



## CAH Financial Conditions and Concerns

Part of a series of fact sheets on Critical Access Hospitals and the North Dakota Medicare Rural Hospital Flexibility (Flex) program.

In three time periods, (2011, 2008, and 2005), the Center for Rural Health has surveyed North Dakota Critical Access Hospital (CAH) administrators on a wide range of subjects. The North Dakota Rural Health Association (NDRHA) surveys and monitors specific CAH financial conditions on a yearly basis. In addition, the national Medicare Rural Hospital Flexibility (Flex) Monitoring Team collects and analyzes CAH financial data for all states. This fact sheet looks at some of that data to summarize the current financial status of North Dakota CAHs (See Figure 1).

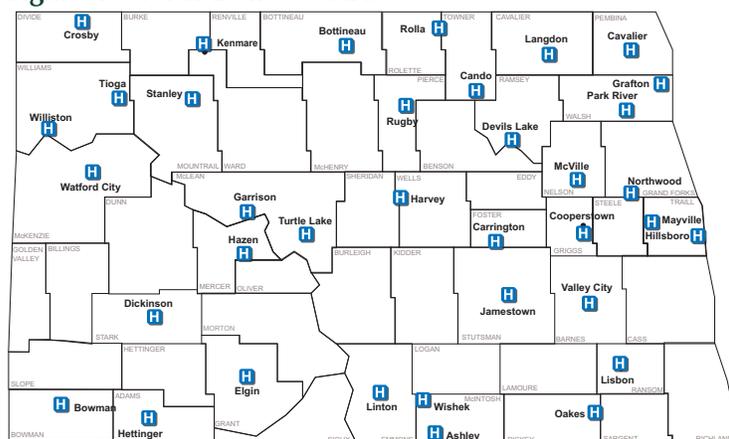
### Background

- Critical Access Hospitals (CAHs) have become the dominant type of rural hospital. With over 1,300 rural hospitals having converted to CAH status, this represents 60% of all rural hospitals and 80% of all small rural hospitals in the country.<sup>1</sup> In North Dakota, 36 of the 38 rural hospitals have converted, with only the two Indian Health Service (IHS) hospitals not converting.
- The Balanced Budget Act (BBA) of 1997<sup>2</sup> created the Flex program which was developed to be a process to designate rural hospitals as CAHs, craft a state rural health plan, and to form at least one rural health network per state operating a Flex program. The Flex program was designed to provide technical assistance to strengthen both the rural health delivery system and CAHs.

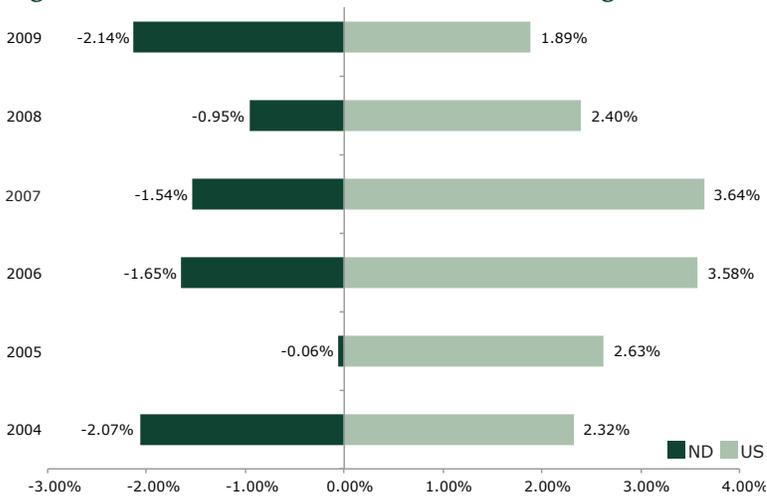
### Financial Picture of North Dakota CAHs

- As is noted in another CAH Fact Sheet, “North Dakota CAH Administrators’ Attitudes toward Issues Facing Rural Hospitals,” administrators expressed concerns regarding hospital financial issues (e.g., private third party reimbursement, Medicare reimbursement, costs associated with uninsured/under-insured, and physical plant issues).
- When compared to national CAH data, North Dakota CAHs tend to experience higher financial constraints. A common measure looks at profitability. North Dakota CAH operating margins (which compares operating expenses with operating revenues associated with patient care services), for example, were a -2.66% in 2009 (most recent data year) in comparison to +0.66 nationally. North Dakota neighboring states of Minnesota, Montana, and South Dakota had operating margins of +3.57, -3.53, and +1.72, respectively.<sup>3</sup>
- Nationally, about 52% of CAHs have negative operating margins whereas in North Dakota the number is over 63%.<sup>4</sup>
- Another measure of profitability is total margins (which looks at all costs and revenues factoring in patient care and non-patient care sources such as public support through local taxes, investments and interests, federal and/or private grants such as Flex grants and Rural Health Outreach grants, donations and contributions, and other sources). In 2009, North Dakota CAHs had total margins of -2.14 in comparison to +1.89 nationally for CAHs. Minnesota, in 2009, had total margins of +2.93; Montana, +1.60; and South Dakota, +1.61. In every year since 2004, North Dakota CAHs averaged, as a state, negative total margins while the country as a whole had positive total margins<sup>1</sup> (See Figure 2).
- Nationally, about 40% of CAHs have negative total margins whereas in North Dakota it stands at about 53%.<sup>4</sup>
- For both total margins and operating margins, over the last year, there has been some improvement in North Dakota as the number of North Dakota CAHs with negative margins has declined somewhat.<sup>4</sup>

Figure 1. North Dakota CAHs



**Figure 2. North Dakota and US CAH Total Margins 2004-2009**



- Another common financial measure is days cash on hand (measures the number of days an organization could operate if no cash was collected and received). A national benchmark is 60 days<sup>1</sup> for CAHs, and the average for CAHs, nationally, was 65.94 days (2009 data); however, North Dakota was significantly below the benchmark and national average at 36.54 days.
- Local community support is fundamental to the survival of CAHs. For example, in 2005 only about four North Dakota CAHs had local tax support (mill levy or sales tax). By 2008 this had increased to 10 CAHs and in 2011 13 CAHs (38% of all CAHs). This can range from a few thousand dollars to three CAHs that receive \$100,000 a year each and two CAHs that garner \$200,000 in yearly local tax support.<sup>5</sup>
- Another source of local support is operating a hospital foundation. This too has trended up over the years. In 2005, about 18 CAHs had hospital foundations but by 2011, 26 CAHs (76%) operated them.<sup>5</sup>

## Conclusions

- For the most part CAH designation has been successful in maintaining access to essential quality services, and in creating a payment platform that is more conducive to rural hospitals. Throughout the country, and particularly so in North Dakota, a number of CAHs still struggle to achieve a profitability margin that is positive. Over the last year, however, there has been an increase in the number of North Dakota CAHs achieving positive operating and/or total margins. This is a positive trend.
- The financial constraints facing rural hospitals in general and CAHs in particular, are significant. CAHs are reimbursed on an allowable cost basis but the hospital needs an adequate patient base for which to be reimbursed. For example, in 2009, North Dakota CAHs had an average daily census for acute beds of 1.66 in comparison to a US rate for CAHs of 4.20.<sup>3</sup>

- In addition, independent analysis<sup>6</sup> of North Dakota CAHs points to the high level of facility integration (i.e., CAHs owning clinics, nursing homes, ambulances, and other non-hospital enterprises) as being a contributor to financial concerns.
- Another factor found in the independent analysis was that third party reimbursement, including private plans, was low in comparison to other states. All of these factors impact the financial viability of North Dakota CAHs.
- Both local tax support and contributions to a hospital foundation indicate that rural North Dakotans are willing to support their local/area hospital with their own money. They recognize this as an investment in stabilizing access to quality, local health services and, ultimately, as an investment in their own community and area.
- CAHs not only serve as the primary access point to local health services but also have a significant impact on the local economy as they generate, on average, about \$6.4 million dollars on the local economy (including primary and secondary impacts) and produce, on average, about 224 jobs (primary and secondary).<sup>7</sup>

## References

- <sup>1</sup> Pink, G.H., Holmes, G.M., Slifkin, R.T., and Thompson, R.E., Developing Financial Benchmarks for Critical Access Hospitals. Health Care Financing Review. Spring 2009, Vol. 30, Num. 3.
- <sup>2</sup> HR 2015 Balanced Budget Act of 1997. Retrieved December 18, 2011, <http://www.ihaonline.org/cah/bba97.pdf>
- <sup>3</sup> CAH Financial Indicators Report: Summary of Indicator Medians by State. Flex Monitoring Team Data Summary Report No. 9. University of Minnesota, University of North Carolina at Chapel Hill, and University of Southern Maine. August 2011.
- <sup>4</sup> North Dakota Rural Health Association, non-published data, Darrold Bertsch, President, NDRHA and CEO Sakakawea Medical Center, October 2011.
- <sup>5</sup> 2011 Flex CAH Administrator Survey, Center for Rural Health, UND School of Medicine and Health Sciences, August 2011.
- <sup>6</sup> North Dakota Flex Program and Critical Access Hospital State Rural Health Plan, Center for Rural Health, UND School of Medicine and Health Sciences, November 2008.
- <sup>7</sup> North Dakota Flex Program, CAH Profiles, Center for Rural Health. Retrieved December 17, 2011, <http://ruralhealth.und.edu/projects/flex/hospitals.php>

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