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

Policy Brief #11
November 2009

Critical Access Hospitals and Financial Benchmark Performance

George Pink, PhD, Mark Holmes, PhD, Rebecca Slifkin, PhD
University of North Carolina at Chapel Hill

Introduction

A research team from the University of North Carolina at Chapel Hill has previously selected 20 financial ratios that were found to be important measures of critical access hospital (CAH) financial performance and could be calculated using Medicare Cost Report data.[1] Benchmarks were developed for five of these indicators with input from CAH administrators. The selected benchmark values were: 5% for cash flow margin; 60 days cash on hand; debt service coverage of 3.0; long-term debt to capitalization of 25%; and Medicare outpatient cost to charge of 0.56. This policy brief presents the results of application of the benchmarks to recent CAH data.[2] Performance relative to benchmark was calculated for all CAHs that had a Medicare Cost Report covering at least 360 days in period and had no missing data for calendar years 2004, 2005, and 2006. 421 hospitals met these criteria.

Findings include the following:

- Very few CAHs (17 of 421) performed better than benchmark on all five indicators in both 2004 and 2006.
- CAHs with net patient revenue less than $5 million were substantially less likely than larger facilities to be able to consistently perform better than the cash flow benchmark.
- It is very difficult for CAHs to concurrently generate high margins, bank a lot of cash, have little debt in the capital structure, and achieve low costs relative to charges.

CAHs that Performed Better than Benchmark

Table 1 shows application of the benchmarks to actual hospital performance. Most CAHs met some, but not all, of the financial benchmarks. In both 2004 and 2006, 6% met none of the benchmarks. The percent of CAHs meeting all benchmarks nearly doubled from 2004 to 2006, increasing from 6% to 11%. Although not shown in the table, the number of benchmarks met by each CAH did not vary tremendously from 2004 to 2006; the number of benchmarks met in 2004 and 2006 differed by more than one for only about one-fifth of CAHs. Nine out of 421 hospitals (2%) did not perform better than benchmark on any indicator in either 2004 or 2006. These hospitals were clearly poor performers and were probably in some degree of financial distress. Conversely, 17 out of 421 hospitals (4%) performed better than benchmark on all five indicators in both 2004 and 2006. These hospitals were clearly high performers and were likely in a very strong financial position. These results indicate that very few hospitals performed better than benchmark on all five indicators in both the year at the beginning of the study period (2004) and in the year at the end of the study period (2006).

Table 1.
Percent of Benchmarks Met in 2004 and 2006 (N=421 CAHs)

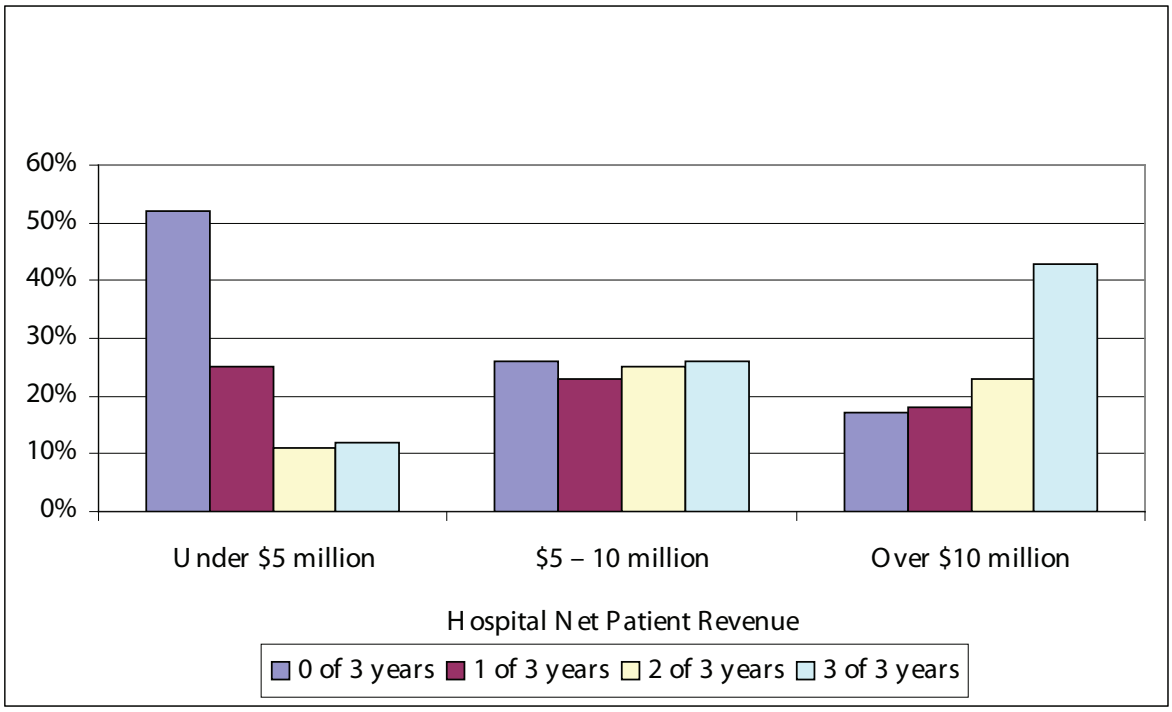
Number of Benchmarks Met	Percent of CAHs Meeting Benchmarks in 2004	Percent of CAHs Meeting Benchmarks in 2006
0	6%	6%
1	21%	20%
2	28%	22%
3	24%	21%
4	15%	20%
5	6%	11%

Number of CAHs that met no benchmark either year: 9 (2%)
Number of CAHs that met all benchmarks both years: 17 (4%)

Benchmark Performance and Hospital Net Patient Revenue

The proportion of hospitals that performed better than benchmark varied among peer groups based on net patient revenue. For example, 43 percent of hospitals with net patient revenue greater than $10 million performed better than cash flow margin benchmark in all three years, compared with 26% and 12% for the other net patient revenue peer groups (see Figure 1). Similar results were obtained for other benchmarks. These results indicate that very few hospitals with net patient revenue less than $5 million were able to consistently perform better than benchmark for three consecutive years.

Figure 1.
Number of Years Cash Flow Margin Benchmark was Met Between 2004 and 2006



Conclusion

The results suggest that it is very difficult for CAHs to concurrently generate high margins, bank a lot of cash, have little debt in the capital structure, and achieve low costs relative to charges. Every day CEOs and CFOs struggle with issues such as Medicare and Medicaid reimbursement, wage inflation, physician and nurse recruitment and retention, aging physical plants, the cost of pharmaceuticals, advances in medical technology, and growth in the uninsured and underinsured. All of these factors have some impact upon the profitability, liquidity, capital structure, costs, and utilization of a CAH, making achievement of benchmark financial performance a significant challenge. These challenges are particularly difficult for CAHs that have less than $5 million in net patient revenue which were much less likely to perform better than benchmark. Although the hospitals that performed better than benchmark are located in diverse geographic areas, there may be important state-specific factors that influence ability to achieve benchmark performance.

This study was conducted by the Flex Monitoring Team (a consortium of the Rural Health Research Centers located at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine) with funding from the federal Office of Rural Health Policy (PHS Grant No. U27RH01080). For more information visit http://www.flexmonitoring.org.

References

1. Pink GH, Holmes GM, D'Alpe C, Strunk L, McGee P, Slifkin RT. Financial indicators for critical access hospitals. *J Rural Health.* 2006;22(3):229-236.
2. Pink GH, Holmes GM, Slifkin RT, Thompson RE. Developing financial benchmarks for critical access hospitals. *Health Care Financ Rev.* 2009;30(3):55-69.