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The Financial Health of California's Critical Access Hospitals

Prepared for

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by

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About the Foundation

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I. Introduction

CRITICAL ACCESS HOSPITALS (CAHS) hold a unique place in the health care delivery system. Typically located in remote, rural parts of the state, they frequently serve as the only provider of health care services in a community. Given their small size—up to 25 acute care beds—CAHs' financial viability can be affected by health care market changes such as shifts in population and demographics, payer mix, and workforce shortages. In 1998, the Centers for Medicare and Medicaid Services (CMS) recognized these challenges and started offering cost-based reimbursement to hospitals designated as CAHs. As a result, over the last decade, more than 1,300 hospitals converted from traditional acute care hospitals to CAHs.¹ By 2008, 28 of these hospitals were located in California.

The purpose of this report is to assess the financial health of California CAHs. Previous studies have focused either on general acute care (GAC) hospitals, using financial data from the Office of Statewide Health Planning and Development (OSHPD), or on CAHs, using data from Medicare Cost Reports. The research in this report broadens the analysis to include additional indicators of financial performance and health care data specific to California. Financial health was assessed based on the following:

- Multi-year analysis of financial performance of CAHs over the past six years;
- Comparative analysis of financial performance of CAHs relative to other California hospitals and among subsets within the California CAH group; and

- Topic-specific analysis of the impact of financial performance before and after conversion.

Key findings from the assessment include the following:

- The CAH program is essential to California CAHs' financial solvency.
- About two-thirds of California CAHs reported negative operating margins in 2008, although 73 percent had positive total margins. Cost-based reimbursement helps, but reliance on non-operating revenue streams is necessary to generate positive margins.
- California CAHs in aggregate perform nearly as well as or even better than the state's GACs on many financial indicators.
- While CAHs are often grouped as a sector of the hospital market based on the requirements to meet critical access status, wide variations in financial performance exist. There do not appear to be consistent or conclusive trends by ownership type, system affiliation, or geographic location within the state (Southern versus Northern California); also subsets of CAHs perform differently.

From the assessment, five key factors were identified as influencing the financial performance of CAHs: geographic location, scale and scope of services, payer mix, partnerships and support, and leadership and managerial experience. A detailed discussion of each of these factors follows.

II. Background

THE CAH PROGRAM ORIGINATED IN 1988, when Medicare initiated the Medical Assistance Facility Program—a demonstration project with the goal of providing cost-based reimbursement to select rural hospitals.² This was followed the next year by the Rural Primary Care Hospital Program, which expanded cost-based reimbursement to small and rural hospitals. By 1998, under the Balanced Budget Act (BBA) of 1997, these two programs had merged into the Medicare Rural Hospital Flexibility Program, also known as the CAH program.

Criteria for CAHs

To be designated a CAH, a hospital must meet four primary criteria. It must:

1. Be located in a rural area, or 35 miles from the nearest hospital;
2. Contain no more than 25 acute care beds at any given time;
3. Furnish a 24-hour staffed emergency department; and
4. Have an average length of stay for acute care services of no longer than 96 hours (four days).³

The BBA legislation quickly produced results. Between 1998 and 2005, more than 1,260 hospitals converted to CAH status, an average of nearly 160 per year.⁴ One reason for the rapid rise in the number of CAHs nationally was the use of waivers under the “state necessary provider” provision, which allowed states to waive the distance requirement of 35 miles for designation as a critical access hospital. Concerned about the growing number of CAHs, Congress included language in the 2003 Medicare

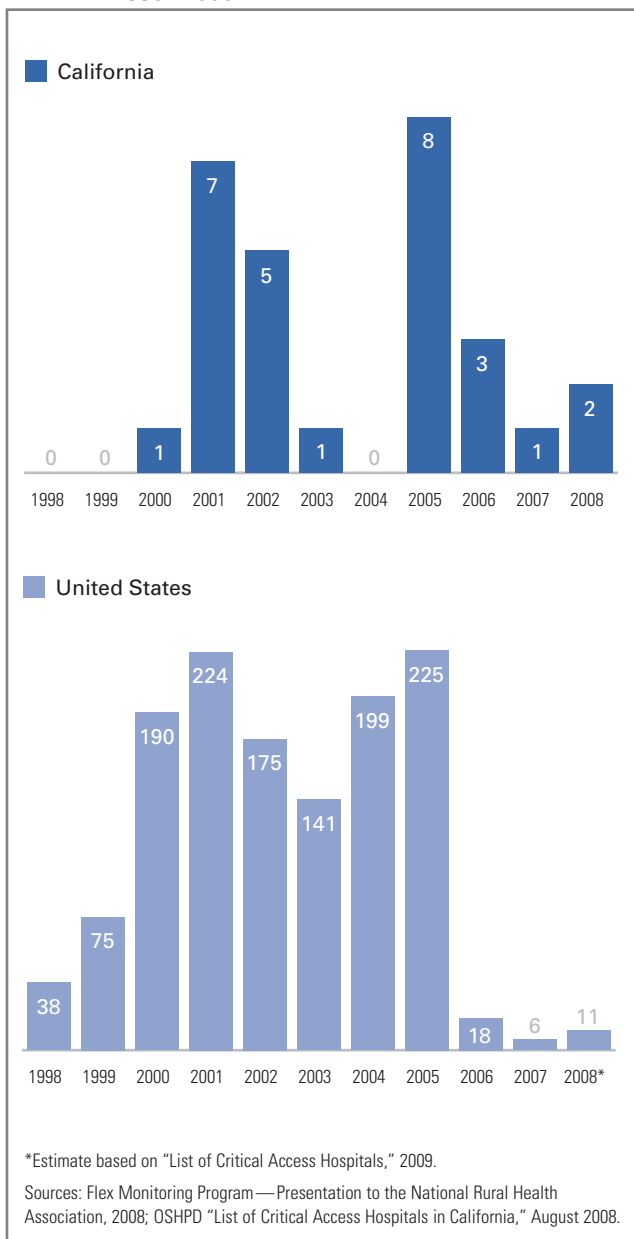
Modernization Act to sunset the state “necessary provider clause” by 2006.⁵ Partially as a result of this legislation, between 2006 and 2008 the average annual number of critical access conversions declined from 160 to 12 per year. Today the nation’s 1,300 CAHs represent slightly more than a quarter of all community hospitals.⁶

In California, the first conversion occurred in 2000, a full two years after the national program had begun. There were no regulatory or legislative constraints, suggesting that the slower conversion time for California may have been due to other factors, such as lack of familiarity with the program, community pressures, and cumbersome administrative processes (e.g., applying for designation, restructuring existing systems/ infrastructure, etc.). Conversions in California occurred in two waves, with half of all conversions occurring between 2000 and 2003, and the other half occurring between 2005 and 2008 (see Figure 1 on page 4).

Coinciding with the passage of the 2003 Medicare Modernization Act, no conversions took place in California in 2004, suggesting uncertainty around the benefits and risks of converting to CAH status. By the end of 2008, 28 hospitals were designated CAHs, with several more either in the process of or contemplating converting.⁷ Though the number of CAHs has increased in the past few years, they account for fewer than 10 percent of all GAC hospitals in the state, well below the overall national average.⁸

The key driver for conversion is the financial benefit of cost-based reimbursement. Medicare reimburses at 101 percent of a hospital’s costs,

Figure 1. Timeline of Critical Access Hospital Conversions, California vs. the United States, 1998–2008



compared to the lower rates currently used for most GAC hospitals, based on the traditional prospective payment system.⁹ Some states also provide CAHs with cost-based reimbursement for Medicaid patients, though this currently is not the case in California. Other drivers of conversion include reduced restrictions on staffing (except for nurse staffing ratios in California) and federal- and state-sponsored grants. The latter have been used for several purposes, including supporting a hospital during conversion, promoting emergency medical services integration initiatives, assisting with the development of rural health networks, and supporting improvements in clinical quality.¹⁰

Though large in number, the small size and low volume associated with CAHs minimize the impact these hospitals have on national and state hospital spending. In 2006, CAHs represented more than half of all rural hospitals (57 percent), but accounted for only 18 percent of Medicare inpatient payments to rural hospitals.¹¹ In California, CAHs accounted for just 1.2 percent of all patient revenue to GACs in 2008 and only 1.1 percent of reported patient revenue from Medi-Cal to GACs.

III. Methodology

TO ASSESS THE FINANCIAL HEALTH OF CAHs in California, a combination of quantitative analyses using publicly available financial data and qualitative findings from interviews was used. For each hospital, data were collected and analyzed across six dimensions of financial health: profitability, liquidity, capital structure, revenue, expenses, and utilization. Financial analyses consisted of a multi-year study, calculating medians across these dimensions from 2003 to 2008, and comparative analyses to assess financial performance across subsets of CAHs (e.g., those with long-term care units and those without).¹² Performance was then benchmarked against GAC hospitals in California and the United States in aggregate. Applicable CAHs were included in the analysis beginning the year following the published conversion date. For example, Kern Valley Hospital converted in 2003, so the first full year as a CAH would have been 2004. The primary data source was the Hospital Annual Financial Data Reports from OSHPD.

Data Limitations and Caveats

Two difficulties arose when analyzing trends for California CAHs: the relatively small number of hospitals included in the sample, and the constantly changing number of CAHs per year. The number increased from 13 in 2003 to 28 in 2008 as small hospitals took advantage of the opportunity to convert. Additionally, although CAHs are similarly sized in terms of acute care beds, the average daily census in 2008 ranged from a low of 0.2 to a high of 15.8. The changing number of CAHs and the magnitude of variability resulted in large shifts in financial performance from year to year for some

indicators. For example, median long-term debt to capitalization increased from 22.1 percent in 2004 to 42.4 percent in 2005, then declined to 33.6 percent in 2006. Given the data limitations, year-by-year median data were included in the report to provide a comprehensive financial assessment and should be viewed as a series of snapshots in time rather than a trend analysis.

In addition, it is helpful to note the relative size of these institutions, since financial ratio comparisons between CAHs and larger GAC hospitals can obscure this. In 2008, the median operating revenue for California CAHs was \$17.1 million, compared to a median of \$111.1 million for all California GAC hospitals.¹³

Significant work assessing the financial health of CAHs nationally by the Flex Monitoring Team, and the financial health of California hospitals by the California HealthCare Foundation, has already been completed.^{14,15} One of the goals of this assessment was to maximize the use of those studies with the intent of providing data and findings that could be comparable and applicable to others within the state and elsewhere. Therefore, the financial indicators used in this assessment are closely aligned with other studies, with slight modifications either to broaden the analysis or compensate for differences between OSHPD data and Medicare Cost Reports.

To gain greater insights around the quantitative findings, telephone interviews were conducted with administrative leadership at several CAHs. Interviewees were selected to ensure a broad representation of CAHs. Criteria included a mix of location (Northern and Southern California), ownership type (district, private not-for-profit,

religious), affiliation (stand-alone and system affiliated), as well as hospitals that converted recently and those that were early adopters. Interviews were also conducted with the California Hospital Association Office of Rural Affairs to understand some of the key issues facing CAHs today. Findings from the interviews were summarized into themes that would be applicable to most CAHs.

IV. Findings

General Characteristics

California’s CAHs can be characterized by several factors, including geography, ownership type, system affiliation, and scope of services, as shown in Table 1.

Of the 28 hospitals, 68 percent (19 hospitals) are north of the San Francisco Bay Area, in a more rural and rugged geography than that of Southern California (see Appendix for a map of California CAHs). Sixty-one percent (17) are district hospitals, 21 percent (six) are members of systems, and 18 percent (four) are stand-alone private not-for-profit hospitals.¹⁶ Only three received designation

through the necessary provider provision, while the rest met the distance requirement of 35 miles. Seven hospitals also met the requirements to receive disproportionate share payments from Medi-Cal.

Financial Performance

To understand the financial health of California CAHs, the researchers assessed 19 indicators of financial performance across five financial dimensions—profitability, liquidity, capital structure, revenue, and expenses. In 2008, CAHs performed better on ten out of the 19 indicators

Table 1. General Characteristics of California Critical Access Hospitals

CONVERSION YEAR / HOSPITAL	DISTRICT HOSPITAL	SYSTEM AFFILIATION	DSH HOSPITAL	NECESSARY PROVIDER	STAND-ALONE, PRIVATE NOT FOR PROFIT
2000					
Eastern Plumas Health Care	✓				
2001					
Catalina Island Medical Center					✓
Glenn Medical Center					✓
John C. Fremont Healthcare District	✓		✓		
Mammoth Hospital	✓				
Mayers Memorial Hospital District	✓		✓		
Southern Inyo Hospital	✓				
Tehachapi Valley Healthcare District	✓				
2002					
Biggs-Gridley Memorial Hospital				✓	✓
Frank R. Howard Memorial Hospital		Adventist Health			
Jerold Phelps Community Hospital	✓		✓		
Mountains Community Hospital	✓		✓		
Surprise Valley Health Care District	✓				
2003					
Kern Valley Healthcare District	✓		✓		

Table 1. General Characteristics of California Critical Access Hospitals, cont.

CONVERSION YEAR / HOSPITAL	DISTRICT HOSPITAL	SYSTEM AFFILIATION	DSH HOSPITAL	NECESSARY PROVIDER	STAND-ALONE, PRIVATE NOT FOR PROFIT
2005					
St. Helena Hospital–Clearlake		Adventist Health	✓		
Banner Lassen Medical Center		Banner Health			
Colorado River Medical Center					
Fairchild Medical Center					✓
Mercy Medical Center, Mt. Shasta		Catholic Healthcare West			
Healdsburg District Hospital	✓			✓	
Redwood Memorial Hospital		St. Joseph Health System		✓	
Trinity Hospital	✓		✓		
2006					
Mendocino Coast District Hospital	✓				
Northern Inyo Hospital	✓				
Plumas District Hospital	✓				
2007					
Seneca Healthcare District	✓				
2008					
Sutter Lakeside Hospital		Sutter Health			
Tahoe Forest Hospital District	✓				

Sources: OSHPD HAFD 2008, OSHPD “List of Critical Access Hospitals in California.” California Hospital Association Membership Guide, 2009.

when compared to the state’s GAC hospitals. However, the level of financial performance varied by indicator and subset of CAHs. Table 2 shows median values for each indicator from 2003 to 2008 (see page 9). Similar to other studies assessing the financial performance of CAHs over time, multi-year data are snapshots in time rather than a trend analysis. Table 3 shows 2008 median values for each indicator for California’s CAHs, GACs, CAHs with and without long term care components, and CAHs with positive and negative operating margins (see page 10).

Profitability

CAHs as a group struggle to break even on operations, yet through the use of non-operating support they are able to achieve a positive median total margin. Of the 26 hospitals included in 2008, 19 had positive total margins, while only nine had positive operating margins.¹⁷ The median total margin and return on equity for CAHs exceeded that of California GACs.

Many CAHs rely on non-operating revenue to bridge the gap between operating losses and positive total margins. As might be expected, CAHs with negative operating margins relied more on non-

Table 2. Median Financial Indicators for California Critical Access Hospitals, 2003–2008

	2003	2004	2005	2006	2007	2008	GENERAL ACUTE CARE, 2008
NUMBER OF HOSPITALS INCLUDED	13	14	14	22	25	26	326
Profitability							
Operating Margin	-4.0%	-7.3%	-7.0%	-4.7%	-5.1%	-3.7%	1.4%
Total Margin	1.8%	4.2%	2.0%	3.1%	1.8%	3.8%	2.6%
Return on Equity	15.8%	10.8%	1.6%	5.1%	7.2%	10.9%	9.7%
Liquidity							
Current Ratio	1.18	1.5	1.5	1.4	1.6	1.7	1.5
Days Cash on Hand	21.6	17.8	16.0	18.0	25.5	39.3	21.9
Days in Accounts Receivable	N/A	69.1	64.0	61.7	58.8	67.1	60.2
Capital Structure							
Equity Financing	34%	38.3%	37.1%	37.3%	30.9%	43.6%	38.3%
Debt Service Coverage	1.8	2.3	2.9	2.1	2.5	3.8	2.9
Debt to Capitalization	17%	22.1%	42.4%	33.6%	45.8%	38.9%	39.7%
Revenue							
Net Operating Revenue (in millions)	\$9.2	\$10.5	\$11.4	\$14.4	\$16.4	\$17.1	\$111.1
Revenue per CM-Adj. Discharge	\$8,557	\$10,326	\$10,217	\$10,033	\$9,451	\$10,616	\$10,085
PAYER MIX – DISCHARGES BY MAJOR PAYER							
Medicare	57%	53.7%	51.6%	48.2%	49.1%	54.2%	42.0%
Medi-Cal	16%	19.3%	22.1%	24.3%	22.7%	21.5%	11.0%
Commercial	17%	16.3%	13.5%	14.4%	14.6%	15.9%	24.2%
Expenses							
Operating Expenses (in millions)	\$9.9	\$12.1	\$12.9	\$15.5	\$18.4	\$19.0	\$110.4
Expense per CM-Adj. Discharge	\$11,111	\$12,321	\$13,173	\$10,495	\$10,509	\$11,618	\$10,008
Salaries to Total Costs	44%	43.1%	43.5%	41.6%	40.5%	39.8%	38.6%
Salaries and Wages per FTE	\$35,392	\$35,318	\$37,233	\$43,098	\$48,096	\$42,636	\$60,292
FTEs per Adj. Occ. Bed	1.9	1.8	1.6	2.7	2.9	2.9	5.2
Uncomp. Care (% of total expenses)	4.5%	4.4%	5.2%	6.3%	6.4%	6.4%	4.6%
Average Age of Plant	9.9	11.4	12.9	10.7	10.5	10.4	9.7
Utilization							
Total Discharges	469	446	456	626	629	747	6,664
ADC Acute Care	3.0	4.0	4.2	5.4	5.2	6.4	106.3
Case Mix Index	0.89	0.89	0.91	0.91	0.92	0.93	1.14
Occupancy Rate	61%	67.6%	73.6%	60.1%	62.1%	63.4%	63.7%
ED Visits	4,800	5,173	4,872	7,429	7,754	7,443	26,802
Total Surgical Volume	11	46	46	457	485	455	4,405

Sources: OSHPD HAFD. KSA Analysis, 2003–2008.

Table 3. Median Financial Indicators for California CAHs, by Hospital Type, 2008

	CRITICAL ACCESS					GENERAL ACUTE CARE
	ALL	WITH LONG TERM CARE	WITHOUT LONG TERM CARE	WITH POSITIVE MARGINS	WITH NEGATIVE MARGINS	
NUMBER OF HOSPITALS INCLUDED	26	14	12	9	17	326
Profitability						
Operating Margin	-3.7%	-10.6%	2.3%	9.3%	-10.6%	1.4%
Total Margin	3.8%	1.6%	5.2%	6.2%	1.8%	2.6%
Return on Equity	10.9%	9.9%	16.6%	16.3%	9.3%	9.7%
Liquidity						
Current Ratio	1.7	1.4	1.9	2.7	1.3	1.5
Days Cash on Hand	39.3	10.3	56.7	49.2	16.5	21.9
Days in Accounts Receivable	67.1	67.2	66.3	66.9	67.2	60.2
Capital Structure						
Equity Financing	43.6%	27.9%	51.4%	70.7%	23.0%	38.3%
Debt Service Coverage	3.8	2.0	5.0	7.2	1.5	2.9
Debt to Capitalization	38.9%	58.5%	19.9%	9.0%	57.9%	39.7%
Revenue						
Net Operating Revenue (in millions)	\$17.1	\$12.9	\$36.5	\$38.1	\$12.3	\$111.1
Non-Operating Revenue (% of total)	6.9%	11.1%	2.5%	1.2%	9.3%	1.1%
Revenue per CM-Adj. Discharge	\$10,616	\$12,332	\$9,196	\$10,072	\$10,953	\$10,085
PAYER MIX – DISCHARGES BY MAJOR PAYER						
Medicare	54.2%	61.0%	49.2%	51.2%	61.0%	42.0%
MediCal	21.5%	19.1%	22.2%	22.1%	18.2%	11.0%
Commercial	15.9%	11.3%	20.0%	20.0%	11.9%	24.2%
Expenses						
Operating Expenses (in millions)	\$19.0	\$16.3	\$31.5	\$31.7	\$16.1	\$110.4
Expense per CM-Adj. Discharge	\$11,618	\$12,967	\$9,573	\$9,448	\$11,965	\$10,008
Salaries to Total Costs	39.8%	40.9%	39.2%	38.5%	39.8%	38.6%
Salaries and Wages per FTE	\$42,636	\$38,181	\$49,158	\$51,896	\$40,012	\$60,292
FTEs per Adj. Occ. Bed	2.9	1.7	7.0	7.3	1.8	5.2
Uncomp. Care (% of total expenses)	6.4%	6.5%	6.4%	6.5%	6.4%	4.6%
Average Age of Plant	10.4	13.6	8.3	8.7	12.0	9.7
Utilization						
Total Discharges	747	446	1,138	1,289	388	6,664
ADC Acute Care	6.4	4.8	10.3	11.6	4.5	106.3
Case Mix Index	0.93	0.93	0.94	0.96	0.93	1.14
Occupancy Rate	63.4%	69.6%	50.5%	54.6%	68.8%	63.7%
ED Visits	7,443	4,400	9,772	9,494	4,985	26,802
Total Surgical Volume	455	135	1,259	1,566	66	4,405

Sources: OSHPD HAFD. KSA Analysis, 2008.

capitalization ratio than those without long term care (58.5 percent compared to 19.9 percent). Similar to liquidity, CAHs with positive operating margins performed better on key measures of capital structure than CAHs with negative operating margins (e.g., those with a positive margin had median debt service coverage of 7.2, compared to only 1.5 for CAHs with a negative margin).

Revenue and Expenses

In 2008, the median revenue per case mix adjusted discharge was slightly higher for CAHs than for GACs (\$10,616 compared to \$10,085). However, CAHs had substantially higher median operating expenses per case mix adjusted discharge (\$11,618 compared to \$10,008), explaining the negative median operating margin. Further assessment of expense indicators showed that, compared to GACs, CAHs had higher median salaries to total cost and had higher uncompensated care as a percentage of expenses. When comparing salaries and wages per FTE, and FTEs per adjusted occupied bed, however, CAHs had lower values compared to GACs.²⁰ The less predictable volume and the difficulty staffing below minimal levels likely limits the opportunity for CAHs to manage costs through greater efficiency in staffing.

Overall, CAHs demonstrated reasonably good performance for many key financial indicators, though median values for operating profitability were negative. While cost-based reimbursement likely contributed to this performance, CAH status did not ameliorate all the challenges inherent in creating a financially successful hospital (see box on page 19). In addition, the financial performance of CAHs varied widely by hospital. There are likely several contributing factors to the financial performance of CAHs, five of which are discussed further below.

V. Discussion

Five Factors Influencing Financial Performance

Based on quantitative analyses and qualitative findings from interviews, the following factors surfaced as strong determinants of financial performance for California CAHs:

- Geographic location;
- Scale and scope of services;
- Payer mix;
- Partnerships and support; and
- Leadership and managerial experience.

Though these factors can be applied to many types of hospitals, they appear to be especially relevant to California CAHs due to their small size and position in the community. These factors are not mutually exclusive; many overlap or influence others directly or indirectly.

Geographic Location

Discussions with hospital leadership suggested that the financial performance and strategic direction of a CAH can be determined by its location. Geographically isolated hospitals with a sizable population base appear to have a stronger financial position. The isolation from other providers allows for improved contracting terms with commercial payers, as there is little ability to shift patients to a facility far from home at the expense of the local provider. Additionally, being located in proximity to areas of strong economic activity (e.g., ski resorts or other vacation areas) can supply the hospital with significant incremental volume from well-insured

tourists and seasonal residents. For example, one CAH is located in an area with a base population of approximately 7,000 year-round residents, yet the area surrounding the town receives roughly 2.8 million visitors annually for winter and summer recreation activities.²¹ The population swell provides the hospital with the opportunity to provide more services including procedural services, which are typically reimbursed at higher rates. This hospital had a commercial payer mix of 50 percent—about 34 percentage points above the CAH median.

Scale and Scope of Services

Although heavily influenced by geography, the scale and scope of services offered at a CAH can also have a significant impact on financial performance. CAHs that have higher volume tend to be more profitable than those with lower volume. In 2008, the median inpatient volume for CAHs with positive operating margins was 1,289 discharges, whereas CAHs with negative margins had a median of only 388 discharges. Low-volume hospitals tend to struggle with the substantial costs associated with running a fully operational facility. Hospitals with higher volumes are afforded the opportunity to offer a wider array of services, including ancillary services beyond inpatient care. Based on current reimbursement rates, ambulatory services can lead to a crucial boost in revenue. In 2008, the median total surgical cases (inpatient and outpatient) for CAHs with a positive operating margin was 1,566, compared to only 66 for CAHs with a negative operating margin.

Many CAHs are looked upon to provide all services necessary to meet the needs of the

community, including obstetrics, long term care (LTC), home health, and hospice care—services that currently are not reimbursed at cost. Similar to previous studies, this research found that CAHs with distinct LTC components perform worse financially than those without LTC.²² In 2008, the median operating margin for CAHs without LTC was 2.3 percent, compared to minus 10.6 percent for CAHs with LTC. CAHs with LTC reported lower medians for key liquidity indicators, including median days cash on hand of only 10.3 compared to 56.7 for CAHs without LTC. In addition, the median current ratio for CAHs with LTC was 1.4, compared to 1.9 for CAHs without LTC. As noted earlier, CAHs with LTC also had lower medians for key capital structure indicators. The difficulty CAHs with LTC have in generating positive operating margins challenges their ability to improve financial measures associated with liquidity and capital structure. As a result administrators at CAHs often struggle to balance community needs with financial viability and strategic growth.

Payer Mix

California's CAHs receive cost-based reimbursement for Medicare patients but not for Medi-Cal patients, indicating that payer mix has a strong influence on the financial health of these hospitals. California has a younger population compared to the nation (median age 34.7 versus 36.7), with several pockets of low-income, under-, and uninsured populations.²³ While the median annual household income for Californians is higher than the national average (\$59,900 versus \$50,700), the state also has a significantly higher share enrolled in Medicaid (29 percent versus 20 percent nationally).²⁴ Thus, hospitals in California are more likely to see patients with Medi-Cal than hospitals in other states.

Cost-based reimbursement has essentially rendered Medicare a neutral factor in a CAH's payer mix. In 2008, CAHs with positive operating margins had a median Medicare percentage of 51 percent, whereas the median for CAHs with negative operating margins was 61 percent. Profitable CAHs had a substantially higher median percentage of discharges from commercial insurers (20 percent versus 11.9 percent) than CAHs with negative operating margins, suggesting a reliance on commercial payers to remain profitable.

Given the importance of CAH payer mix, the ability to negotiate higher rates for commercial contracts is critical to financial performance. Two potential advantages enable CAHs to leverage better rates from their commercial contracts. First, CAHs that are geographically isolated and maintain a strong market share within the community have the potential to negotiate more favorable rates for commercially insured patients. Second, CAHs belonging to a system are often able to take advantage of the parent system's rates. Of five CAHs that were part of systems in 2008, four had positive operating margins.²⁵

Although Medi-Cal reimbursement for CAHs is substantially lower than commercial or Medicare reimbursement, several CAHs do qualify for disproportionate share payments (DSH). These payments are allocated to hospitals to help mitigate financial losses from providing services to high numbers of Medi-Cal and uninsured patients. In 2008, seven CAHs received DSH payments, which ranged from \$8,600 to \$500,000 per year.²⁶ However, DSH payments alone are not a solution for financial viability, as evidenced by the fact that no CAH receiving DSH funding achieved a positive operating margin in 2008.²⁷

Partnerships and Support

Partnerships and support refer to relationships (formal or informal) that exist between a CAH and another entity that can provide some type of financial, operational, or educational benefit to the CAH. Such relationships are important to all nonprofit hospitals, but seem to be even more so for CAHs due to their small size and remote locations. Several types of partnerships and support seem to be particularly important for improving financial performance (both operationally and non-operationally), including support from the district, system, local community, and formal or informal inter-hospital network.

District support. In 2008 there were 45 district hospitals in California, of which 16 were designated critical access.²⁸ Districts offer hospitals broader community engagement, a greater voice for the community in shaping the strategic direction of the hospital, and an alternative source of revenue through their local district taxing authority. In 2008, the median district-provided revenue for district CAHs was \$847,000, and ranged from \$162,000 to \$3,300,000. However, profitability for district CAHs (as captured in the total margin) was only 0.5 percent in 2008, suggesting that these hospitals need to look for additional cost savings and funding opportunities to remain financially viable.

System support. System relationships can often provide financial, logistic, operational, and educational support for CAHs. In 2008, CAHs that were affiliated with a system had higher operating margins than CAHs not affiliated. Of the five CAHs with the highest operating margins in 2008, three belonged to a system. Only one of the affiliated CAHs reported a negative operating margin; this hospital also happened to be a DSH-eligible hospital. One advantage of system affiliation is enhanced access to short-term capital for operating purposes,

which can be critical when disruptions to service or revenue threaten the operation. System membership can also help CAHs by supplying more management support as well as access to system resources like IT, quality improvement, compliance, and HR than they could likely acquire alone.

Other community support. Foundations set up in support of the hospital can provide essential help to purchase new equipment, refurbish patient rooms, and support physician recruitment efforts. Seventy-one percent (20) of CAH Web sites reported having a foundation that was established to assist the hospital.²⁹ Listed activities include raising funds for items ranging from the purchase of maternal fetal monitoring stations to a \$500,000 capital campaign to support the development of a new hospital. Though likely much smaller in resources and fundraising capabilities than their urban hospital peers, these organizations can provide important resources to assist the hospital.

Inter-hospital networks. Some administrators at stand-alone CAHs have expressed a feeling of isolation and perceive the issues at their hospital as unique. Networks offer a way for leaders to discuss issues common to many CAHs. These relationships can be harnessed for information, sharing of staff, and even potentially for financial gain (e.g., through the use of group purchasing arrangements). Several CAH administrators indicated they had benefited by this type of network by understanding what others are doing in terms of staffing and service offerings.

Leadership and Managerial Experience

Leadership and managerial skills are difficult to assess through either quantitative or qualitative means. However, through discussions with CAH administrators, it became clear that a high level of acumen regarding CAHs is necessary to be successful financially. Experience in rural markets

and at other CAHs are thought to be particularly valuable. Also, because of the CAH's role as the sole community provider, leaders must be able to develop a strong relationship with the community to maintain support for the hospital. Finally, due to their small size and limited budgets, executive and departmental leaders often find themselves "doing" as much as leading, and must assume roles that executives with similar titles in larger hospitals would have vice presidents and directors handling for them. Administrators frequently are responsible for a range of activities, from contract negotiations, to updating billing systems, to recruiting physicians and staff. The ability to "wear many hats" requires a different skill set than is required at a larger hospital. Therefore effective leadership can positively impact the financial performance of a CAH.

VI. Future Challenges

LIKE MOST NONPROFIT PROVIDERS, CAHs nationwide face a variety of issues that threaten their financial viability, including patient mix, reimbursement levels, bad debt, and workforce shortages. In California, CAHs face several specific challenges, including:

- Physician recruitment/retention;
- Access to capital; and
- Rural demographic challenges.

Physician recruitment/retention. Recent studies have shown that rural counties in California have fewer physicians per capita than in urban counties.³⁰ CAH administrators reported difficulty attracting new physicians (particularly specialists) to their communities given the lower volumes of patients, fewer job opportunities and school choices for spouses and families, and limited income potential. Some CAHs also lack the funds to conduct national recruiting or provide income guarantees to new recruits. In interviews, many CAH administrators expressed concern that, in California, unlike many other states, the limited ability of hospitals to directly employ physicians hampers recruitment efforts. It is difficult to develop strong clinical programs, enhance quality of care, and improve financial performance without effective recruitment and retention capability.

Access to capital. CAHs often lack access to capital for critical infrastructure investments. The recent economic downturn has been especially difficult for nonprofit organizations, which historically have relied on inexpensive debt financing through municipal bond markets. CAHs have had a more difficult time obtaining debt financing due to their lower cash flows and the small asset base. Some CAHs, through system affiliations or with support from their district, have obtained financing for improved infrastructure.

Rural demographics. CAHs are at the epicenter of rural health challenges. Rural residents are more likely to be unemployed, lack health insurance, be diagnosed with chronic conditions such as diabetes and heart disease, and be less likely to receive medical exams for common procedures than other Californians.³¹ Meeting the diverse medical needs of rural communities requires additional resources (financial and professional) that are difficult to obtain when finances are already constrained.

VII. Conclusion

THE OVERALL PERFORMANCE FOR CALIFORNIA CAHs in 2008—although not high enough to be described as “financially healthy,” was better than for the state’s GACs for most indicators assessed. Some CAHs have performed exceptionally well in difficult operating environments, and some overcame operating deficits with non-operating support. Others fell well below their peers across most dimensions of financial health. Without continued improvements in reimbursement or expense management, these CAHs will continue to struggle.

Five factors appear to influence the financial performance of CAHs:

- The geographic location can influence the potential volumes, the competitive landscape, and the level of reimbursement for a CAH.
- The payer mix can be heavily influenced by local market demographics. Large numbers of Medicare patients provide a stable base, but with Medicare providing only a 1-percent margin, the balance of commercially insured patients against Medi-Cal and uninsured patients largely predicts financial performance.
- Offering a wide variety of services positions a CAH to do better financially. However, hospitals that offer services not reimbursed at cost, such as long term care, home health, or hospice, dilute the financial benefit.
- Hospital leaders with expertise in rural environments or with other CAHs can improve the performance of an institution.
- CAHs that can leverage partnerships with districts, systems, communities, or hospital networks are in a better position to improve financial performance.

The extent to which CAHs can influence these factors in the future will be reflected in their ability to expand and improve the care delivered within these communities.

Financial Impact of Conversion to CAH Status

Conversion to critical access status confers certain benefits to hospitals, but also has costs. Conducting due diligence and obtaining legal as well as community approval require time and money. Research has demonstrated CAHs in other parts of the country improve profitability within one year of converting to critical access status.³²

To gain a better understanding of the impact of conversion on the financial performance of California CAHs, data for seven hospitals that underwent conversion in 2005 were analyzed two years before and two years after conversion (2003 and 2007).³³ The results indicate that conversion generally proved to be a financially prudent decision. Median values for profitability, liquidity, and debt service measures increased two years post-conversion, even though average daily census declined by 9.9 percent. Revenue and expense per adjusted discharge and case-mix adjusted discharge both increased, although expenses increased more than revenue. This may be a result of lower volumes of high-severity patients served or increased expenses related to fixed costs. For this group of CAHs, conversion proved to be financially beneficial two years after conversion; while reducing the average number of patients seen, they were able to improve on multiple indicators of financial performance.

Table 4. Select Median Indicators Among a Group of Seven Hospitals, Two Years Before (2003) and Two Years After (2007) CAH Conversion

INDICATOR	TWO YEARS BEFORE (2003)	TWO YEARS AFTER (2007)
Operating Margin	2.1%	5.0%
Total Margin	0.2%	6.0%
Days Cash on Hand	3.9	21.7
Debt Service Coverage Ratio	3.9	4.5
Revenue per Adjusted Discharge (CM adj.)	\$8,746	\$8,834
Expense per Adjusted Discharge (CM adj.)	\$8,629	\$9,386
ADC Acute	14.3	12.9

Sources: OSHPD HAFD 2003, 2007; OSHPD "List of Critical Access Hospitals in California," August 2008; KSA Analysis.

Appendix: California Critical Access Hospitals



1 St. Helena Hospital – Clearlake	Clearlake	15 Mendocino Coast District Hospital	Fort Bragg
2 Banner Lassen Medical Center	Susanville	16 Mercy Medical Center, Mt. Shasta	Mt. Shasta
3 Biggs-Gridley Memorial Hospital	Gridley	17 Mountains Community Hospital	Lake Arrowhead
4 Catalina Island Medical Center	Avalon	18 Healdsburg District Hospital	Healdsburg
5 Colorado River Medical Center	Needles	19 Northern Inyo Hospital	Bishop
6 Eastern Plumas Health Care	Portola	20 Plumas District Hospital	Quincy
7 Fairchild Medical Center	Yreka	21 Redwood Memorial Hospital	Fortuna
8 Frank R. Howard Memorial Hospital	Willits	22 Seneca Healthcare District	Chester
9 Glenn Medical Center	Willows	23 Southern Inyo Hospital	Lone Pine
10 Jerold Phelps Community Hospital	Garberville	24 Surprise Valley Health Care District	Cedarville
11 John C. Fremont Healthcare District	Mariposa	25 Sutter Lakeside Hospital	Lakeport
12 Kern Valley Healthcare District	Lake Isabella	26 Tahoe Forest Hospital District	Truckee
13 Mammoth Hospital	Mammoth Lakes	27 Tehachapi Valley Healthcare District	Tehachapi
14 Mayers Memorial Hospital	Fall River Mills	28 Trinity Hospital	Weaverville

Sources: OSHPD HAFD 2008, OSHPD "List of Critical Access Hospitals in California." California Hospital Association Membership Guide, 2009.

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Endnotes

1. Centers for Medicare and Medicaid Services. *Fact Sheet: Critical Access Hospitals*. Washington, DC, 2008.
2. MedPac Payment Basics. Critical Access Hospitals. October 2008.
3. See note 1.
4. Flex Monitoring Program. Presentation to the National Rural Health Association. 2008.
5. See note 1.
6. KSA Analysis based on dividing current number of CAHs by the current number of community hospitals. The American Hospital Association (AHA) Guide 2009.
7. From Interviews with California Hospital Association Office of Rural Affairs.
8. General acute care hospitals reporting financial data in the OSHPD Hospital Annual Financial Data (HAFD) report, based on GAC hospital list developed by California HealthCare Foundation (CHCF); KSA analysis based on dividing current number of CAHs nationally by the current number of Community Hospitals from The AHA Guide 2009.
9. See note 1.
10. MedPac Payment Basics. Critical Access Hospitals. October 2008.
11. Ibid.
12. Long term care status was determined using the automated licensing information and report tracking system from OSHPD.
13. OSHPD HAFD. California General Acute Care list developed by California HealthCare Foundation.
14. PricewaterhouseCoopers and The Flex Monitoring Team. "CAH Financial Indicators Report: Summary of Indicator Medians by State." *Financial Health of California Hospitals*. California HealthCare Foundation, 2008. The Flex Monitoring Team, "CAH Financial Indicators Report: Summary of indicator Medians by State."
15. The Flex Monitoring Team (FMT) is made up of Principal Investigators from the Rural Health Research Centers at: University of Minnesota, University of North Carolina-Chapel Hill, and University of Southern Maine. These universities were granted a five year cooperative agreement from the Federal Office of Rural Health Policy and charged with monitoring and evaluating the Medicare Rural Hospital Flexibility Grant Program (Flex program) as well as sharing this information with state and federal policy makers and rural health providers. Through this cooperative, the FMT developed 20 indicators to benchmark and evaluate the financial health of Critical Access Hospitals. The data for assessing these indicators was derived from Medicare Cost Reports for individual CAHs within each state from 2004 through 2006.
16. Numbers do not add to 100 percent. Colorado River Hospital was not included in the calculation; it is currently owned by the city of Needles, CA.
17. Sutter Lakeside Hospital and Tahoe Forest Hospital District were excluded from the 2008 analysis of CAHs, as they converted during 2008.
18. Two hospitals reported extreme values for their operating margins: minus 59.9 percent and plus 53.7 percent. While large in percentage terms, these two hospitals reported operating losses of minus \$6.2 million and plus \$4.8 million, respectively. These CAHs underwent either substantial management changes or ownership changes in the past two years, likely contributing to the extreme values reported in the Annual Financial Data from OSHPD.
19. Moody's Investors Service. "Not-for-Profit Healthcare Medians for Fiscal Year 2008 Show Weakening Across All Major Ratios and All Ratings Categories." August 2009.
20. FTEs per adjusted occupied bed (AOB) are much lower for CAHs than California GACs primarily due to the impact of long term care revenues that are often larger than inpatient revenues. For example, CAHs with long term care had a median FTE per AOB of 1.7 compared to 7.0 for CAHs without long term care.

21. Information from hospital Web site. Data not validated; used for illustrative purposes only.
22. Pink, G.H., G.M. Holmes, C. D'Alpe, S.A. Strunk, P. McGee, and R.T. Slifkin. Summer 2007. "Financial Indicators for Critical Access Hospitals." *The Journal of Rural Health* 22 (3); 229–336.
23. American Community Survey, 2006–2008.
24. United States Census Bureau *Quick Facts* Web site and Henry J. Kaiser Family Foundation *State Health Facts* Web site.
25. One system-affiliated CAH converted in 2008 and was not included in the quantitative analysis of financial performance for that year.
26. References to DSH payments are net DSH (i.e., less any DSH transfers to state).
27. DSH payments are considered part of operating income due to the way OSHPD records them on the HAFD reports. DSH payments are labeled as a negative patient deduction (i.e., a positive contribution) and therefore fall under operational revenue.
28. OSHPD HAFD, 2008.
29. Internet research conducted between January 22 and January 25, 2010.
30. California HealthCare Foundation. *Fewer and More Specialized: A New Assessment of Physician Supply in California*, June 2009, www.chcf.org/topics/view.cfm?itemID=133962.
31. California Rural Health Update, California Department of Health Care Services, State Office of Rural Health, December 2008.
32. Rural Health Research Policy Centers. "Impact of Conversion on Hospital Finances and Service Mix." August 2008.
33. One CAH, Colorado River Medical Center, was excluded due to multiple ownership changes and substantial variation in financial indicators before and after conversion.



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