# Q4 2018 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

February 20, 2019

4000 Kruse Way Place • Suite 100 • Lake Oswego, OR 97035 • Tel: (503) 479-6034 • www.apprisehealthinsights.com
APPRISE HEALTH INSIGHTS IS A SUBSIDIARY OF THE OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

© 2019 Apprise Health Insights

# Q4 2018 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## ABOUT THIS REPORT

This report aims to provide a quarterly analysis of the utilization and financial data submitted by Oregon's hospitals to the DATABANK program.

DATABANK is a state-mandated monthly hospital data program administered by Apprise Health Insights in collaboration with the Office for Oregon Health Policy and Research (OHPR). Please note that all DATABANK data are self-reported by the hospital and represent a twelve-month calendar year. Accuracy is the responsibility of the reporting hospitals.

Because this report's objective is to provide a complex dive into the data, the graphs and methods may change between reports. This forces only the most compelling stories to be exhibited. The determination of which graphs and stories to focus on is evaluated by hospital finance and data experts at Apprise.

## LAYOUT INFORMATION

Aggregate vs Median
This report uses two statistics to report statewide hospital data: median and aggregate. Aggregate numbers sum up the entire amount for all hospitals into one number, where median only takes the number from the middle of the pack. Aggregate is useful when looking at the industry as a whole, such as the percent of Medicaid charges or the total number of patients visiting Emergency Departments in the state. Median is useful when outliers can be highly-influential on a statistic, such as a large hospital having a significant negative margin dragging down the statistic for the whole state. Apprise tries to conform to the Oregon Health Authority's Office of Health Analytics on the subject as much as possible: https://www.oregon.gov/oha/analytics/Pages/Hospital-Reporting.aspx

Trend vs Seasonal-Adjusted
Each metric in this report contains two graphs: a trend analysis and a seasonal-adjusted graph. The trend analysis is a simple line graph that shows how the metric has changed over time linearly. However, because many of these metrics tend to be affected largely by seasonal influences, the seasonal-adjusted graph shows a comparison of each quarter to the same quarter in the previous two years.

© 2019 Apprise Health Insights

# Q4 2018 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## QUICK STATS

1. **Operating Margins** decreased from Q3, but remain highly seasonal

**2. Self Pay Payer Mix** is showing a slight upward trend

3. **Medicaid Payer Mix** continues to decrease

4. **Medicare Payer Mix** continues to increase

5. **Charity Care** continues to increase

---

Notes for the Q4 2018 Report
-The numbers and figures in this report are based on a DATABANK download from February 19, 2019.

-Kaiser Sunnyside and Westside Medical Centers now have a full year of financial data and are included in this report. Please note that because of this, aggregated data may see slight changes in 2018.

-Blue Mountain Hospital and Mid-Columbia Medical Center have been excluded from this report due to unavailable data.

-Shriners Hospital for Children is automatically excluded from this report because of their unique status. They often have margins of ≤ 100% and wildly fluctuating payer mixes that make them difficult to compare with traditional hospitals.

© 2019 Apprise Health Insights

# Q4 2018 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## TABLE OF CONTENTS


Operating Margin....Page 5

Net Patient Revenue....Page 5

Payer Mix....Page 6

Charity Care....Page 8

Bad Debt....Page 8

Inpatient Discharges....Page 9

Total Outpatient Visits....Page 9

Ambulatory Surgery Visits....Page 10

Emergency Department Visits....Page 10

Appendix A: Hospital Types....Page 11

Appendix B: Definitions....Page 12


© 2019 Apprise Health Insights

# Q4 2018 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## OPERATING MARGIN

*Measure of profitability from the reporting entity's operations*

Median Operating Margin continues to follow its recent pattern of seasonal swings, with highs in Q2 and lows in Q4 of each year. (Figures 1 & 2).

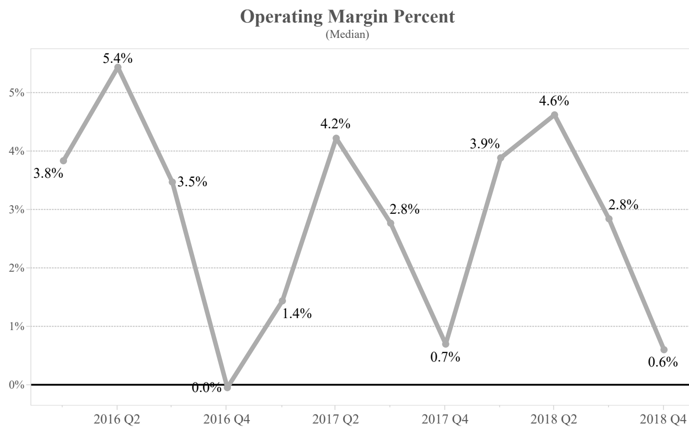


Figure 1

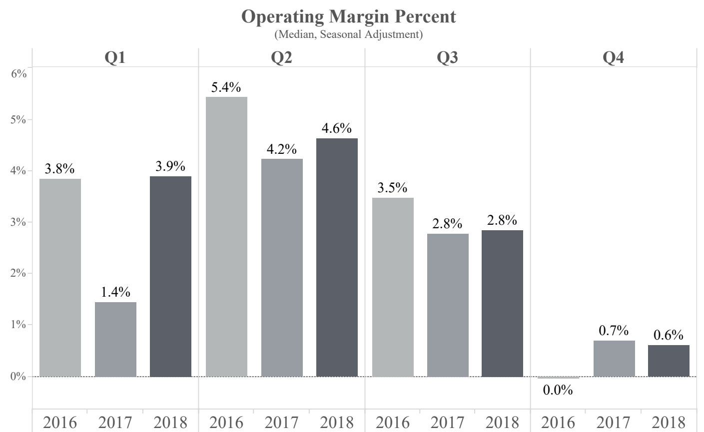


Figure 2

## NET PATIENT REVENUE

*The revenue the reporting entity generates from patient care*

Aggregate Net Patient Revenue (NPR) continues to follow its steady upward trend. The past eight quarters have all seen increases in seasonally-adjusted NPR (Figures 3 & 4).

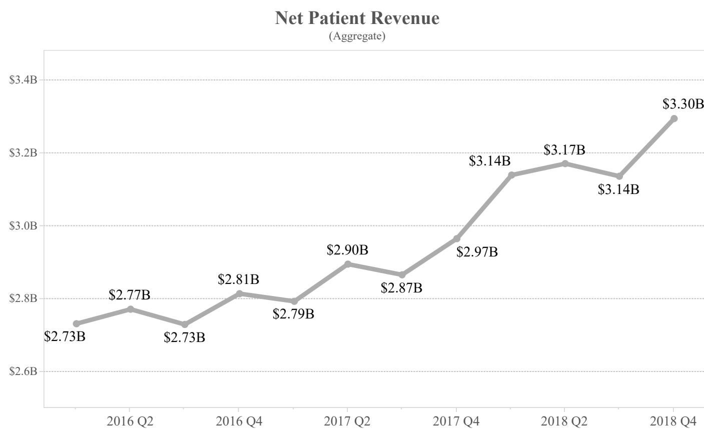


Figure 3

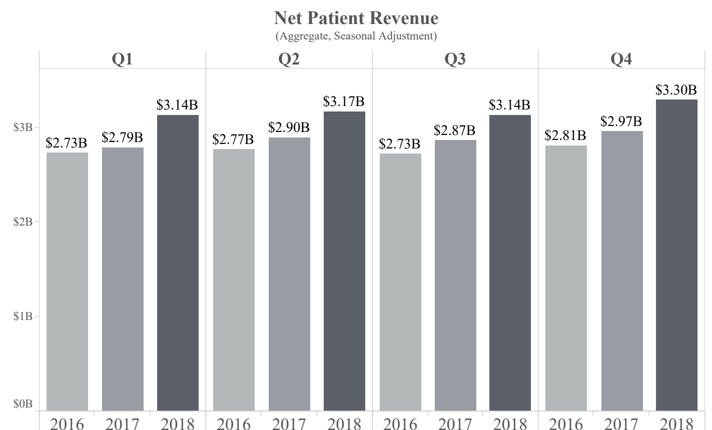


Figure 4

© 2019 Apprise Health Insights

## MEDICAID PAYER MIX

*The amount of total charges that were attributable to Medicaid*

Aggregate Medicaid Payer Mix continues to decrease (Figures 5 & 6). The past eight quarters have all seen decreases in seasonally-adjusted Medicaid payments.

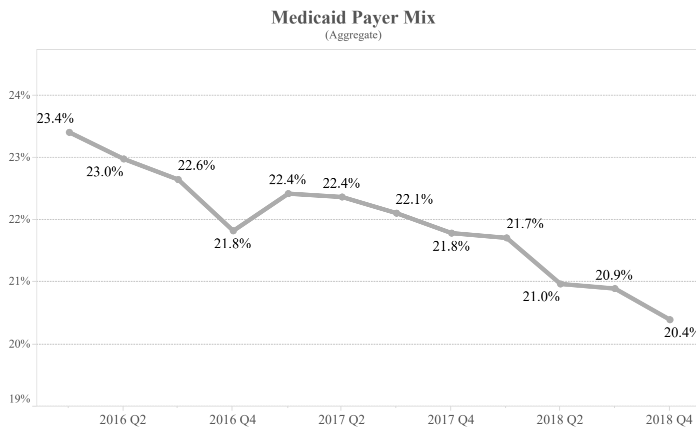


Figure 5

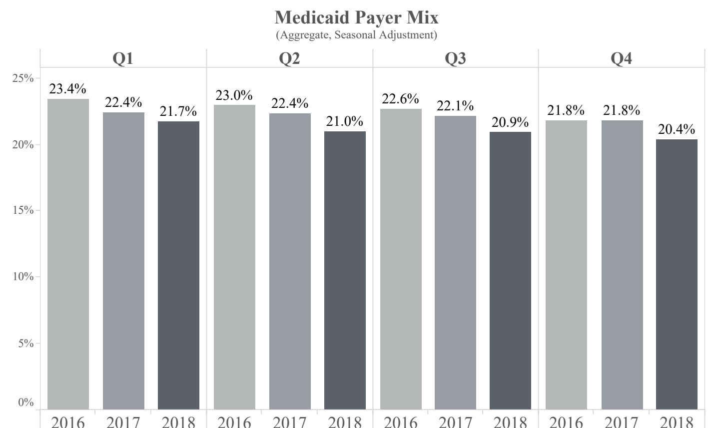


Figure 6

## MEDICARE PAYER MIX

*The amount of total charges that were attributable to Medicare*

Aggregate Medicare Payer Mix continues to increase (Figures 7 & 8). The past eight quarters have all seen increases in seasonally-adjusted Medicare payments.

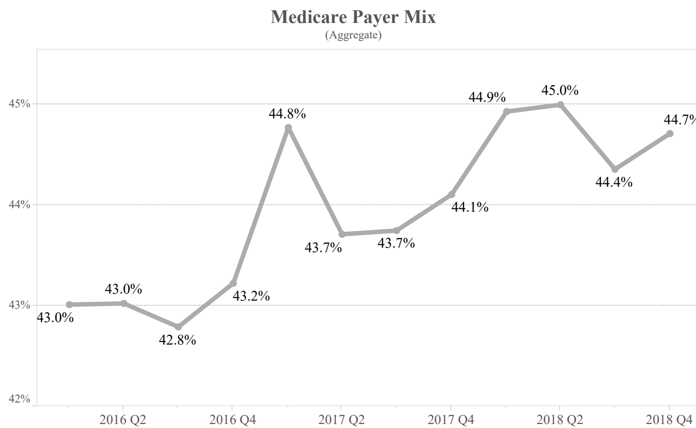


Figure 7

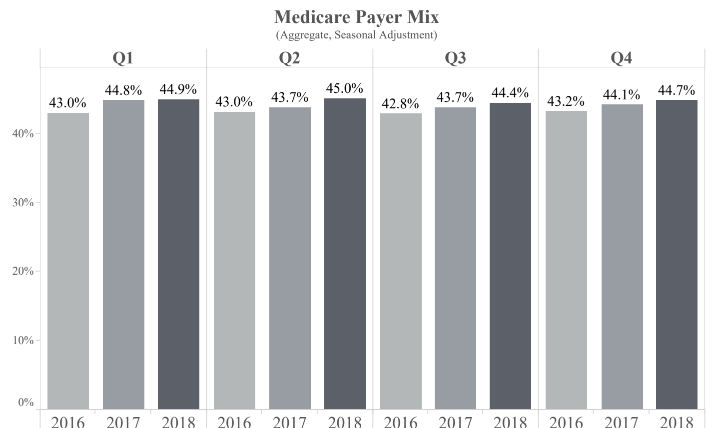


Figure 8

© 2019 Apprise Health Insights

## COMMERCIAL & OTHER PAYER MIX

*The amount of total charges that were attributable to a commercial insurer or other payer*

Aggregate Commercial & Other Payer Mix remains fairly stable at roughly 32-33% (Figures 9 & 10).

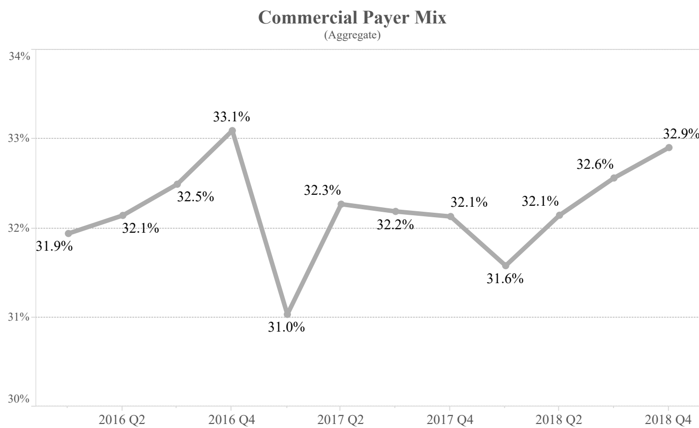


Figure 9

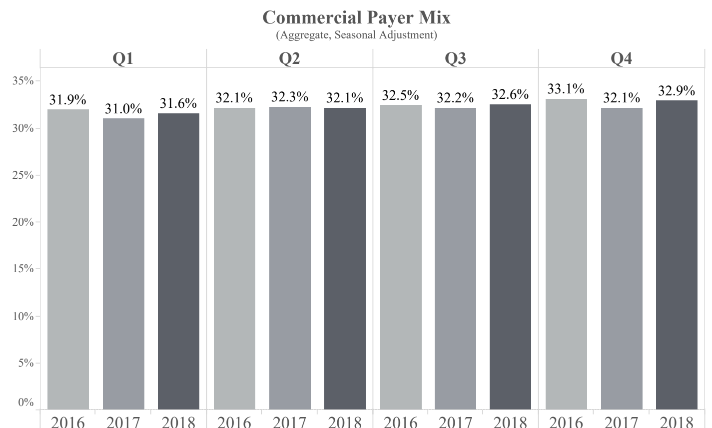


Figure 10

## SELF PAY PAYER MIX

*The amount of total charges that were attributable to patients paying primarily out-of-pocket*

Aggregate Self-Pay Payer Mix is showing a slight upward trend. Six of the past eight quarters have seen increases in seasonally-adjusted Self-Pay payer mix (Figures 11 & 12).

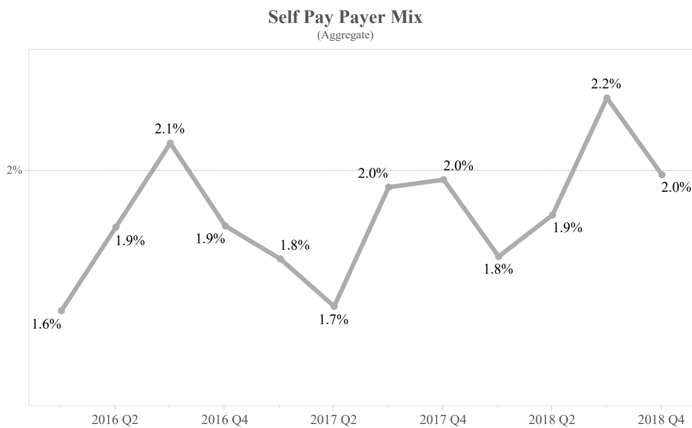


Figure 11

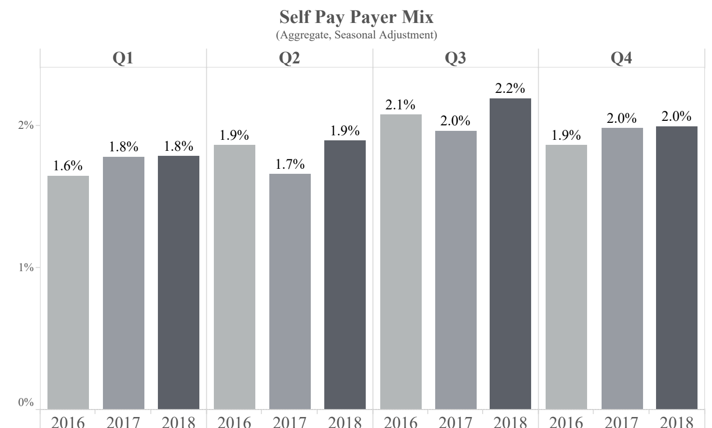


Figure 12

© 2019 Apprise Health Insights

## CHARITY CARE PERCENTAGE

*The amount of free care provided to patients who are determined by the hospital to be unable to pay their bill*

Median Charity Care as a percentage of Total Charges has been steadily increasing (Figures 13 & 14). The past eight quarters have all seen increases in seasonally-adjusted Charity Care percentage.

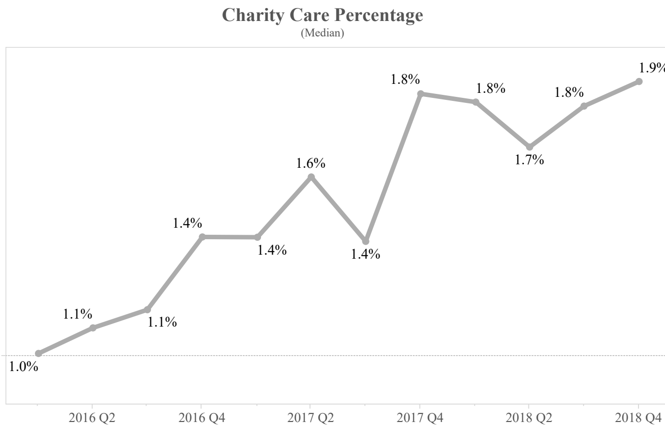


Figure 13

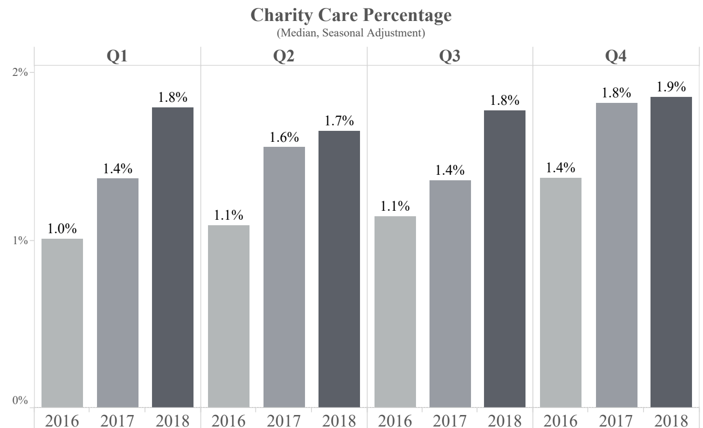


Figure 14

## BAD DEBT PERCENTAGE

*Unpaid obligation for care from patients who have not requested or do not qualify for financial assistance and have been unwilling to pay their bill*

Oregon hospitals have seen a slight decrease in Bad Debt Percentage recently. Seven of the past eight quarters have seen decreases in seasonally-adjusted Bad Debt Percentage (Figures 15 & 16).

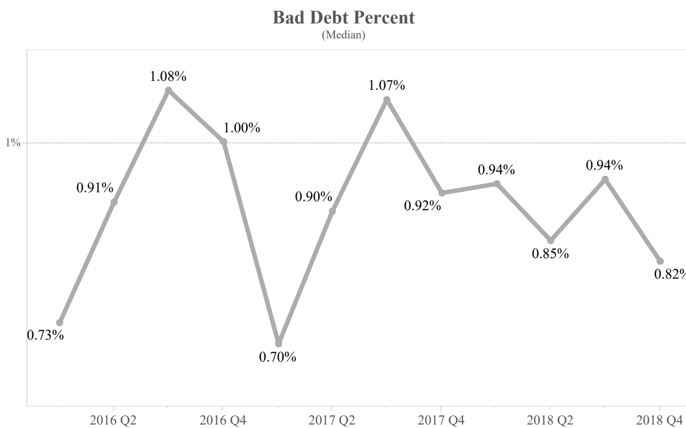


Figure 15

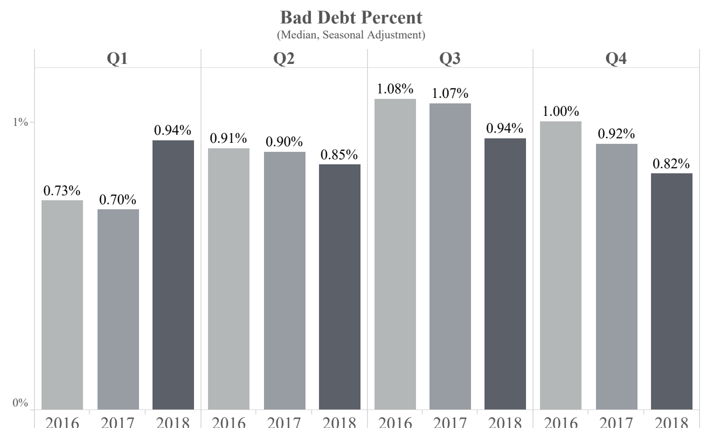


Figure 16

© 2019 Apprise Health Insights

# Q4 2018 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## TOTAL DISCHARGES

*The total number of inpatient discharges during the reporting period*

Aggregate Inpatient Discharges remain highly seasonal, with highs in Q1 and lows in Q3 of each year (Figures 17 & 18).

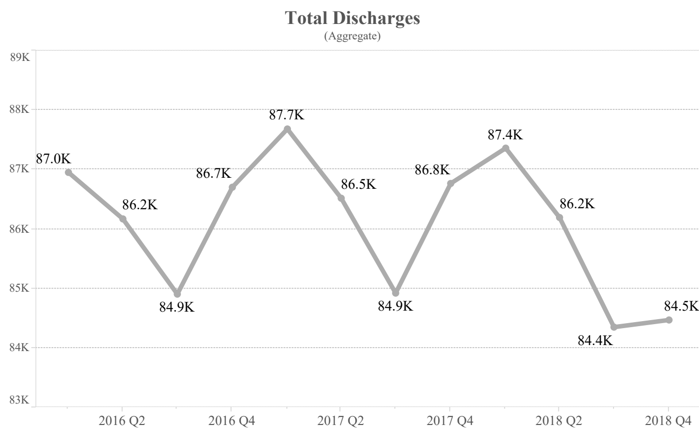


Figure 17

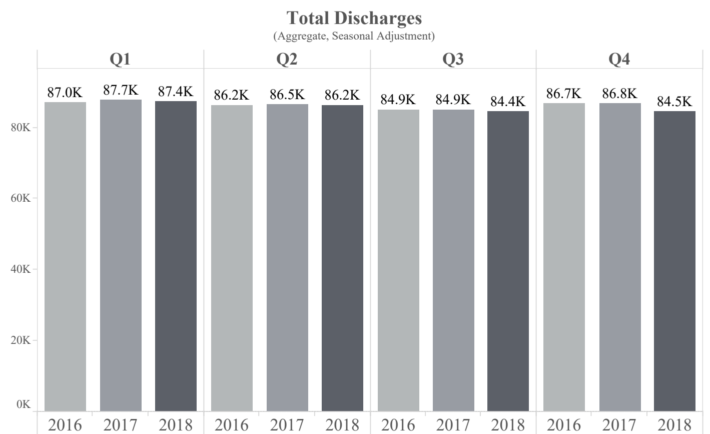


Figure 18

## TOTAL OUTPATIENT VISITS

*The total number of outpatient visits during the reporting period*

Aggregate Total Outpatient Visits increased this quarter in overall trend.  However, the past three quarters have seen decreases in seasonally-adjusted Total Outpatient Visits. (Figures 19 & 20). This unusual occurrence may be due to adjustments as hospitals convert to different reporting systems.

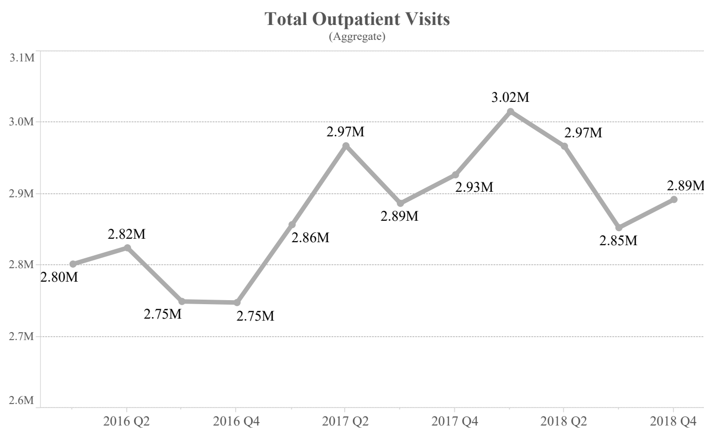


Figure 19

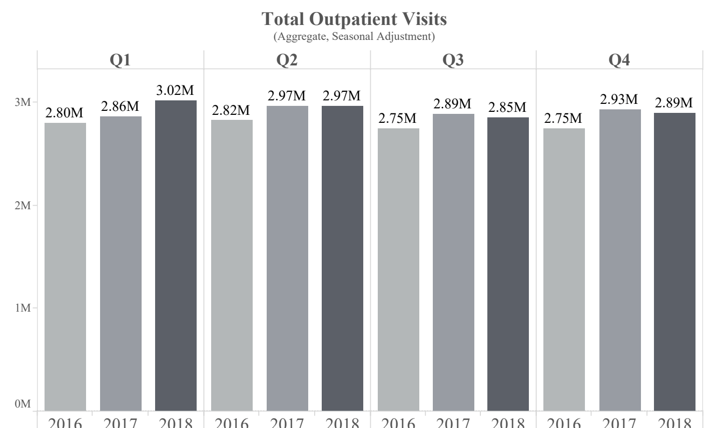


Figure 20

© 2019 Apprise Health Insights

## AMBULATORY SURGERY VISITS

*The total number of ambulatory surgery visits during the reporting period*

Aggregate Ambulatory Surgery Visits remain highly seasonal, with counts typically much higher in Q2 and Q4 (Figures 21 & 22). The past five quarters have seen increases in seasonally-adjusted Ambulatory Surgery visits.

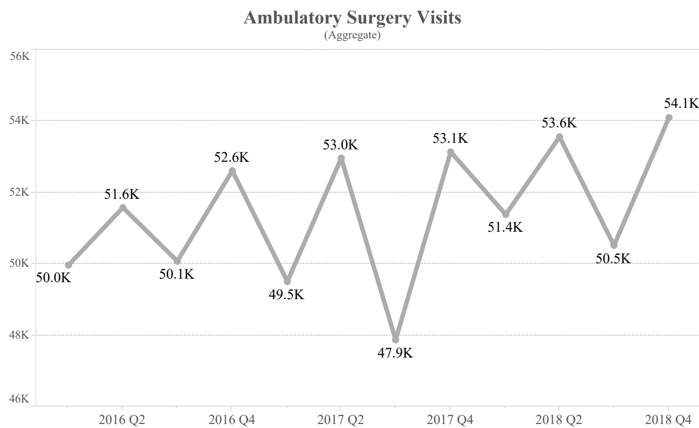


Figure 21

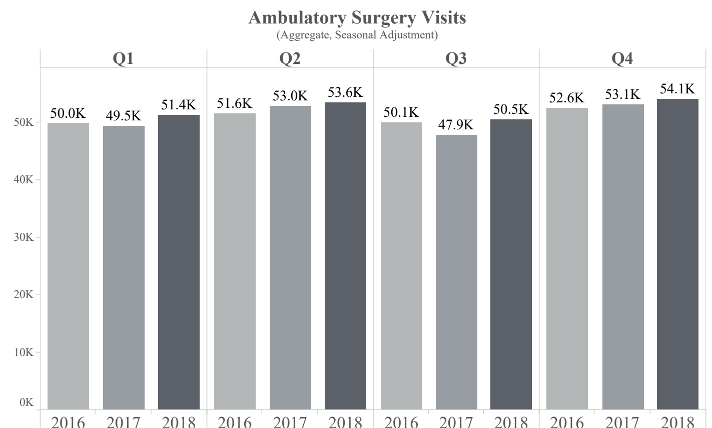


Figure 22

## EMERGENCY DEPARTMENT VISITS

*The total number of patients seen in the emergency department who are not later admitted as inpatients*

Aggregate Emergency Department Visits is showing a slight downward trend overall (Figure 23). However, only three of the past eight quarters have seen decreases in seasonally-adjusted ED visits (Figure 24).

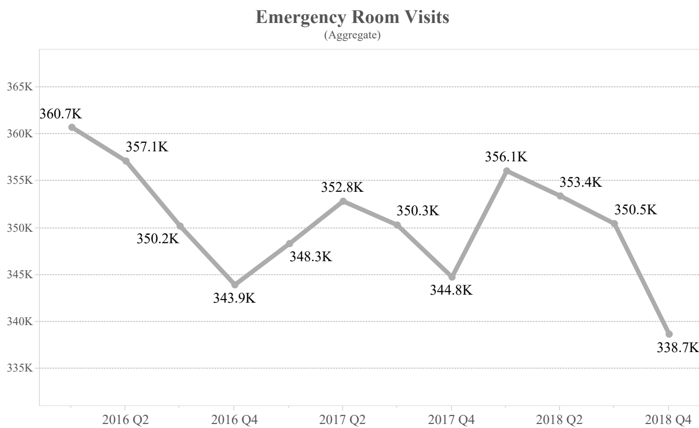


Figure 23

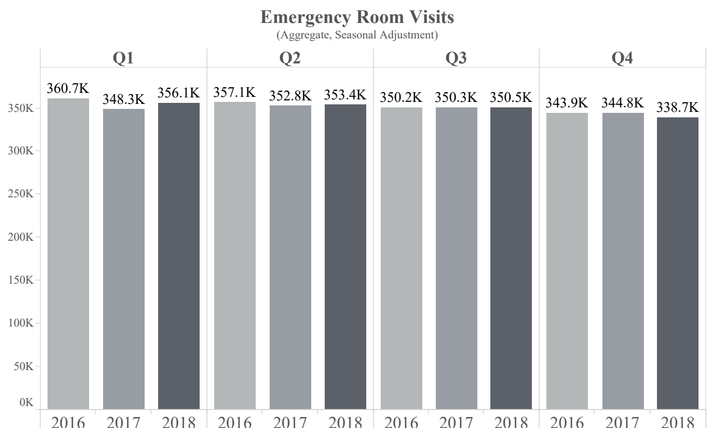


Figure 24

© 2019 Apprise Health Insights

# Q4 2018 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## APPENDIX A: HOSPITAL TYPES

### Urban

#### DRG Hospitals

- Adventist Health Portland
- Asante Rogue Regional Medical Center
- Asante Three Rivers Medical Center
- Bay Area Hospital
- Good Samaritan Regional Medical Center
- Kaiser Sunnyside Medical Center
- Kaiser Westside Medical Center
- Legacy Emanuel Medical Center
- Legacy Good Samaritan Medical Center
- Legacy Meridian Park Medical Center
- Legacy Mount Hood Medical Center
- McKenzie-Willamette Medical Center
- Mercy Medical Center
- OHSU Hospital
- PeaceHealth Sacred Heart Medical Center at RiverBend
- PeaceHealth Sacred Heart Medical Center University District
- Providence Medford Medical Center
- Providence Milwaukie Hospital
- Providence Portland Medical Center
- Providence St. Vincent Medical Center
- Providence Willamette Falls Medical Center
- Salem Hospital
- Samaritan Albany General Hospital
- Shriners Hospital-Portland
- Sky Lakes Medical Center
- St. Charles Bend
- Tuality Healthcare

### Rural

#### Type A Hospitals

- Blue Mountain Hospital*
- CHI St. Anthony Hospital*
- Curry General Hospital*
- Good Shepherd Health Care System*
- Grande Ronde Hospital*
- Harney District Hospital*
- Lake District Hospital*
- Pioneer Memorial Hospital-Heppner*
- St. Alphonsus Medical Center-Baker City*
- St. Alphonsus Medical Center-Ontario
- Tillamook Regional Medical Center*
- Wallowa Memorial Hospital*

#### Type B Hospitals

- Asante Ashland Community Hospital
- Columbia Memorial Hospital*
- Coquille Valley Hospital*
- Legacy Silverton Medical Center
- Lower Umpqua Hospital*
- Mid-Columbia Medical Center
- PeaceHealth Cottage Grove Community Hospital*
- PeaceHealth Peace Harbor Medical Center*
- Providence Hood River Memorial Hospital*
- Providence Newberg Medical Center
- Providence Seaside Hospital*
- Salem Health West Valley*
- Samaritan Lebanon Community Hospital*
- Samaritan North Lincoln Hospital*
- Samaritan Pacific Communities Hospital*
- Santiam Memorial Hospital
- Southern Coos Hospital & Health Center*
- St. Charles Prineville*
- St. Charles Madras*
- St. Charles Redmond
- Willamette Valley Medical Center

**Type A** Hospitals are small and remote and have 50 or fewer beds. Type A hospitals are located more than 30 miles from another acute care, inpatient facility.

**Type B** Hospitals are small and rural and have 50 or fewer beds. Type B Hospitals are located 30 miles or less from another acute care facility

*Designates a CAH facility (more information in Appendix C: Definitions)

© 2019 Apprise Health Insights

## APPENDIX B: DEFINITIONS

**Bad Debt:** Bad debt is the unpaid obligation for care, based on a hospital's full established rates, for patients who are unwilling to pay their bill. Unlike charity care, bad debt arises in situations where the patient has either not requested financial assistance or does not qualify for financial assistance. In these cases the hospital will generate a bill for services provided. For uninsured patients, the amount of bad debt can pertain to all or any portion of the bill that is not paid. For patients with insurance, certain amounts that are the patient's responsibility—such as deductibles and coinsurance—are expensed as bad debt if not paid.

**Charity Care:** The dollar amount of free care, based on a hospital's full established rates, provided to patients who are determined by the hospital to be unable to pay their bill. The determination of a patient's ability to pay is based on the hospital's charity care policy. Hospitals will typically determine a patient's inability to pay by examining a variety of factors such as individual and family income, assets, employment status, or availability of alternative sources of funds. Determination of charity care status is made prior to admission if the patient has requested and applied for financial assistance. Charity care status may be granted at a later date depending on the circumstances of the admission, such as an emergency admission, no request for financial assistance prior to admission, or lack of information about the patient's financial status at the time of admission. Financial assistance provided by the hospital may pertain to all or a portion of the patient's bill.

**Critical Access Hospitals (CAHs):** A designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services. Created by Congress in the 1997 Balanced Budget Act, the CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare in those areas. A CAH must have no more than 25 inpatient beds, maintain an annual average length of stay of less than 96 hours, offer 24/7 emergency care, and be located at least 35 miles away from another hospital.

**Emergency Department Visits:** The total number of patients seen in the emergency department who are not later admitted as inpatients.

**Net Nonoperating Gains:** Amount of income or loss after expenses which result from the hospital's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the control of the reporting entity and its management. An example would be sale of investments in marketable securities.

**Net Patient Revenue:** The revenue the reporting entity generates from patient care.

**Operating Margin Percent:** Measure of profitability from the reporting entity's operations.

**Other Operating Revenue:** Revenue derived from the reporting entity's operations other than direct patient care. Examples are revenue generated from operation of the cafeteria and gift shop.

**Outpatient Surgeries:** A planned operation for which the patient is not expected to be admitted to the hospital.

**Outpatient Visits:** Total number of outpatient visits reported during the reporting period. This includes emergency room visits, ambulatory surgery visits, observation visits, home health visits, and all other visits.

**Payer Mix:** The amount of total charges that were attributable to one of four payer categories: Medicaid, Medicare, commercial, and self pay.

**Reporting Entity:** A hospital and any additional consolidated entities that are included in the Income Statement at the front of the audited financial statement. The only exceptions are foundations that the hospital does not want included in its financial reporting.

© 2019 Apprise Health Insights

## APPENDIX B: DEFINITIONS (CONT.)

**Tax Subsidies:** Tax revenues from cities, counties or special hospital districts, which assess levies to subsidize the reporting entity.

**Total Charges:** Amount billed for services at full established rates.

**Total Contractuals:** The amount of total charges that have been negotiated away by payers. This is the difference between what the hospital bills for and what it expects to receive as revenue.

**Total Discharges:** The termination of the granting of lodging in the hospital and the formal release of the patient (includes patients admitted and discharged the same day). When a mother and her newborn are discharged at the same time, they count as one discharge. When the baby stays beyond the mother's discharge (boarder baby), it counts as one discharge for the mother and one discharge for the boarder baby.

**Total Margin Percent:** Measure of profitability from all sources of the reporting entity's income.

**Total Operating Expenses:** All expenses incurred from the reporting entity. Examples are salaries and benefits, purchased services, professional fees, supplies, interest expense, depreciation, and amortization and rent and utilities.

**Total Operating Revenue:** All revenue derived from the reporting entity's operations directly related to patient care. Includes net patient revenue and other operating revenue.

**Uncompensated Care:** The total amount of health care services, based on full established rates, provided to patients who are either unable or unwilling to pay. Uncompensated care includes both charity care and bad debt.

© 2019 Apprise Health Insights