

# Critical Access Hospitals It's Time for a Reality Check

Presented by  
Cynthia R. DuPree, CPA, CCS



How do you know where you are going,  
if you don't know where you are?



## **Critical Access Hospital Financial Analyses - 2008**

Prepared for  
Georgia State Office of Rural Health (SORH)  
An office of the Georgia Department of Community Health (DCH)

Prepared by  
Draffin & Tucker, LLP

January 2009

Supported by the Medicare Rural Hospital Flexibility Grant Program  
CFDA Number 93.241

Georgia State Office of Rural Health  
229-401-3090

# Georgia Critical Access Hospital Financial Analyses - 2008

Georgia State Office  
of Rural Health



# Critical Access Hospital Financial Analyses - 100

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100 pages  
over 65 charts

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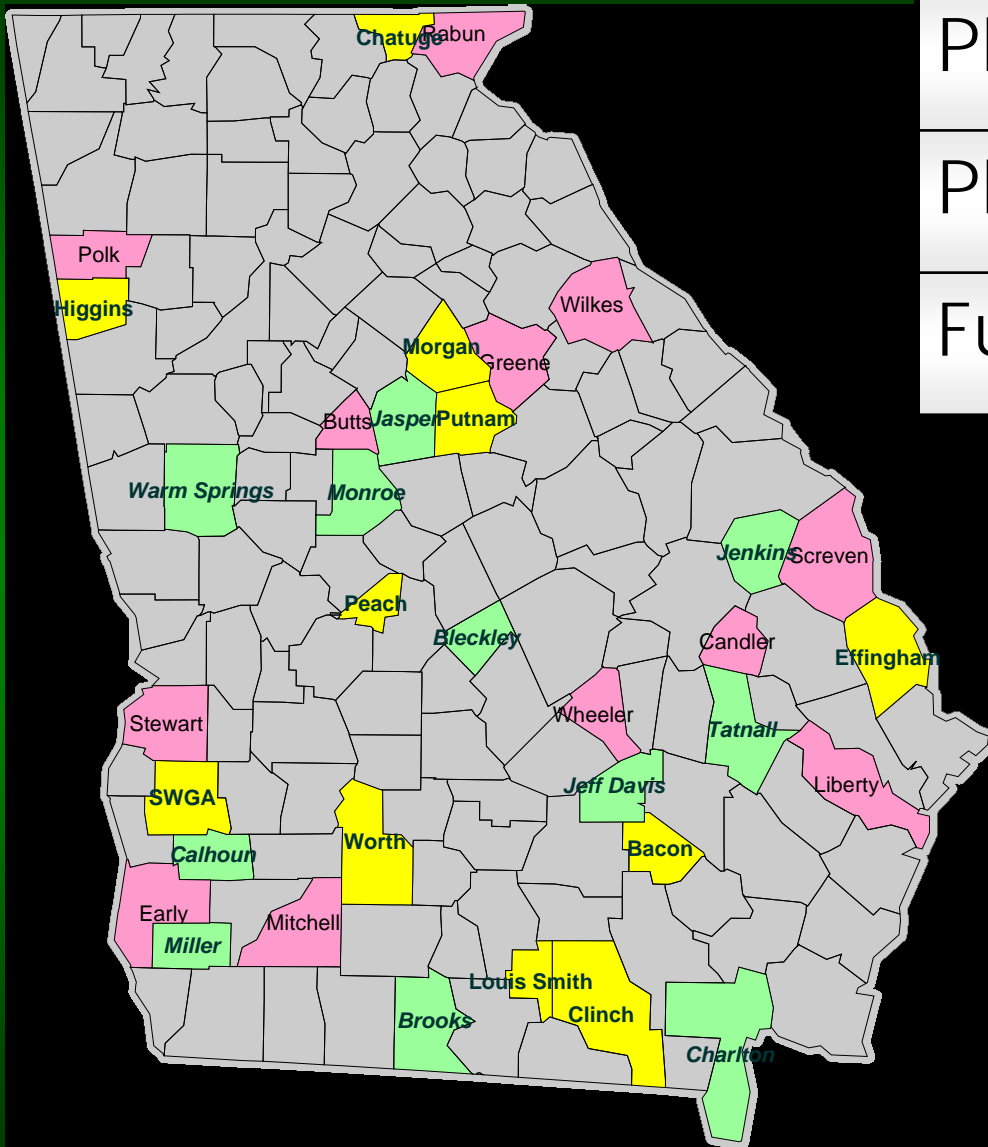
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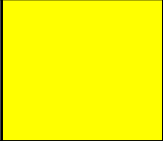


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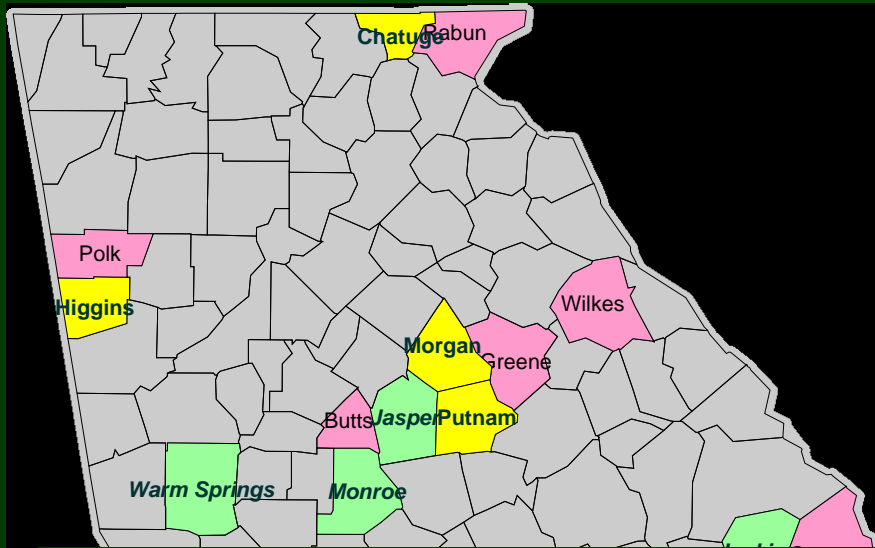
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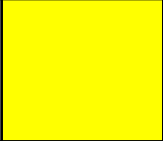


# The Participants

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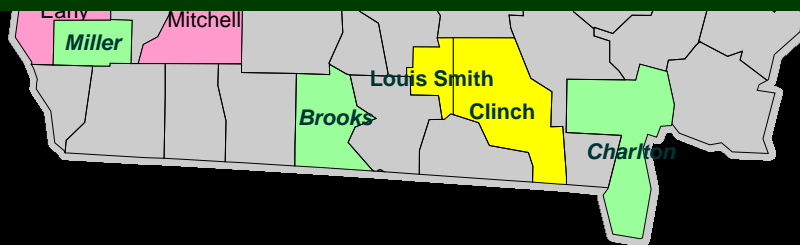


Phase I - 11	
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Future - 12	



Phase I - 11	
Phase II - 11	
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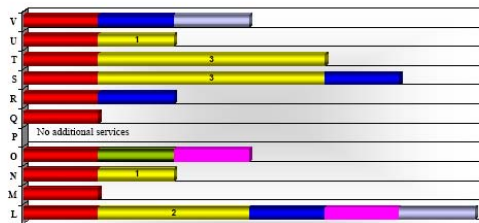
“If you’ve seen one Critical Access Hospital, you’ve seen one Critical Access Hospital.”



# The CAHs have different operating structures.

## Service Components

A significant factor affecting the comparability of CAH financial information is the degree of service integration among the participants. Medicare and Medicaid cost per day will be reduced with the ability to spread fixed costs over other service components. As indicated below, each facility offers various types of services with no one common model found.



Summary	
Swing Beds	10
Rural Health Clinic(s)	5
Skilled Nursing Facilities	4
Physician Practices	1
Ambulance Services	2
Other	2

## Service Components

**Swing Beds**

95%

**Rural Health Clinics**

41%

**Skilled Nursing Facilities**

45%

**Physician Practices**

27%

**Ambulance Services**

18%

**Other**

9%

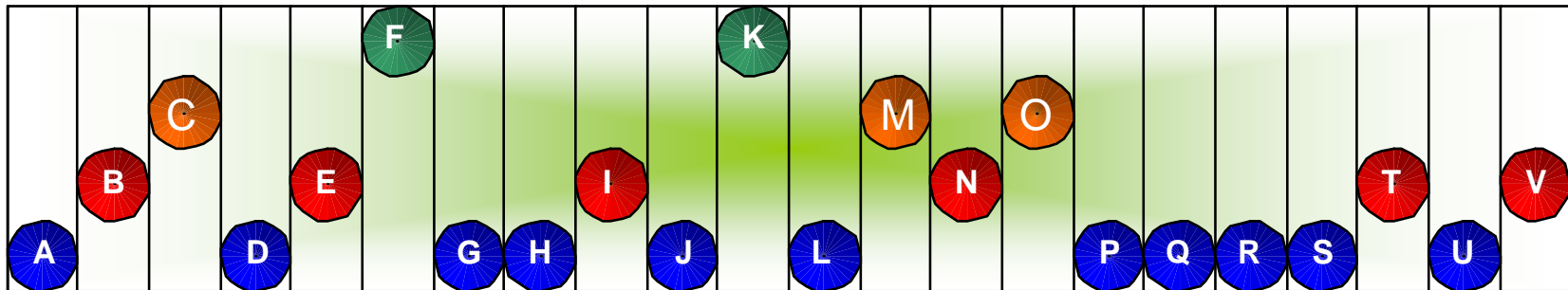
# The ownership and management structure of the CAHs are not the same.

## Ownership and Management

The chart below summarizes the various management and control structures of the CAHs participating in this study. Consulting and management services provided by affiliated organizations can distort financial comparisons. Efforts were made to identify and account for such differences when presenting comparative data.



Independent Authorities	50%
Owned / Leased	27%
Managed	14%
Affiliated	9%



■ Independent/Authority 
 ■ Owned/Leased 
 ■ Managed 
 ■ Affiliated

Since June 2007, there has been significant turnover in key management positions.

**Management Experience**

There are notable differences among the experience of the Chief Executive Officers (CEOs) and the Chief Financial Officers (CFOs) of the participants as indicated in the table below.

Chief Executive Officer	Chief Financial Officer
YEARS AGGREGATE	YEARS AGGREGATE

Chief Executive Officer			Chief Financial Officer		
AGE	YEARS TENURE	YEARS AGGREGATE HOSPITAL EXPERIENCE	AGE	YEARS TENURE	YEARS AGGREGATE HOSPITAL EXPERIENCE

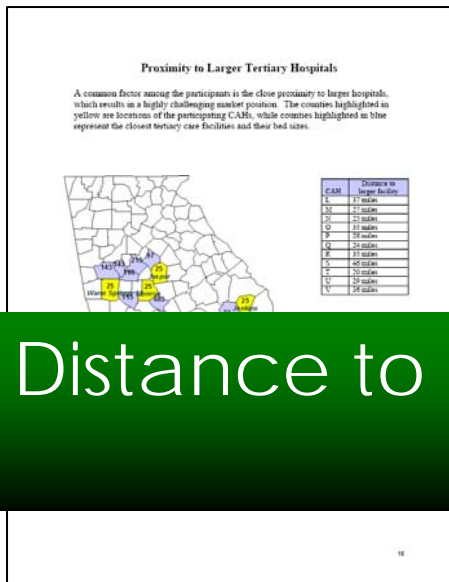
Chief Executive Officers with tenure < 5 years – 54%

E	42	0 mo.	18	60	10	38
F	54	8	30	40	3 mo.	3 mo.

Chief Financial Officers with tenure < 5 years – 45%

K	NA	NA	NA	NA	NA	NA
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# CAHs compete for patients with nearby acute care facilities.



CAH	Distance to larger facility	CAH	Distance to larger facility
A	22 miles	L	37 miles
B	53 miles	M	27 miles

Distance to larger hospitals ranged from 12 to 53 miles.

F	19 miles	Q	24 miles
G	31 miles	R	35 miles
H	26 miles	S	46 miles
I	21 miles	T	20 miles
J	22 miles	U	29 miles
K	45 miles	V	36 miles

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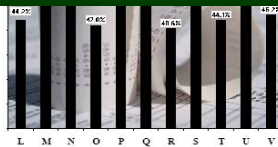
# Medicare and Medicaid reimbursement methodologies are not structured to provide a profit to the CAH.

## Analyses of Costs

Often the public has the misconception that CAHs are reimbursed for full costs of operations. The Medicare (inpatient and outpatient) and Medicaid (outpatient) payment methodologies reimburse only the portion of the allowable COSTS that are related to the Medicare and Medicaid beneficiary's stay. The remaining hospital expenses related to other patients must be recovered from other sources. Due to significant indigent and charity patient percentages, it is extremely difficult to recover these remaining expenses without supplemental funding from the county and state.

The chart below indicates the portion of hospital costs that were reimbursed at 100 to 101 percent of allowable costs. The remaining portion must be recovered from fixed fee payments or supplemental funding.

Percentage of Hospital Costs Which Are Cost Based Reimbursed



In comparing the expenses of the CAHs, one must always consider the various factors that make them unique. Cost comparisons among the hospitals in this study are significantly affected by organizational structure, related party costs and diversity of services offered.

## Percentage of Hospital Costs Which Are Cost Based Reimbursed (includes SWB)



Median Medicare utilization was 62%.

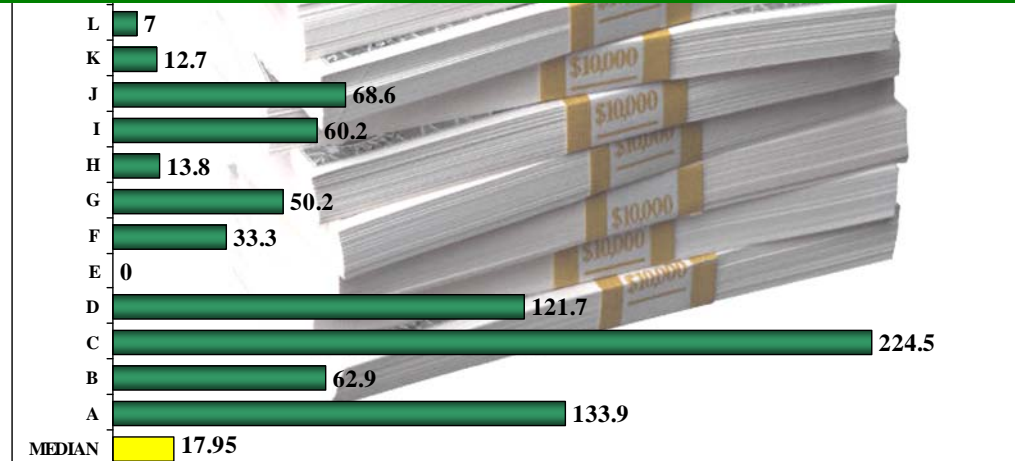
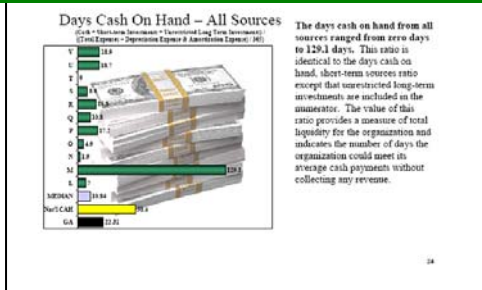
# Cash reserves are depleted.

## Days Cash On Hand – All Sources

$(\text{Cash} + \text{Short-term Investments} + \text{Unrestricted Long Term Investments}) / ((\text{Total Expenses} - \text{Depreciation Expense} \& \text{Amortization Expense}) / 365)$



Median days cash on hand was 18 days.



# CAHs are experiencing decreasing operating margins.

## Operating Margin

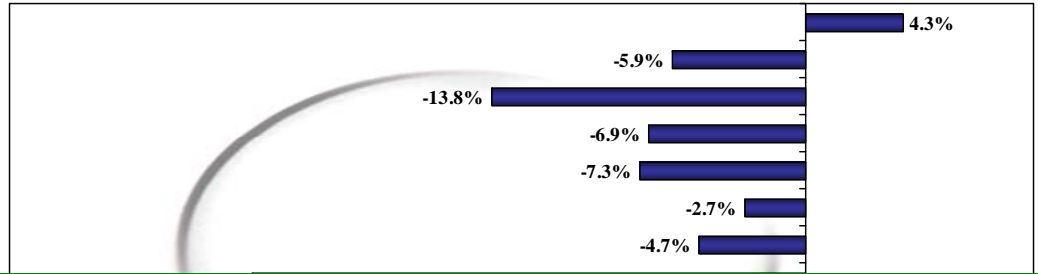
$$\left( \frac{\text{Operating Revenue} - \text{Total Operating Expenses}}{\text{Operating Revenue}} \right) \times 100$$

**Key Financial Ratios**

The following key financial ratios present an overall picture of each hospital's profitability. Detailed underlying information regarding financial performance follows in this report.

Ten of the 11 CAHs are operating with a negative operating margin. Operating margin measures how profitable a hospital is when looking at

**Operating Margin**  
 $\left( \frac{\text{Operating Revenue} - \text{Total Operating Expenses}}{\text{Operating Revenue}} \right) \times 100$

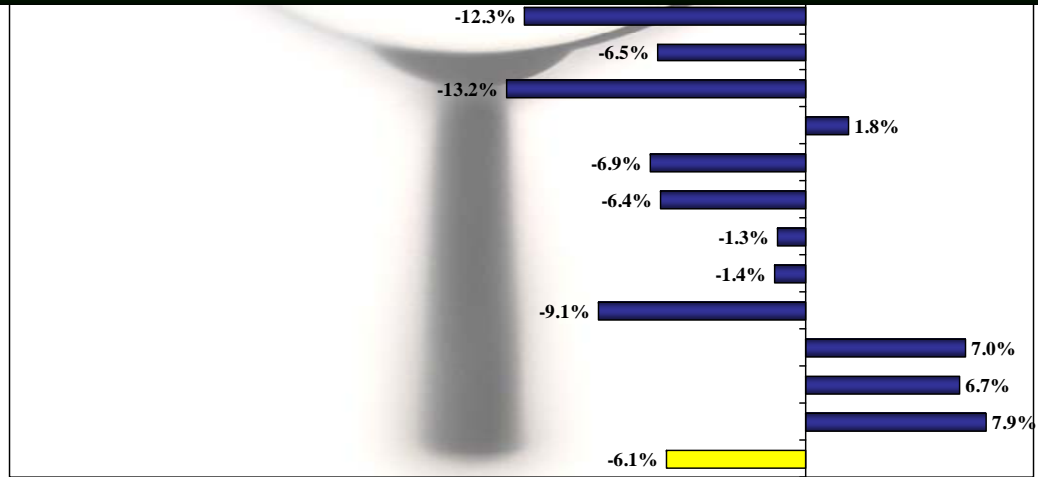


CAHs with negative operating margins – 78%

is usually an early sign of financial difficulty.

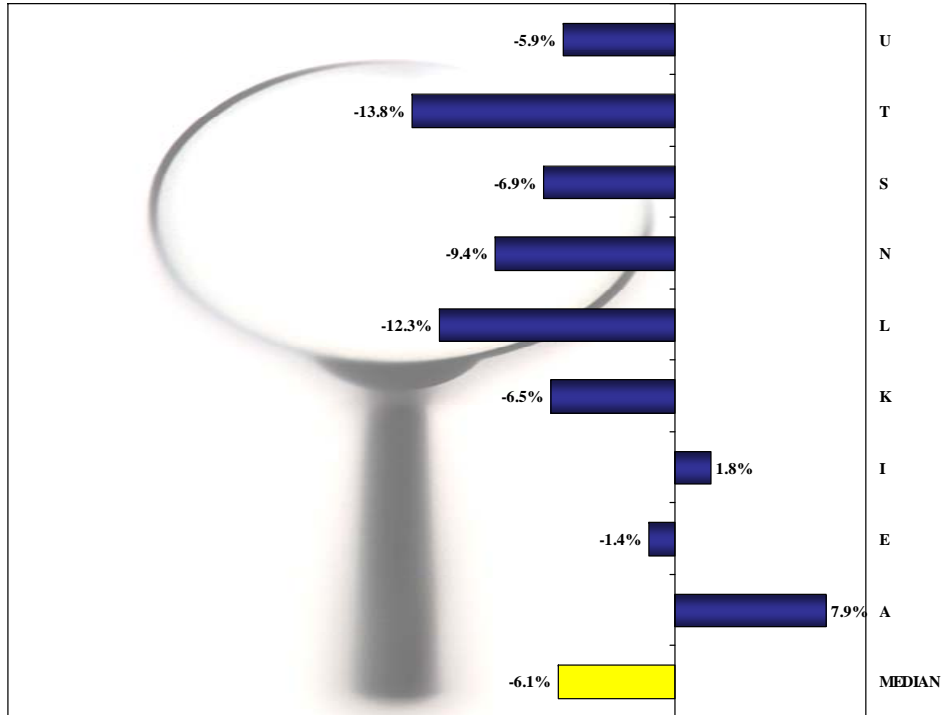
**Total Margin**  
 $\left( \frac{\text{Excess Revenues over Expenses}}{\text{Total Revenues}} \right) \times 100$

Nine of the 11 CAHs are operating with a negative total margin. This ratio defines the percentage of total revenue that has been realized in the form of net income, or excess revenues over expenses. It is used by many analysts as a primary measure of total hospital profitability. The total margins differ from operating margins primarily due to other revenue sources such as county support, the levels of which are indicated on the following chart.



# Operating Margin w RHC

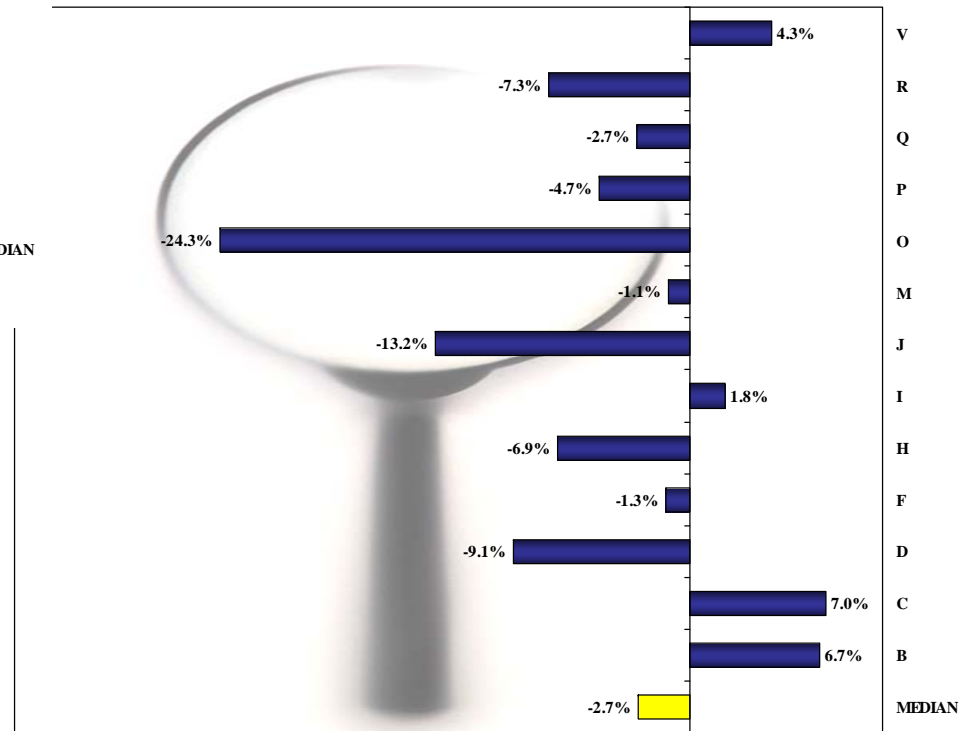
$((\text{Operating Revenue} - \text{Total Operating Expenses}) / \text{Operating Revenue}) \times 100$



## Effect of Provider Based Rural Health Clinics

# Operating Margin w/o RHC

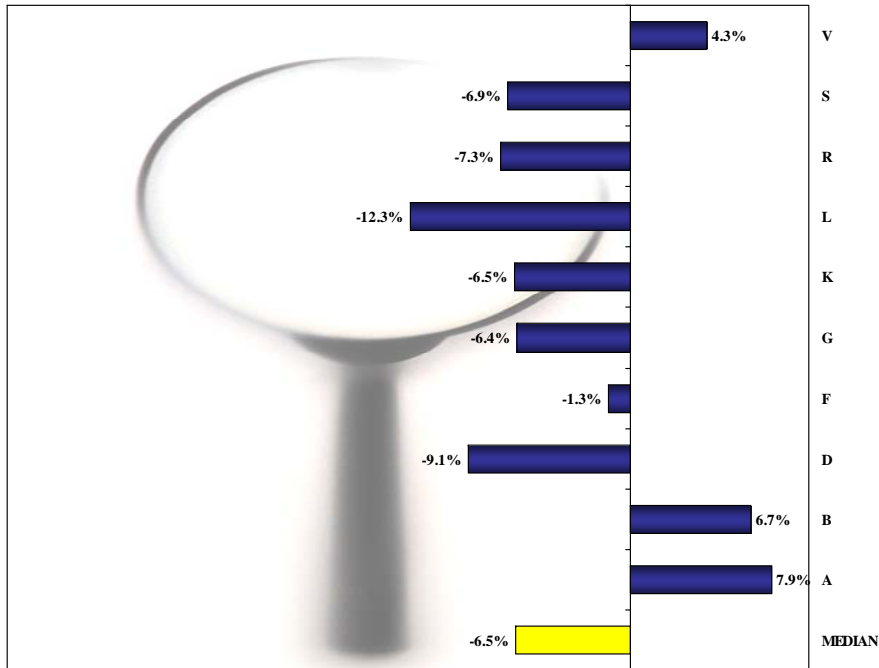
$((\text{Operating Revenue} - \text{Total Operating Expenses}) / \text{Operating Revenue}) \times 100$



w RHC – 22% +OM  
w/o RHC – 30% +OM

# Operating Margin w SNF

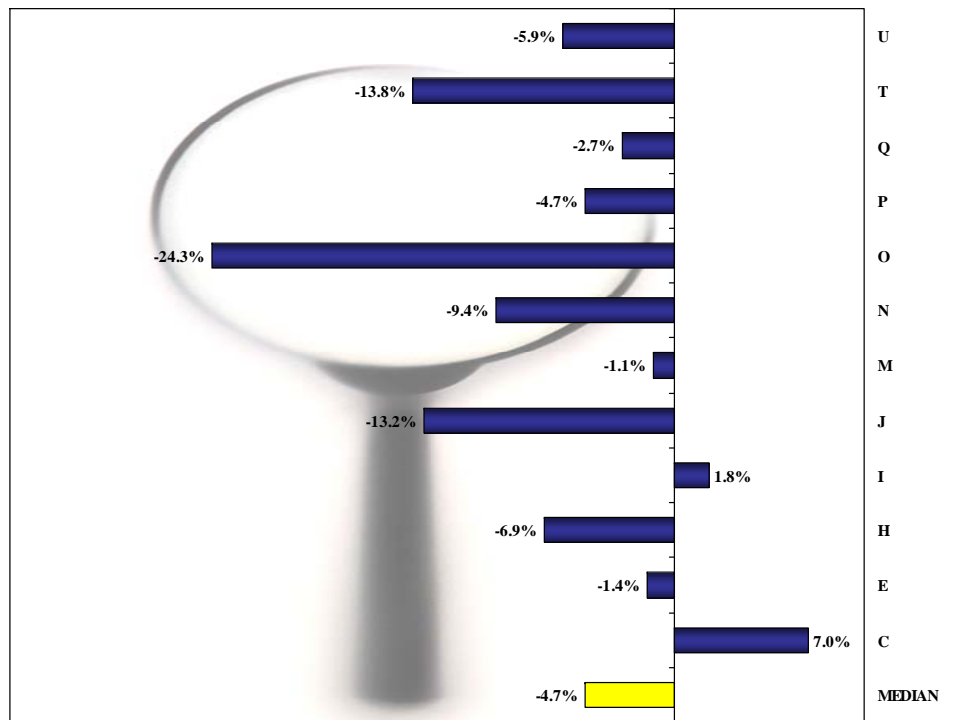
$((\text{Operating Revenue} - \text{Total Operating Expenses}) / \text{Operating Revenue}) \times 100$



Effect of Provider Based Skilled Nursing Facility

# Operating Margin w/o SNF

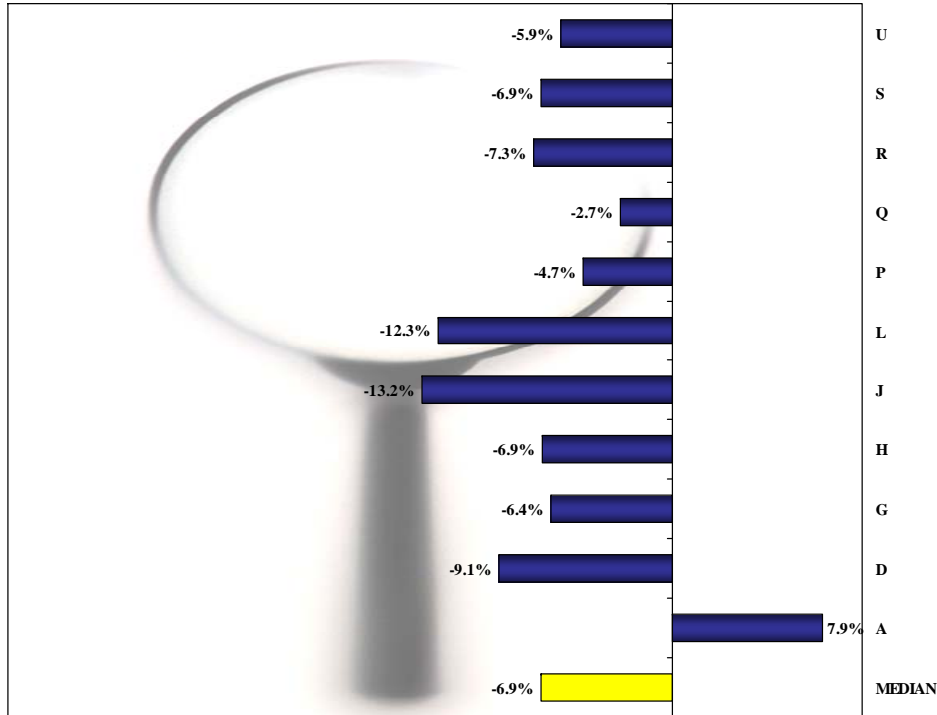
$((\text{Operating Revenue} - \text{Total Operating Expenses}) / \text{Operating Revenue}) \times 100$



w SNF – 30% +OM  
w/o SNF – 16% +OM

# Operating Margin- Independent

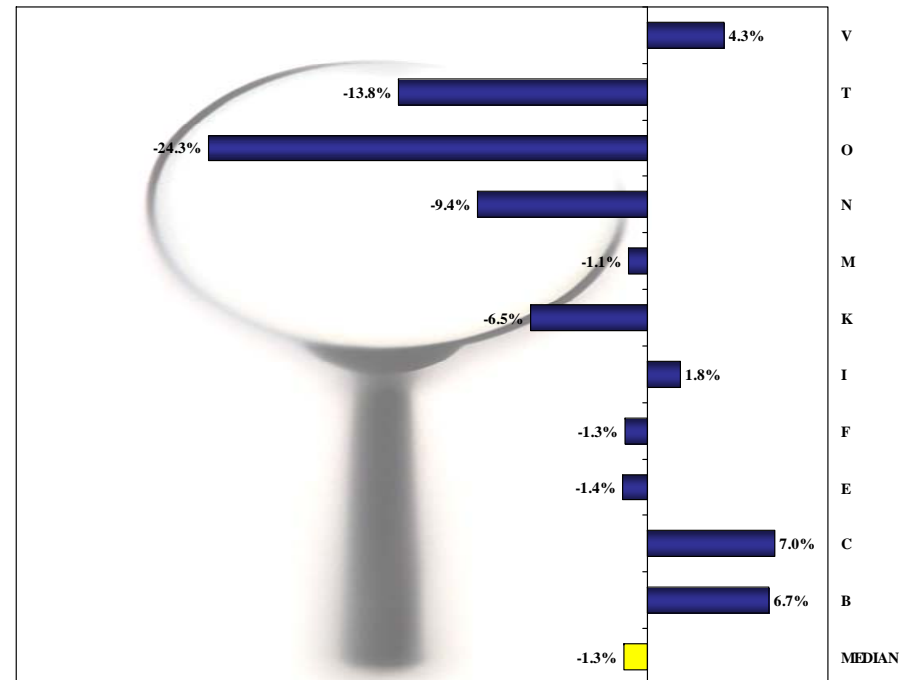
$((\text{Operating Revenue} - \text{Total Operating Expenses}) / \text{Operating Revenue}) \times 100$



# Effect of Hospital Ownership/Management

# Operating Margin- Not Independent

$((\text{Operating Revenue} - \text{Total Operating Expenses}) / \text{Operating Revenue}) \times 100$

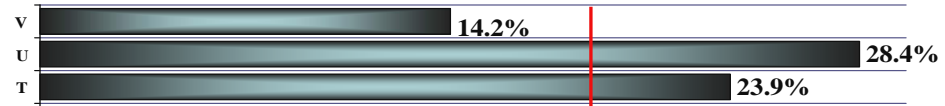


Independent – 9% +OM  
 Not independent – 36% +OM

# Poverty levels in the CAH counties are higher.

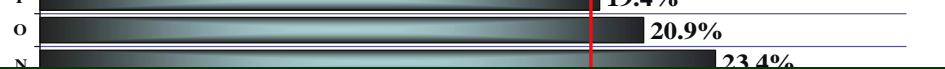
## Poverty Levels

County residents with income below poverty levels in 2007

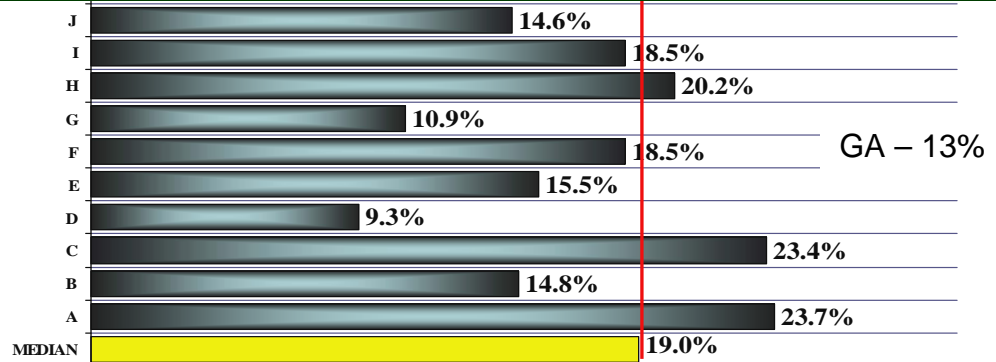
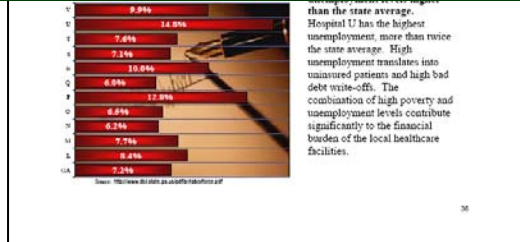


Poverty levels ranged from 9% to 28%.

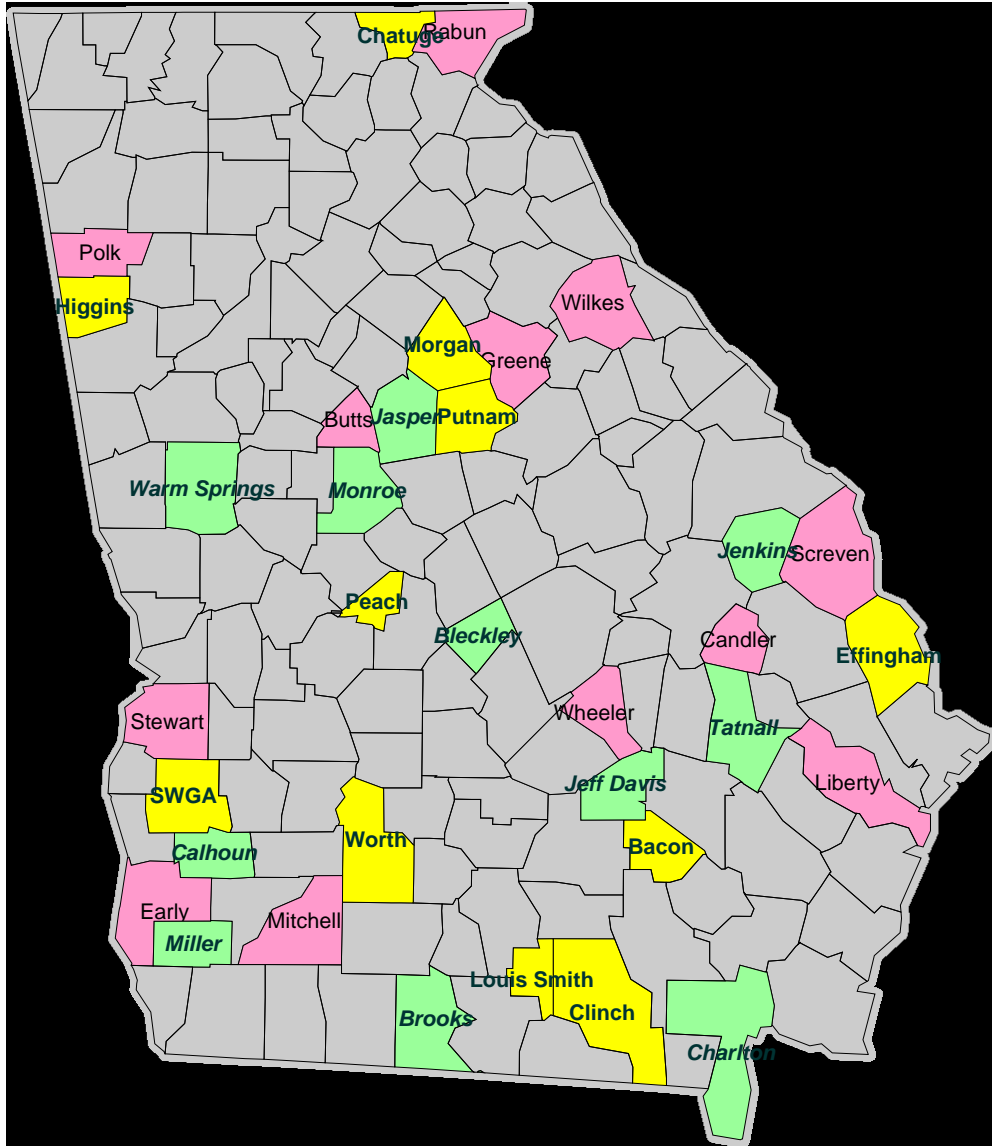
Each of the 11 participants' cities has poverty levels above the state average. Ten of the participants' counties are above the state average. Many participants cited growing indigent and charity populations as one of the most significant challenges faced by their hospitals. As government reimbursement



CAHs with poverty levels > state average – 50%



Source: www.city-data.com



Jul 20, 2008

Georgia has one of the largest areas of severe poverty in the United States. This extreme isolation of the poorest Georgians can only make matters worse.



With a poverty rate of 13.7%, Georgia has the 15th highest poverty rate in the United States, which is slightly better than [North Carolina](#) and slightly behind [Montana](#).

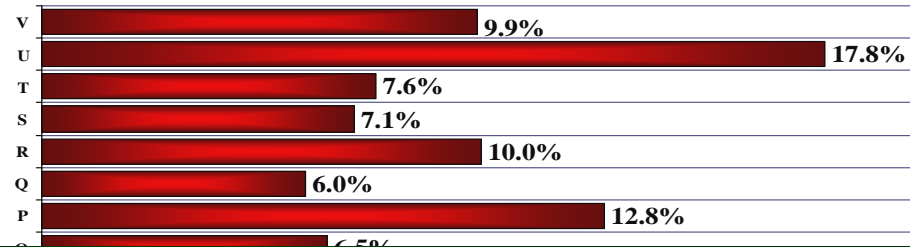
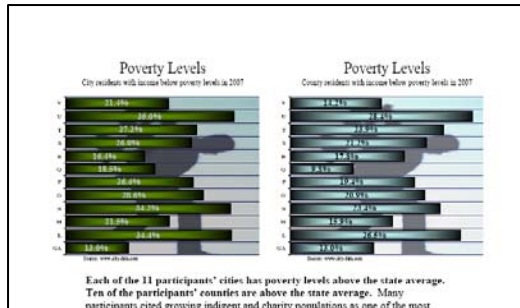
**Where the Worst Poverty in Georgia Occurs**

The most critical levels of poverty in Georgia primarily occurs in the southwestern corner, and it stretches across Georgia in a northeastern direction until it hits the Atlantic Ocean at Burke County (see map below article).

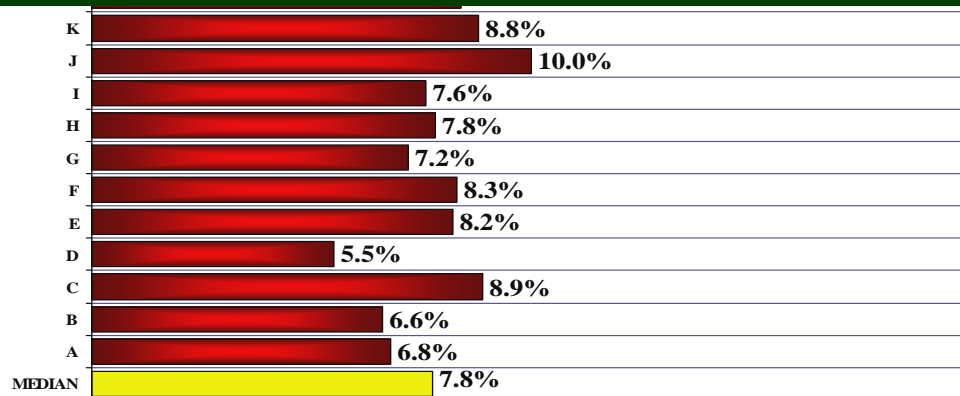
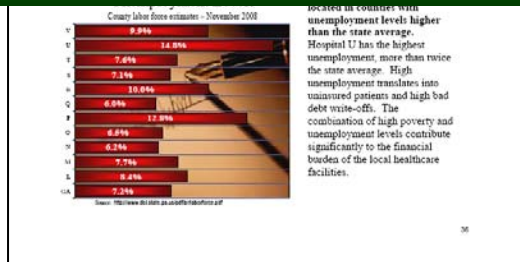
# Unemployment levels in the CAH counties are higher.

## Unemployment Levels

County labor force estimates – November 2008



Unemployment ranged from 5.5% to 17.8%.

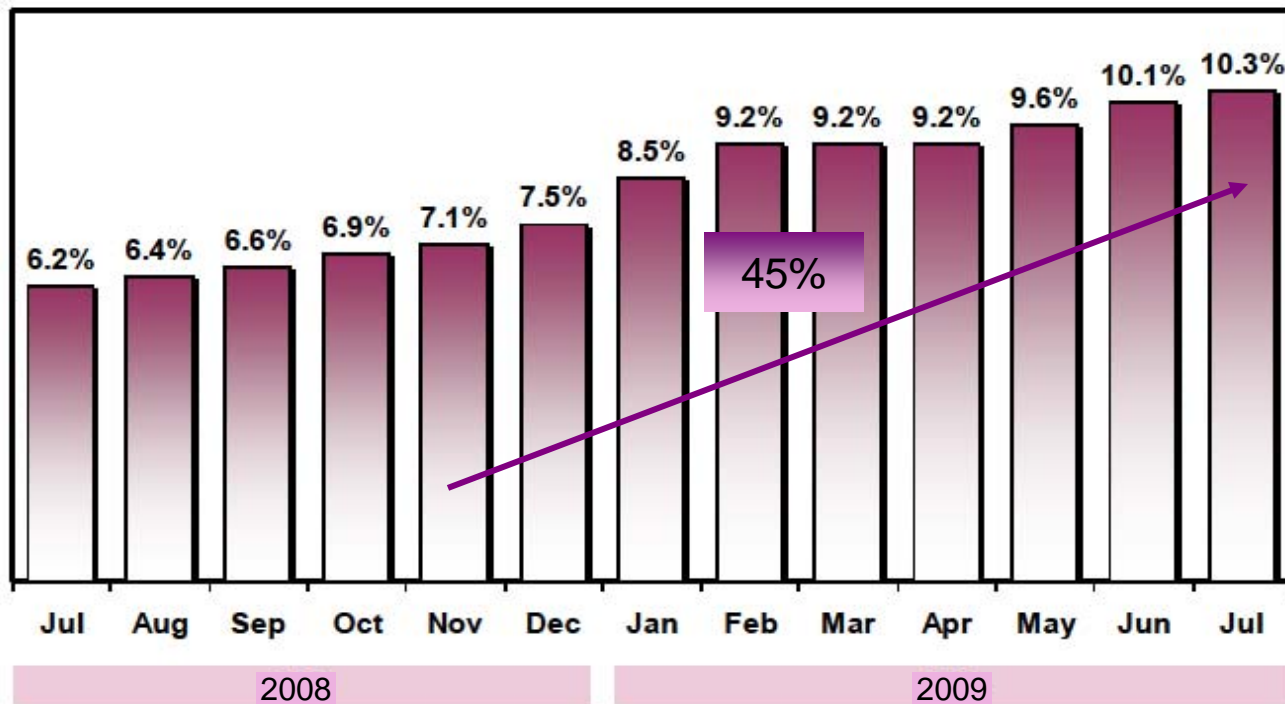


Based on 11/2008

# Unemployment levels have climbed since November 2008

## Georgia Unemployment Rate

(Not Seasonally Adjusted)



Source: Georgia Department of Labor - Michael L. Thurmond, Commissioner

# County support is vital to the sustainability of the CAH.

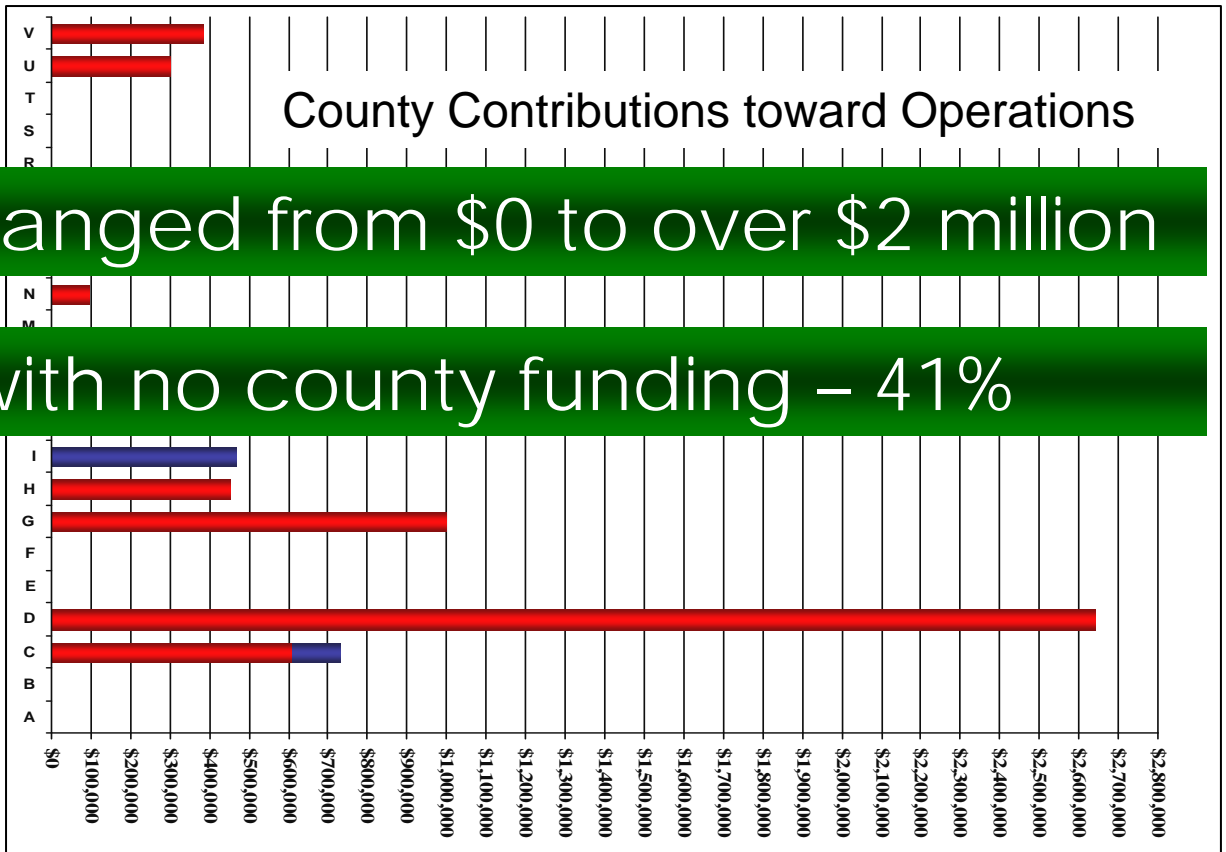
One of the participating hospitals received county support of over one million dollars during their reporting year. County financial support contributes

## County Contributions toward Operations

Contributions ranged from \$0 to over \$2 million

Hospitals with no county funding – 41%

experienced negative returns on equity. These eight facilities also had net losses for the fiscal year. The return on equity ratio defines the amount of net income or excess revenues over expenses and losses earned per dollar of equity investment. This ratio has been discussed by some hospitals, especially investor-owned, as an alternative way to establish rates. Many financial analysts consider the return on equity ratio the primary test of profitability. Failure to maintain a satisfactory value for this ratio may prevent the hospital from obtaining equity capital in the future. Due to a recent sale, Hospital T's percentage is not included in this chart. The percentage for Hospital S is -698.0%.



# State supplemental payments are crucial to the survival of the CAH.

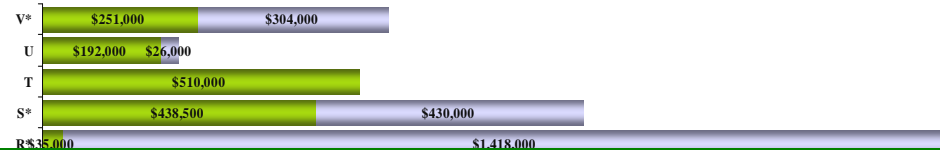
## ICTF / UPL Participation

(includes SNFs)

### Medicaid Supplemental Payments

The Georgia Medicaid Disproportionate Share Hospital (DSH) Program is a federal program that works to increase health care access for the poor. Hospitals that treat a "disproportionate" number of Medicaid and other indigent patients qualify for ICTF payments through the state's Medicaid program based on the hospitals' estimated uncompensated cost of services to the uninsured.

The Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) provide for enhanced payments to Medicaid providers under the UPL methodology. Subsequent to the implementation of the UPL methodology, federal budget concerns have led to reconsideration of the

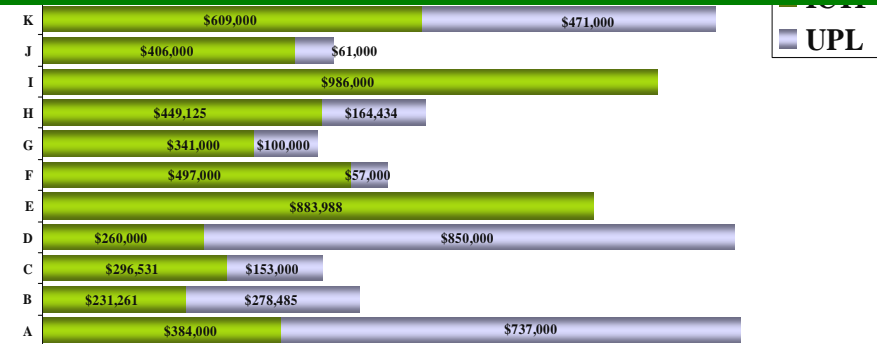


Participation levels ranged from \$218,000 to \$1,450,000.



\* Hospitals with SNF components

38



# Key Provisions H.R. 3200

**Medicare DSH: \$10 billion in cuts.** If the uninsured rate is reduced between 2012 and 2014, Medicare DSH payments are reduced beginning in 2017, to the "empirically justified level," but with an upward adjustment for hospitals with high levels of uncompensated care costs.

**Medicaid DSH: \$10 billion in cuts.** Beginning in 2017, federal spending is reduced \$10 billion over three years (\$1.5 billion in 2017, \$2.5 billion in 2018, \$6 billion in 2019). No later than 2016, the Secretary must report to Congress with recommendations on the appropriate targeting of DSH payments within states, and the appropriate distribution across states. The methodology for cuts would depend on state rates of uninsurance, and use of DSH money, which would be measured by uncompensated care and hospital Medicaid volume.

# Key Provisions H.R. 3200

Medicare DSH: \$10 billion over three years through 2014, Medicare DSH level," but with an increase in costs.

Medicaid DSH: \$10 billion over three years through 2016, the Secretary targeting of DSH. The method of targeting DSH.

uninsured rate is reduced beginning in 2012 and

between 2012 and 2014, empirically justified uncompensated care

reduced \$10 billion over three years through 2016, No later than 2016, the Secretary targeting of DSH. The method of targeting DSH.



Federal Disproportionate-Share Hospital (DSH) Allotments for 2009, According to State.

State	DSH Payment per Capita	DSH Payment per Uninsured Citizen	State	DSH Payment per Capita	DSH Payment per Uninsured Citizen
		<i>dollars</i>			<i>dollars</i>
Alabama	88.93	508.19	Montana	13.14	75.07
Alaska	31.13	177.88	Nebraska	22.32	127.55
Arizona	14.57	83.27	Nevada	17.54	100.22
Arkansas	15.68	89.59	New Hampshire	197.52	1128.68
California	29.22	166.95	New Jersey	85.75	490.01
Colorado	20.21	115.46	New Mexico	8.20	46.86
Connecticut	109.02	622.99	New York	110.44	631.09
Delaware	15.98	91.32	North Carolina	33.87	193.56
District of Columbia	182.29	1,041.67	North Dakota	24.69	141.08
Florida	9.54	54.51	Ohio	58.33	333.3
Georgia	28.72	164.14	Oklahoma	9.93	56.74
Hawaii	17.43	99.59	Oregon	12.39	70.8
Idaho	13.33	76.19	Pennsylvania	83.39	476.49
Illinois	22.05	126.01	Rhode Island	113.73	649.91
Indiana	51.99	297.11	South Carolina	82.92	473.83
Iowa	23.85	136.27	South Dakota	22.80	130.27
Kansas	21.61	123.49	Tennessee	63.59	363.4
Kentucky	42.61	243.49	Texas	29.27	167.24
Louisiana	156.00	891.44	Utah	8.90	50.87
Maine	156.15	892.29	Vermont	59.87	342.11
Maryland	17.62	100.68	Virginia	14.64	83.67
Massachusetts	109.49	625.66	Washington	44.39	253.66
Michigan	43.36	247.78	West Virginia	47.76	272.94
Minnesota	29.24	167.10	Wisconsin	35.82	204.68
Mississippi	47.48	271.33	Wyoming	0.55	3.13
Missouri	111.88	639.34	<b>Average</b>	<b>51.20</b>	<b>292.57</b>

# Key Provisions H.R. 3200

**Rural providers:** Extends Section 508 reclassifications, as well as the outpatient hold-harmless provision. 😊

**340B:** Expands the 340B program to inpatient drugs for public and high-DSH non-profit hospitals. Also extends access to 340B inpatient and outpatient drugs for children's, critical access hospitals, Medicare-dependent hospitals, sole community hospitals, and rural referral centers. 😊

**Healthcare-acquired conditions:** State Medicaid programs are required to include policies that do not allow higher payments to a hospital if a patient gets a healthcare-acquired infection during the hospital stay, similar to the Medicare hospital-acquired conditions policy. 😞

**Readmissions:** \$16 billion in cuts. Reduces payments in 2012 to hospitals, including critical access hospitals, based on the value of each hospital's percentage of potentially preventable readmissions for three conditions. Beginning in 2013, expands the policy to an unlimited number of other conditions. 😞

# Continuing Challenges

## Unattractive Payer Mix

- ✓ High Medicare utilization
- ✓ High poverty and unemployment

## Decreasing Cash Flow

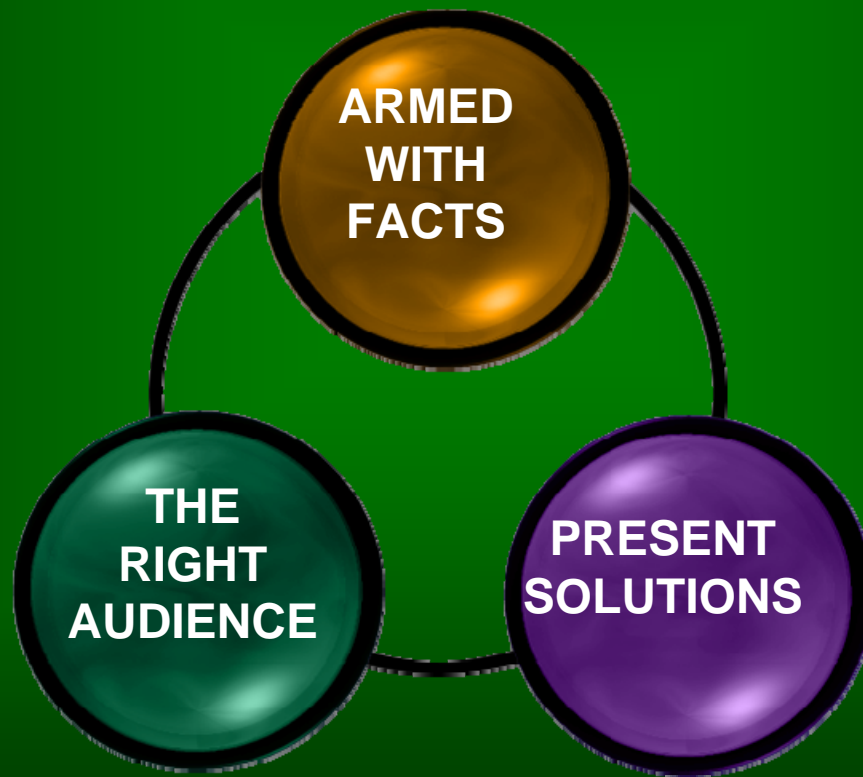
- ✓ Dependency on county funding
- ✓ Depletion of cash reserves

# Continuing Challenges

## Uncertainty of Federal and State

- ✓ Funding
  - ✓ Dependency on ICTF/UPL funding
  - ✓ Sensitivity to regulatory changes
- ## Health Care Reform

The report is not an ending, but a beginning.  
Now the story must be told...





**ARMED  
WITH  
FACTS**

# What is your story?

Know the facts surrounding your hospital.

Don't rely on the cost report alone.

How do you compare?

What are your circumstances?

**THE  
RIGHT  
AUDIENCE**

## Who to tell?

Identify hospital advocates

Employees

Community leaders

Associations and advocates

State legislators

Congressional representatives



**Present  
Solutions**

## **Be Proactive . . .**

Don't rely on the government to take care of you!

Monitor legislation and its impact.

Take advantage of grants and funding.

Listen and learn!

To view reports

[www.dch.ga.gov](http://www.dch.ga.gov)

Programs

Rural Health

Publications and Presentations

Critical Access Hospital Fiscal Analysis

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