD-9-CM codes.

• Which primary diagnoses are included?
  – The top 20 primary diagnoses ranked by the number of claims are included in the report.
What financial indicators are included?

- The report includes charges and provider payment per claim and per patient per year. Charges and provider payment per claim provide hospitals with information about their pricing and contractual allowances / discounts for outpatient services. Charges and provider payment per patient per year provide hospitals with annual information that may be helpful to CAHs considering participation in an accountable care organization (ACO) or bundled payment.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Primary Diagnosis (AHRQ)</th>
<th>Per claim</th>
<th>Per patient per year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Average charge</td>
<td>Average provider payment</td>
</tr>
<tr>
<td>1</td>
<td>Other aftercare</td>
<td>$162</td>
<td>$66</td>
</tr>
<tr>
<td>2</td>
<td>Cardiac dysrhythmias</td>
<td>$310</td>
<td>$134</td>
</tr>
<tr>
<td>3</td>
<td>Essential hypertension</td>
<td>$368</td>
<td>$150</td>
</tr>
<tr>
<td>4</td>
<td>Diabetes mellitus without complication</td>
<td>$313</td>
<td>$129</td>
</tr>
<tr>
<td>5</td>
<td>Other screening for suspected conditions (not mental disorders or infectious disease)</td>
<td>$446</td>
<td>$170</td>
</tr>
<tr>
<td>6</td>
<td>Disorders of lipid metabolism</td>
<td>$340</td>
<td>$135</td>
</tr>
<tr>
<td>7</td>
<td>Deficiency and other anemia</td>
<td>$716</td>
<td>$302</td>
</tr>
<tr>
<td>8</td>
<td>Spondylosis; intervertebral disc disorders; other back problems</td>
<td>$1,122</td>
<td>$482</td>
</tr>
<tr>
<td>9</td>
<td>Rehabilitation care; fitting of prostheses; and adjustment of devices</td>
<td>$887</td>
<td>$405</td>
</tr>
<tr>
<td>10</td>
<td>Other lower respiratory disease</td>
<td>$977</td>
<td>$422</td>
</tr>
<tr>
<td>11</td>
<td>Other non-traumatic joint disorders</td>
<td>$654</td>
<td>$291</td>
</tr>
<tr>
<td>12</td>
<td>Urinary tract infections</td>
<td>$592</td>
<td>$237</td>
</tr>
<tr>
<td>13</td>
<td>Other connective tissue disease</td>
<td>$808</td>
<td>$351</td>
</tr>
<tr>
<td>14</td>
<td>Residual codes; unclassified</td>
<td>$887</td>
<td>$378</td>
</tr>
<tr>
<td>15</td>
<td>Genitourinary symptoms and ill-defined conditions</td>
<td>$440</td>
<td>$179</td>
</tr>
<tr>
<td>16</td>
<td>Abdominal pain</td>
<td>$1,638</td>
<td>$700</td>
</tr>
<tr>
<td>17</td>
<td>Coronary atherosclerosis and other heart disease</td>
<td>$846</td>
<td>$365</td>
</tr>
<tr>
<td>18</td>
<td>Congestive heart failure; nonhypertensive</td>
<td>$847</td>
<td>$351</td>
</tr>
<tr>
<td>19</td>
<td>Nonspecific chest pain</td>
<td>$2,140</td>
<td>$909</td>
</tr>
<tr>
<td>20</td>
<td>Thyroid disorders</td>
<td>$336</td>
<td>$136</td>
</tr>
<tr>
<td></td>
<td>All Other Diagnoses</td>
<td>$1,121</td>
<td>$480</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$819</strong></td>
<td><strong>$349</strong></td>
</tr>
</tbody>
</table>
Medicare outpatient indicators

- Average charge per claim = Total charges / total number of claims
- Average provider payment per claim = Total provider payment / total number of claims
- Average charge per patient per year = Average charge per claim X average number of claims per patient per year
- Average provider payment per patient per year = Average provider payment per claim X average number of claims per patient per year
- Average number of claims per patient per year = Total number of claims / total number of unique patients
2012-13 Major New Flex Monitoring Team Initiative

- Development of hospital-specific reports and state reports that incorporate quality, finance, and community measures for CAHs
- Will integrate and expand finance, quality and market/community measures in one report
Financial distress

Risk of Financial Distress Among Critical Access Hospitals:
A Proposed Model

Mark Holmes, PhD and George H. Pink, PhD
North Carolina Rural Health Research and Policy Analysis Center, University of North Carolina
Existing financial distress models (a sample list)

- **Financial strength index (FSI):** (Cleverly) adds the percentage difference between the hospital’s value and a “benchmark”
- **Altman’s z-score:** Developed using publicly traded companies
- **Neural networks, logistic regression, mixed logit, stochastic spline:** Statistical methods.
Core principles

• Develop specifically for CAHs
• Use scientific approach – can we predict “bad outcomes”?
• Have high face validity
• Use data publicly available for all CAHs
• Focus on identifying CAHs at risk for distress (rather than identify high performers)
• Make the model parsimonious and easy to understand
Basic model

Today’s Characteristics

Critical Access Hospitals

Risk of Distress in Two Years

High

Mid-High

Mid-Low

Low
Markers of financial distress

1. Closure
2. Negative fund balance
3. Declining (>25%) fund balance
4. 3 years negative operating margin
5. Negative cash flow margin

- In some circumstances, there may not be financial distress even though the markers suggest otherwise
We considered a broad list of potential variables expected to predict whether a CAH would be in distress within two years:

- Financial measures
- Hospital characteristics
- Market characteristics
- Plus trends in these values
“Predicting variables”

• Financial
  1. EBITA / total expenses
  2. Operating margin
  3. Operating margin two years earlier
  4. Retained earnings / total assets
  5. Net patient revenue
“Predicting variables”

• Hospital
  6. Distance to nearest hospital with 100 beds
  7. Market share (if <25%)

• Market
  8. Unemployment rate
  9. Population
Risk of financial distress markers

By category

Percent experiencing event

Low  |  Mid-Low  |  Mid-High  |  High
---   |          |           |     
2%    | 8%        | 19%       | 67%
8%    | 12%       | 40%       | 70%
12%   | 19%       | 48%       |     
8%    | 8%        | 59%       |     
2%    | 8%        | 30%       |     
8%    | 8%        | 30%       |     

Legend:
- Black: Negative Fund Balance
- Blue: Large decline in fund balance
- Gray: Negative cash flow margin
- Light gray: Negative op margin for 3 years
Distribution of financial distress category
By Census Division: 2005–2007

Risk of Financial Distress
- Low
- Mid-Low
- Mid-High
- High

N = 3004 hospital–years.
Percentages may not add to 100 due to rounding.
New England had zero at high risk during this period.
For the CAHs in AZ, what is the current risk of financial distress compared to all CAHs?
A well-functioning prediction model can be used by administrators and boards as an early warning system so that remedial action may be taken before financial distress occurs. The model uses financial performance variables (current profitability, reinvestment, and hospital size) and market characteristics variables (competition, economic status, and market size) to predict financial distress (equity decline, unprofitability, and closure) two years later.

### Risk of Financial Distress

<table>
<thead>
<tr>
<th>Risk</th>
<th>AZ</th>
<th>NM</th>
<th>NV/UT</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>6 (55%)</td>
<td>5 (83%)</td>
<td>14 (70%)</td>
<td>813 (63%)</td>
</tr>
<tr>
<td>Mid-Low</td>
<td>4 (36%)</td>
<td>1 (17%)</td>
<td>4 (20%)</td>
<td>232 (18%)</td>
</tr>
<tr>
<td>Mid-High</td>
<td>1 (9%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>119 (9%)</td>
</tr>
<tr>
<td>High</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>2 (10%)</td>
<td>124 (10%)</td>
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</table>
What do CEOs and CFOs think really works to improve financial performance?
Literature review

- We reviewed existing literature on what works to improve financial and operational performance in rural hospitals
- Very little, and most of the existing evidence were case studies – “We did X and our Y increased.”
- Suggestive of potential strategies, but not at all definitive
On-line survey

• When CEOs and CFOs downloaded the CAH Financial Indicators Report for their hospital in August and September 2010, they were asked to complete a questionnaire about 44 financial strategies and activities

• 317 people responded
“We request your help with a 5-minute survey regarding the strategies and activities that your Critical Access Hospital has used to cope with the economy during the past three years. The survey does not ask for data and should take less than 5 minutes to complete. Please be assured that your responses are confidential and that we will not identify you or your hospital. We are hoping that this will be of value to CAHs by identifying strategies and activities that have actually helped other hospitals.

Below is a list of strategies and activities that can affect the financial condition of a Critical Access Hospital. Please check off the activities that your hospital has tried with good results, tried with poor results, tried with unknown results, and hasn’t tried.”
Classification of financial improvement strategies

1. Widely used, good results
2. Widely used, mediocre results
3. Somewhat used, good results
4. Rarely used, good results
5. Rarely used, mediocre 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, mediocre results

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
Were strategies influenced by CAH characteristics?

• Larger CAHs reported trying more strategies
• CAHs with RHCs reported more service expansion activities
• CAHs with LTC reported more service reduction strategies
• CAHs in the South attempted fewer capital strategies and more service reduction strategies
  – Little evidence that characteristics affected perceived success of strategy
Some cold water

- Using our data, we could not identify any evidence that these strategies led to improved performance among the respondents
  - Perception v. reality?
  - Limitation of available data (cost report data too crude to capture the relevant outcomes)?
What strategies are used by financial high performers?

FEATURE STORY

M. Alexis Kirk
George M. Holmes
George H. Pink

achieving benchmark financial performance in CAHs

lessons from high performers

116 APRIL 2012 healthcare financial management
Benchmarks

- Included in *CAH Financial Indicators Report*
- Developed from survey of CEOs and CFOs:
  - cash flow margin > 5%
  - days cash on hand > 60 days
  - debt service coverage > 3
  - long-term debt to capitalization < 25%
  - Medicare outpatient cost to charge ratio < 0.56
How many CAHs perform better than benchmark?

- 2006-2008 Medicare Cost Report data
- Out of 1300 CAHs, only 32 hospitals performed better than benchmark:
  - On all five indicators
  - For all three years
- Structured interviews of CEOs and / or CFOs to determine strategies
- 19 hospitals agreed to participate
### Top performing CAHs between 2006 and 2008

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Town</th>
<th>State</th>
<th>CEO</th>
<th>CEO Tenure</th>
<th>CFO</th>
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<tbody>
<tr>
<td>Bear Lake Memorial Hospital</td>
<td>Montpelier</td>
<td>ID</td>
<td>Rod Jacobson</td>
<td>27</td>
<td>N/A</td>
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<tr>
<td>Beatrice Community Hospital</td>
<td>Beatrice</td>
<td>NE</td>
<td>Thomas Sommers</td>
<td>7</td>
<td>Jon McMillan</td>
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<td>Decatur County Memorial Hospital</td>
<td>Greensburg</td>
<td>IN</td>
<td>Bill Alloy</td>
<td>5</td>
<td>N/A</td>
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<td>Door County Memorial Hospital</td>
<td>Sturgeon Bay</td>
<td>WI</td>
<td>Gerald Worrick</td>
<td>24</td>
<td>Bob Scieszinski</td>
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<td>Gothenburg Memorial Hospital</td>
<td>Gothenburg</td>
<td>NE</td>
<td>John Johnson</td>
<td>13</td>
<td>Taci Bartlett</td>
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<td>Hardin Memorial Hospital</td>
<td>Kenton</td>
<td>OH</td>
<td>Mark Seckinger</td>
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<td>Ronald Snyder</td>
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<td>Humboldt General Hospital</td>
<td>Winnemucca</td>
<td>NV</td>
<td>Jim Parrish</td>
<td>N/A</td>
<td>Larry Hutcheson</td>
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<tr>
<td>Life Care Medical Center</td>
<td>Roseau</td>
<td>MN</td>
<td>Keith Okeson</td>
<td>6</td>
<td>Cathy Huss</td>
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<tr>
<td>Madison Community Hospital</td>
<td>Madison</td>
<td>SD</td>
<td>Tamara Miller</td>
<td>15</td>
<td>Teresa Mallett</td>
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<td>Morris County Hospital</td>
<td>Council Grove</td>
<td>KS</td>
<td>Jim Reagan</td>
<td>13</td>
<td>Ron Christenson</td>
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<td>Muncy Valley Hospital</td>
<td>Muncy</td>
<td>PA</td>
<td>Chris Ballard</td>
<td>5</td>
<td>Charles Santangelo</td>
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<td>Murray County Medical Center</td>
<td>Slayton</td>
<td>MN</td>
<td>Mel Snow</td>
<td>6</td>
<td>Renee Logan</td>
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<td>Perry Memorial Hospital</td>
<td>Princeton</td>
<td>IL</td>
<td>Rex Conger</td>
<td>2</td>
<td>Tricia Ellison</td>
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<tr>
<td>Regional Health Serv of Howard County</td>
<td>Cresco</td>
<td>IA</td>
<td>David Hartberg</td>
<td>4</td>
<td>Brenda Moser</td>
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<td>Salem Township Hospital</td>
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<td>IL</td>
<td>S Hilton-Siebert</td>
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<td>Teresa Stroud</td>
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<tr>
<td>Shenandoah Memorial Hospital</td>
<td>Shenandoah</td>
<td>IA</td>
<td>Susan McGough</td>
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<td>Sandra Chesshire</td>
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<td>Tri Valley Health System</td>
<td>Cambridge</td>
<td>NE</td>
<td>Roger Steinkruger</td>
<td>3</td>
<td>Diana Rippe</td>
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<td>United Hospital District</td>
<td>Blue Earth</td>
<td>MN</td>
<td>Jeff Lang</td>
<td>5</td>
<td>N/A</td>
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<td>Windom Area Hospital</td>
<td>Windom</td>
<td>MN</td>
<td>Gerri Burmeister</td>
<td>11</td>
<td>Kim Armstrong</td>
</tr>
</tbody>
</table>
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
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