Critical Access Hospital Symposium – Navigating Finances in 2020

July 2020

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Critical Access Hospital Symposium – Financial Update

Agenda - Navigating Finances in 2020:

- CAH Financial Update and Best Practices
- Cash Planning Strategies
- Clinic Strategies
- Telemedicine Overview
- Price Transparency

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CAH Financial Update
And Best Practices

FLEX monitoring team indicators report

2020 report based on 2018 data:

- Operating indicators in Arkansas continue to be more negative than the US average CAH
- Average daily census in Arkansas is higher than the US average

2018 Median Indicator Values for Arkansas and the United States

Indicator	Arkansas	US	
Total Margin	-3.22	1.61	
Cash Flow Margin	0.63	5.71	
Return on Equity	-1.86	4.24	
Operating Margin	-4.55	0.17	
Current Ratio	1.71	2.54	
Days Cash on Hand	7.55	75.88	
Days in Net Accounts Receivable	48.16	50.68	
Days in Gross Accounts Receivable	34.00	49.06	
Equity Financing	63.18	59.69	
Debt Service Coverage	6.76	3.43	
Long-Term Debt to Capitalization	33.56	30.83	
Outpatient Revenues to Total	75.91	79.40	
Patient Deductions	54.00	45.22	
Medicare Inpatient Payer Mix	69.94	71.94	
Medicare Outpatient Payer Mix	34.85	37.13	
Medicare Outpatient Cost to Charge	37.56	43.51	
Medicare Revenue per Day	1898	2830	
Salaries to Net Patient Revenue	49.53	45.10	
Average Age of Plant	11.07	11.52	
FTEs per Adjusted Occupied Bed	4.48	5.56	
Average Salary per FTE	50310	59370	
Average Daily Census Swing-SNF	1.58	1.53	
Average Daily Census Acute Beds	4.35	2.54	
Number of Included CAHs	22	1215	

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CAH Financial Update

Possible Key Issues to be Addressed:

- Low volumes/volume fluctuations - market shift to regional hospitals for hospital care
- Significant RHC/clinic losses, not able to be offset by hospital profits
- Revenue cycle issues – coding, documentation, billing, collection and technology
- Low payment rates from commercial and Medicaid payors not covering cost of care
- Staffing turnover – providers & staff
- Other

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CAH Financial Update

What can we learn from reviewing financial information by type of service?

Sample Hospital 1						
Type of Service	**Charges**	**Reimbursement**	**Contribution Margin**	**Overhead Allocated**	**Total Margin**	**Total Margin % of Reimbursement**
Outpatient	18,841,950	9,310,086	4,530,153	2,995,826	1,534,326	16%
Inpatient	10,773,156	7,031,300	3,526,753	4,117,477	(590,725)	-8%
Emergency	9,061,975	4,415,133	1,524,229	1,804,955	(280,726)	-6%
Ambulatory Surgical	8,420,513	4,520,848	1,300,268	1,833,810	(533,542)	-12%
Recurring Outpatient	3,600,332	1,958,995	1,287,747	915,774	371,974	19%
Observation	2,783,717	1,547,184	824,953	795,112	29,840	2%
Urgent Care	1,238,737	750,245	290,535	274,421	16,114	2%
Swing Bed	1,022,593	1,625,456	1,049,610	1,078,819	(29,209)	-2%
Newborn	569,883	367,112	284,778	270,652	14,127	4%
Ambulatory Medical	10,314	5,638	2,226	2,160	66	1%
Hospice	7,807	14,134	4,199	20,453	(16,254)	-115%
Totals	**56,330,975**	**31,546,131**	**14,625,450**	**14,109,459**	**515,991**	**2%**

- Outpatient services (diagnostics and therapy) generated the positive margin for this hospital, offsetting other losses
- In general, hospitals need to generate a positive margin on outpatient services in order to fund clinic and other losses
- Inpatient margins typically break even/loss – primarily Medicare volumes

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CAH Financial Update

What can we learn from reviewing financial information by type of service?

Sample Hospital 2						
Type of Service	**Charges**	**Reimbursement**	**Contribution Margin**	**Overhead Allocated**	**Total Margin**	**Total Margin % of Reimbursement**
Outpatient	40,030,770	15,168,020	6,715,451	7,247,283	(531,832)	-4%
Inpatient	3,172,391	1,502,700	632,082	783,286	(151,204)	-10%
Swing Bed	2,301,752	1,465,151	748,756	709,782	38,974	3%
Hospice	1,918,852	713,505	278,385	267,103	11,282	2%
Professional	859,740	161,543	(323,804)	-	(323,804)	-200%
Home Health	61,438	21,157	7,029	9,987	(2,959)	-14%
Totals	**48,344,943**	**19,032,077**	**8,057,898**	**9,017,442**	**(959,543)**	**-5%**

- Outpatient services generated a loss for this hospital - a focus on surgical procedures actually generated a loss for this hospital due to low commercial rates for procedures coupled with significant investment in equipment and staff.
- This key factor contributed to an overall loss of over $900,000 for the hospital

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CAH "Best Practices" – Based on High Performing CAHs

- Taking calculated risks
- Being driven by data
- Engaging and valuing staff
- Integration with the community

Source: FLEX Monitoring Team Policy Brief #53 April 2020

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Best Practices Linked to Key Issues

- Low volumes/volume fluctuations - integration with the community to capture hospital and clinic volumes
- Significant RHC/clinic losses, not able to be offset by hospital profits – use data to make strategic decisions about clinics, improve clinic operations and financial results, particularly with the shift toward telemedicine
- Revenue cycle issues – coding, documentation, billing, collection and technology – use data to improve – could increase reimbursement by 3-5% with proper systems
- Low payment rates from commercial and Medicaid payors not covering cost of care – take calculated risks on contract negotiation – focus on outpatient rates
- Staffing turnover – providers & staff – engage and value staff

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Cash Planning Strategies

Cash Planning Strategies

Overview – cash management and planning is essential more than ever given the fluctuation in patient volumes and changes in services (such as telemedicine).

- Create ongoing cash flow forecast with weekly monitoring
- Ensure all avenues are explored for cash planning to meet cash needs
- Optimize telemedicine services
- Make strategic decisions as required to maintain cash at target levels

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Cash Planning Strategies

Public Health Emergency End-Date	Projected Utilization Assumptions Compared to Budget								
	April	May	June	July	August	September	October	November	December
May (Optimistic)	60%	65%	70%	75%	80%	85%	90%	90%	90%
June (Realistic)	60%	60%	65%	70%	75%	80%	85%	90%	90%
July (Pessimistic)	60%	60%	60%	65%	70%	75%	80%	85%	90%

- During April, all scenarios reflect volumes at 60% of expected levels
- The optimistic view assumes volumes to begin increasing in May, and the pessimistic view assumes volumes beginning to increase in July.
- By the end of 2020, all scenarios assume volumes to return to 90% of budgeted levels
- These volume assumptions were used to understand possible cash balances to the end of 2020 on the next page.

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Cash Planning Strategies

Create Cash Forecast

- Create ongoing cash flow forecast with weekly monitoring
- Key assumption will be when/speed of “ramp up” to historical volumes
- Need to understand anticipated cash balances and days cash on hand before operational changes are made
- Understand what the gap is go close and create operating scenarios to close the gap

2020 Projected

	Budget	Projected 2020		
	Total			
		Optimistic	Realistic	Pessimistic
Total Operating Revenue	111,747,406	92,781,873	89,991,158	87,052,224
Compared to budget		*83%*	*81%*	*78%*
Salaries/Benefits	67,641,374	67,604,046	67,604,046	67,604,046
Depreciation	6,500,196	6,450,381	6,450,381	6,450,381
Interest	3,011,176	178,152	178,152	178,152
Other Operating Expense	36,671,956	35,874,005	35,874,005	35,874,005
Total Operating Expense	113,824,702	110,106,584	110,106,584	110,106,584
Compared to budget		*97%*	*97%*	*97%*
Operating Income (Loss)	**(2,077,296)**	**(17,324,711)**	**(20,115,426)**	**(23,054,360)**
Total Non-Operating Income	1,875,497	3,509,941	3,524,364	3,508,833
Net Income	**(201,799)**	**(13,814,771)**	**(16,591,062)**	**(19,545,527)**
Cash View				
Cash & Cash Equivalents	33,973,263	15,962,852	13,156,606	10,202,141
Restricted Cash	1,979,825	6,182,094	6,182,094	6,182,094
Total Cash	35,953,088	22,144,946	19,338,700	16,384,235
Salary Expense/Day	184,812	184,711	184,711	184,711
Operating Expense/Day	293,236	283,214	283,214	283,214
Days Cash on Hand	**116**	**56**	**46**	**36**
Decrease in Cash from Budget		**(14,009,941)**	**(16,816,187)**	**(19,770,652)**

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Closing the Cash Flow Gap

Ensure all avenues of cash are explored if needed to balance the budget

Cash Flow Opportunities	Cash Advance/Payment Deferral	Grants/Forgivable Loans	Loans
Accelerated/advanced payments from Medicare	X		
Public Health and Social Services Emergency Fund Grant/Targeted Allocations		X	
SHIP Grants		X	
RHC Funding		X	
SBA Paycheck Protection Program Forgivable Loan		X	
Payroll tax credits/deferrals	X		
FEMA Grants		X	
FCC Telemedicine Grants		X	
Economic Injury Disaster Loan (EIDL)			X
Emergency Economic Injury Grant (EEIG)		X	
Mainstreet Lending program			X
Possible deferral of interest and principal on USDA Community Facilities	X		
Consider interim Medicare Cost Report to adjust interim rates	X		
Other (work with bank on line of credit etc.)			X

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Closing the Cash Gap

- Consider CARES Funding and other cash inputs in the cash flow budget.
- Evaluate gap in cash balances that would need to be addressed through operating changes.
- Proposed expense reduction – need to understand what is possible. Consider impact on Medicare reimbursement.

Public Health Emergency End-Date		May	June	July
Projected Cash Flow Impact w/o CARES Act & Other				
Cash		(14,009,941)	(16,816,187)	(19,770,652)
Days Cash-on-Hand		56	46	36
Projected Cash Flow Impact with CARES Act & Other				
Cash		(4,881,215)	(7,687,461)	(10,641,926)
Days Cash-on-Hand		89	79	68
Post COVID-19 Cash **Target**				
Cash		28,358,441	28,358,441	28,358,441
Days Cash-on-Hand Target (**equal to or greater than 100 days**)		100	100	100
Cash Short-Fall		(3,229,789)	(6,036,035)	(8,990,500)
Potential Budget Reductions				
		-5%	-10%	-15%
Budget Variable Cost	**May - Dec**			
Salaries & Benefits	45,359,974	(2,415,888)	(4,514,965)	(6,724,910)
Physician Fees	3,166,645	(168,657)	(315,196)	(469,476)
Professional Fees	1,007,600	(53,665)	(100,293)	(149,383)
Supplies	11,107,317	(591,580)	(1,105,581)	(1,646,732)
Variable Cost	**60,641,535**	**(3,229,789)**	**(6,036,035)**	**(8,990,500)**

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Cash Planning Strategies

Other Considerations

- Be proactive – adapt to community needs for services
- Elective surgeries and procedures are coming back – focus on your “reopening plan” and how patients will be SAFE
- Understand that patients with chronic conditions may have care needs unmet for a number of months – many with significant needs
- Telemedicine services will be key moving forward – estimating 25% of primary care encounters in the future could be provided virtually
- Think about changes in facilities that may be needed to align with patient volumes, safe patient flow and patient expectations

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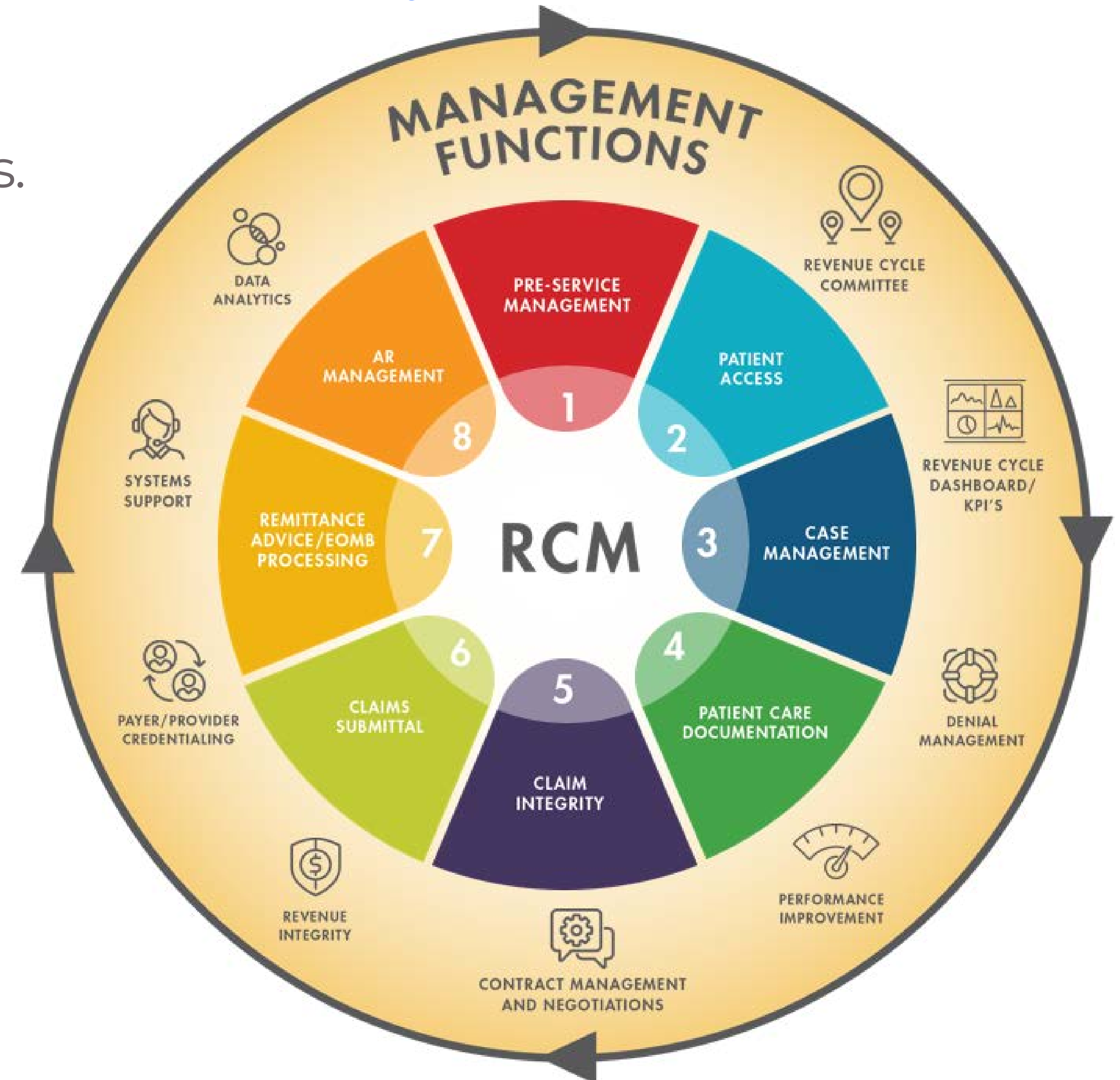
Cash Flow Planning – Consider a Revenue Cycle "Check-Up"

Integrated Revenue Cycle – a visual to assess your CAH's revenue cycle functions.

Calculate the potential cash impact if collections were improved by 1%, 3% 5% etc.

- The impact of proper documentation, prior authorization, coding, billing and follow up cannot be under estimated.
- Requires a rigorous process to understand gaps in each phase of the cycle and to create an improvement plan.



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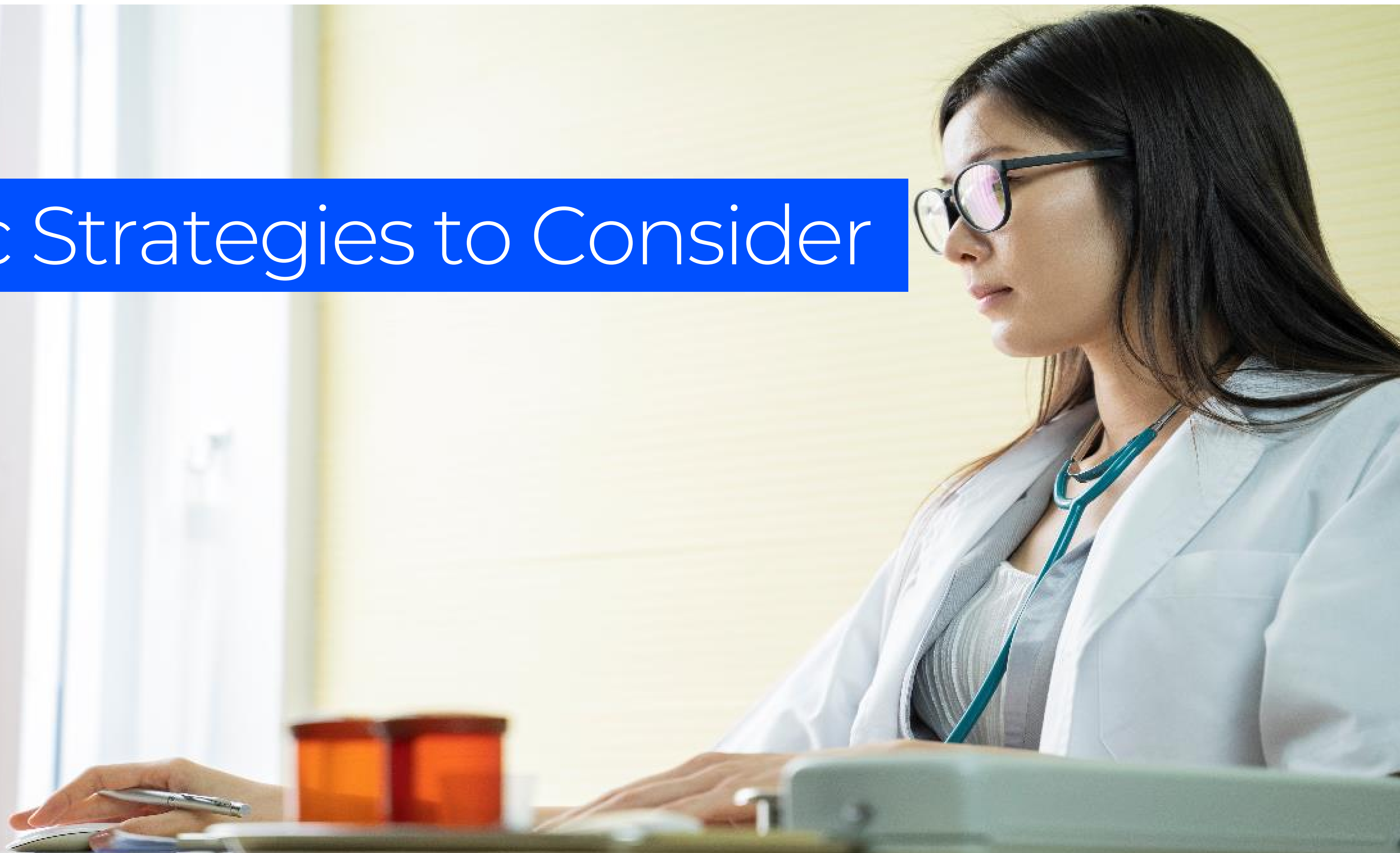
Clinic Strategies to Consider



Clinic Strategies to Consider

- Evaluate potential for converting free standing clinics and provider based clinics to Provider Based RHCs
- Review specialty services provided at the CAH to determine if any should be integrated into an existing Provider Based RHC
- Potentially acquire independent physicians, optometrists or other health care providers that may be interested in an affiliation at this time – downstream revenue opportunities
- Create team based care models to support population health initiatives and improve patient engagement
- Perform operational assessments of your RHCs – do you have the right providers in the right locations?

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Telehealth – Moving to Main Stream

Telehealth Overview

Readiness to embrace technology

- ~75% of hospitals leveraging telehealth substantially above pre-COVID-19 levels.
- ~90% of all hospitals expect to continue using increased levels of telehealth post COVID-19 in all regions

Telehealth market size in 2019 was $45 billion and is projected to grow to more than $175 billion by 2026

Lower regulatory barriers

- Privacy restrictions for telemedicine dissolved during pandemic
- Controlled substance prescriptions now possible based on telehealth visit

Source: Definitive Healthcare

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Telehealth Overview

Improved financial impact and reimbursement

- Fewer patient no shows
- Expansion of Medicare, Medicaid, and some private payer coverage for virtual care services

Technology continuously improving – good to even better

- Federal Communications Commission launched its own $100 million Covid-19 Telehealth Program, to support broadband expansion projects designed to push telehealth services into rural areas
- Rapid advancement in remote imaging technology and multi-service telemedicine platforms

Source: Definitive Healthcare

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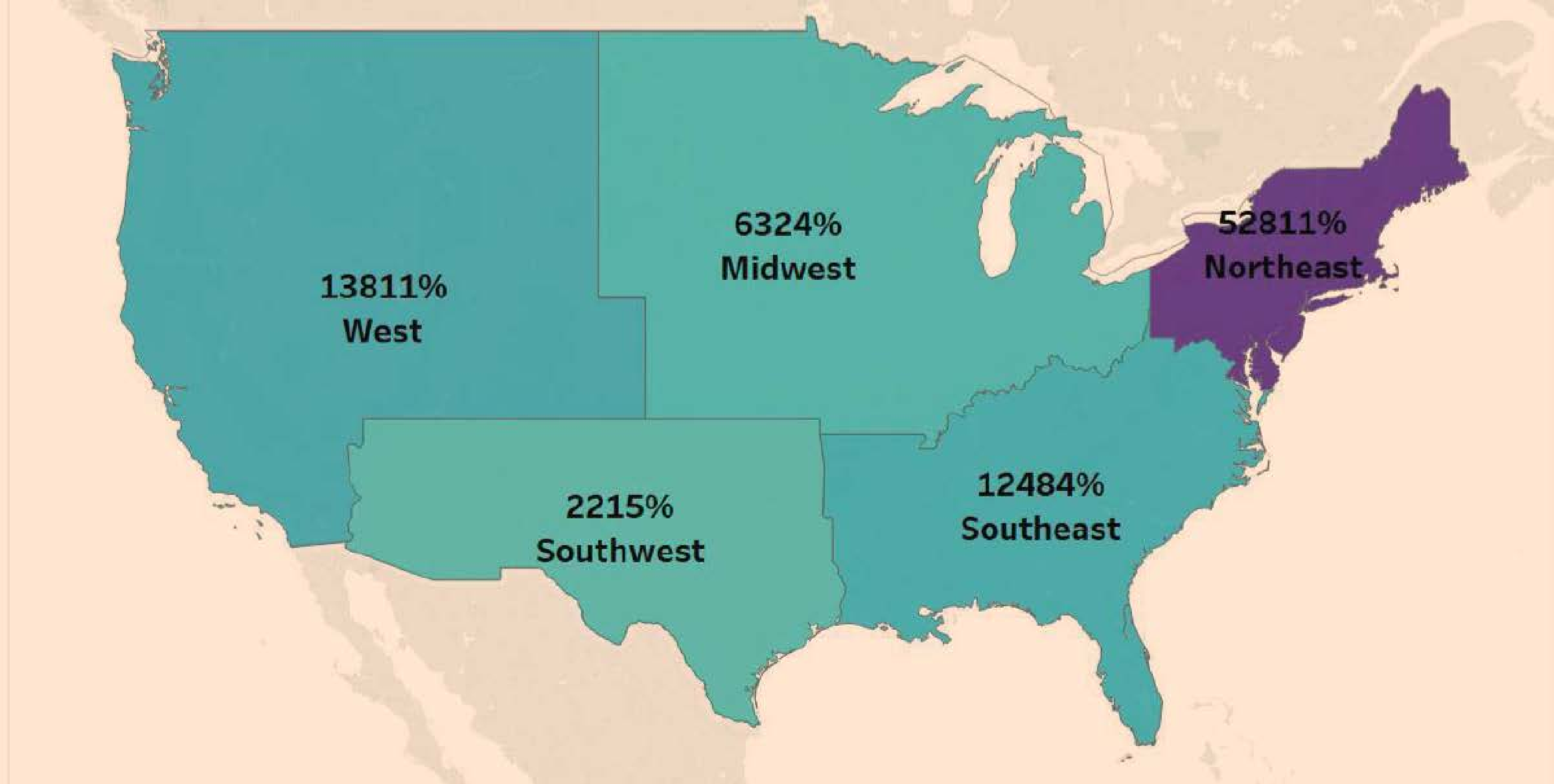
Rise in Telehealth by Region April 2019 to April 2020



Source: Definitive Healthcare

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Telehealth Overview

How does your organization deliver virtual care today?

- Telephone visits
- Video visits
- E-visits
- All the above

What types of challenges are you encountering with virtual visits?

- Technical difficulties
- Provider acceptance
- Patient acceptance
- All the above

Wipfli provides in-depth training sessions on telemedicine documentation, coding and billing rules for CAHs and RHC's. https://www.wipfli.com/industries/health-care

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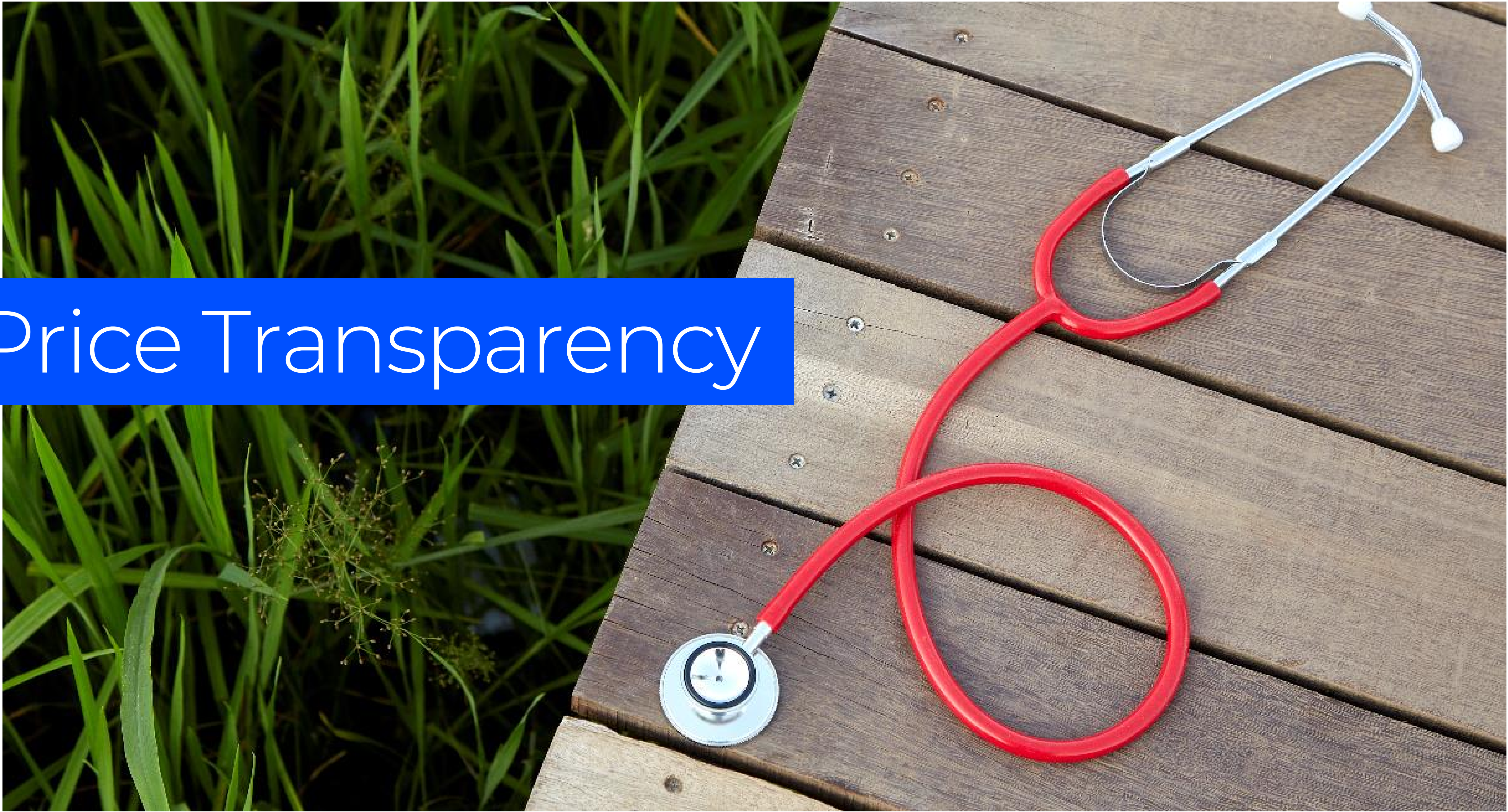
Price Transparency



Price Transparency Regulations

Overview

On November 15, 2019, CMS finalized its expanded interpretations of section 2718 of the Public Health Service Act. The final rule requires all hospitals to make a list of gross charges, negotiated charges, a self-pay “walk-in rate” and a minimum and maximum negotiated charge for all services in the hospital charge description master (CDM) publicly available in a machine-readable format.

It also defines a list of 300 shoppable services that must be made publicly available in a searchable, consumer-friendly format. The rule specifies the manner and format in which the lists are to be made publicly available.

Hospitals that do not comply with these requirements may be subject to civil monetary penalty (CMP) of up to $300 per day.

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Price Transparency Regulations

Specifics

- All facilities licensed as a hospital are covered under this regulation (including CAHs)
- Facilities with separate off site locations are required to publish prices for all locations if prices are different
- “Items and services” covered by the proposal are all items and services, including individual items and services and service packages that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge.

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Price Transparency Regulations

Specifics

- Standard charges are defined for 5 types of prices for CDM price list reporting:
  - Gross charge
  - Payor specific negotiated charge
  - Deidentified negotiated minimum negotiated charge
  - Deidentified negotiated maximum negotiated charge
  - Discounted cash price
- These 5 types of prices are also required for the posting of prices for 300 shoppable services
- Made publicly available in a machine readable format (easy to read, etc.)

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Price Transparency Regulations

Shoppable Service

A shoppable service is defined as a service that can be scheduled by a healthcare consumer in advance. The rule states the charges for shoppable services should be displayed as a grouping of related services, meaning that the charge for the shoppable service (primary service) is displayed along with charges for ancillary items and services the hospital customarily provides as part of, or in addition to, the primary shoppable service.

Ancillary services mean an item or service a hospital customarily provides as part of, or in conjunction with, a shoppable primary service. This will help consumers see the cost of the service in the same way they experience the service.

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Price Transparency Regulations

Shoppable Service

CMS requires hospitals to report at least 300 shoppable services. 70 commonly shoppable services are listed in the regulation, with the balance to be provided by each hospital based on that hospital's common services provided.

Sample Display of Shoppable Services

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes or disclaimers]

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Colonoscopy	Primary Diagnostic Procedure	45378	$750
	Anesthesia (Medication Only)	[Code(s)]	$122
	Physician Services	Not provided by hospital (may be billed separately)	
	Pathology/Interpretation of Results	Not provided by hospital (may be billed separately)	
	Facility Fee	[Code(s)]	$500
Office Visit	New Patient Outpatient Visit, 30 Min	99203	$54
Vaginal Delivery	Primary Procedure	59400	[$]
	Hospital Services	[Code(s)]	[$]
	Physician Services	Not provided by hospital (may be billed separately)	
	General Anesthesia	Not provided by hospital (may be billed separately)	
	Pain Control	Not provided by hospital (may be billed separately)	
	Two Day Hospital Stay	[Code(s)]	[$]
	Monitoring After Delivery	[Code(s)]	[$]

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Price Transparency Regulations

How to Comply?

- State resources (some states like Virginia have created websites for pricing)
- Price estimator tools
- Hospital specific reporting
- Other
- Option to pay the fine?

Will the regulation be amended or will the implementation date be extended?

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