Using the Flex Monitoring Team Financial Indicators Report and Other Financial Resources

Flex Program Workshop/TASC Webinar
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CAH Financial Indicators Report Team

A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex Monitoring Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Agenda

- What is the *CAH Financial Indicators Report (CAHFIR)*?
- What do CEOs and CFOs think really works to improve financial performance?
- What strategies are used by financial high performers?
- How do I use the CAHFIR? A tale of two states

What is the CAH Financial Indicators Report (CAHFIR)?

CAHFIR

- 21 indicators of financial performance and condition developed with expert advice
- Profitability, liquidity, capital structure, revenue, cost, and utilization
- Peer groups
- Benchmarks
- Financial distress model
- Proposed outpatient indicators

CAHFIR Resources available to State Flex Coordinators

- ***State level***
  - State Summary
  - State Graphs
  - State Data
  - State Medians
- ***Hospital level***
  - Hospital Summary
  - Hospital Report
  - Hospital Graphs
  - Hospital Cover Letters
- ***Other resources***
  - Presentation
  - Calculator
  - Primer
  - FMT Reports and Data

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

What do CEOs and CFOs think really works to improve financial performance?

THE JOURNAL OF RURAL HEALTH

ORIGINAL ARTICLE

Adoption and Perceived Effectiveness of Financial Improvement Strategies in Critical Access Hospitals

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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

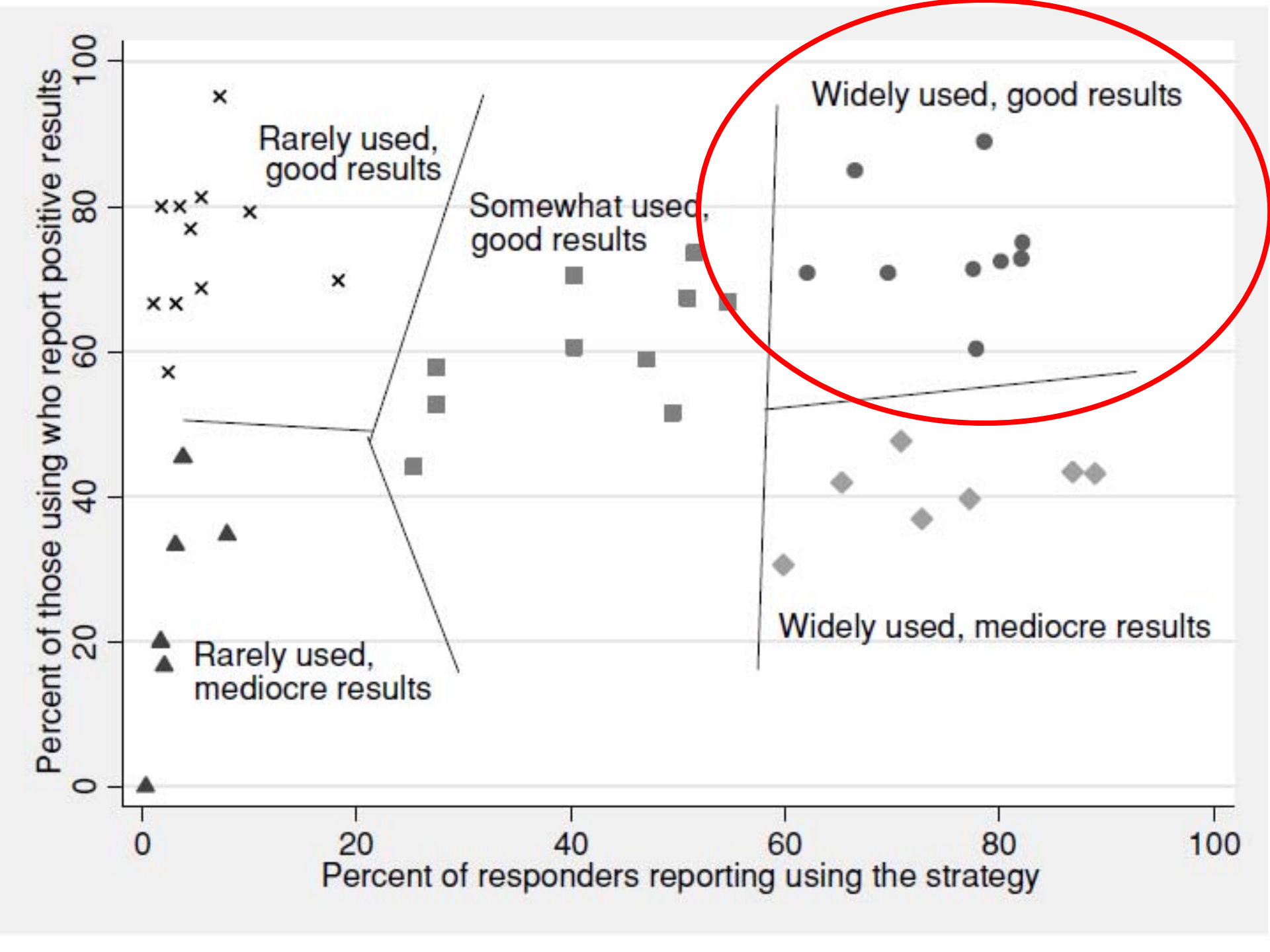
Questions

"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
Rarely used,
good results
Somewhat used,
good results
Widely used, mediocre results
Rarely used,
mediocre results
Percent of those using who report positive results
0
20
40
60
80
100
Percent of responders reporting using the strategy

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

Hospital	Town	State	CEO	CEO Tenure	CFO
Bear Lake Memorial Hospital	Montpelier	ID	Rod Jacobson	27	N/A
Beatrice Community Hospital	Beatrice	NE	Thomas Sommers	7	Jon McMillan
Decatur County Memorial Hospital	Greensburg	IN	Bill Alloy	5	N/A
Door County Memorial Hospital	Sturgeon Bay	WI	Gerald Worrick	24	Bob Scieszinski
Gothenburg Memorial Hospital	Gothenburg	NE	John Johnson	13	Taci Bartlett
Hardin Memorial Hospital	Kenton	OH	Mark Seckinger	10	Ronald Snyder
Humboldt General Hospital	Winnemucca	NV	Jim Parrish	N/A	Larry Hutcheson
Life Care Medical Center	Roseau	MN	Keith Okeson	6	Cathy Huss
Madison Community Hospital	Madison	SD	Tamara Miller	15	Teresa Mallett
Morris County Hospital	Council Grove	KS	Jim Reagan	13	Ron Christenson
Muncy Valley Hospital	Muncy	PA	Chris Ballard	5	Charles Santangelo
Murray County Medical Center	Slayton	MN	Mel Snow	6	Renee Logan
Perry Memorial Hospital	Princeton	IL	Rex Conger	2	Tricia Ellison
Regional Health Serv of Howard County	Cresco	IA	David Hartberg	4	Brenda Moser
Salem Township Hospital	Salem	IL	S Hilton-Siebert	2	Teresa Stroud
Shenandoah Memorial Hospital	Shenandoah	IA	Susan McGough	4	Sandra Chesshire
Tri Valley Health System	Cambridge	NE	Roger Steinkruger	3	Diana Rippe
United Hospital District	Blue Earth	MN	Jeff Lang	5	N/A
Windom Area Hospital	Windom	MN	Gerri Burmeister	11	Kim Armstrong

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

How do I use the CAHFIR? A tale of two states

	2010 Median Indicator values		
Performance Dimension and Indicator	**High State**	**U.S.**	**Low State**
Profitability			
Total margin	4.5%	1.9%	-1.4%
Cash flow margin	9.5%	6.2%	-4.2%
Return on equity	5.9%	4.7%	-3.0%
Operating margin	2.3%	0.8%	-8.4%
Liquidity			
Current ratio	3.0	2.3	2.2
Days cash on hand	122	68	51
Net days revenue in accounts receivable	54	52	54
Capital Structure			
Equity financing	71%	60%	63%
Debt service coverage	4.1	2.6	1.3
Long-term debt to capitalization	20%	26%	18%
Revenue			
Outpatient revenues to total revenues	72%	72%	66%
Patient deductions	22%	37%	27%
Medicare inpatient payer mix	78%	73%	86%
Medicare outpatient payer mix	47%	36%	47%
Medicare outpatient cost to charge	0.58	0.48	0.57
Medicare revenue per day	$2098	$1897	$1582
Cost			
Salaries to net patient revenue	46%	45%	53%
Average age of plant	9.1 years	9.9 years	12.9 years
FTEs per adjusted occupied bed	6.3 FTEs	5.8 FTEs	5.87 FTEs
Utilization			
Average daily census swing-SNF beds	1.53	1.63	2.22
Average daily census acute beds	2.50	3.90	2.27

A Tale of Two States – Three questions

1. In general, what do you think about the financial performance and condition of the two states?
2. What reasons might account for the differences in profitability between the two states?
3. What actions might the State Flex Coordinators consider to help hospitals in their states improve profitability?

1) Financial performance and condition of the two states

- Profitability:
- Liquidity:
- Capital structure:
- Revenue:
- Cost:
- Utilization:

1) Financial performance and condition of the two states

- Profitability: Much lower in the low state and much higher in the high state compared to U.S. medians.
- Liquidity: Much lower days cash on hand in low state and much higher DCOH in high state compared to US median.
- Capital structure: Much lower debt service coverage in low state and much higher DSC in high state compared to U.S. median.

1) Financial performance and condition of the two states

- Revenue:
  - Lower outpatient revenue to total revenues in low state
  - Lower patient deductions in high state
  - Higher Medicare inpatient payer mix in low state
  - Lower Medicare revenue per day in low state
- Cost:
  - Much older average age of plant in low state
  - Higher salaries to net patient revenue in low state
- Utilization
  - Higher ADC-SNF in low state

2) Profitability – Potential Explanations

- In the low state:

2) Profitability – Potential Explanations

- In the low state:
  - Gross charges are relatively lower (less volume, lower Blue Cross rates, poorer payer mix, Medicaid?)
  - Allowances are relatively higher (more competition?)
  - Costs are relatively higher (wage rates, bad debt, charity care, inefficiency, or new debt?)
  - Non-operating income is relatively lower (lower investments, less state or county support, lower charitable revenue?)
  - Revenue, cost, and utilization indicators may provide additional insights

3) Profitability – Potential SFC Actions

3) Profitability – Potential SFC Actions

- Consultation, education, networks, facilitation, policy to help hospitals to:
  - Increase revenues (better data capture, fewer referrals, fewer denials, new services, new markets, more physicians?)
  - Control expenses (wage rates, staffing patterns, group purchasing, 340B, equipment management, information technology?)
  - Improve negotiation policy with third party payers
  - Increase investment returns
  - Reduce charity care and bad debt

Conclusion

- "Firms that have high profits, lots of cash, little debt, and new plants have great financial strength. Firms with losses, little cash, lots of debt, and old physical facilities will not be in business long." (Cleverley and Cameron)

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