Financial Education Presentation
Seneca Healthcare District
Board of Directors
March 25, 2019

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Program Outline

- Overview of rural healthcare
- Overview of rural healthcare finance
- Overview of Seneca Healthcare District
- Overview of healthcare finance and reporting
- Overview of Seneca Healthcare District finance and reporting
- Overview of Revenue Cycle

Supplemental Materials

1. AHA Rural Report and Advocacy Agenda
2. Rural Healthcare Provider Types
3. Rural Hospital and Clinic Finance
4. Rural Healthcare and Critical Access Hospital Reimbursement
5. SHD Monthly Board Financial Packet
6. Analysis of SHD Operations
7. Revenue Cycle in a Rural Hospital

Overview of Rural Healthcare

What is Rural?

- Non-urban!
- Urban= Metropolitan statistical area(MSA)
- MSA= Urban population core of greater than 50,000 people
- Chico, Redding, and Yuba City are MSAs
- Plumas County has an estimated population of 18,742, as of July 2017, and has been designated rural by the Health Resources and Services Administration (HRSA)

Rural Healthcare Provider Types

- Critical Access Hospital
- Rural Referral Center
- Sole Community Hospital
- Medicare-Dependent Hospital
- Disproportionate Share Hospital
- Rural Health Clinic
- Federally Qualified Health Center

Critical Access Hospital

- Located in rural area, no less than 35 miles (15 in mountainous terrain) from nearest like hospital
- Provide 24 hour emergency care
- Average length of stay less than or equal to 96 hours
- No more than 25 acute/swing beds
- Allowed 10 inpatient/distinct-part unit psych and rehab beds in addition to the 25 acute/swing

Rural Health Clinic

- Must be located in a non-urbanized area as defined by the U.S. Census Bureau
- Must be designated as a health professional shortage area (HPSA) or medically underserved area (MUA) by HRSA
- Have a nurse practitioner (NP) or physician assistant (PA) at the clinic at least 50 percent of the time the RHC operates
- Directly furnish routine laboratory services

Overview of Rural Healthcare Finance

Critical Access Hospital Reimbursement - Medicare

Go to Tab 4
of the Supplemental Materials

Rural Health Clinic- Medicare

- All-inclusive payment for a qualifying face-to-face encounter (visit)
- Hospital-based RHCs receive a cost-based per visit amount without limitation
- Laboratory and technical components of certain diagnostic RHC services are paid separately (hospital outpatient service)
- Co-insurance for Medicare patients is 20 percent of total charges, except for certain preventative services (waived)

Medi-Cal Reimbursement

- Inpatient= Prospective per diem rate (well below cost)
- Outpatient= Fee schedule payment (well below cost)
- Nursing Home= Prospective per diem rate with supplemental payment based upon total allowed cost
- Rural Health Clinic= Per visit payment (somewhat below cost). Medi-Cal supplements managed care payments

Overview of Seneca Healthcare District

Inpatient Services

- 10 medical/surgical, telemetry, and pediatric beds
- Swing bed program
- 16 long-term care beds
- Surgery
- Diagnostic services (lab, radiology, and cardiac monitoring)
- Therapies (PT, OT, and respiratory)

Outpatient Services

- 24-hour emergency room
- Observation care
- Same services as inpatient, plus MRI (every other week) and ultrasound (three times per week)
- Contracted physical therapy
- Rural health clinic
- Telemedicine (psych and pain mgmt)

Overview of Healthcare Finance and Reporting

Basic Financial Statements

- Statement of net position (balance sheet)
- Statement of revenue, expense, and change in net position (income statement)
- Statement of cash flow
- Notes to financial statements
- Supplemental information
- Management discussion and analysis (MD&A)

Statement of Net Position- Assets

- Cash and cash equivalents
- Patient accounts receivable, net
- Cost report settlement, due to SHD
- Other assets
- Property, plant, and equipment (net of accumulated depreciation)
- Designated and/or board restricted cash and investments

Statement of Net Position- Liabilities and Net Position

- Accounts payable and accrued expenses
- Accrued payroll and related liabilities
- Cost report settlement, due to Medicare
- Current maturities of long-term debt
- Long-term debt, net of current maturities
- Net position

Statement of Revenue, Expenses, and Change in Net Position

- Gross patient revenue
- Third party contractual adjustments
- Bad debt and charity care expense
- Other operating revenue
- Labor related expenses
- Non-labor related expenses
- Non-operating revenue/expense

Overview of
Seneca Healthcare District
Finance and Reporting

Seneca Healthcare District Financial Statement Presentation

Go to Tab 5
of the Supplemental Materials

Seneca Healthcare District Financial Statement Analysis

Go to Tab 6
of the Supplemental Materials

Revenue Cycle Management in a Rural Hospital

Revenue Cycle Management

Go to Tab 7
of the Supplemental Materials

Seneca Healthcare District
Financial Education Program

Questions and Discussion

Seneca Healthcare District
Financial Education Program
Supplemental Materials

1. American Hospital Association Rural Report and Advocacy Agenda

2. Rural Healthcare Provider Types

3. Rural Hospital and Clinic Finance

4. Rural Healthcare and Critical Access Hospital Reimbursement

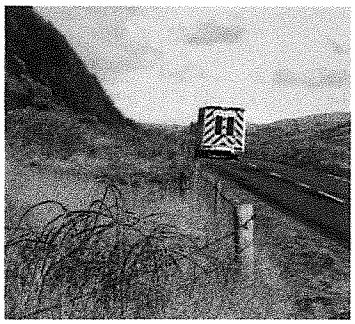
5. Seneca Healthcare District (SHD) Monthly Board Financial Packet

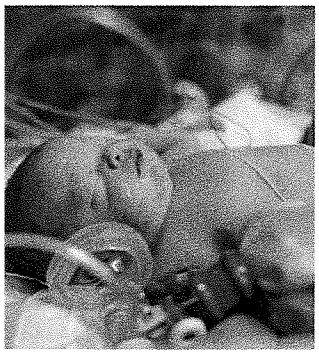
6. Analysis of SHD Operations

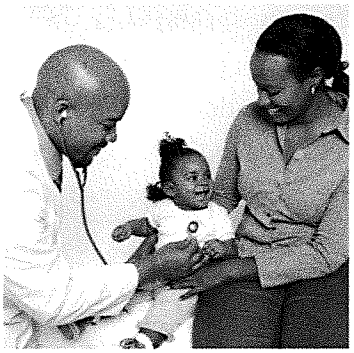
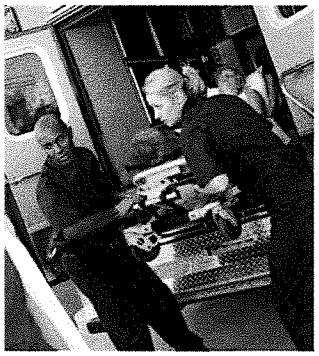
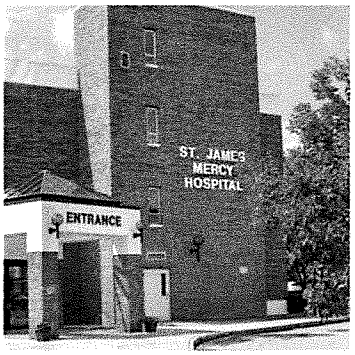
7. Revenue Cycle in a Rural Hospital

Seneca Healthcare District
Financial Education Program

Tab 1- American Hospital Association (AHA) Rural Report and Advocacy Agenda

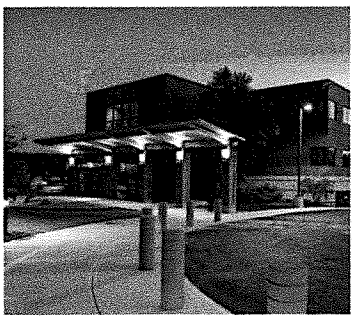










American Hospital Association™

Advancing Health in America

RURAL REPORT

Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care

Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care

Nearly 20 percent of Americans live in rural areas and depend on their hospitals as important – and often only – sources of care in their communities.[1,2] Rural hospitals provide access to care close to home and improve the health and well-being of the patients and communities they serve. The availability of local, timely access to care saves lives and reduces the added expense, lost work hours and inconvenience of traveling to facilities farther away.

These more vulnerable populations are at increased risk of losing access to some types of health care, exacerbation of health disparities and loss of hospital and other types of local employment.

– George H. Pink, Ph.D., Research Fellow, Sheps Center for Health Services Research, University of North Carolina (UNC), as quoted in Health Resources & Services Administration eNews, "Hospital closings likely to increase" (October 2017)

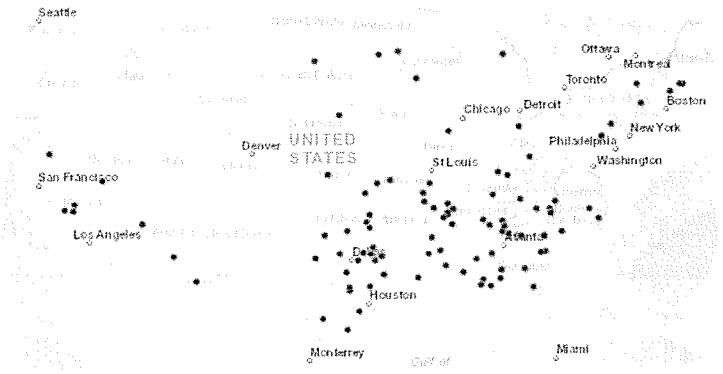
Rural hospitals also serve as economic anchors in their communities; they provide both direct employment opportunities[3] and indirect reinforcement of the local economy through the purchase of goods and services from other private sector entities.[4] The availability of local access to health care is an important factor for businesses considering whether to invest or locate in a particular area. Moreover, private sector employment generated by rural hospitals supports a healthy tax base, which funds services such as public education, fire, police and road maintenance.

Although rural hospitals endeavor to meet the health care needs in their communities, many struggle to address the persistent challenges of providing health care in rural America, such as low patient volumes and geographic isolation. At the same time, they are working to manage more recent and emergent challenges, including economic fluctuations, increased regulatory burden, and the opioid epidemic. In response to these difficulties, some hospitals have elected to merge with larger health systems, engage in other types of affiliations or partnerships, or modify their service offerings, in order to stay viable and protect health care access for their communities. In fact, there have been 380 rural hospital mergers between 2005 and 2016, with some rural hospitals merging more than once.[5]

While some hospitals are continuing to thrive, others find that the cumulative burden of persistent, recent and emerging challenges threaten their ability to maintain access to services. In fact, the North Carolina Rural Health Research Program reports that as of December 2018, 95 rural hospitals have closed since 2010 (Figure 1). Moreover, the Government Accountability Office reports that more than twice the number of hospitals have closed between

Figure 1: Rural Hospital Closures Since 2010

December 2018



Source: NC Rural Health Research Program. (2018). 95 Rural Hospital Closures: January 2010 – Present. The Cecil G. Sheps Center for Health Services Research, University of North Carolina; *www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/*

2013 and 2017 than in the previous five-year period, indicating a worsening trend.[6] These closures stem from numerous factors, including failure to recover from the recession, population demographic trends, ongoing financial struggles and decreased demand for inpatient services.[7] The effects of these closures vary: in some cases, hospital closures resulted in a noticeable reduction in a particular set of services (e.g., elimination of obstetric services or conversion of a full-service acute care hospital to an urgent care center), while others led to a complete elimination of local access to care. But, in all cases, local residents are put in a position of having to seek alternatives – sometimes long distances away – to obtain the care they need.

Losing an employer of 150 people with good jobs is like losing a manufacturing plant. Hospitals are usually the largest, or the second-largest, employer in a community. That's something that's easy to lose sight of because we think of this from a health standpoint. But the effects are wide-ranging when a hospital closes.

– Mark Holmes, Director, Sheps Center for Health Services Research, UNC, as quoted in PBS.org article, "Rural hospitals rely on Medicaid to stay open, study shows" (Jan. 9, 2018)

Many rural hospitals, especially those with very limited resources, become overburdened as challenges intensify, accumulate, and compound each other. Moreover, the issues of today may hinder rural providers' preparedness for the challenges of tomorrow.

In this report, we examine the persistent, recent, and emergent challenges facing rural hospitals and communities; and recommend updates to existing federal policies and areas for new federal investment to support rural hospitals and communities to ensure access to high-quality, affordable, and efficient health care. To be sure, the policy environment for rural providers is not limited to federal activities; laws and regulations at the state and local levels play critical roles in shaping the rural health care context. However, this report focuses on federal policies and investments in light of their nationwide impact and reach. A complete listing of AHA policy priorities and recommendations for America's rural hospitals and communities is available in the 2018 Rural Advocacy Agenda, 2018 Advocacy Agenda, and the Task Force on Ensuring Access in Vulnerable Communities Report. All are available at www.aha.org.

Persistent, Recent and Emergent Challenges Facing Rural Communities

Rural hospitals have always faced a unique set of circumstances, including a challenging payer and patient mix and geographic isolation. In the 1990s and early 2000s, Congress sought to help account for these circumstances and address the growing number of rural hospital closures by creating several special designations and payment programs – the low-volume adjustment, Medicare-dependent hospital program, and ambulance add-on adjustment, among others – which provide enhanced reimbursement under the Medicare program. The designations and programs that remain today are identified and defined in the Appendix. While these programs remain critical to the financial viability of many rural hospitals, they no longer provide the financial predictability they once did, and rural hospitals continue to grapple with an increasing set of new and ongoing challenges.

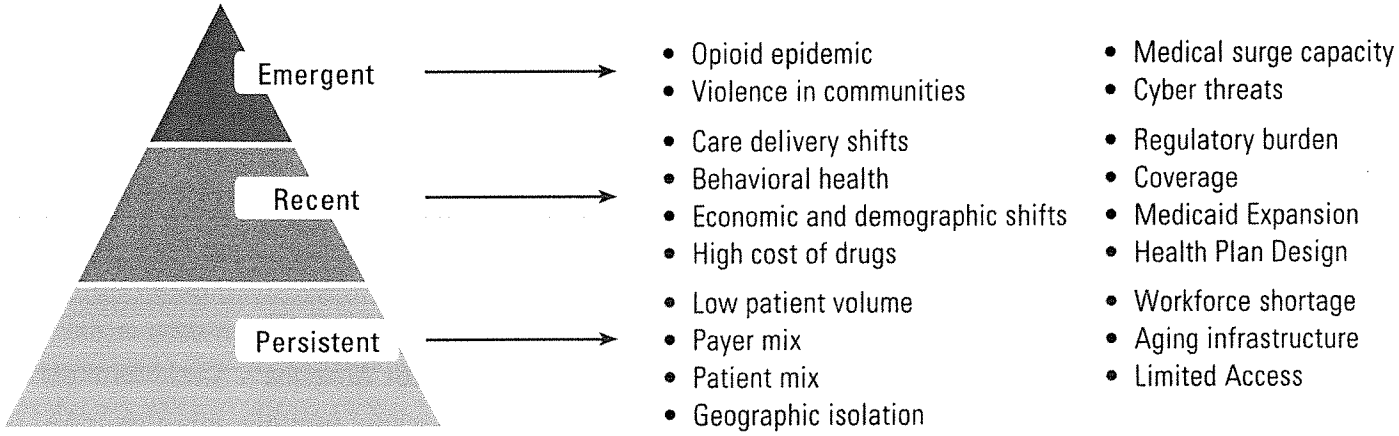
Persistent Challenges

Low Patient Volume. Due to low population density in rural areas, hospitals lack scale to cover the high fixed operating costs. In fact, as early as 1990, the Government Accountability Office found that

low occupancy was associated with higher risk of hospital closure.[8] Given the clear link between volume and hospital viability, Congress established the Low-volume Hospital Adjustment (LVA) program in 2003. However, the program continues to face threats of retrenchment despite the effectiveness of LVA in assisting hundreds of rural hospitals (excluding Critical Access Hospitals [CAHs], which are not eligible).[9]

Low patient volume, in addition to other rural provider challenges, also can be a hindrance to participating in performance measurement and improvement activities. Rural providers may not be able to obtain statistically reliable results for some performance measures without meeting certain case thresholds, making it difficult to identify areas of success or areas for improvement. Additionally, quality programs often require reporting on measures that are not relevant to the low-volume, rural context. Given these issues, the Centers for Medicare Medicaid Services (CMS) tasked the National Quality Forum to identify a core set of rural-relevant measures and develop rural-focused recommendations on measuring and improving access to care. The final report may be found at *www.qualityforum.org*.

Figure 2: Persistent, Recent, and Emergent Challenges Facing Rural Communities



Source: American Hospital Association, 2018

Challenging Payer Mix. Rural hospitals are more likely to serve a population that relies on Medicare and Medicaid. However, these programs reimburse less than the cost of providing care, making rural hospitals especially vulnerable to policy changes in payment of services. Specifically, in 2017 Medicare and Medicaid made up 56 percent of rural hospitals' net revenue.[10] Yet, overall hospitals receive payment of only 87 cents for every dollar spent caring for Medicare and Medicaid patients.[11] Notably, the Medicare Payment Advisory Commission (MedPAC), found in its March 2018 report to Congress that rural hospitals (excluding CAHs) Medicare margin was -7.4 percent.

Dependence on government programs also makes rural hospitals vulnerable to reductions and shifts in government funds, such as the Affordable Care Act (ACA)-mandated productivity cut, which is a 0.8 percent reduction for inpatient payments in fiscal year 2019. Additionally, Medicare sequestration has reduced payments to all hospitals by 2 percent, including CAHs, which see a reduction in payment from 101 percent to 99 percent of allowable costs. Meanwhile, hospitals in states that did not expand Medicaid under the ACA have higher rates of unrecoverable debt and charity care, as well as higher rates of uninsured patients.[12]

Challenging Patient Mix. Rural hospitals treat a patient population that is often older, sicker and poorer compared to national averages. For example, although less than 14 percent of the nation's population is over age 65, this group makes up more than 18 percent of residents in rural areas.[13] In 2016, the Robert Wood Johnson Foundation published its County Health Rankings Key Findings Report, which showed that across health behaviors, clinical care, and social and economic factors, rural counties performed worse in nearly all categories: adult smoking, adult obesity, teen births, uninsured rates, preventable hospitals stays, education, children living in poverty, and injury deaths. These characteristics underscore the importance of local access to care and the need for resources to support the changing needs of the community.

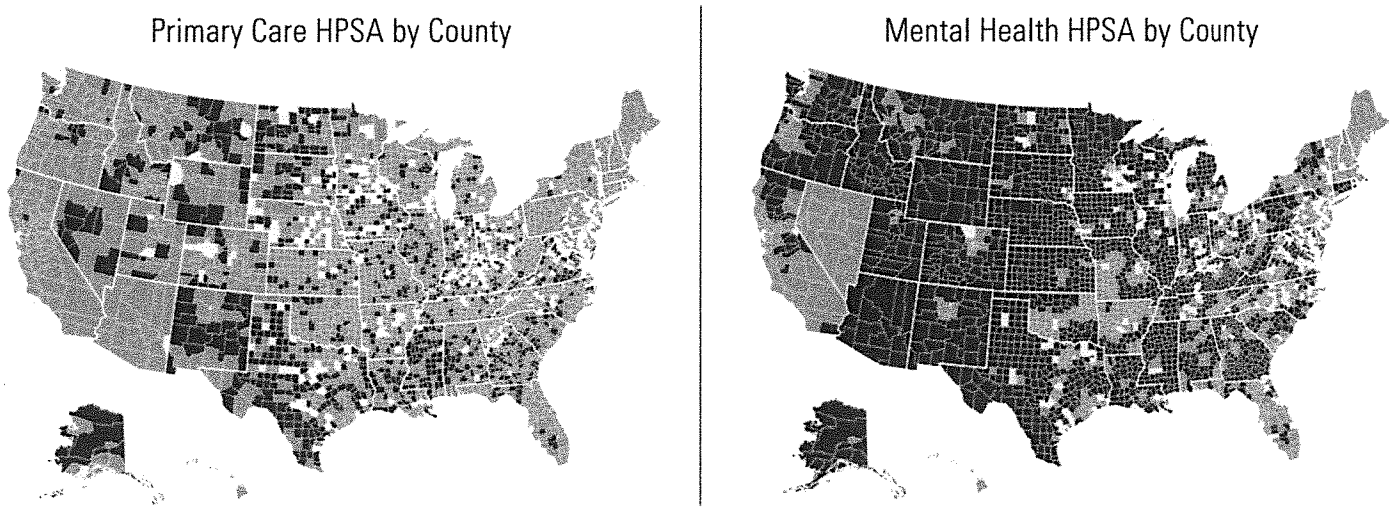
Rural America is a little bit older, a little bit sicker, a little bit poorer.

– Anand Parekh M.D., Chief Medical Advisor, Bipartisan Policy Center, as quoted in the Advisory Board Daily Briefing (March 3, 2018)

Geographic Isolation. Rural communities are often located away from population centers and other health care facilities. According to a recent Pew Research Center survey, among the quarter of rural Americans traveling the longest to reach an acute care facility, the average travel time is 34 minutes by car.[14] Beyond this, in some rural communities, inclement weather or hazardous terrain can make transportation impossible or unsafe. And for many, public transportation is not reliable or available at all. Geographic challenges such as these can cause patients to delay or forego health care services,[15] which can increase the complexity and overall cost of care once services are delivered.[16] Isolation also may be a barrier to professional development and continuing clinical education.

Workforce Shortages. Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. While almost 20 percent of the U.S. population lives in rural areas, less than 10 percent of U.S. physicians practice in these communities.[17] Figure 3 shows how widespread Health Professional Shortage Areas (HPSAs) are across rural America.

Figure 3: HPSAs in Non-metro Counties, 2017



Source: Rural Health Information Hub. (2017 September). Healthcare Access in Rural Communities Chart Gallery; *https://www.ruralhealthinfo.org/topics/healthcare-access/charts*

Primary care is experiencing widespread professional shortages in rural areas. As of November 2018, two-thirds of the nation's 6,941 primary care Health Professional Shortage Areas (HPSAs) were in rural or partially rural areas.[18]

There is no community (public) mental health care, and often there are no relevant hospital services within a reasonable distance. So, people are just left on their own.

– www.CNN.com, "There's a severe shortage of mental health professionals in rural areas. Here's why that's a serious problem" (June 22, 2018)

Nurse practitioners, midwives and physician assistants have helped to address the shortages. In fact, nurse practitioners and physician assistants currently account for 19 percent and 7 percent, respectively, of the primary care workforce and contribute substantially to the total supply of primary care visits.[19] However, many state licensure laws limit the ability of advanced practice clinicians to practice at the top of their license, thus limiting the services they may offer to patients. Physician supervision regulations also may hinder maximal use of advanced professional staff.

Clinical workforce shortages exist across specialties, but the limited number of behavioral health providers is particularly striking.[20] In fact, a 2016 JAMA study found that mental health conditions were responsible for nearly 80 percent of telemedicine visits among rural Medicare beneficiaries from 2004-2013, highlighting both the scarcity of behavioral health specialists and a need for innovative solutions.[21]

In addition, non-clinical staff to support rural health care activities also are in short supply. A 2018 Medical Group Management Association Stat poll found that more than 60 percent of respondents indicated

Figure 4: AHA Task Force on Vulnerable Communities Essential Health Care Services

Emerging Strategy	Primary Care	Psychiatric and substance use treatment services	ED and observation care	Prenatal care	Transportation	Diagnostic services	Home care	Dentistry services	Robust referral structure
Addressing the Social Determinants of Health					X				X
Global Budget Payments	X	X	X	X	X	X	X		X
Inpatient/Outpatient Transformation Strategy	X	X	X	X		X			X
Emergency Medical Center	X		X		X	X			X
Urgent Care Center	X					X			X
Virtual Care Strategies	X	X	X						X
Frontier Health System	X	X	X	X	X	X	X		X
Rural Hospital-Health Clinic Strategy	X	X	X	X		X		X	X
Indian Health Services Strategies	X	X	X	X	X	X	X		X

Source: American Hospital Association. (2018). Access to Care in Vulnerable Communities; *www.aha.org/vulnerablecommunities*

that their organization had a shortage of qualified applicants for non-clinical positions in the past year.[22] Difficulty in recruiting to rural areas was noted as one of the reasons for the hiring deficit.[23]

Limited Access to Essential Services. Workforce shortages, geographic isolation and other persistent challenges facing rural communities contribute to low availability of services, including primary care, behavioral health services and dental care. For example, while the average rate of primary care physicians (PCPs) across the United States is approximately 80 PCPs per 100,000 people, rural areas experience a rate of only 68 PCPs per 100,000 people.[24] Insufficient access to primary care and other essential services leads to poorer health outcomes and increases the likelihood of more costly, higher acuity episodes at the time of treatment. Moreover, limited transportation options in rural areas exacerbate access challenges, contributing to delayed (or forgone) medical attention and subsequent disease progression.[25]

In recognition of the challenges facing vulnerable communities and the need for new strategies to address them, in 2015 the AHA Board of Trustees created the Task Force on Ensuring Access in Vulnerable Communities. The Task Force identified a set of essential services, illustrated in Figure 4, that should be available in all communities. These services, along with strategies to help to rural communities maintain access to them, are described in the Task Force's report, which is available at *www.aha.org/ensuringaccess*.

Aging Infrastructure and Access to Capital. Many rural hospitals were constructed following the passage of the Hill-Burton Act of 1947, which provided grants and loans for the construction and modernization of hospitals and other health care facilities. Currently, many rural hospitals need to update their facilities and services to better align with how care is delivered in the 21st century. Yet, narrow financial margins limit rural hospitals' ability to retain earnings and secure access to capital or qualify for U.S. Department of Agriculture or the U.S. Department of Housing and Urban Development mortgage guarantees. Without some or all of these resources, rural hospitals are unable to update facilities and purchase needed equipment. Moreover, the Tax Cuts and Jobs Act of 2017 included changes that could affect interest rates for tax-exempt bonds, making borrowing more expensive for hospitals.[26]

Recent Challenges

Changes in health care delivery, the high cost of prescription drugs and other challenges have emerged recently, requiring flexibility, additional resources and new strategies for hospitals to meet the needs of their communities.

Changes in Health Care Delivery. Across the United States, numerous health care services that have previously only been provided on an inpatient basis are now offered in outpatient settings. This shift reflects advancements in clinical practices, sophisticated technologies, innovations and changes in patient preferences. Between 2006 and 2016, outpatient visits have risen by nearly 50 percent among Medicare beneficiaries across the country, while inpatient discharges have dropped by more than 20 percent.[27] On the whole, rural hospitals are experiencing this broader trend: during the past three years, total inpatient admissions in rural hospitals have decreased by 4 percent while outpatient visits have increased by 9 percent.[28] And, in 2016, outpatient services represented nearly two-thirds of rural hospitals' total gross revenue.[29]

However, the movement from inpatient care toward more outpatient services can be problematic for some hospitals, especially those with low patient volumes. Most Medicare designations and special payment programs for rural hospitals are tied to inpatient services (see Appendix for descriptions), reflecting the health care system's longstanding emphasis on acute, inpatient care. Yet, in light of low patient volume overall and the rise of outpatient care, these programs may not be sufficient to bolster the financial stability of these providers. To be sure, inpatient payment programs are necessary to support rural health care, but policymakers must also consider ways to maintain viability of outpatient care and other types of services, given the overall shift of many services out of the inpatient setting.

Coverage. Affordable health coverage is one of the most pressing financial challenges facing health care stakeholders, including consumers, providers, employers, and state and federal governments. Recent changes in coverage availability, eligibility criteria, and health plan design may reduce short-term costs for some areas of the health care system while at the same time cause negative – and often broader – unintended consequences in other areas. Individuals without adequate health insurance and those with plans that have high out-of-pocket expenses often cannot pay for emergency and other acute health services, leaving providers with higher rates of uncompensated care.

Medicaid Expansion. States that chose not to expand Medicaid coverage under the ACA, citing future costs to state budgets, have higher numbers of uninsured individuals.[30] Moreover, approximately 80 percent of rural hospital closures since 2014 have occurred in non-expansion states.[31] Although the percentage of insured individuals is not the sole factor in closures occurring across the U.S., researchers have found an association between Medicaid expansion and improved hospital financial performance, especially in rural areas.[32]

The effect, in terms of the closure rates between [Medicaid] expansion and non-expansion states, seems to be especially strong for rural hospitals.

– Gregory Tung, Ph.D., Assistant Professor, Colorado School of Public Health, University of Colorado, as quoted in Healthline.com newsletter (Jan. 16, 2018)

Health Plan Design. Among the approaches employers and private health plans are taking to manage costs is to offer limited coverage plans, such as high-deductible health plans (HDHPs), so-called "skinny" plans, which cover fewer services, and short-term insurance plans. These types of health plans have grown significantly in recent years: nearly half of all non-elderly adults with private insurance are enrolled in a HDHP, and 39 percent of large employers only offer HDHPs.[33] While these plans are less expensive options for some payers, they often leave consumers with large, unexpected, costs for care, which are then shifted to hospitals in the form of uncompensated care. Evidence suggests that the uptake of HDHPs is greater in rural areas, leading to provider concerns about uncompensated care costs and inadequate patient access to services in these communities.[34]

Behavioral Health Trends. Although behavioral health concerns – including mental illness, emotional distresses and substance use disorders – have long affected the American population nationwide, recent evidence suggests that some of these conditions disproportionately affect rural communities.[35] For example, a 2017 study found that suicide rates have been consistently higher in rural areas for nearly two decades. [36] Additionally, as the entire country continues to confront the opioid crisis, rates of drug

overdose deaths in rural communities are notably on the rise.[37] These trends are especially alarming in light of the fact that more than 60 percent of mental health HPSAs are rural or partially rural (see Figure 3).[38] Without sufficient capacity – including financial, staffing and organizational resources – to provide access to crucial services, rural hospitals will not be adequately equipped to address the unique behavioral needs of their communities.

Economic, Population and Social Changes. In recent years, economic, demographic, and social changes have deepened the challenges faced by rural communities. Numerous factors are at work, including the shift from a manufacturing-intensive economy to a more service-driven, technology-based economy. The Great Recession hit rural communities hard with higher unemployment and lagging economic growth.

Many small towns have had to cut back [public] services or deliver them in combination with neighboring towns as the number of taxpayers has dwindled.

– Doug Farquhar, National Conference of State Legislatures, as quoted in pewtrusts.org, Rural Counties are Making a Comeback, Census Data Shows (March 22, 2018)

For example, access to capital for rural businesses has still not rebounded, and real estate appreciation in rural communities continues to lag behind, affecting the value of home ownership – a primary source of wealth and savings for families.[39] And between 2010 and 2014, a majority of rural counties lost businesses spanning multiple industries, including farming, manufacturing, coal, timber and fishing.[40]

Fortunately, hard work, ingenuity and entrepreneurial energy can be found in every community in the country. Policymakers should focus on empowering those forces to rekindle the grassroots economic growth that made this country the world's leading economy in the first place.

– Economic Innovation Group, The 2017 Distressed Communities Index

In addition, from 2010-2016, the population in rural areas declined, due to the combination of migration (including younger workers seeking employment in urban areas) and natural changes (births minus deaths).[41,42] Social challenges as well have changed in recent years. An analysis by the Wall Street Journal found that by several measures of socio-economic well-being, rural counties fare worse than the other three major population groupings: suburbs, and medium or small metropolitan areas.[43]

Increased Regulatory Burden. According to "Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers," a 2017 study conducted by the AHA, the nation's hospitals, health systems and post-acute care providers spend $39 billion each year on non-clinical regulatory requirements. These costs include the staff required to meet the demands of the regulations concerning physicians, nurses, legal, management, health information technology professionals and others. CMS has acknowledged the regulatory burden on providers and continues to review the effectiveness of current regulation through its Patients over Paperwork initiative.

While rural hospitals are subject to the same regulations as other hospitals, lower patient volumes mean that, on a per-discharge basis, their cost of compliance is often higher than for larger facilities. The volume of regulation, pace of change, and complexity of the regulatory framework requires scale to

implement – and rural areas lack scale. For rural hospitals, the opportunity cost – the next best thing that could be done with the financial and human resources spent on regulatory burden – can mean the loss of local access to services.

High Cost of Prescription Drugs. Spending on pharmaceuticals has skyrocketed over the past several years. The burden of this increase falls on all purchasers, including patients and the providers who treat them. Hospitals face significant resource constraints and trade-offs as spending on drugs increases. In 2016, the AHA and the Federation of American Hospitals worked with the NORC at the University of Chicago to document hospital and health system experience with inpatient drug spending. Results showed that, while retail spending on prescription drugs increased by 10.6 percent between 2013 and 2015, hospital spending on drugs in the inpatient space rose 38.7 percent per admission during the same period.[44,45]

Emergent Challenges and Threats

In addition to managing ongoing challenges, rural hospitals also must be prepared to respond immediately to events and crises that affect the community, including those that occur unexpectedly. Capacity to address these emergent challenges – such as the opioid epidemic, violence, natural disasters and cyber attacks – represent an essential component of our nation's health and public safety infrastructure. However, this role is not explicitly funded, making it even more challenging for rural hospitals to spread scarce resources to meet the increasing challenges and needs in their communities.

When we heard there was a shooter inside the school, we braced for the worst. But we were prepared. We had practiced. The staff knew what their roles were and we followed our playbook.

– David L. Schreiner, President & CEO, Katherine Shaw Bethea Hospital, Dixon, Ill.

Opioid Epidemic. In 2017, more than 42,000 deaths were attributed to opioid overdoses.[46] And in 2017, the Department of Health and Human Services declared the opioid epidemic a public health emergency. Also in 2017, the Centers for Disease Control and Prevention announced that the rates of deaths from drug overdoses in rural areas were rising to surpass rates in urban areas.[47,48] According to a recent National Public Radio poll, one quarter of rural Americans say opioid and other drug abuse is the biggest issue that faces their communities.[49]

While no corner of the country has gone untouched by this issue, the opioid epidemic has hit rural America particularly hard.

– U.S. Department of Agriculture, Opioid Misuse in Rural America, (2018)

Congress recently passed comprehensive bipartisan legislation in response to the opioid epidemic. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 comprises dozens of individual bills that direct additional federal resources toward prevention, education, coverage, treatment, workforce and law enforcement.

Hospitals have a key role in responding to the nation's opioid epidemic: from treating overdoses in the emergency department to caring for babies with neonatal abstinence syndrome to connecting patients with treatment and recovery resources.

Violence in Communities. Incidences of violence, such as mass shootings, are events that communities hope never occur; yet hospitals must be prepared to respond. Shootings in workplaces, schools and public spaces have not been limited to any one geographic area; rather, they have occurred all across America. To prepare for incidences of mass violence, many hospitals conduct preparedness drills with local law enforcement. Conducting these drills requires hospitals to temporarily shut down non-emergency services and redirect staff to participate in preparedness activities. Federal and state agencies often provide resources to help hospitals purchase equipment to prepare for emergencies; however, the cost for lost services and staff time are borne by the hospital. Hospitals also are dealing with a wave of violence within their walls, sometimes directed at employees.[50] To keep patients and employees safe, rural hospitals are increasingly establishing partnerships with local law enforcement or hiring security, creating another necessary, but indirect cost to operating a hospital.

Human trafficking is another example of violence that is increasing in rural communities.[51,52] Victims of human trafficking will likely seek medical attention for emergency or preventive care at some point.[53] Health care professionals are on the front lines of this challenge, helping to identify and appropriately treat victims, both of which require special training.[54]

If a medical professional is able to identify a potential trafficking situation, he or she can connect that victim to the appropriate services that may save that victim's life.

– Polaris Project blog post, "Healthcare Professionals on the Frontline of Helping Trafficking Victims" (April 14, 2016)

Medical Surge Capacity. The ability to care for a significantly increased volume of patients when a tragic event strikes – referred to as "medical surge capacity" – is a key marker of an effective health care system.[55] For America's hospitals, such readiness is an imperative; they are always there, prepared to care in times of need. While hospitals have always had disaster plans in place, more recent incidences of hurricanes, wildfires, flooding, and threats of viruses like Ebola and Zika have raised the bar for emergency preparedness. Although rural areas are not immune to natural disasters, terrorist attacks and epidemics, these communities may not be adequately prepared for large-scale events if they lack sufficient medical staff and resources to respond to such emergencies. While federal resources, such as those authorized through the Pandemic and All-Hazard Preparedness Act, provide some support to help hospitals and communities prepare for and respond to disasters and public health emergencies, they have not kept pace with the ever-changing and growing responsibilities hospitals have in times of crisis.

Cyber Threats. Hospitals, and health care overall, remain heavily targeted by cyber adversaries. The health care field is increasingly realizing the promise of networked information technologies to improve quality and patient safety and bring efficiencies to our systems. However, with those opportunities come vulnerabilities to theft and threats to the security of personal health and payment information for patients and employees, billing records, and even the function of medical devices. Increasingly, bad actors are using phishing emails, malware, vendor access and other tactics to attempt to attack hospital computers, networks and connected devices.

Protecting information and appropriately responding to threats creates significant indirect cost for hospitals and can require individuals with specialized skills. These costs are not reimbursed by payers and can be especially difficult for rural hospitals with limited financial and human resources. This is made more challenging by the significant shortages of cybersecurity professionals across the nation.

Roadmap for Action: Updating Federal Policies and Investing in Rural Communities

In light of the persistent, recent and emergent challenges of providing care in rural areas, as well as the ongoing transformation of the health care system, federal policies need to be updated for the 21st century. New investments of resources that protect access to care also are needed to provide the tools to ensure local access to high-quality, affordable, efficient health care. Policy recommendations are identified in this section.

New Models of Care

The health care system is changing at a rapid pace, and new models of care offer alternative ways of delivering and paying for care. One important example of a new model of care is the establishment of an emergency medical center designation under the Medicare program for rural hospitals. Such a designation would allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient services. In addition to having emergency services provided 24 hours a day, 365 days a year, communities would have the flexibility to align additional outpatient and post-acute services with local needs, and receive enhanced reimbursement.

A New Medicare Designation for Rural Providers

- Eligible rural hospitals that discontinue inpatient care could convert to the new designation
- Services include 24/7 emergency and observation services, ambulance and transportation to acute facilities as needed
- Facilities may also provide skilled nursing (separate licensed unit) and outpatient services

This type of designation has been supported in bipartisan, bicameral legislation in the 115th Congress, including the Rural Emergency Acute Care Hospital (REACH) Act (S.1130) and the Rural Emergency Medical Center Act (H.R. 5678). MedPAC also recommended the establishment of such a model in its June 2018 Report to Congress.

CMS' Center for Medicare & Medicaid Innovation (CMMI) also continues to test several new models for rural providers, including:

- The *Rural Community Hospital Demonstration,* which tests the feasibility of cost-based Medicare reimbursement for inpatient services for 30 smaller rural hospitals with 25-50 beds;
- The *Frontier Community Health Integration Project (FCHIP) Demonstration,* which tests several care delivery innovations across 10 hospitals, including cost-based reimbursement for telehealth services and certain CAH-owned ambulance services, and;
- The *Pennsylvania Rural Health Model,* which will test an all-payer global budget payment structure along with care delivery redesign for certain rural hospitals in the state.

While these demonstrations are promising, additional opportunities are needed to expand successful models and make them permanent, continue assessments of model performance, and develop new models that are flexible and meaningful for rural communities.

As rural hospitals employ new models of care and embark on pathways to transformation, such as value-based care and population health strategies, they need flexibility and resources to be successful. **Congress and CMS should expand opportunities for rural communities to choose new models of care (e.g., establishment of an emergency medical center designation, development of new demonstrations), while ensuring flexibility in payment and delivery design.**

Reimbursement

Rural hospitals are committed to caring for their communities and improving value; however, without financial predictability, including an adequate margin for capitalization, they cannot maintain local access to essential services. For many rural hospitals, the "no margin, no mission" adage rings terribly true.

Given the persistent, recent and emergent challenges faced by rural hospitals, it is increasingly difficult to cover the high fixed costs of operating a hospital and maintain access to services while also pursuing new pathways to improve quality and value. Unfortunately, in recent years, policymakers have repeatedly cut payments to hospitals. For example, while seeking reductions to the federal budget in 2011, Congress passed Medicare sequestration, which bluntly cut all payments to hospitals and CAHs by 2 percent; these cuts have been extended several times.

Another example of recent hospital payment cuts are so-called "site-neutral" policies, which seek to reduce reimbursement for non-emergency services delivered in hospitals' off-campus provider-based departments (PBDs), including those serving rural communities. The intention of these policies is to make total payment for a service provided in a hospital the same as when a service is provided in a physician office or ambulatory surgery center. However, patient needs, cost structures and regulatory requirements vastly differ across these settings. For example, PBDs treat patients who are more likely to be Medicare or Medicaid beneficiaries, have medically complex conditions, and live in high-poverty areas. In addition, patients are commonly referred to PBDs by physicians for safety reasons, as hospitals are better equipped to handle complications and emergencies. Overall, site-neutral policies fail to recognize the reality in which hospitals operate to serve the needs of their communities.

While PBDs across the country feel the impact of these policies, rural hospitals may be especially affected in light of PBDs being frequently used as important health care access points in more remote areas. In particular, recent proposals also would reduce payments to off-campus PBDs that were previously exempt from cuts given the critical role they play in their communities. Cutting support for these facilities would clearly impede access to care for the most vulnerable patients.

Federal and private payers need to update covered services and increase reimbursements rates to cover the cost of providing care, including by opposing any further site-neutral payment policies.

Easing Regulatory Burden

Hospitals and health systems must comply with 341 mandatory regulatory requirements and an additional 288 requirements for post-acute care.[56] The AHA found that health systems, hospitals and post-acute care providers spend $39 billion each year – $7.6 million for an average-sized community hospital – on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other

hospitals, lower patient volumes mean that, on a per-patient basis, the cost of compliance is often higher. **Policymakers should protect access to health care in rural areas by providing relief from outdated or unnecessary regulations.**

Health Information Technology (HIT). Rural hospitals are committed to improved care through use of HIT in order to meet past and current regulatory requirements. The use of electronic health records (EHRs) and other health IT to meet increased requirements for information exchange through programs like the Promoting Interoperability Program (formerly known as the EHR Incentive Programs, or meaningful use) result in significant investment to purchase, upgrade, and maintain equipment and software. Many of these costs are ongoing, including expensive system upgrades required by regulation and the recruitment and retention of trained staff to use and service the technology. Rural hospitals must meet the same regulatory requirements for the Promoting Interoperability Program as other hospitals, yet often do not need the additional technology functionality contained in required, expensive system upgrades; nor do they have the available infrastructure such as adequate broadband to support them. **While CMS recently provided needed flexibility in the Promoting Interoperability Program, concerns remain that the requirements and technology costs, particularly related to the 2015 edition certified EHR technology, are beyond the reach of some rural hospitals.**

Medicare Conditions of Participation (CoP) and Compliance. Medicare CoPs require providers to adhere to established health quality, safety and operational standards in order to participate in the Medicare program. There is tremendous value in having CoPs to ensure the safe delivery of care; however, the preparatory work, surveys and follow-up documentation required to certify that hospitals adhere to all standards presents a growing burden to providers. CoPs for Medicare are a significant source of the cost of regulatory compliance. **Surveyors assessing hospital compliance should be provided with training and guidance related to rural-specific circumstances, including low patient volume and sometimes limited capacity. In addition, future CoPs should be developed with more flexibility, a strong evidence base and alignment with other laws and industry standards.**

Direct Supervision. CMS also enforces a policy for CAHs and small (i.e., fewer than 100 beds) rural hospitals, requiring "direct supervision" for all outpatient therapeutic services (with some exceptions). This policy requires that a physician be immediately available for even the lowest risk outpatient therapeutic services, such as the application of a splint to a finger. Without adequate numbers of health professionals in rural communities to provide direct supervision, some hospitals may limit their hours of operation or reduce services due to their inability to meet this requirement. **Congress should pass a permanent moratorium on enforcement of CMS's "direct supervision" requirement for outpatient therapeutic services provided in CAHs and certain small, rural hospitals.**

96-Hour Rule. Currently, to maintain their designation, CAHs must maintain an annual length of stay (LOS) of 96 hours or less. However, in recent years, CMS enforced a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. This additional step and limitation is detrimental to CAHs, and may force them to eliminate "96-hour-plus" services, ultimately affecting access to appropriate care for Medicare beneficiaries in these facilities. **CAHs appreciate recent efforts by CMS to reduce this regulatory burden, however a statutory change is required to remove the physician certification requirement from the 96-hour rule.**

Co-location. Hospitals often create arrangements with other hospitals or providers of care in order to offer a broader range of medical services, improve care coordination, and better meet the needs of patients – including specific patient populations. For example, a rural hospital may lease space once a month to medical specialists from out of town so that people from the community can get needed specialty care. Unfortunately, in recent years, CMS has expressed several conflicting interpretations of these rules that may differ from prior understanding, such as standards about what constitutes separateness, when separate entrances are required, which types of services may be shared, and how an adequate level of public awareness is achieved when one provider leases space to another. **CMS should clarify its rules related to shared space or "co-location" arrangements between hospitals and/or health care professionals.**

Stark Law and Anti-Kickback Statute. The Stark Law and Anti-Kickback Statute are intended to prevent fraud and abuse and govern financial arrangements between physicians and hospitals. However, they need to be updated to reflect how care is delivered today, including value-based and coordinated care. While not intended by the laws, the potential for violating these statutes may be higher for rural hospitals in light of their unique conditions. For example, limited patient volume may necessitate the need to share specialists with non-affiliated hospitals; as a result, ongoing patient referrals to these facilities could implicate the Anti-Kickback Statute. **Policymakers should remove barriers to care transformation, such as creating a "safe harbor" under the Anti-Kickback Statute and reforming the Stark Law and certain civil monetary penalties to foster and protect arrangements that promote value-based care.**

Telehealth

Telehealth expands access to services which may not otherwise be sustained locally due to provider recruitment/ retention difficulties, low patient volume, or inadequate local resources. It also holds great potential to address health care disparities, which have long existed in rural communities, including those based on geographic isolation, an aged population, and race and ethnicity. As technology has improved and people are increasingly comfortable with the delivery of care through virtual connections, the utilization of telehealth services has dramatically increased. Indeed, among rural Medicare beneficiaries, the number of telehealth visits increased from 7,015 in 2004 to 107,955 in 2013 and continues to rise.[57] Telehealth also may be especially important for providing care in specialties that are not well represented in rural areas. In a recent analysis of rural Medicare beneficiaries, researchers found that nearly 80 percent of telehealth visits were related to mental health conditions, underscoring both the need and opportunity for this type of care in rural America.[58]

Rural hospitals often play the role of "originating site," meaning that patients still physically go to the hospital to receive a service provided from a health professional located at a distant site. Even in cases where originating sites are eligible to bill Medicare for a telehealth facility fee, the reimbursement rates are marginal compared to the overall costs.

– American Hospital Association, 2018

Medicare has increased its coverage of telehealth services for patients living in rural areas, and in 2018,

Congress further expanded coverage to include telestroke care. However, barriers to widespread use of telehealth remain, including:

- statutory and regulatory restrictions on how Medicare covers and pays for telehealth;
- lack of adequate broadband connectivity in some areas;
- cross-state licensure hurdles for practitioners; and
- high cost of acquiring and maintaining necessary equipment.[59]

The promise of telehealth cannot be realized in rural areas without additional governmental support for these services. **Federal payers should expand coverage of services and technologies; provide payment parity with services delivered in-person; assist with the expensive start-up costs of providing access to telehealth services; and cover the cost of providing telehealth at the patient's site of care ("originating site").**

The 25-bed [hospital]... loses Internet connections often enough that ambulance drivers are told to divert critical patients, whose CT scans are transmitted to specialists, to a hospital 50 minutes away.

– "Rural America is Stranded in the Dial-Up Age," Wall Street Journal, (June 15, 2017)

Broadband. According to the Federal Communications Commission (FCC), 34 million Americans still lack access to adequate broadband. Many of these are located in rural areas. Lack of affordable, adequate broadband infrastructure impedes routine health care operations (such as widespread use of EHRs and imaging tools) and limits their availability.[60] In August 2018, the FCC proposed the creation of a new $100 million Connect Care Pilot Program to support telehealth for low-income Americans, especially those living in rural areas. If established, the program would support the expansion of broadband and promote the use of broadband-enabled telehealth services among low-income families and veterans, with a focus on services delivered directly to patients beyond the doors of brick-and-mortar health care facilities.[61] **Federal investment in broadband connectivity should continue to be a priority.**

Prescription Drug Costs

Increased spending on prescription drugs is putting access and quality of care at risk by straining providers' ability to access the drug therapies they need to care for their patients and the ability of patients to pay for the medicines they need. The primary driver behind this growth in drug spending is higher prices, not increased utilization. Within the health care field, "pharmaceuticals" was "the fastest growing category" in terms of pricing for every month of 2016 and for most of 2017.[62] Drug manufacturers have full control over the initial price for a drug and any subsequent price increases. They are responsible for setting the price of a drug at $89,000,[63] $159,000,[64] or even $850,000[65] for a course of treatment. They also solely decide whether to increase that price by 20 percent,[66] 948.4 percent, or 1,468 percent.[67]

Actions must be taken to address the high price of prescription drugs including: fast-tracking generic medicines to market; preventing drug manufacturers from making small adjustments to older drugs and receiving financial benefits and protections reserved for new drugs; and paying generic manufacturers to delay the release of a cheaper version of the drug.[68]

340B Program. For more than 25 years, the 340B Drug Pricing Program has been critical in expanding access to lifesaving prescription drugs and comprehensive health care services in vulnerable communities that include low-income and uninsured individuals. Congress established the 340B program in response to the pressure high-drug costs were putting on providers and with the stated objective "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."

In 2015, 340B hospitals provided $23.8 billion in uncompensated care and $51.7 billion in total benefits to their communities.[69,70] Hospitals were able to provide these benefits despite significant fiscal pressures. Also in 2015, one out of every four 340B hospitals had a negative operating margin, and one in three 340B CAHs had a negative operating margin.[71] **Any focus on limiting the 340B program as part of a plan to lower drug prices is misplaced. Efforts to scale back the program would have devastating consequences for the patients and communities served.**

Workforce

Graduate Medical Education (GME). Medicare GME funding is critical to maintain the physician workforce and sustain access to care in rural communities and across the nation. The Balanced Budget Act of 1997 (BBA) imposed caps on the number of residents for which each teaching hospital is eligible to receive GME reimbursement. The BBA also reduced over time the additional payment teaching hospitals receive for Medicare discharges, known as the indirect medical education (IME) adjustment, that reflect the higher patient care costs at these facilities. **Congress should lift the cap on the number of Medicare-funded residency slots, which would expand training opportunities in rural settings and help address health professional shortages.**

Targeted Programs. Recruitment and retention of health professionals is a persistent challenge for rural providers, resulting in workforce shortages, reduced access to care for patients and high ongoing costs to providers. Some existing programs work to ameliorate workforce deficits by incentivizing clinicians to work in rural areas, such as the Conrad State 30 and the National Health Service Corps programs, which are administered by federal agencies with funding from Congress. In addition, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 establishes a loan repayment program for substance use disorder treatment professionals in mental health professional shortage areas or counties hardest hit by drug overdoses. Despite the promise of these programs, with only one percent of medical residents and fellows indicating a preference for practicing in a small town or rural area, designers of rural recruitment programs will have to consider additional, unique ways to attract the next generation of clinicians.[72]

In addition, as mentioned above, advancements in telehealth can address workforce challenges by connecting patients and their providers to specialists in other locations; however, state licensure restrictions often limit the reach of telehealth services. In response, 17 states have enacted legislation supporting the Interstate Medical Licensure Compact, which expedites the licensure process for physicians wishing to practice medicine in multiple states.[73] **These recruitment and retention programs are important to support a sustainable rural health care workforce; however, additional solutions need to be developed to address workforce shortages and challenges in rural areas.**

Conclusion

Although rural hospitals have long faced unique circumstances that can complicate health improvement efforts, more recent and emergent challenges are exacerbating their financial instability – and by extension, the economic health of their communities. Individually, these are complex, multifaceted challenges. Taken together, they are immense, requiring policymakers, stakeholders and communities to work together, innovate and embrace value-based approaches to improving health in rural communities.

The federal government must play a principal role by updating policies and investing new resources in rural communities. A complete listing of AHA policy priorities and recommendations for America's rural hospitals and communities is available in the 2019 Rural Advocacy Agenda, 2019 Advocacy Agenda and the Task Force on Ensuring Access in Vulnerable Communities Report; all are available at www.aha.org.

Appendix

Figure 5: Medicare Designations for Rural Hospitals

Designation	Eligibility Criteria	Medicare Payment
Critical Access Hospital (CAH)	• Rural or acquires rural status (42 CFR 412.103 for detail) • More than 35 miles from nearest hospital or CAH or more than 15 miles in areas with hazardous terrain or only secondary roads or designated by state as "necessary provider" before 2006 • 25 beds or fewer (including swing beds) • 24-hour emergency services • Annual average length of stay of 96 hours or less per patient for acute care	• 101 percent of "reasonable costs" for both inpatient and outpatient care. CAHs are not subject to inpatient prospective payment system (PPS) or outpatient (PPS) and are not "subsection (d)" hospital • 101 percent of reasonable costs for swing bed services
Sole Community Hospital (SCH)	More than 35 miles from other "like" hospitals (excludes CAHs) or rural and one of the following: • Between 25 and 35 miles from other like hospitals and serves as main hospital in the vicinity (42 CFR 412.92 for detail) • Between 15 and 25 miles, but other hospitals often inaccessible (e.g., due to severe weather) • Nearest like hospital is at least 45 minutes away	• **Inpatient:** Higher of standard inpatient PPS or hospital-specific rate (HSR) • HSR derived from cost per discharge in a base year (1982, 1987, 1996, 2006), adjusted for inflation and case mix • **Outpatient:** Outpatient PPS + 7.1 percent (except drugs and biologics)
Medicare Dependent Hospital (MDH)	• Rural or acquires rural status (42 CFR 412.103 for detail). Expired in 2017 but extended through 2022 • Not a SCH • 100 beds or fewer • At least 60 percent of inpatient days or discharges are Medicare Part A beneficiaries (42 CFR 412.108 for detail)	• **Inpatient:** Standard IPPS + 75 percent of amount by which highest HSR exceeds PPS • HSR derived from cost per discharge in base year (1982, 1987, 2002), adjusted for inflation and case mix • **Outpatient:** Standard outpatient PPS
Rural Referral Center (RRC)	Rural plus one of the following (42 CFR 412.96): • 275 beds or more, or • Most Medicare patients referred by outside providers AND most (services provided to) Medicare patients live 25+ miles away, or • High case-mix + high discharge volume + one of the following: mostly specialty practitioners, most inpatients live 25 miles away, many patients referred by outside providers	• **Inpatient:** Standard inpatient PPS; special treatment for Medicare DSH and geographic reclassification • **Outpatient:** Standard outpatient PPS; receive inpatient reclassified wage index
Rural Community Hospital (RCH)	Demonstration model; extended in 2016 for 5 years (30 participating hospitals) • Rural • Fewer than 51 acute care beds • 24-hour emergency services • Not designated/ eligible to be CAH	• **Inpatient:** 100 percent of reasonable costs (first year). Lesser of reasonable costs and target amount (subsequent year) • **Outpatient:** Standard outpatient PPS

Medicare Designations for Rural Hospitals (Continued)

Program	Eligibility Criteria	Medicare Payment
Low-volume Adjustment (LVA)	Expired in 2017 but extended through 2022 with new criteria beginning in 2019: • Fewer than 3,800 total discharges • Located more than 15 road miles from the nearest subsection (d) hospital	• **Inpatient:** Sliding scale add-on: 25 percent for hospitals ≤ 500 total discharges to 0 percent for hospitals ≥ 3,800 total discharges • **Outpatient:** Standard outpatient PPS
Ambulance Add-on Adjustment	• Rural and "super" rural areas (lowest 25 percent in terms of population density)	• 3 percent add-on to the ambulance fee schedule rate payment for trips originating in rural areas or rural census tracts of urban areas • 22.6 percent increase in the base rate of the fee schedule for ground services originating in "super" rural areas

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#RuralHealth

February 2019

American Hospital Association™
Advancing Health in America

2019 Rural Advocacy Agenda

America's rural hospitals are committed to serving their communities and ensuring local access to high-quality, affordable health care. The AHA is working to ensure federal policies and regulations are updated for 21st century innovation and care delivery, and new resources are invested in rural communities to protect access.

Ensure Fair and Adequate Reimbursement

Medicare and Medicaid each pay approximately 87 cents for every dollar spent caring for patients, according to the latest AHA data. Additionally, these programs do not cover the range of services needed in many communities, such as certain behavioral health and addiction treatment services. **Given the persistent, recent and emergent challenges of providing care in rural areas, Medicare and Medicaid payment rates need to be updated to cover the cost of providing care.**

Site-neutral Policies. Site-neutral policies seek to reduce reimbursement for non-emergency services delivered in provider-based departments (PBDs). These policies fail to recognize that patients treated in PBDs – relative to those seen in physician offices – are more likely to be on Medicare, Medicaid, have medically complex conditions and live in high-poverty areas. PBDs also must comply with more comprehensive licensing and regulatory requirements. **AHA opposes any expansion of site-neutral policies.**

Behavioral Health. Eliminating statutory barriers to treatment and reforming information-sharing laws related to a patient's substance use disorder history will improve care in rural communities. **We urge Congress to fully fund authorized programs to treat substance use disorders, including expanding access to medication-assisted treatment; implement policies to better integrate and coordinate behavioral health services with physical health services; and increase access to care in underserved communities.**

Sequestration. We urge Congress to end Medicare sequestration, which bluntly cuts all payments to hospitals and critical access hospitals (CAHs) by 2 percent.

Support New Models of Care

As the health care field moves toward value-based care and population health, hospitals are participating in alternative payment and care delivery models that have different incentives than the traditional fee-for-service system, and often connect patients to services beyond the walls of the hospital. However, many new models either exclude rural providers or overlook the unique challenges of providing care in rural communities. **New rural models need to be developed and those currently being tested by the Centers for Medicare & Medicaid Services (CMS) need to be evaluated for success, and if appropriate, expanded and extended.**

Rural Emergency Hospital (REH). Establishment of a REH designation under the Medicare program would allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient care. Emergency services would be provided 24 hours a day, 365 days a year, and communities would have the flexibility to align additional outpatient and post-acute services

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with community needs and receive enhanced reimbursement. **AHA supports legislation that would establish a new designation under the Medicare program to allow rural hospitals to continue providing necessary emergency and observation services (at enhanced reimbursement rates), but cease inpatient services.**

Bundled Payments and Alternative Payment Models (APMs). Bundled payment arrangements generally provide a single, comprehensive payment that involves all of the services involved in a patient's episode of care. Yet most of the existing bundled payment models are not available to rural hospitals due to their low volume and other unique circumstances. **Voluntary bundled payment models for rural providers should be tested to determine their feasibility and success in improving quality and affordability. In addition, a gradual, flexible approach to increasing reporting requirements under the Merit-based Incentive Payment System (MIPS) should be continued, and opportunities for small and rural providers to participate in advanced APMs should be expanded.**

Rural Community Hospital (RCH) Demonstration Program. Congress has twice extended the RCH Demonstration Program to allow hospitals with 25-50 beds to test the feasibility of cost-based Medicare reimbursement for inpatient services. A recent evaluation of this program found that beneficiaries were assured access to quality care and participants largely benefitted from the demonstration reimbursement structure. **The RCH Demonstration Program should be expanded and made permanent.**

Frontier Community Health Integration Project (FCHIP) Demonstration. This three-year demonstration, which started in 2016, tests several care delivery innovations, including cost-based reimbursement for telehealth services. Given the small number of participants (10 hospitals), an extension of the demonstration would increase data availability and allow for a more comprehensive evaluation of performance. **The FCHIP demonstration should be extended and new models of care that address the varying circumstances of rural hospitals should continue to be tested and evaluated for effectiveness and cost.**

Remove Red Tape

Hospitals and health systems must comply with 341 mandatory regulatory requirements and an additional 288 requirements for post-acute care. They spend $39 billion each year on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other hospitals, their lower patient volumes mean that, on a per-patient basis, the cost of compliance is often higher. **Policymakers should provide relief from outdated or unnecessary regulations that do not improve patient care.**

Direct Supervision. The "direct supervision" of a physician for low-risk procedures provided in CAHs and small, rural hospitals strains the already limited workforce in many rural communities, and increases costs, ultimately threatening access. **We urge Congress to make permanent the enforcement moratorium on the CMS's "direct supervision" policy for outpatient therapeutic services provided in CAHs and small, rural hospitals.**

96-hour Rule. We urge Congress to pass legislation to permanently remove the 96-hour physician certification requirement for CAHs. These hospitals would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay, but removing the physician certification requirement would allow CAHs to serve patients needing critical medical services that have standard lengths of stay greater than 96 hours.

Co-location. CMS should clarify its rules related to shared space or "co-location" arrangements between hospitals and/or health care professionals to allow rural hospitals to partner with other providers to offer

a broader range of services. These arrangements may include leasing space once a month to specialists, such as cardiologists and behavioral health professionals, as well as implementing structural changes in order to facilitate patient experience.

Care Coordination. We urge Congress to create a safe harbor under the Anti-kickback Statute to protect clinical integration arrangements that work to improve care through collaboration, and eliminate compensation from the Stark Law to return its focus to government ownership. While not intended by the laws, the potential for violating these statutes may be higher for rural hospitals in light of their unique conditions. For example, low patient volume may necessitate the need to share specialists with non-affiliated hospitals, as a result, ongoing patient referrals to these facilities could implicate the Anti-kickback Statute.

Support Health Information Technology

Rural hospitals are committed to the improved care made possible through health information technology (HIT), including electronic health records (EHRs) and telehealth. However, they continue to face barriers that can impede their efforts. **Updates to federal telehealth coverage policies are needed along with additional resources for providers to continue to adopt and utilize HIT.**

Promoting Interoperability Program (PIP). The use of EHRs to meet increased requirements for information exchange through programs like the PIP (formerly known as the EHR Incentive Programs, or meaningful use), result in significant investment to purchase, upgrade, and maintain equipment and software. Many of these costs are ongoing, including expensive system upgrades required by regulation and the recruitment and retention of trained staff to use and service the technology. Rural hospitals must meet the same regulatory requirements for the PIP as other hospitals, yet often do not need the additional technology functionality contained in required, expensive system upgrades. **While CMS recently provided needed flexibility in the PIP, concerns remain that the requirements and technology costs are beyond the reach of some rural hospitals.**

Telehealth. Telehealth expands access to services that may not otherwise be sustained locally. By increasing access to physicians and specialists, telehealth helps ensure patients receive the right care, at the right place, at the right time. However, even in cases where originating sites are eligible to bill Medicare for a telehealth facility fee, the reimbursement rates are marginal compared to the overall costs. **Medicare policies should be updated to cover telehealth delivery for all services that are safe to provide, eliminate geographic and setting requirements, ensure adequate reimbursement for originating sites, and expand the types of technology which may be used (e.g., remote patient monitoring). Payers should also provide payment parity with services delivered in-person and Congress should pass legislation to allow eligible hospitals to test and evaluate telehealth services for Medicare patients.**

Broadband. Lack of affordable, adequate broadband infrastructure impedes routine health care operations (such as widespread use of EHRs and imaging tools) and limits their availability. **Federal investment in broadband connectivity should continue to be a priority.**

Bolster the Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. More than 60 percent of the health professional shortage areas (HPSAs) are located in rural or partially rural areas.

Targeted programs that help address workforce shortages in rural communities should be supported and expanded. Workforce policies and programs also should encourage nurses and other allied professionals to practice at the top of their license.

Conrad State 30 Program. We urge Congress to pass legislation to extend and expand the Conrad State 30 J-1 visa waiver program, which waives the requirement to return home for a period of time if physicians holding J-1 visas agree to stay in the U.S. to practice in a federally designated underserved area for three years.

Graduate Medical Education. We urge Congress to pass legislation to increase the number of Medicare-funded residency slots, which would expand training opportunities in rural settings and help address health professional shortages.

Rein in Prescription Drug Prices

The increased cost of prescription drugs is straining providers' ability to access the drug therapies they need to care for their patients and the ability of patients to pay for their medicines. Action is needed to reduce the cost of prescription drugs and to prevent erosion of the 340B drug pricing program, which helps hospitals serving vulnerable populations stretch scarce resources.

340B Program. In 2015, 340B hospitals provided $50 billion in total benefits to their communities. Hospitals were able to provide these benefits despite significant fiscal pressures: in that same year, one out of every four 340B hospitals had a negative operating margin, and one in three 340B CAHs had a negative operating margin. **Any effort to scale back or limit the effectiveness of the 340B program as part of a plan to lower drug prices is misplaced. Reducing the program would have devastating consequences for the patients and communities served; 340B is vital to rural communities and must be protected.**

High Price of Prescription Drugs. Policymakers need to take action to make prescription drugs more affordable. Possible actions include fast-track generic medicines to market; prevent drug manufacturers from making small adjustments to older drugs in order to reap the financial benefits and protections reserved for new drugs; and prohibit payments to generic manufacturers to delay the release of a cheaper version of a prescription drug.

To learn more and view the full 2019 Advocacy Agenda, visit www.aha.org.

Seneca Healthcare District
Financial Education Program

Tab 2- Rural Healthcare Provider Types

NC Rural Health Research & Policy Analysis Center

A Comparison of Rural Hospitals with Special Medicare Payment Provisions to Urban and Rural Hospitals Paid Under Prospective Payment

Final Report No. 98

August, 2010

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A Comparison of Rural Hospitals with Special Medicare Payment Provisions to Urban and Rural Hospitals Paid Under Prospective Payment

Final Report No. 98

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Executive Summary

The financial performance of rural hospitals has long been a concern to federal and state agencies. Four specific Medicare hospital classifications, each with different payment enhancements and qualification criteria, are available to hospitals that serve rural communities [sole community hospital (SCH), Medicare-dependent hospital (MDH), rural referral center (RRC), and critical access hospital (CAH)]. The perceived benefits of conversion to CAH status have led to calls for expansion of cost-based reimbursement to other rural hospitals that are purported to be under financial pressure. However, the financial performance and condition of these other rural hospitals have not been empirically assessed.

This study compares the financial performance and condition of rural hospitals with special Medicare payment provisions to urban and rural hospitals paid under prospective payment (U-PPS and R-PPS hospitals, respectively). Nine ratios from the three most common categories of ratios used in financial statement analysis (profitability, liquidity, and capital structure) as well as four other ratios that are commonly used to evaluate rural hospital financial performance are assessed.

There are five principal findings from this study:

- *There is variation in financial condition across types of rural hospitals.* It is inaccurate to characterize all rural hospitals as being under financial pressure; rather it appears that some types have many hospitals under a lot of pressure (CAHs, MDHs and R-PPS hospitals), some have some hospitals under pressure (SCHs), and some have few hospitals under pressure (RRCs and RRC/SCHs). The hospitals under a lot of pressure should be of greater concern to policy makers and those concerned with access to hospital care by people who live in rural America.

- *There were substantial differences between CAHs and other hospitals.* On average, CAHs took longer to collect their receivables, received more of their revenue from outpatient business, and had lower levels of allowances and discounts. In terms of profitability, on average, CAHs, MDHs, and R-PPS hospitals were consistently less profitable than other hospital classifications. CAHs had the oldest fixed assets in two of three years. With older plant and equipment, CAHs may in the future have diminished ability to attract patients and retain physicians.

- *RRCs appear to have performed well as a group.* They had greater ability to pay obligations related to long-term debt, principal payments and interest expense. Probably the strongest finding of this study is the higher profitability of RRC/SCHs. These hospitals were better at controlling expenses relative to revenues, generating cash flow from providing patient care services, and avoiding financial distress from negative margins. These findings are likely influenced by the fact that RRCs and RRC/SCHs are the largest type of rural hospital.

- *Substantial differences in cash management exist among hospitals with different payment classifications.* U-PPS hospitals may have greater opportunities for short-term investment of surplus cash, or a higher proportion of U-PPS hospitals may belong to a system. Many systems "sweep" the cash accounts of their affiliated hospitals daily, so fewer dollars are left

on hand, and the hospitals depend upon their corporate office for any short-term credit or liquidity needs.

- *The profitability of all hospitals declined sharply in 2008.* The profitability decline likely reflects the worsening economy and raises concern for the hospital industry as a whole. Even RRCs, the strongest performers as a group, appear to have substantially deteriorated financial positions in 2008. It will be important to monitor future rural hospital financial performance to gauge the effects of both the economy and health reform legislation.

The benefit of Medicare cost-based reimbursement for CAHs has led to calls for its expansion to other rural hospital classifications that are purported to be under financial pressure. However, this study has found that CAHs remain relatively less profitable, suggesting that Medicare cost-based reimbursement, while potentially improving Medicare revenues, should not be seen as a panacea for rural hospitals. (Note that this study did not specifically consider the potential effect of changes to reimbursement methods.) The financial performance of CAHs relative to other hospital classifications suggests that low volumes, payment from other payers (private insurance, Medicaid, and self pay), and uncompensated care still have a substantial impact on the financial condition of these hospitals. Therefore, while extending Medicare cost-based reimbursement to other rural hospitals would likely result in financial benefit, the degree of improvement in financial condition to expect is uncertain.

Introduction

The profitability and financial performance of rural hospitals has long been a concern to federal and state agencies as well as banks, creditors, bond rating firms, and regulators. Some rural hospitals are at greater financial risk under the Medicare inpatient prospective payment system (PPS) because they have a low patient volume. These hospitals may struggle to cover their fixed costs with revenue that depends, in part, on how many patients they see. Many rural hospitals are the only hospital facility in their community and their survival is vital to ensure timely access to health care. For nearly as long as Medicare has paid for hospital services prospectively, Federal law makers have authorized the Medicare program to address the challenges faced by different kinds of rural hospitals with alternative payments and adjustments that address these challenges. There are currently four classifications of rural hospitals that can qualify for special payment provisions under Medicare: Critical Access Hospitals (CAHs), Medicare Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs), and Rural Referral Centers (RRCs).

The majority of rural hospitals are classified as CAHs, which are reimbursed for 101% of their Medicare allowable costs for inpatient and outpatient care. Reimbursement to all other rural hospitals with special Medicare payment provisions is based on either an adjusted PPS payment or a hospital-specific rate calculated from historical costs. Table 1 presents payment methods applied to each classification in greater detail.

Current payment methodologies and eligibility criteria reflect a series of legislative changes which have occurred since the four rural hospital Medicare payment classifications were each originally created. The changes have been primarily to increase reimbursement levels and expand eligibility. The Medicare Modernization Act of 2003 (MMA) increased the maximum average daily census for CAHs from 15 to 25. The MMA also increased CAH payment from 100% of reasonable costs to 101% and permitted CAHs to operate distinct part psychiatric and rehabilitation units that are not counted in the 25-bed limit. The MMA ended states' authority to declare hospitals "necessary providers," which had previously allowed hospitals to qualify for CAH status even when they did not meet distance requirements.

Successive legislative changes have allowed SCHs and MDHs to base their hospital-specific base payment on more recent years' cost per discharge. The most recent updates were in the Deficit Reduction Act of 2005 (DRA) which allows MDHs to use 2002 cost per discharge trended forward, and in the Medicare Improvements for Patients and Providers Act of 2008, which allows SCHs to use their 2006 costs per discharge to determine a hospital specific rate. The DRA also increased the proportion of the difference between the hospital specific rate and the PPS rate that is used in MDH payment from 50% to 75%.

The disproportionate share adjustment available to RRCs and SCHs was increased through the Benefits Improvement and Protection Act of 2000. The percent of additional reimbursement increased again in the MMA, but was also capped at 12% for SCHs.

Table 1: Medicare Payment Classifications of Rural Hospitals

Classification	Payment method	Eligibility criteria
Critical access hospital (CAH)	• Reimbursement is 101 percent of allowable costs for inpatient, outpatient, laboratory, therapy services, and post acute services in swing beds (BBA 1997); • If CAH owns and operates the only ambulance service within 35 miles, this service receives cost-based reimbursement; and • While IPPS and OPPS do not apply, Medicare Part A and B deductible and coinsurance rules do except for pneumococcal pneumonia vaccines, influenza vaccines, related administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests.	• Distance from nearest like hospital • Size (<25 beds) • Formerly states could declare hospitals "necessary providers" to qualify[1] • Provide 24-hour emergency care • Average LOS<=96 hours

Sole community hospital (SCH)	• Inpatient reimbursement is the greatest aggregate of the federal rate applicable to the hospital or the updated hospital-specific rate based on fiscal year 1982, 1987 (OBRA 1989), 1996 (BBRA 1999), or 2006 costs per discharge (MIPPA 2008);
	• Disproportionate share adjustment (DSH):
	  • If DSH patient percentage (DPP) > 20.2%: Adjustment = 5.88% + .825*(DPP-20.2%)
	  • If DSH patient percentage (DPP) =< 20.2%: Adjustment = 2.5% + .65*(DPP-15%)
	  • Adjustment may not exceed a cap of 12%. (MMA 2003); and
	• Volume decline adjustment: If caseload falls by 5% due to circumstances beyond the SCH's control, it may receive payments necessary to fully compensate for fixed costs (OBRA 1989).
		• > 35 miles from nearest like hospital OR
		• 25-35 miles from nearest like hospital AND
		  • Bed size (<50) OR
		  • Exclusive Medicare service in area OR
		  • Closer hospitals are inaccessible.
		OR
		• Other hospitals are 15-24 miles but are inaccessible
		• Driving time to next hospital >45mins.

Medicare-dependent hospital (MDH)	• Inpatient reimbursement is the PPS rate plus 75% of the amount by which costs per discharge for Medicare patients from 1982, 1987 (OBRA 1993), or 2002 trended forward (DRA 2005) exceed the PPS rate;
	• Disproportionate share adjustment
	  • Same as SCH
	  • No cap (DRA 2005); and
	• Volume decline adjustment: If caseload falls by 5% due to circumstances beyond the MDH's control, it may receive payments necessary to fully compensate for fixed costs (renewed through 2011 in DRA 2005).
		• Rurality
		• Bed size (<100 beds)
		• Not SCH eligible
		• > 60% inpatient discharges to Medicare patients

Rural referral center (RRC)	• Reimbursement is based on the urban PPS rate (OBRA 1989); and
	• Disproportionate share adjustment:
	  • Same as SCH
	  • No cap, and;
	• Exempt from demonstrating two of three criteria for geographic reclassification: Proximity to the redesignation area and that its wages exceed 106 percent of area's average wage.
		• Rurality
		• High case-mix intensity and sufficient supply of specialists OR
		• Size (>275 beds) OR
		• High referral volume

BBA: Balanced Budget Act; IPPS: Inpatient perspective payment system; OPPS: Outpatient perspective payment system; DRA: Deficit Reduction Act; OBRA: Omnibus Budget Reconciliation Act; BBRA: Balanced Budget Refinement Act.

[1] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated this provision, effective January 2006.

Despite the payment augmentations for MDHs, SCHs and RRCs, continued reported financial difficulties for rural hospitals (both those that qualify for special Medicare payment provisions and those that are reimbursed under PPS) have attracted the interest of rural hospital advocates. Several parties, in and outside of Congress, have proposed expanding the cost-based reimbursement that is available to CAHs to other rural hospitals.

In the MMA, Congress instituted a demonstration program for expanding cost-based reimbursement to hospitals with 25-50 beds. The Rural Community Hospital (RCH) Demonstration Program selected a small sample of rural hospitals which may be MDHs, SCHs or rural hospitals paid under PPS. In the first pay period they received reasonable cost-based reimbursement, followed by either the lower of cost-based reimbursement or the previous year's amount updated to the current cost period. For MDHs and SCHs, this provides reimbursement that covers current year costs more closely than the current payment methods.

In its 2009 Legislative and Regulatory Agenda, the National Rural Health Association advocated that Medicare payment to SCHs should be 101% of reasonable costs. Similarly, in its 2009 Rural Agenda, the American Hospital Association advocated extending and expanding the RCH Demonstration Program.

Despite several proposals to expand cost-based reimbursement to rural hospitals other than CAHs, the relative financial performance of rural hospitals with different Medicare payment classification has not been extensively studied. In its 2003 Annual Report to the Congress, the Medicare Payment Advisory Commission published 2000 total margins by hospital classification but no other analyses were undertaken (MedPac, 2003).

Several studies have concluded that CAH conversion improved the financial viability of small rural hospitals. Stensland et al. (2002) showed average total profit margins for converting hospitals increased from -2.5% to 3.7% two years after gaining CAH status. Time series regression models on data from converting hospitals in Nebraska and Oklahoma also detected financial improvements following conversion, controlling for other hospital characteristics (Chen et al., 2004; Li, Schneider, and Ward, 2009). Lawler, Doeksen and Schott (2003) calculated that CAH status was associated with significantly smaller financial losses for the 15 Oklahoma hospitals in their study.

Other studies have investigated rural hospital financial performance. Younis (2003) found that rural and small hospitals face significant factors that hinder performance in comparison to urban and larger hospitals, such as diseconomies of scale. McCue (2007) compared large, rural for-profit and nonprofit hospitals and found that for-profit rural hospitals achieved a greater positive cash flow by focusing on both control of labor costs and operating costs per discharge. McCue and Nayar (2009) compared for-profit and nonprofit RRCs and concluded that for-profit RRCs generated a substantially higher cash flow margin by controlling their operating costs.

This study fills the gap in existing knowledge by comparing the financial performance and condition of rural hospitals with special Medicare payment provisions to hospitals paid under PPS - both urban (U-PPSs) and rural (R-PPSs). More specifically, the profitability, liquidity, and capital structure is compared across classifications over time. Financial distress, measured by the percent of hospitals with negative margins, is also assessed.

Seneca Healthcare District
Financial Education Program

Tab 3- Rural Hospital and Clinic Finance

Small Rural Hospital and Clinic Finance 101

Updated July 2018

NATIONAL
RURAL HEALTH
RESOURCE CENTER

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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 rural health clinic 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 2 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 2016 CAH US medians as listed in the *CAH Financial Indicators Report: Summary of 2016 Medians by State* updated by the Flex Monitoring Team in April 2018. Each indicator also notes if favorable values are trending above or below the median.

Table B. CAH Financial Indicator Medians, 2016

CAH Financial Indicator	2016 US Median	Favorable Trending
Days in Net Accounts Receivable	51.34	Down
Days in Gross Accounts Receivable	48.91	Down
Days Cash on Hand	77.72	Up
Total Margin	2.74%	Up
Operating Margin	0.93%	Up
Debt Service Coverage	3.35	Up
Salaries to Net Patient Revenue	44.90%	Down
Medicare Inpatient Payer Mix*	72.70%	Down
Average Age of Plant (years)	10.48	Down
Long Term Debt to Capitalization	27.20%	Down

*Summit participants agreed Overall Payor Mix was a more comprehensive indicator of financial performance than Medicare Inpatient Payor Mix alone.
Source: Flex Monitoring Team CAH Financial Indicators Reports Primer and Calculator Resources, Template for Presentation of CAHFIR Data, April 2018.

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:

	2015	2016	2017
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 2016 CAH US Median = **51.34 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:

	2015	2016	2017
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 2016 CAH US Median = **58.91 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:

	2015	2016	2017
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 2016 CAH US Median = **77.72 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:

	2015	2016	2017
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 2016 CAH US Median = **2.74 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:

	2015	2016	2017
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 2016 CAH US Median = **0.93 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:

	2015	2016	2017
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 2016 CAH US Median = **3.35**.

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:

	2015	2016	2017
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 2016 CAH US Median = **44.90 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 measures the percentage of total inpatient days that are provided to patients of each payer type. The 2016 CAH US Median for Medicare inpatient payer mix was **72.70 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 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:

	2015	2016	2017
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 2016 CAH US Median = **10.48 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:

	2015	2016	2017
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 2016 CAH US Median = **27.20 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:

	2015	2016	2017
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 2016 CAH US Median = **2.48**.

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 rural health clinic, 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 2018, Medicare provides $25.76 in reimbursement for the originating site. This includes the CAH and rural health clinic. 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 it 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 Hospital 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 Hospital 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 rural health clinic 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, rural health clinics 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 rural health clinics (RHC) 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]		2015	2016	2017
	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]		2015	2016	2017
	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]		2015	2016	2017
	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

Seneca Healthcare District
Financial Education Program

Tab 4- Rural Healthcare and Critical Access Hospital (CAH) Reimbursement

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Critical Access Hospitals
Basics of Cost-Based Reimbursement

Jeffrey M. Johnson, CPA
Partner, WIPFLI
August 2015

Basics of Cost-Based Reimbursement for Critical Access Hospitals (CAHs)

Objective of the discussion: To gain a high-level understanding of cost-based reimbursement for CAHs and it's impact on financial reporting

Discussion agenda:

- Provide understanding of differences in Medicare hospital reimbursement methods
- Understand how CAHs get paid - (Interim rates vs. final settlement)
- Understand the impact of cost-based reimbursement on financial statement reporting

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Medicare Overview

Medicare reimbursement depends on the services provided:

Inpatient and swing bed services:

- Based on 101% of average cost per day for inpatient services (as computed in the Medicare cost report):
  - Paid on an interim basis using a per diem rate for routine and ancillary costs
  - Final settlement for each fiscal year is based on the filed Medicare cost report after the intermediary completes their audit

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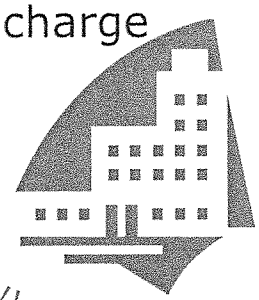
Medicare Overview

Outpatient (OP) services:

- Based on 101% of cost to provide services to Medicare patients (as computed in the Medicare cost report):
  - Paid on an interim basis using a percentage of Medicare charges
    - Percentage calculated by dividing the overall allowable Medicare costs by the overall Medicare charges, Medicare cost-to-charge ratio
  - Final settlement for each fiscal year is based on the filed Medicare cost report after the intermediary completes their audit



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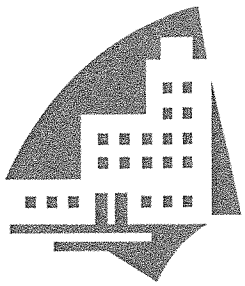
Medicare Overview

Services often tied to a CAH that are not cost-based reimbursed:

- Freestanding clinics
- Professional component physician and non-physician practitioners
- Hospital-based home health agencies
- Hospital-based skilled nursing facility
- Ambulance services (if not the only local provider)
- Distinct part psych and rehab units
- Reference lab



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Summary of Differences Between Prospective Payment (PPS) Hospital vs. CAH Reimbursement

Type of Service	PPS Hospital	CAH
Inpatient	DRG	101% x Cost
OP procedures (Surgery, etc.)	APC	101% x Cost
Lab	Fee schedule	101% x Cost (Except for reference lab)
Radiology	APC	101% x Cost
Other diagnostics	APC	101% x Cost
Therapies	Fee schedule	101% x Cost
Swing bed	MDS	101% x Cost
Ambulance service	Fee schedule	Fee schedule (Unless only one within 35 miles, then cost)
OP clinics (Facility component)	APC	101% x Cost

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PPS vs. CAH Reimbursement

Type of Service	PPS Hospital	CAH
OP clinics (Professional component)	Fee schedule (Reduced for site of service)	Fee schedule (reduced SOS) and Method II Billing (if elected)
CRNA services	Fee schedule (Unless elect cost if less than 800 procedures per year)	Fee schedule and Method II Billing (if elected) OR elect cost if less than 800 procedures per year
Outlier payments	Cost (Generally insignificant for rural providers)	N/A
Disproportionate Share Hospital (DSH)	Add-on to DRG payments	N/A

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PPS vs. CAH Reimbursement

Type of Service	PPS Hospital	CAH
Indirect medical education (IME)	Add-on to DRG payment	N/A
72-hour rule (DRG window)	Applies	N/A
Exempt units	Rehab units Psychiatric units	Limited to 10 exempt unit beds
Hold harmless provisions (For rural hospitals with fewer than 100 beds and Sole Community Hospitals (SCH)/Essential Access Community Hospitals (EACH))	Applied through December 31, 2012	N/A
Sequestration in effect reducing Medicare payments by 2% through 2025	Applies	Applies

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Overview of the Medicare Cost Report

- Medicare (and many Medicaid programs) – CAH services are reimbursed based on cost as computed on the cost report
- The cost report is a systematic method of cost accounting determining allowable cost
- Requires a settlement process at the end of each entity's fiscal year that reconciles cost of providing Medicare services to interim payments made throughout the year
- CAH settlement can have a very dynamic impact on financial statements if not closely monitored
- Cost report is due five months after provider's year-end

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Overview of the Medicare Cost Report

Interim reimbursement is not final reimbursement

- Interim reimbursement:
  - Determined from hospital records
  - Based on historical or budgeted information
- Final reimbursement:
  - Determined by cost report "as filed"
  - Tentative settlement
  - Final settlement (may not be determined for two to three years after filing)

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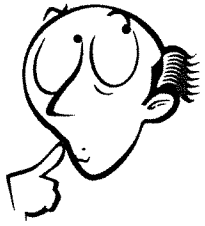
Overview of the Medicare Cost Report: CAH Reimbursement Methodologies

Service Line	Interim Rate	Final Settlement
Inpatient – routine & ancillary services	Per diem	101% of cost
Swing Bed – routine & ancillary services	Per diem	101% of cost
SNF – Part A - routine & ancillary services	RUG IV	N/A
SNF – Part B - ancillary services	Fee schedule	N/A
OP Services:		
Radiology & other diagnostics	Ratio of cost to charges (RCC)	101% of cost
ASC & other OP surgeries/procedures	RCC	101% of cost
Emergency room	RCC	101% of cost
Chemotherapy, IV therapy & blood administration	RCC	101% of cost
Observation	RCC	101% of cost
Supplies & drugs	RCC	101% of cost
Clinical lab (Not subject to coinsurance)	RCC	101% of cost
Other OP services (PB clinics, mental health, etc.)	RCC	101% of cost
Non-patient (reference) lab	Fee schedule	N/A
CRNA professional services	Fee schedule	N/A
CRNA – low volume exception (less than800 procedures/year)	Pass-through – bi-weekly	Cost
HHA	HHRG	N/A
Ambulance	Primarily fee schedule	Primarily fee schedule
Provider-based physician services	Fee schedule – SOS reduction	N/A
Provider-based physician services (Method II billing)	115% of fee schedule (SOS)	N/A
Provider-based RHC (less than 50 bed exception)	Per encounter	Cost per visit – not subject to federal limit
Free-standing RHC (not provider-based)		Lower of cost per visit or federal limit

Overview of the Medicare Cost Report

What is reasonable cost?



- Providers cannot claim excessive costs:
  - Follows "prudent buyer" principle
  - Necessary and proper in providing services
  - Must be related to patient care
  - Adequate cost data and cost finding support

Overview of the Medicare Cost Report

Certain costs are always not allowable:

- Non-Medicare bad debts
- Certain advertising
- Other revenue collected needs to be offset against costs:
  - Cafeteria revenue
  - Investment income (except on funded depreciation investments)
  - Space rental income

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Overview of the Medicare Cost Report

Cost centers:

- Overhead cost centers/departments examples:
  - Capital (i.e., depreciation, interest expense)
  - Employee benefits
  - Administration
  - Maintenance
  - Laundry
  - Housekeeping
  - Dietary
  - Nursing administration

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Overview of the Medicare Cost Report

Cost Centers:

- Examples of patient care cost centers:
  - Adults and pediatrics
  - Operating room
  - Lab
  - Radiology
  - Physical therapy
  - Drugs charged to patients
  - Medical supplies charged to patients
  - Emergency room

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Medicare Cost Report and Financial Reporting

Hospitals need to be proactive - Avoid surprises!

- Monitor financial statements regularly
- Prepare interim cost reports
- Review allowances and settlements (payables vs. receivables)
- Request interim rate adjustments

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Resources

- CAH Finance 101 Manual: Designed to be as non-technical as possible and to provide answers to frequently asked questions regarding finance and financial performance.
- Rural Assistance Center
- Flex Monitoring Team
- CMS Online Manuals:
  - Pub 100-4, Chapter 3, Section 30, Inpatient Part A Hospital Manual
  - Pub 100-4, Chapter 4, Section 250, Part B Hospital (including Inpatient Hospital Part B and OPPS)
  - Pub 100-4, Chapter 6, Section 20, SNF Inpatient Part A Billing
  - Pub 100-4, Chapter 16, Sections 30.3 & 40.3.1, Laboratory Services from Independent Labs, Physicians & Providers

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Appendix: Cost Report/ Reimbursement Acronyms

A&G	Administrative and General
AHSEA	Adjusted Hourly Salary Equivalency Amount
ASC	Ambulatory Surgery Center
APC	Ambulatory Payment Classification
BBA	Balanced Budget Act
BIPA	Benefits Improvement and Protection Act
CAH	Critical Access Hospital (10/97)
CCU	Coronary Care Unit
CFR	Code of Federal Regulations
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid
CMS Pub.	Health Care Financing Administration Facility
CORF	Comprehensive Outpatient Rehabilitation Facility
CRNA	Certified Registered Nurse Anesthetist
CTC	Certified Transplant Center
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospital
EACH	Essential Access Community Hospital
FI	Fiscal Intermediary – Medicare Part A
FQHC	Federally Quality Health Center
FR	Federal Register
FTE	Full Time Equivalent
GME	Graduate Medical Education
HHA	Home Health Agency
HMO	Health Maintenance Organization
ICF/MR	Intermediate Care Facility for the Mentally Retarded (9/96)
ICU	Intensive Care Unit
IME	Indirect Medical Education
IP	Inpatient
LCC	Lesser of Reasonable Cost or Customary Charges
LTC	Long Term Care
MAC	Medicare Administrative Contractor (i.e. FI)
MDH	Medicare Dependent Hospital (10/97)
MSA	Metropolitan Statistical Area (10/97)
MSP	Medicare Secondary Payer
NF	Nursing Facility
OBRA	Omnibus Budget Reconciliation Act
OT	Occupational Therapy
OP	Outpatient
OPPS	Outpatient Prospective Payment System
OHCI	Office of Healthcare Information
PBP	Provider-Based Physician
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
PS&R	Provider Statistical and Reimbursement System
PT	Physical Therapy
RCC	Ratio of Costs to Charges
RCE	Reasonable Compensation Equivalent
RHC	Rural Health Clinic
RPCH	Rural Primary Care Hospital
RT	Respiratory Therapy
RUG	Resource Utilization Group
SCH	Sole Community Hospitals
SNF	Skilled Nursing Facility
ST	Speech Therapy
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TOPPS	Transitional Corridor Payment for Outpatient Prospective Payment System
WKST	Worksheet

Seneca Healthcare District
Financial Education Program

Tab 5- Seneca Healthcare District (SHD) Monthly Board Financial Packet

Seneca Healthcare District

Financial Statements - Board Report

January 2019

Summary

Seneca Healthcare District had net income of $739k, during the month, compared to budgeted net income of $843k; for a negative variance of $104k. This was due to a negative variance in operating expenses and other operating revenue (PRIME Grant); which was somewhat offset by a positive variance in net patient revenue. For the year to date, there was a loss of $418k compared to a budgeted loss of $138k.

Revenues

Gross patient revenue, for the month, ended at $2.48M compared to a budgeted amount of $2.24M, for a positive variance of $236k. Net patient revenue, as a percent of gross, is 51.3%, compared to the budget of 52.0%. This was due to a negative variance in bad debt.

We had 33 acute inpatient days in the month (budget of 34), and 45 swing bed days (budget of 17), resulting in an average daily census (ADC) of 2.52 patients per day. The skilled nursing unit had an ADC of 15.90, resulting in an occupancy percent of 99.40%.

Outpatient volumes were both up (ED, PT, and radiology) and down (lab, pharmacy, and surgery). The Lake Almanor Clinic visits were down due to a decrease in available provider days (open office).

Expenses

Total operating expenses for the month were $1.46M ,versus a budget of $1.39M, for a negative variance of $68k.

Salaries & Wages: Salaries and wages were under budget by $5k, due to staffing shortages covered by contract labor. FTEs, for the month, were 115.10 versus a budget of 106.80.

Contract Labor: Contract labor is over budget by $30k this month, mainly due to continued staffing shortages in nursing areas (Acute and LTC) and radiology, and continued new hire training in LTC.

Pro Fees Medical: Negative variance in actual ED physician hourly rate ($163.87 versus $136.88) and OT services, which was somewhat offset by a decrease in the use of locum providers in the clinic (open office).

Other Expenses: Over budget due to agency placement fee for an RN and housing/travel for locum providers.

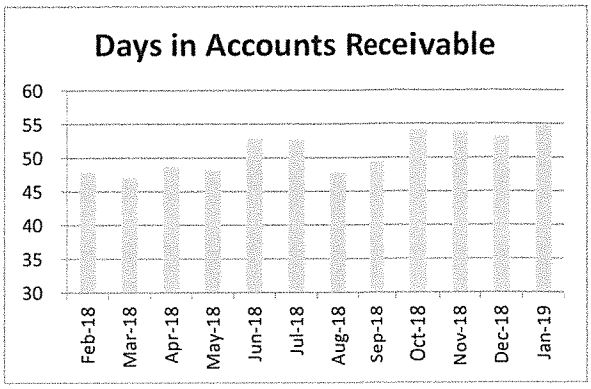
All Other Expense Categories: Mainly within budget.

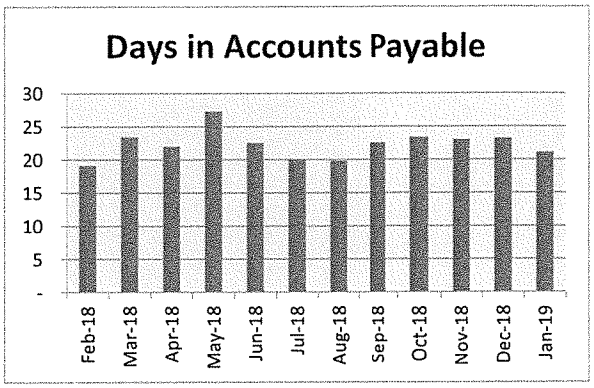
Additional Information

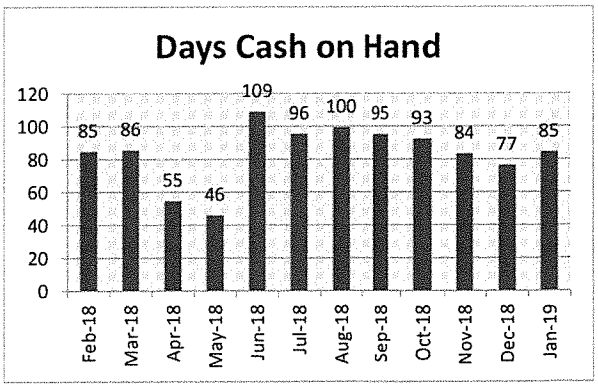
Days of cash on hand increased from 76.6 to 84.6 due to the receipt of PRIME Grant funds and the semi-annual property tax payment. The PRIME Grant receipt was $150k less than the budgeted amount.

Revenue Cycle

Gross accounts receivable ended the month at $4.11M, which is a $155k increase over last month. Gross accounts receivable days increased this month to 54.8, and remains just within the range of best practices of 45-55 days.







Key Financial Ratios - YTD

Current Ratio	5.92
Operating Margin	-8.5%
Days in Accounts Receivable	54.8
Long-Term Debt to Capitalization	0.02
Debt Service Coverage	-143%
Days Cash on Hand Excl. Board Restr	84.6

Seneca Healthcare District
Income Statement
For the Month of January 2019

		% Net Pt Revenue	Month-to-Date Actual	Budget	$ Variance	% Net Pt Revenue	Year-to-Date Actual	Budget	$ Variance
1	**REVENUE**								
2	Inpatient Revenue - Acute		106,557	112,684	(6,127)		823,395	808,453	14,942
3	Inpatient Revenue - Swing Bed		143,055	64,138	78,917		616,726	460,156	156,570
4	Inpatient Revenue - SNF		246,486	248,000	(1,514)		1,632,151	1,720,000	(87,849)
5	Inpatient Revenue - Ancillary		203,299	197,675	5,624		1,387,076	1,418,224	(31,149)
6	Inpatient Revenue - Total		699,397	622,497	76,901		4,459,348	4,406,833	52,514
7	Outpatient Revenue		1,781,182	1,621,980	159,201		12,484,635	11,636,925	847,710
8	Total Patient Revenue		2,480,579	2,244,477	236,102		16,943,983	16,043,758	900,225
9	Contractual Allowances		(1,074,125)	(1,007,245)	(66,880)		(7,601,939)	(7,225,410)	(376,530)
10	Charity Discount		(992)	(4,702)	3,711		(1,052)	(33,811)	32,760
11	Other Allowances		(30,943)	(22,581)	(8,362)		(121,473)	(162,363)	40,890
12	Bad Debt		(102,575)	(41,726)	(60,849)		(586,562)	(300,024)	(286,538)
13	Total Deductions		(1,208,634)	(1,076,254)	(132,380)		(8,311,026)	(7,721,608)	(589,418)
14	Net Patient Revenue		1,271,945	1,168,223	103,722		8,632,957	8,322,150	310,807
	% of Gross Revenue		*51.3%*	*52.0%*	*-0.8%*		*50.9%*	*51.9%*	*-0.9%*
15	Meaningful Use Revenue			-	-		-	-	-
16	Quality Payments			-	-		70,460	70,500	(40)
17	Other Operating Revenue		640,155	811,705	(171,550)		917,585	1,150,936	(233,351)
18	Total Operating Revenue		1,912,100	1,979,928	(67,828)		9,621,003	9,543,586	77,417
19	**EXPENSES**								
20	Salaries & Wages	45.4%	(578,063)	(582,543)	4,480	46.5%	(4,010,975)	(4,065,917)	54,942
21	Employee Benefits	11.6%	(148,050)	(130,861)	(17,189)	11.4%	(985,862)	(958,598)	(27,264)
22	Contract Labor	5.5%	(69,488)	(39,058)	(30,430)	7.5%	(644,003)	(387,284)	(256,719)
23	Professional Fees - Medical	22.5%	(286,685)	(266,137)	(20,549)	24.3%	(2,093,583)	(1,862,957)	(230,626)
24	Professional Fees - Other	1.4%	(17,455)	(17,393)	(62)	1.2%	(102,666)	(119,753)	17,087
25	Supplies	5.8%	(73,309)	(93,320)	20,010	6.7%	(578,653)	(653,237)	74,584
26	Purchased Services	10.1%	(128,364)	(137,646)	9,282	11.1%	(955,611)	(963,525)	7,914
27	Insurance	0.8%	(9,834)	(11,309)	1,475	0.8%	(67,422)	(86,309)	18,887
28	Rentals and Leases	1.1%	(13,728)	(12,328)	(1,400)	1.1%	(92,215)	(93,688)	1,473
29	Repairs and Maintenance	1.6%	(20,859)	(17,786)	(3,073)	1.4%	(124,785)	(140,367)	15,582
30	Utilities and Telephone	3.2%	(40,891)	(38,824)	(2,067)	2.9%	(252,829)	(262,136)	9,307
31	Depreciation & Amortization	2.6%	(32,442)	(25,833)	(6,609)	2.5%	(215,734)	(201,930)	(13,804)
32	Other Expenses	3.1%	(39,479)	(17,380)	(22,099)	3.7%	(318,923)	(183,024)	(135,899)
33	Total Operating Expenses	114.7%	(1,458,646)	(1,390,418)	(68,229)	121.0%	(10,443,261)	(9,978,725)	(464,536)
34	Income From Operations	35.7%	453,454	589,510	(136,057)	-9.5%	(822,258)	(435,139)	(387,119)
35	Tax Revenue	20.9%	265,612	235,000	30,612	3.1%	265,612	235,000	30,612
36	IGT - Incoming Portion	0.0%		-	-	0.0%	-	-	-
37	Non Capital Grants and Donations	0.0%	75	4,182	(4,107)	1.2%	100,675	29,091	71,584
38	Interest Income	1.7%	21,670	15,475	6,195	0.5%	44,563	38,400	6,163
39	Interest Expense	-0.1%	(1,398)	(750)	(648)	-0.1%	(6,368)	(5,250)	(1,118)
40	Non-Operating Income (Expense)	0.0%			-	0.0%	-	-	-
41	Total Non-Operating Gain (Loss)	22.5%	285,958	253,907	32,051	4.7%	404,482	297,241	107,241
42	**Net Income**	58.1%	739,412	843,417	(104,005)	-4.8%	(417,776)	(137,897)	(279,879)
43	Operating Margin %		23.7%	29.8%	-6.06%		(8.5%)	(4.6%)	-3.99%
44	Net Margin %		38.7%	42.6%	-3.93%		(4.3%)	(1.4%)	-2.90%
45	Payroll as % of Operating Expense		39.63%	41.90%	-2.27%		38.41%	40.75%	-2.34%
46	IGT Transaction Summary								
47	Outgoing				-		300,000	375,000	75,000
48	Incoming		600,000	750,000	(150,000)		600,000	750,000	(150,000)
49	Net Impact		600,000	750,000	(150,000)		300,000	375,000	(75,000)

Seneca Healthcare District
Income Statement
13-Month Trend Ended January 31, 2019

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
1	**REVENUE**													
2	Inpatient Revenue - Acute	187,282	161,450	119,473	83,954	51,664	132,389	155,442	113,015	119,473	122,702	116,244	61,351	106,557
3	Inpatient Revenue - Swing							28,611	19,074	15,895	133,518	143,055	133,518	143,055
4	Inpatient Revenue - SNF	308,825	248,648	317,911	281,327	286,086	265,398	276,543	247,925	229,856	209,466	211,500	238,986	246,486
5	Inpatient Revenue - Ancillary	339,252	228,741	218,859	177,094	50,195	126,953	230,809	101,087	141,516	217,278	284,466	208,620	203,299
6	Inpatient Revenue - Total	835,359	638,839	656,243	542,375	387,946	524,739	691,405	481,101	506,741	682,964	755,265	642,475	699,397
7	Outpatient Revenue	1,472,662	1,424,367	1,549,357	1,591,161	1,587,023	1,732,086	2,080,805	2,021,906	1,840,175	1,734,684	1,482,943	1,542,941	1,781,182
8	Total Patient Revenue	2,308,021	2,063,206	2,205,599	2,133,536	1,974,968	2,256,826	2,772,210	2,503,007	2,346,915	2,417,648	2,238,208	2,185,416	2,480,579
9	Contractual Allowances	(803,144)	(1,000,631)	(1,046,313)	(1,092,943)	(920,554)	(930,457)	(1,251,891)	(1,091,290)	(1,066,626)	(1,082,372)	(1,075,445)	(960,189)	(1,074,125)
10	Charity Discount	-	-	(2,980)	-	(7,891)	-	(60)	-	-	-	-		(992)
11	Other Allowances	(48,380)	(12,264)	(9,482)	(13,964)	(15,345)	(72,170)	(9,672)	(10,101)	(12,630)	(9,552)	(42,387)	(6,188)	(30,943)
12	Bad Debt	(50,818)	(43,299)	(36,513)	(62,206)	5,968	(67,761)	(126,818)	(82,629)	(79,468)	(88,864)	(22,681)	(83,527)	(102,575)
13	Total Deductions	(902,342)	(1,056,194)	(1,095,287)	(1,169,113)	(937,823)	(1,070,389)	(1,388,441)	(1,184,020)	(1,158,723)	(1,180,788)	(1,140,513)	(1,049,905)	(1,208,634)
14	Net Patient Revenue	1,405,679	1,007,012	1,110,312	964,424	1,037,146	1,186,437	1,383,769	1,318,987	1,188,192	1,236,859	1,097,696	1,135,511	1,271,945
	% of Gross Revenue	*60.9%*	*48.8%*	*50.3%*	*45.2%*	*52.5%*	*52.6%*	*49.9%*	*52.7%*	*50.6%*	*51.2%*	*49.0%*	*52.0%*	*51.3%*
15	Meaningful Use Revenue	-	-	-	-	-	-	-	-	-	-	-	-	
16	Quality Payments	-	-	53,553	-	77,330	303,475	-	70,460	-	-	-	-	
17	Other Operating Revenue	48,872	63,244	39,301	47,840	54,760	42,630	44,382	41,023	55,366	45,137	46,540	44,982	640,155
18	Total Operating Revenue	1,454,551	1,070,256	1,203,167	1,012,264	1,169,236	1,532,542	1,428,151	1,430,470	1,243,558	1,281,997	1,144,235	1,180,493	1,912,100
19	**EXPENSES**													
20	Salaries & Wages	(506,579)	(543,097)	(588,915)	(564,461)	(573,093)	(534,386)	(562,913)	(603,691)	(601,758)	(558,131)	(526,918)	(579,501)	(578,063)
21	Employee Benefits	(115,163)	(124,348)	(140,589)	(130,826)	(133,394)	(135,454)	(137,248)	(141,954)	(153,960)	(137,091)	(134,014)	(133,546)	(148,050)
22	Contract Labor	(87,390)	(58,218)	(52,990)	(47,635)	(68,017)	(62,120)	(80,406)	(93,143)	(107,203)	(108,023)	(101,487)	(84,253)	(69,488)
23	Professional Fees - Medical	(277,441)	(294,669)	(234,470)	(288,430)	(246,885)	(268,621)	(303,864)	(329,565)	(277,180)	(319,206)	(294,980)	(282,102)	(286,685)
24	Professional Fees - Other	(31,206)	(30,165)	(24,420)	(19,998)	(5,318)	(5,793)	(12,356)	(8,033)	(8,190)	(8,955)	(16,711)	(30,967)	(17,455)
25	Supplies	(83,457)	(84,452)	(77,025)	(86,990)	(95,012)	(82,051)	(102,724)	(94,057)	(67,379)	(93,570)	(70,719)	(76,894)	(73,309)
26	Purchased Services	(133,736)	(120,377)	(124,698)	(128,198)	(135,483)	(130,053)	(137,087)	(135,345)	(126,836)	(142,300)	(159,920)	(125,760)	(128,364)
27	Insurance	(11,251)	(11,088)	(11,480)	(11,161)	(11,976)	(15,704)	(9,687)	(9,808)	(9,604)	(9,454)	(9,442)	(9,593)	(9,834)
28	Rentals and Leases	(8,107)	(12,187)	(13,816)	(12,179)	(12,265)	(13,415)	(12,234)	(13,835)	(14,870)	(12,053)	(12,765)	(12,731)	(13,728)
29	Repairs and Maintenance	(13,990)	(24,653)	(14,819)	(12,994)	(24,519)	(18,493)	(16,228)	(19,931)	(16,256)	(20,161)	(17,536)	(13,814)	(20,859)
30	Utilities and Telephone	(36,986)	(37,774)	(31,591)	(25,617)	(24,093)	(27,484)	(36,260)	(35,930)	(24,560)	(37,134)	(37,663)	(40,391)	(40,891)
31	Depreciation & Amortization	(28,595)	(28,452)	(28,452)	(28,363)	(25,995)	(29,770)	(29,770)	(29,709)	(29,709)	(29,709)	(32,197)	(32,197)	(32,442)
32	Other Expenses	(43,961)	(18,507)	(17,186)	(24,792)	(14,550)	(20,555)	(63,060)	(34,800)	(33,498)	(49,744)	(33,366)	(64,977)	(39,479)
33	Total Operating Expenses	(1,377,862)	(1,387,987)	(1,360,451)	(1,381,644)	(1,370,598)	(1,343,898)	(1,503,837)	(1,549,800)	(1,471,004)	(1,525,531)	(1,447,718)	(1,486,725)	(1,458,646)
34	Income From Operations	76,689	(317,731)	(157,284)	(369,381)	(201,362)	188,644	(75,686)	(119,330)	(227,446)	(243,535)	(303,483)	(306,232)	453,454
35	Tax Revenue	250,887	-	-	-	216,824								265,612
36	IGT - Incoming Portion	-	-	-	-	-	2,812,181							
37	Non Capital Grants and Donations	75	-	75	75	9,270	32,075	75	20,075	75	75	75	80,225	75
38	Interest Income	2,464	774	732	2,658	3,047	150	2,903	764	276	18,191	418	340	21,670
39	Interest Expense	(1,977)	(1,718)	(1,477)	(1,019)	(981)	(1,005)	(904)	(895)	(824)	(775)	(767)	(806)	(1,398)
40	Non-Operating Income (Expense)	-	-	-	-	-	-	-	-	-	-	-		
41	Total Non-Operating Gain (Loss)	251,449	(944)	(670)	1,714	228,160	2,843,402	2,074	19,944	(473)	17,491	(273)	79,759	285,958
42	**Net Income**	328,138	(318,675)	(157,954)	(367,667)	26,798	3,032,046	(73,611)	(99,386)	(227,919)	(226,043)	(303,756)	(226,473)	739,412
43	Operating Margin %	5.3%	(29.7%)	(13.1%)	(36.5%)	(17.2%)	12.3%	(5.3%)	(8.3%)	(18.3%)	(19.0%)	(26.5%)	(25.9%)	23.7%
44	Net Margin %	22.6%	(29.8%)	(13.1%)	(36.3%)	2.3%	197.8%	(5.2%)	(6.9%)	(18.3%)	(17.6%)	(26.5%)	(19.2%)	38.7%
45	Payroll as % of Operating Expense	36.77%	39.13%	43.29%	40.85%	41.81%	39.76%	37.43%	38.95%	40.91%	36.59%	36.40%	38.98%	39.63%
46	IGT Transaction Summary													
47	Outgoing	-			(1,143,293)	(300,000)							300,000	
48	Incoming	-					2,812,181							600,000
49	Net Impact	-	-	-	(1,143,293)	(300,000)	2,812,181		-	-	-	-	(300,000)	600,000

Seneca Healthcare District
Comparative Balance Sheets - Board Report
Dates as Indicated

	Unaudited	Audited	Audited	Audited	FY 2019-2018	
	FY 2019	FY 2018	FY 2017	FY 2016	$ Change	% Change
	as of 1/31/2019	6/30/2018	6/30/2017	6/30/2016		
ASSETS						
Current Assets						
Cash	$ 621,694	$ 3,049,118	$ 545,974	$ 479,334	$ (2,427,424)	-79.61%
Short-term Investments	3,404,552	1,785,509	2,448,283	1,099,283	1,619,043	90.68%
Total Cash and Equivalents	**4,026,247**	**4,834,627**	**2,994,258**	**1,578,617**	**(808,381)**	**-16.72%**
Patient Accounts Receivable	4,111,280	3,690,839	3,753,966	3,963,203	420,441	11.39%
Accounts Receivable Reserves	(2,758,669)	(2,351,508)	(2,523,762)	(2,526,195)	(407,161)	17.31%
Net Accounts Receivable	**1,352,611**	**1,339,331**	**1,230,204**	**1,437,008**	**13,280**	**0.99%**
% of Gross Accounts Receivable	*32.9%*	*36.3%*	*32.8%*	*36.3%*		
Inventory	270,109	271,364	289,935	313,664	(1,255)	-0.46%
Other Assets	540,563	386,736	118,285	1,031,124	153,827	39.78%
Board Restricted Funds - Facility Capital	349,224	500,000	500,000	0	(150,776)	
Board Restricted Funds	589,743	569,274	561,217	555,966	20,470	3.60%
Total Other Assets	1,749,640	1,727,373	1,469,437	1,900,753	22,267	1.29%
Total Current Assets	**7,128,498**	**7,901,332**	**5,693,899**	**4,916,379**	**(772,834)**	**-9.78%**
Fixed Assets						
Land	90,610	90,610	90,610	90,610	0	0.00%
Buildings	5,507,447	5,474,869	5,474,869	5,474,869	32,578	0.60%
Capital Equipment	4,816,542	4,551,366	4,368,480	4,352,629	265,176	5.83%
Total Plant & Equipment	10,414,598	10,116,844	9,933,959	9,918,108	297,754	2.94%
Accumulated Depreciation	(8,327,856)	(8,112,122)	(8,227,224)	(8,220,918)	(215,734)	2.66%
Net Fixed Assets	**2,086,742**	**2,004,722**	**1,706,735**	**1,697,190**	**82,020**	**4.09%**
TOTAL ASSETS	**$ 9,215,240**	**$ 9,906,054**	**$ 7,400,637**	**$ 6,613,569**	**$ (690,813)**	**-6.97%**
LIABILITIES AND RETAINED EARNINGS						
Current Liabilities						
Accounts Payable	$ 487,199	$ 459,765	$ 468,249	$ 566,130	$ 27,434	5.97%
Accrued Payroll & Benefits	625,537	470,965	349,249	341,361	154,572	32.82%
Accrued Other Liabilities	90,740	138,836	47,000	0	(48,095)	0.00%
Total Current Liabilities	**1,203,476**	**1,069,566**	**864,498**	**907,490**	**133,910**	**12.52%**
Long-Term Liabilities						
Loans	39,008	131,633	347,912	583,760	(92,625)	-70.37%
Capitalized Leases	141,195	155,519	85,293	183,755	(14,324)	-9.21%
Total Long-Term Liabilities	**180,203**	**287,152**	**433,205**	**767,515**	**(106,949)**	**-37.24%**
TOTAL LIABILITIES	**1,383,680**	**1,356,718**	**1,297,703**	**1,675,005**	**26,962**	1.99%
FUND BALANCE	**7,831,561**	**8,549,336**	**6,102,934**	**4,938,564**	**(717,776)**	**-8.40%**
TOTAL LIABILITIES AND FUND BALANCE	**$ 9,215,240**	**$ 9,906,054**	**$ 7,400,637**	**$ 6,613,569**	**$ (690,814)**	**-6.97%**

Seneca Healthcare District
Detail of Long Term Debt
As of January 31, 2019

Description	Original Amount	Origination Date	Interest Rate	Monthly Payment	Maturity	Secured By	Balance on Jan 31, 2019
Loans							
CHFFA Help II Loan	387,890	July 2011	3.00%	5,179	September 2018	Patient AR	0
CHFFA Help II Loan	400,000	January 2015	3.00%	7,187	February 2019	Patient AR	1,008
PG&E	70,258	December 2015	0.00%	2,423	April 2018	Assets	0
Evident	114,000	October 2017	0.00%	4,750	September 2019	Equipment	38,000
Total Loans	972,148			19,539			39,008
Capitalized Leases							
Siemens	172,672	September 2017	5.63%	2,492	August 2024	Equipment	141,195
Jules	500,081	February 2013	5.80%	9,622	February 2018	Equipment	0
Total Capitalized Leases	672,753			12,114			141,195
Total Long Term Liabilities	1,644,901			31,653			180,203

Seneca Healthcare District
Summary Statement of Cash Flows - Board Report
Fiscal Year-to-Date

	YTD 1/31/2019
Net Income (Loss)	$ (417,776)
Changes in:	
Depreciation	215,734
(Increase)/Decrease in Net Accounts Receivable	(13,279)
(Increase)/Decrease in Inventory	1,255
(Increase)/Decrease in Other Assets	(153,827)
Increase/(Decrease) in Accounts Payable	27,434
Increase/(Decrease) in Accrued Payroll & Benefits	154,572
Increase/(Decrease) in Other Accrued Liabilities	(48,095)
Net Cash Provided (Used) by Operating Activities	183,792
Purchases of Equipment	(297,754)
Net Cash Provided (Used) in Investing Activities	(297,754)
Proceeds from New Loans	-
Principal Payments of Loans	(92,625)
Principal Payments under Capital Leases	(14,324)
Principal Payments under Inter-Governmental Transfer Program	(300,000)
Net Cash Provided (Used) in Financing Activities	(406,949)
Net Change in Cash and Cash Equivalents	(938,687)
Cash and Cash Equivalents, Beginning of Period	5,903,901
Cash and Cash Equivalents, End of Period	$ 4,965,214

*Inclusive of Board Restricted Cash

Cash Detail by Account

Operating Checking - Plumas Bank	$ 615,923
Suspense General Ledger for Receipts Pending R.A.'s	(32)
Payroll Checking - US Bank	5,458
Business Savings - Plumas Bank	732,400
Petty Cash - Receptionists	645
Local Agency Investment Fund	3,558,764
Series EE Bonds	52,056
Total Cash and Cash Equivalent Detail	$ 4,965,214

SENECA HEALTHCARE DISTRICT
ACTIVITY SUMMARY
FOR THE MONTH OF JANUARY 2019

		MONTH TO DATE			YEAR TO DATE	
		CURRENT MONTH JAN 2019	PRIOR MONTH DEC 2018	PRIOR YEAR MONTH JAN 2018	JULY 2018 - JAN 2019	JULY 2017 - JAN 2018
1.	In Patient Stays					
	1.a Admissions	10	7	20	85	81
	1.b Discharges	8	8	19	83	80
2.	Out Patient Observations	9	10	16	63	91
3.	Out Patient Surgeries	19	23	14	134	129
4.	Emergency Visits	265	223	175	1,979	1,684
5.	Lab Procedures	2,379	2,586	2,968	19,565	19,323
6.	Radiology Procedures	367	236	274	2,306	2,000
	6.a X-Ray Procedures	198	135	183	1,344	1,341
	6.b Mammography	0	0	9	0	99
	6.c MRI	7	3	12	58	64
	6.d Ultrasound	40	18	0	188	38
	6.e C T Scan	122	80	70	716	458
	6. f Dexascanner	0	0	0	0	0
7.	Respiratory Therapy/ABG/PFT	441	189	402	1,578	1,411
8.	CardioPulmonary EKG/Holter	61	54	50	451	404
9.	Stress Tests	0	1	0	2	7
10.	Physical Therapy	301	280	287	1,888	1,868
11.	Lake Almanor Clinic Visits	892	833	1,056	6,823	6,796
	Dr. Ware	192	181	221	1,521	1,520
	Dr. Walls	106	139	192	1,059	1,148
	Dr. Salehi	200	219	235	1,610	1,334
	Dr. Suarez/Open office	20	86	162	614	1,146
	Nurse Practitioner/Walk-in	255	119	188	1,278	1,177
	Specialty/Other	119	89	58	741	471
	ACUTE CARE					
12.	Acute Patient Days	33	19	58	255	278
13.	Acute ADC	1.06	0.61	1.87	1.19	1.31
14.	% Occupancy	10.65	6.13	18.71	11.86	13.11
15.	Avg Length of Stay	3.30	2.71	2.90	3.00	3.43
16.	Swing Bed Days	45	42	25	194	60
17.	Swing Bed ADC	1.45	1.35	0.81	0.90	0.28
18.	Total ADC	2.52	1.97	2.68	2.09	1.59
	SKILLED NURSING UNIT					
19.	Patient Days	493	478	458	3,265	2,859
20.	Average Daily Census	15.90	15.42	14.77	15.19	15.54
21.	% Occupancy	99.40	96.37	92.34	94.91	97.11
	TOTALS					
22.	Patient Days	571	539	541	3,714	3,655
23.	Average Daily Census	18.42	17.39	17.45	17.27	17.24
24.	Total Adjusted Patient Days	2,025	1,833	1,488	14,112	14,084

Seneca Healthcare District
Financial Education Program

Tab 6- Analysis of SHD Operations

Seneca Healthcare District

Statements of Revenues, Expenses and Changes in Net position

For The Years Ended June 30, 2018 and 2017

	2018	2017
Operating revenues		
Net patient service revenue	$ 18,610,917	$ 15,093,531
Other operating revenue	2,626,985	2,301,891
Total operating revenues	21,237,902	17,395,422
Operating expenses		
Salaries & wages	6,253,979	5,258,476
Employee benefits	1,454,009	1,290,014
Professional Fees	4,597,489	4,698,806
Purchased services	1,540,215	1,571,746
Supplies	1,001,398	977,238
Repairs & maintenance	229,190	297,766
Utilities	438,202	439,499
Rentals and leases	153,687	129,215
Insurance	139,012	129,981
Depreciation & amortization	314,184	221,336
Other operating expenses	240,450	208,065
Total operating expenses	16,361,815	15,222,142
Operating income	4,876,087	2,173,280
Nonoperating revenues (expenses)		
District tax revenues	506,078	475,593
Non-capital grants and donations	179,679	180,515
Investment income	21,136	18,006
Interest expense	(15,667)	(30,761)
Other non-operating income (expense)	-	11,000
Total nonoperating revenues (expenses)	691,226	654,353
Excess of revenues (expenses)	5,567,313	2,827,633
Inter-governmental transfers	(3,120,910)	(1,663,263)
Increase (decrease) in net position	2,446,403	1,164,370
Net position, beginning of the year	6,102,934	4,938,564
Net position, end of year	$ 8,549,337	$ 6,102,934

See accompanying notes to the financial statements

Seneca Healthcare District
Statements of Revenues, Expenses, and Changes in Net Position- Per Audit
June 30, 2019 through 2015

	Budget 2019	Audited 2018	Audited 2017
Operating revenue:			
Net patient service revenue	$ 17,194,293	$ 18,610,917	$ 15,093,531
Other operating revenue	2,760,000	2,626,985	2,301,891
Total revenue	19,954,293	21,237,902	17,395,422
Operating expenses:			
Salaries and wages	6,858,973	6,253,979	5,258,476
Employee benefits	1,620,622	1,454,009	1,290,014
Professional fees & purchased service	5,565,017	6,137,704	6,270,552
Supplies	1,119,834	1,001,398	977,238
Insurance	150,000	139,012	129,981
Other operating expenses	1,156,452	1,061,529	1,074,545
Depreciation	352,193	314,184	221,336
Total expenses	16,823,091	16,361,815	15,222,142
Gain/(loss) from operations	3,131,202	4,876,087	2,173,280
Non-operating revenue, net	601,500	691,226	654,353
Excess of revenue over expense	3,732,702	5,567,313	2,827,633
Inter-governmental transfers	(2,000,458)	(3,120,910)	(1,663,263)
Change in net position	1,732,244	2,446,403	1,164,370
Net position – Beginning of year	8,549,337	6,102,934	4,938,564
Net position – End of year	$ 10,281,581	$ 8,549,337	$ 6,102,934
Operating margin	15.69%	22.96%	12.49%
Total margin (w/o IGT)	18.71%	26.21%	16.26%
Total margin (with IGT)	8.68%	11.52%	6.69%
Supplemental payments included in Net patient service revenue	3,120,074	4,805,222	1,867,283
PRIME Grant funds included in Other operating income	1,500,000	1,980,000	1,620,000
Supplemental Payments:			
Hospital Quality Assurance Fee (HQAF) Program		845,787	438,701
PRIME Grant Program	1,500,000	1,980,000	1,620,000
Rate Range Program	3,120,074	3,959,435	1,428,582
Inter-governmental Transfers:			
Hospital Quality Assurance Fee (HQAF) Program		187,720	199,534
PRIME Grant Program	750,000	990,000	810,000
Rate Range Program	1,250,458	1,943,190	653,729
Net Benefit:			
Hospital Quality Assurance Fee (HQAF) Program	-	658,067	239,167
PRIME Grant Program	750,000	990,000	810,000
Rate Range Program	1,869,616	2,016,245	774,853
	2,619,616	3,664,312	1,824,020

Seneca Healthcare District
Statements of Revenues, Expenses, and Changes in Net Position- Per Internal F/S, net
June 30, 2019 through 2015

		Budget 2019	Audited 2018	Audited 2017
Operating revenue:				
Net patient service revenue	$	14,074,219	13,805,695	13,226,248
Other operating revenue		1,260,000	646,985	681,891
Total revenue		15,334,219	14,452,680	13,908,139
Operating expenses:				
Salaries and wages		6,858,973	6,253,979	5,258,476
Employee benefits		1,620,622	1,454,009	1,290,014
Professional fees & purchased service		5,565,017	6,137,704	6,270,552
Supplies		1,119,834	1,001,398	977,238
Insurance		150,000	139,012	129,981
Other operating expenses		1,156,452	1,061,529	1,074,545
Depreciation		352,193	314,184	221,336
Total expenses		16,823,091	16,361,815	15,222,142
Gain/(loss) from operations		(1,488,872)	(1,909,135)	(1,314,003)
Non-operating revenue, net		3,221,116	4,355,538	2,478,373
Excess of revenue over expense		1,732,244	2,446,403	1,164,370
Inter-governmental transfers		0	0	0
Change in net position		1,732,244	2,446,403	1,164,370
Net position – Beginning of year		8,549,337	6,102,934	4,938,564
Net position – End of year	$	10,281,581	8,549,337	6,102,934
Operating margin		-9.71%	-13.21%	-9.45%
Total margin (w/o IGT)		N/A	N/A	N/A
Total margin (with IGT)		11.30%	16.93%	8.37%
Supplemental payments, net, included in Non-operating revenue		1,869,616	2,674,312	1,014,020
PRIME Grant funds, net, included in Non-operating income		750,000	990,000	810,000

Seneca Healthcare District

Statements of Revenues, Expenses and Changes in Net position

For The Years Ended June 30, 2016 and 2015

	2016	2015
Operating revenues		
Net patient service revenue	$ 16,110,996	$ 13,127,743
Other operating revenue	657,741	180,039
Total operating revenues	16,768,737	13,307,782
Operating expenses		
Salaries & wages	5,275,163	4,989,216
Employee benefits	1,432,160	1,377,235
Professional Fees	4,857,638	3,784,914
Purchased services	1,431,187	1,068,745
Supplies	995,584	816,177
Repairs & maintenance	347,681	328,934
Utilities	443,918	412,372
Rentals and leases	164,371	166,923
Insurance	124,600	105,847
Depreciation & amortization	213,998	237,643
Other operating expenses	344,165	219,179
Total operating expenses	15,630,465	13,507,185
Operating loss	1,138,272	(199,403)
Nonoperating revenues (expenses)		
District tax revenues	534,715	434,621
Non-capital grants and donations	235,699	211,397
Investment income	23,015	12,089
Interest expense	(35,047)	(71,967)
Other non-operating income (expense)	(5,950)	155,000
Total nonoperating revenues (expenses)	752,432	741,140
Excess of revenues (expenses)	1,890,704	541,737
Inter-governmental transfers	(595,578)	(155,118)
Increase (decrease) in net position	1,295,126	386,619
Net position, beginning of the year	3,643,438	3,256,819
Net position, end of year	$ 4,938,564	$ 3,643,438

See accompanying notes to the financial statements

Seneca Healthcare District
Statements of Revenues, Expenses, and Changes in Net Position- Per Audit
June 30, 2019 through 2015

	Audited 2016	Audited 2015
Operating revenue:		
Net patient service revenue	$ 16,110,996	$ 13,127,743
Other operating revenue	657,741	180,039
Total revenue	16,768,737	13,307,782
Operating expenses:		
Salaries and wages	5,275,163	4,989,216
Employee benefits	1,432,160	1,377,235
Professional fees & purchased service	6,288,825	4,853,659
Supplies	995,584	816,177
Insurance	124,600	105,847
Other operating expenses	1,300,135	1,127,408
Depreciation	213,998	237,643
Total expenses	15,630,465	13,507,185
Gain/(loss) from operations	1,138,272	(199,403)
Non-operating revenue, net	752,432	741,140
Excess of revenue over expense	1,890,704	541,737
Inter-governmental transfers	(595,578)	(155,118)
Change in net position	1,295,126	386,619
Net position – Beginning of year	3,643,438	3,256,819
Net position – End of year	$ 4,938,564	$ 3,643,438
Operating margin	6.79%	-1.50%
Total margin (w/o IGT)	11.28%	4.07%
Total margin (with IGT)	7.72%	2.91%
Supplemental payments included in Net patient service revenue	1,240,220	321,471
PRIME Grant funds included in Other operating income	-	-
Supplemental Payments:		
Hospital Quality Assurance Fee (HQAF) Program	222,414	321,471
PRIME Grant Program		
Rate Range Program	1,017,806	
Inter-governmental Transfers:		
Hospital Quality Assurance Fee (HQAF) Program	86,037	155,118
PRIME Grant Program		
Rate Range Program	509,541	
Net Benefit:		
Hospital Quality Assurance Fee (HQAF) Program	136,377	166,353
PRIME Grant Program	-	-
Rate Range Program	508,265	-
	644,642	166,353

Seneca Healthcare District
Statements of Revenues, Expenses, and Changes in Net Position- Per Internal F/S, net
June 30, 2019 through 2015

	Audited 2016	Audited 2015
Operating revenue:		
Net patient service revenue	14,870,776	12,806,272
Other operating revenue	657,741	180,039
Total revenue	15,528,517	12,986,311
Operating expenses:		
Salaries and wages	5,275,163	4,989,216
Employee benefits	1,432,160	1,377,235
Professional fees & purchased service	6,288,825	4,853,659
Supplies	995,584	816,177
Insurance	124,600	105,847
Other operating expenses	1,300,135	1,127,408
Depreciation	213,998	237,643
Total expenses	15,630,465	13,507,185
Gain/(loss) from operations	(101,948)	(520,874)
Non-operating revenue, net	1,397,074	907,493
Excess of revenue over expense	1,295,126	386,619
Inter-governmental transfers	0	0
Change in net position	1,295,126	386,619
Net position – Beginning of year	3,643,438	3,256,819
Net position – End of year	4,938,564	3,643,438
Operating margin	-0.66%	-4.01%
Total margin (w/o IGT)	N/A	N/A
Total margin (with IGT)	8.34%	2.98%
Supplemental payments, net, included in Non-operating revenue	644,642	166,353
PRIME Grant funds, net, included in Non-operating income	-	-

Seneca Healthcare District

Statements of Revenues, Expenses, and Changes in Net Position- Per Internal F/S, net

June 30, 2019 through 2015

	Budget 2019	Audited 2018	Audited 2017	Audited 2016	Audited 2015
Operating revenue:					
Net patient service revenue	$ 14,074,219	13,805,695	13,226,248	14,870,776	12,806,272
Other operating revenue	1,260,000	646,985	681,891	657,741	180,039
Total revenue	15,334,219	14,452,680	13,908,139	15,528,517	12,986,311
Operating expenses:					
Salaries and wages	6,858,973	6,253,979	5,258,476	5,275,163	4,989,216
Employee benefits	1,620,622	1,454,009	1,290,014	1,432,160	1,377,235
Professional fees & purchased service	5,565,017	6,137,704	6,270,552	6,288,825	4,853,659
Supplies	1,119,834	1,001,398	977,238	995,584	816,177
Insurance	150,000	139,012	129,981	124,600	105,847
Other operating expenses	1,156,452	1,061,529	1,074,545	1,300,135	1,127,408
Depreciation	352,193	314,184	221,336	213,998	237,643
Total expenses	16,823,091	16,361,815	15,222,142	15,630,465	13,507,185
Gain/(loss) from operations	(1,488,872)	(1,909,135)	(1,314,003)	(101,948)	(520,874)
Non-operating revenue, net	3,221,116	4,355,538	2,478,373	1,397,074	907,493
Excess of revenue over expense	1,732,244	2,446,403	1,164,370	1,295,126	386,619
Inter-governmental transfers	0	0	0	0	0
Change in net position	1,732,244	2,446,403	1,164,370	1,295,126	386,619
Net position – Beginning of year	8,549,337	6,102,934	4,938,564	3,643,438	3,256,819
Net position – End of year	$ 10,281,581	8,549,337	6,102,934	4,938,564	3,643,438
Operating margin	-9.71%	-13.21%	-9.45%	-0.66%	-4.01%

Seneca Healthcare District
Financial Education Program

Tab 7- Revenue Cycle in a Rural Hospital

Revenue Cycle Management in a Critical Access or Small Rural Hospital

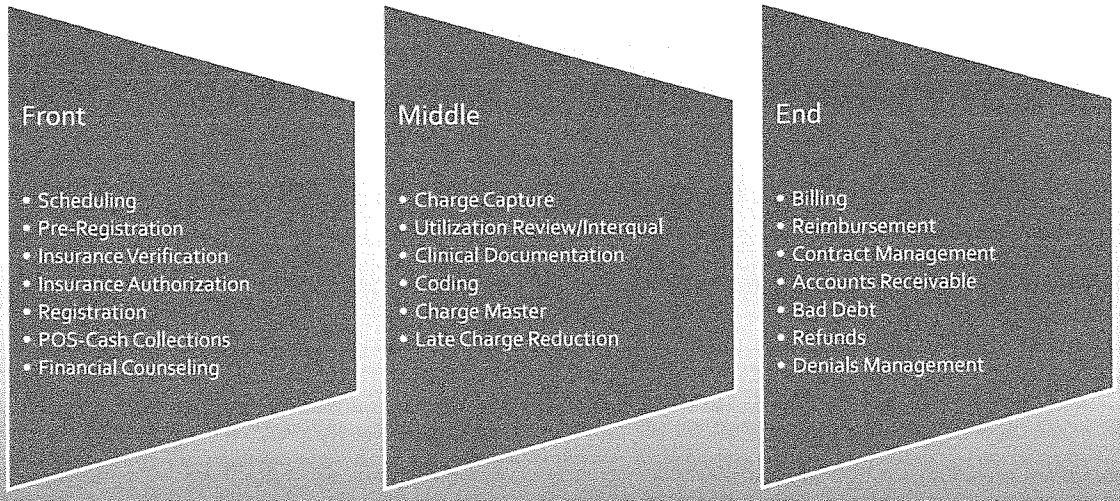
National Conference of State Flex Programs
July 11, 2012

Steve Boline, CPA
Regional CFO

Presentation Outline

- What is Revenue Cycle
- Revenue Cycle Opportunities/Benefits (why do it)
- Revenue Cycle Implementation (how to do it)
- Nevada Case Study (outcomes)
- Quality Assurance, Performance Monitoring, and Benchmarking

- A means to improve hospital revenue and reimbursement by streamlining workflow, processes, and education in the following areas:



What is Revenue Cycle?

- Permanently improve financial and operational performance
- Increase focus on financial and customer service outcomes
- Establish an accountable and proactive environment
- Change management and interdepartmental communication tools
- Implement comprehensive measurement and reporting
- Monitor and consistently recognize employee performance

Revenue Cycle Vision

- Provide financial stability and sustainability
- Increase cash flow
- Improve operating margin
- Cement the success of business services
- Accelerate the pace of change
- Significantly enhance the capability of tools
- Build a stronger leadership team

Revenue Cycle Objectives

- Focus on improving balance sheet performance, reducing A/R days, and increasing cash flow
- Application of more labor, more technology, and special "one-time" projects
- Silo/single department orientation
- Does not address root-cause process breakdowns and dysfunctional culture
- Results are typically short-lived

Traditional Revenue Cycle Approach

- Multi-disciplinary
- Comprehensive
- Executive level sponsorship and visibility
- Mandatory not optional
- Enhancement of tools
- Culture change is integral
- Dramatic and permanent results

Holistic Revenue Cycle Approach

- Unique opportunity to increase first year cash flow
- Reduce controllable write-offs and denials
- Improve contract compliance to reduce underpayments
- Improve coding quality and documentation
- Reduce medical necessity denials
- Revise charge master and perform charge capture and rate structure assessments
- Insulate facilities from the potential negative impact of government regulatory programs, such as RAC

Revenue Cycle Opportunities

- Fundamentally restructure revenue cycle processes to achieve desired outcomes through the assessment of the condition of the current processes (as is) and identification of the needed process (to be)
- Quickly address readiness for change
- Develop a team approach through the creation and utilization of revenue cycle related committees
- Utilize current IT functionality to manage the revenue cycle
- Reinforce revenue cycle "basics" with day to day coaching
- Evaluate staff using objective performance metrics

Implementation Approach

Question	Drop Down Response Option
What software system do you use for registration?	
Enter comments in the text box if appropriate option is not available in the drop down response option box.	
What software system do you use for financial?	
Enter comments in the text box if appropriate option is not available in the drop down response option box.	
What system do you use for billing? (Clearinghouse and scrubber software)	
Enter comments in the text box if appropriate option is not available in the drop down response option box.	
How many registrations are performed daily? Please provide an average by area: OPT, IP, ER, LT Care, Clinics.	
Enter comments in the text box if appropriate option is not available in the drop down response option box.	
Do you utilize a quick registration process for emergency room patients?	
Enter comments in the text box if appropriate option is not available in the drop down response option box.	
Do you have a benefits/eligibility process?	

Assessment Questionnaire

- Don't assume there is no opportunity
- Executive leadership, visibility, and involvement are vital
- Expect proactive behavior and collaboration
- Reorganization and reporting changes are necessary
- Human and financial investment is essential
- Standardized process creates better outcomes
- Comprehensive measures are key
- Requires a sustained effort by all parties
- Recognize when you need external expertise

Success Factors

Nevada Rural Hospital Partners
Revenue Cycle
Improvement Program
(RCIP)

South Lyon Medical Center (SLMC) in Yerington Nevada

- Sole community PPS hospital
- Service area population of 5,000
- 14 acute beds, 49 LTC, 3 rural health clinics
- Flat utilization in recent years
- 2/3 of patient revenue = Medicare/Medicaid
- SLMC reported a loss of $487,756, and cash reserves fell by 50% to just under $650,000 (3/31/07)

NRHP Case Study

- Initiated as objectives of Flex and SHIP Grant programs in April 2004; funding provided by these two grants
- Key measures established and data collection undertaken
- Revenue cycle and charge master committees formed
- Full Revenue Cycle program initiated May 2007 and fully in place March 2009

BEFORE		AFTER	
• Net A/R days	80	• Net A/R days	53
• Bad debt %	8.5	• Bad debt %	7.8
• Net revenue per PE	$186.95	• Net revenue per PE	$196.27

NRHP Case Study

- A/R Days –

  Reduction in A/R days (27) times average daily revenue ($28,000) = $756,000

- Bad Debt Expense –

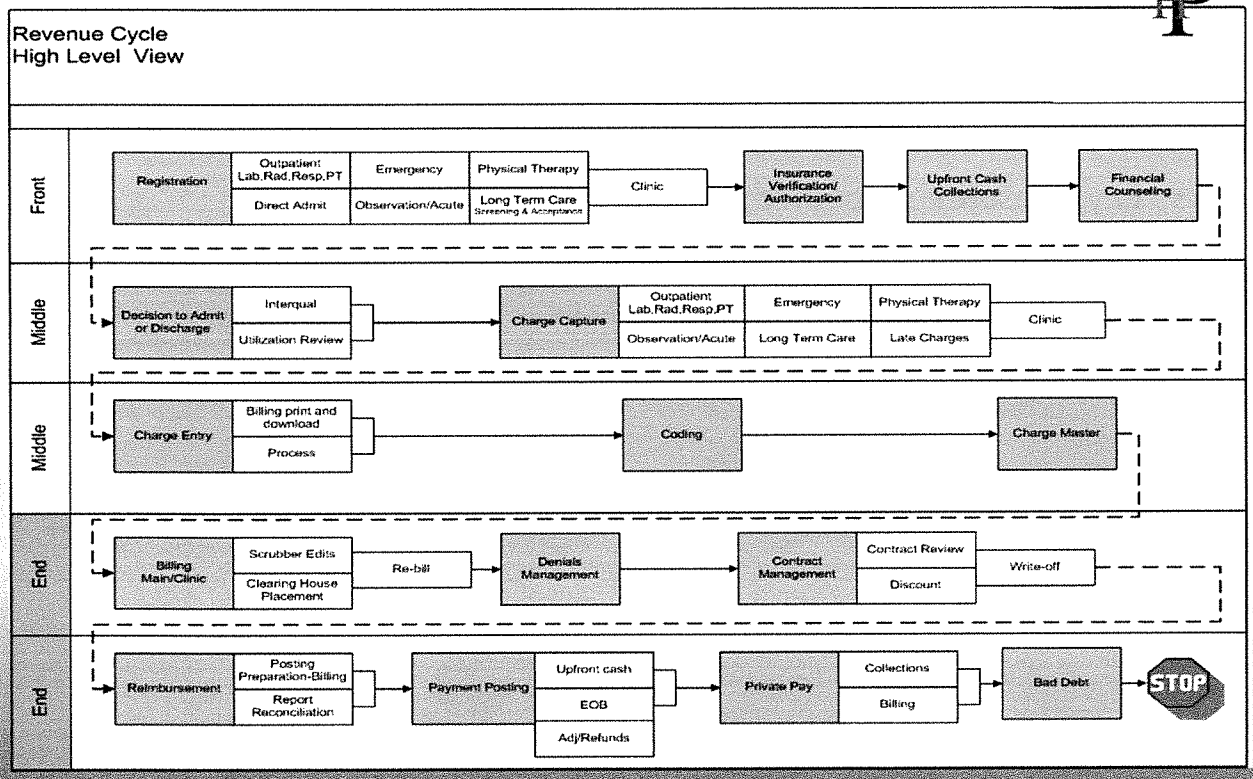
  Reduction in bad debt percentage (.75%) times gross patient revenue ($16,600,000) = $124,500

- Net Revenue per Patient Encounter (PE) –

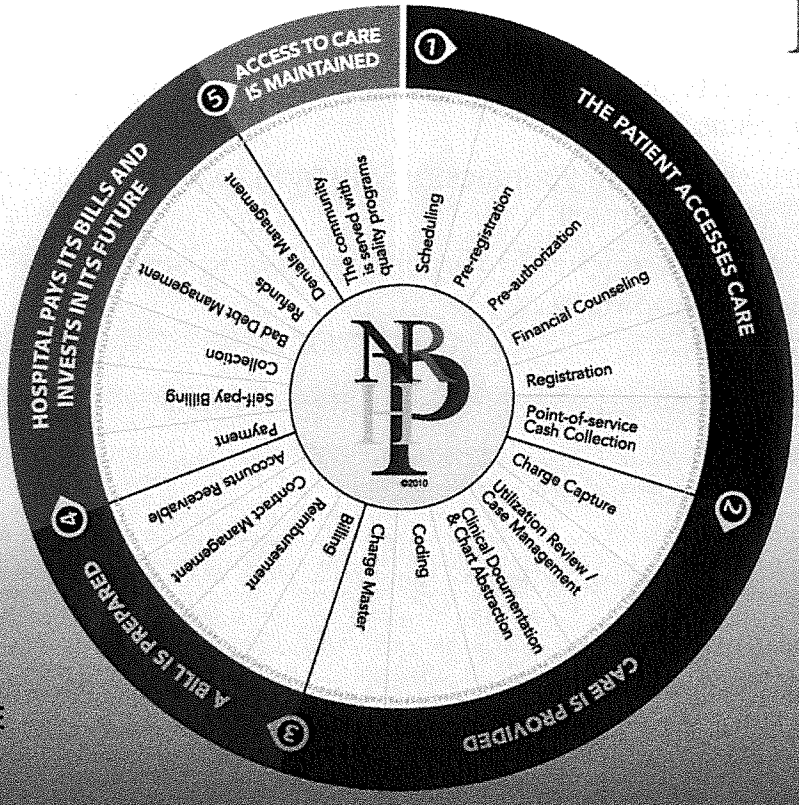
  Increase in net revenue per PE ($9.32) times patient encounters (52,000) = $485,000

- Total impact: $1,365,500

Impact of Case Study



Revenue Cycle Map



NRHP
REVENUE CYCLE
IMPROVEMENT
PROGRAM

Quality Improvement and Core Measures

- It supports change in perceptions (you can not argue with quantifiable data)
- It sets the tone in your facility (you monitor both negative and positive outcomes)
- It provides a mechanism for understanding outcomes, thus fostering employee buy-in
- It establishes accountability for failing, non-invested employees
- It drives focused retraining/education for your staff
- It provides data to your leadership allowing them to focus on areas of potential struggle
- And finally, it allows a means to celebrate improvement once goals and targets have been achieved

Why Measure the Data?

- Net Patient Revenue per Patient Encounter (PE)
- Net Patient Revenue as a Percent of Gross Patient Revenue
- Cash Collected as a Percent of Net Patient Revenue
- Bad Debt Expense as a Percent of Gross Patient Revenue
- Gross A/R Days
- % of A/R greater than 90 days
- Discharged Not Final Billed (DNFB)
- Denials Management
- Registration Accuracy
- Point of Service (POS) Collections

Revenue Cycle Core Measures

NRHP Dashboard													
		POS Collections	Overall Collections	Registration Accuracy	Denials (W/O)	Initial Denials %	Net Pt. Revenue per Pt. Encounter	Net Pt. Revenue as % of Gross Pt. Revenue	Cash Collected as % of Net Pt. Revenue	Bad Debt Expense as % of Gross Pt. Revenue	Gross A/R Days	% of A/R > 90 days	DNFB
Targets				95%		5%							
January	Admitting	$ 14,550.16	$ 29,137.46	98%	$ 7,681.00	3%							
	Business Off	$ 2,654.09		NC									
	Clinic 1	$ 8,873.12		96%									
	Clinic 2	$ 3,060.09		96%									
February	Admitting	$ 16,095.48	$ 31,553.64	97%	$ 10,414.00	2%							
	Business Off	$ 2,654.09		NC									
	Clinic 1	$ 9,662.18		98%									
	Clinic 2	$ 3,141.89		99%									
March	Admitting	$ 10,000.00	$ 20,600.00	98%	$ 55,000.00	5%							
	Business Off	$ 2,600.00		95%									
	Clinic 1	$ 3,000.00		99%									
	Clinic 2	$ 5,000.00		100%									

Sample Core Measure Dashboard

Facility Name Here									
Accounts	User Name	Patient Information	Guarantor	Emergency Contact		Insurance 2	Insurance 3	Occurrence Code	Monthly Error Total
67	WC 5	9	0	0	0	4	0	3	16
45	WC 6	1	0	0	0	1	0	2	4
22	WC 4	0	0	0	4	0	0	0	4
30	WC 3	2	0	0	0	6	0	2	10
124	WC 1	0	0	0	1	1	0	0	2
62	WC 2	4	0	2	0	6	0	5	17
									53
350		16	0	2	5	18	0	12	Total By Category

 # OF ACCOUNTS

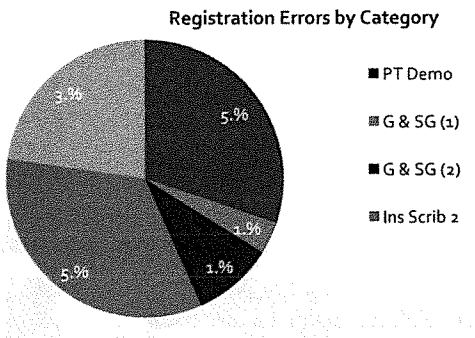
Input data in the shaded area to auto populate accuracy/error percentages

Monthly Registration Number by Area and User			Error % by User	Accuracy % by User
	Total Accounts	Total Errors	Error % by user	Monthly Accuracy
WC 5	67	16	24%	76%
WC 6	45	4	9%	91%
WC 4	22	4	18%	82%
WC 3	30	10	33%	67%
WC 1	124	2	2%	98%
WC 2	62	17	27%	73%
	350	53	15%	85%
Monthly Totals				
			Accuracy Requirement per Policy	95%
			Efficient/Deficient Accuracy	-10%

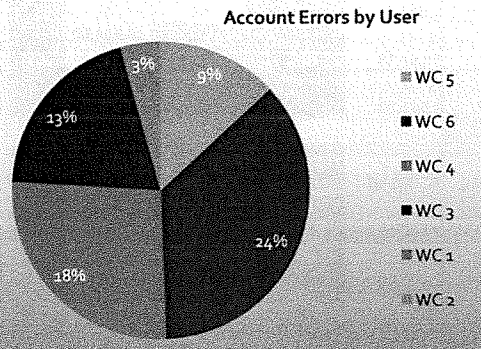
Registration Accuracy

Sample Template

Registration Errors by Category		
Demographic Category	Number of Errors per Category	User Error Percentage
Patient Information	16	5%
Guarantor	0	0%
Emergency Contact	2	1%
Insurance 1	5	1%
Insurance 2	18	5%
Insurance 3	0	0%
Occurrence Code	12	3%
Percentage calculated by # of accounts	350	



Account Errors by User		
User Name	Number of Errors per User	User Error Percentage
WC 5	16	24%
WC 6	4	9%
WC 4	4	18%
WC 3	10	33%
WC 1	2	2%
WC 2	17	27%
Percentage calculated by # of accounts	350	



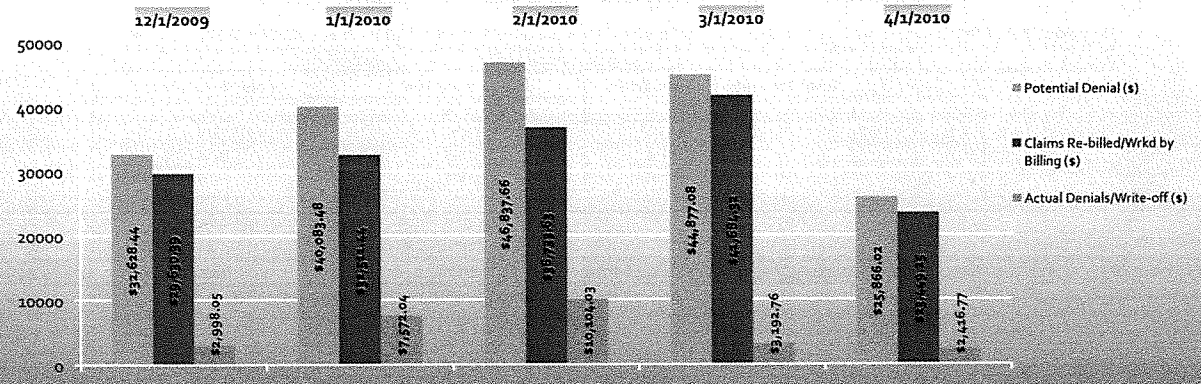
Registration Errors by Category

Sample Template

Facility Name-Potential Denials vs. Actual Write-offs

Month/Year	Total Claims Received	Potential Denials (#)	Potential Denial ($)	Claims Re-billed/Worked by Billing (#)	Claims Re-billed/Wrkd by Billing ($)	Actual Denials/Write-off	Actual Denials/Write-off ($)	Monthly Denials Percentage (#)	Monthly Denials Percentage ($)
Dec-2009	2749	123	$ 32,628.44	99	$ 29,630.39	24	$ 2,998.05	1%	9%
Jan-2010	2948	142	$ 40,083.48	107	$ 32,511.44	33	$ 7,572.04	1%	19%
Feb-2010	2886	131	$ 46,837.66	112	$ 36,733.63	19	$ 10,104.03	1%	22%
Mar-2010	3218	148	$ 44,877.08	127	$ 41,684.32	21	$ 3,192.76	1%	7%
Apr-2010	3398	123	$ 25,866.02	95	$ 23,449.25	28	$ 2,416.77	1%	9%
	15199	667	$ 190,292.68	540	$ 164,009.03	125	$ 26,283.65	1%	13%

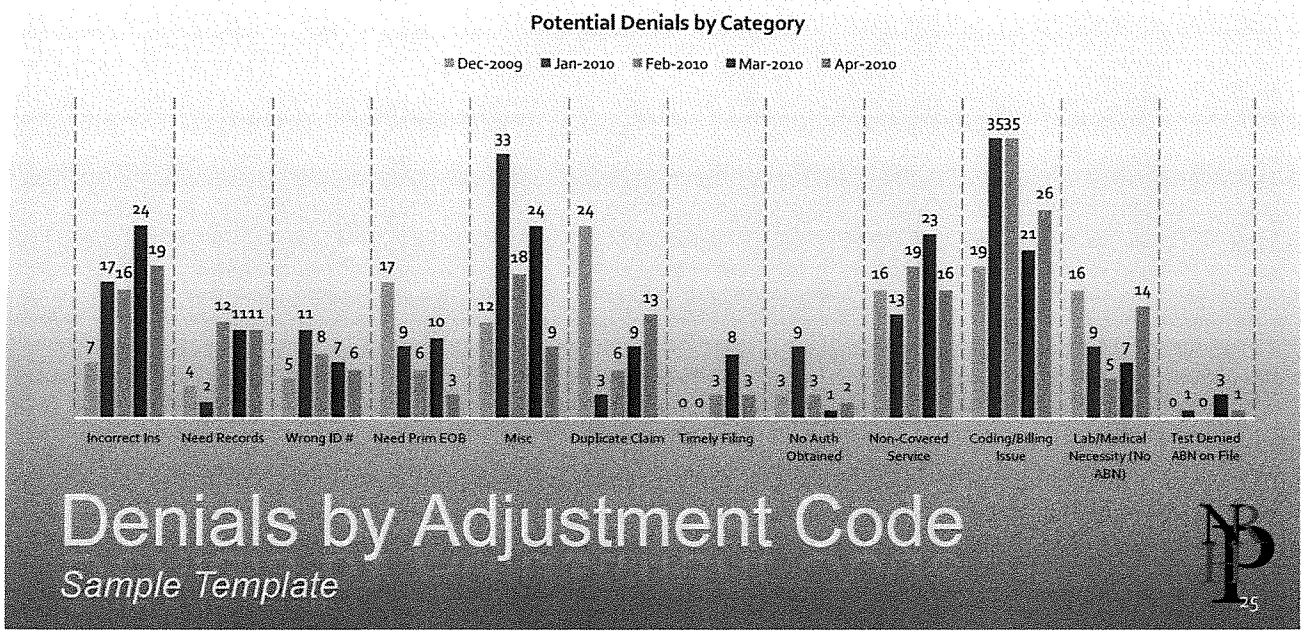
Column I: Monthly denials % calculated actual denials # vs. total claims rcvd/Column J: Monthly denials calculated monthly $ vs. potential denials $ *3%-5% (=) National Average*



Denials Management

Sample Template

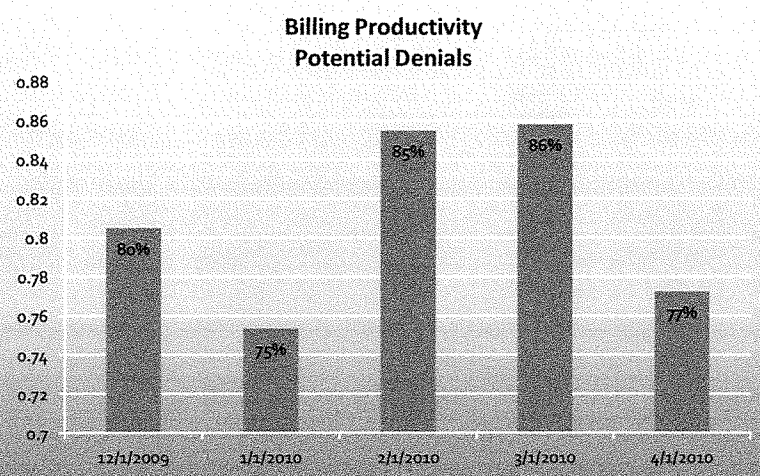
Facility Name-Potential Denials by Adjustment Code												
Month/Year	Incorrect Ins	Need Records	Wrong ID #	Need Prim EOB	Misc	Duplicate Claim	Timely Filing	No Auth Obtained	Non-Covered Service	Coding/Billing Issue	Lab/Medical Necessity (No ABN)	Test Denied ABN on File
Dec-2009	7	4	5	17	12	24	0	3	16	19	16	0
Jan-2010	17	2	11	9	33	3	0	9	13	35	9	1
Feb-2010	16	12	8	6	18	6	3	3	19	35	5	0
Mar-2010	24	11	7	10	24	9	8	1	23	21	7	3
Apr-2010	19	11	6	3	9	13	3	2	16	26	14	1
	83	40	37	45	96	55	14	18	87	136	51	5
Total Monthly (/) by Category	12%	6%	6%	7%	14%	8%	2%	3%	13%	20%	8%	1%



Denials by Adjustment Code

Sample Template

Billing Productivity (Denials)			
Month/Year	Potential Denials	Denial Productivity (Billing)	Monthly Productivity %
Dec-2009	123	99	80%
Jan-2010	142	107	75%
Feb-2010	131	112	85%
Mar-2010	148	127	86%
Apr-2010	123	95	77%



Potential Denials Productivity

Sample Template