Q1 2016 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

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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 will likely 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. While reading this, if you would like a different view of the data in any section, please reach out to Apprise and a custom view will be generated for you.

Note: Kaiser Sunnyside and Kaiser Westside hospitals are excluded from this analysis due to the lack of financial data available in Databank.

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OPERATING MARGIN

Although operating margin increased this quarter when looking at the median (Figure 1), DRG hospitals' median operating margin came down from 4.6% in Q4 2015 to 4.3% in Q1 2016 (Figure 2). This is primarily what led the decrease in aggregate margin this quarter. Rural hospitals saw an increase from 0.8% to 1.9% during the same time period.

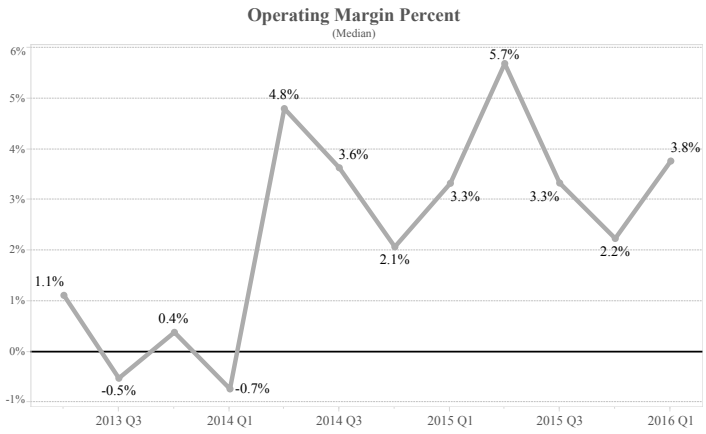

Figure 1

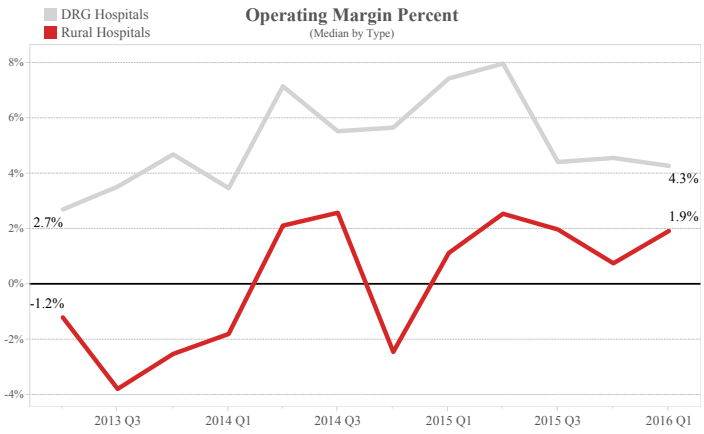

Figure 2

NET PATIENT REVENUE

Overall Net Patient Revenue has decreased slightly from last quarter, but is higher than previous Q1's (Figures 3 & 4). There appears to be a trend of flat or negative growth in the first and third quarters compared to the previous quarter, followed by a sharper rise in the second and fourth quarters.

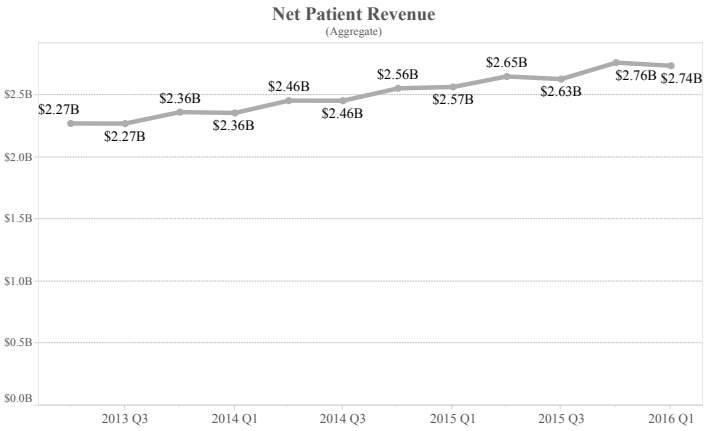

Figure 3

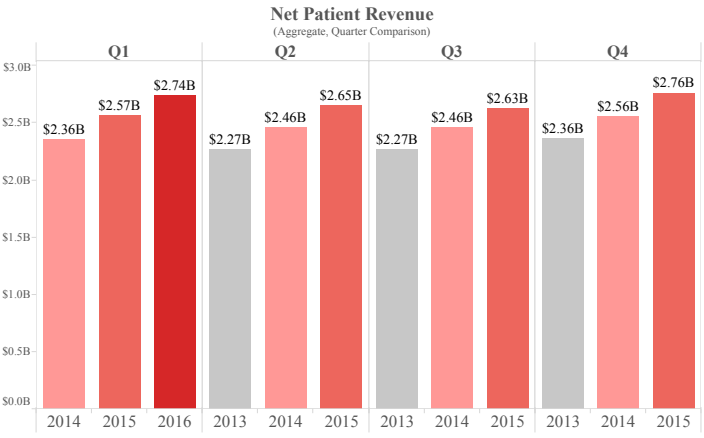

Figure 4

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MEDICAID PAYER MIX

Medicaid payer mix is still increasing since the ACA expansion, but now at nearly a crawl. It appears that it is stabilizing around a new normal of ~23%, up from ~15% pre-ACA (Figure 5).

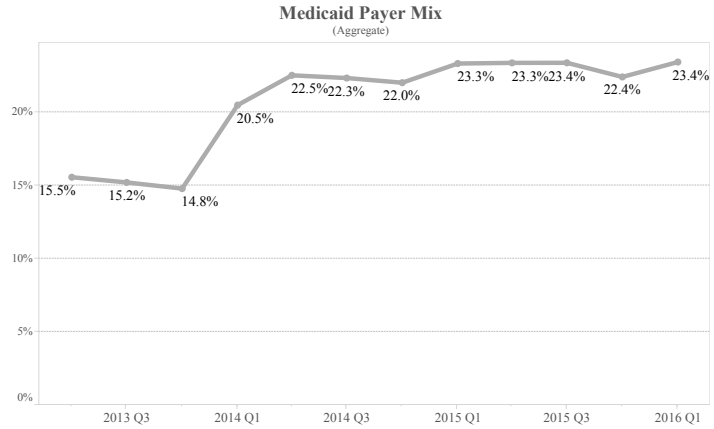

Figure 5

MEDICARE PAYER MIX

Medicare payer mix seems fairly stable around 42-43%, with the ACA 2014 having a negligible effect (Figure 6). CAH hospitals still have a slightly larger percentage than non-CAH hospitals (Figure 7).

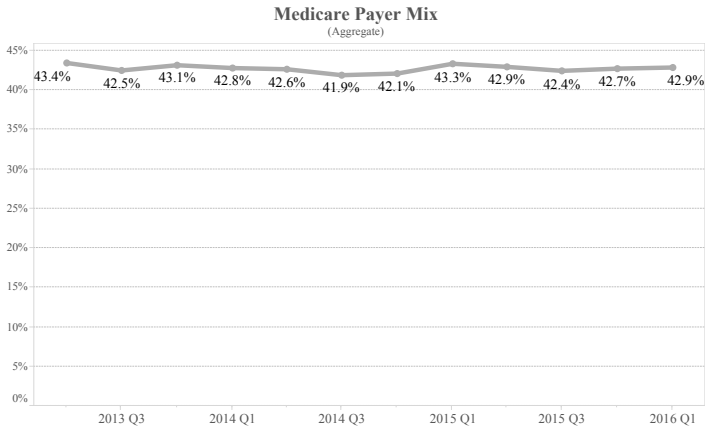

Figure 6

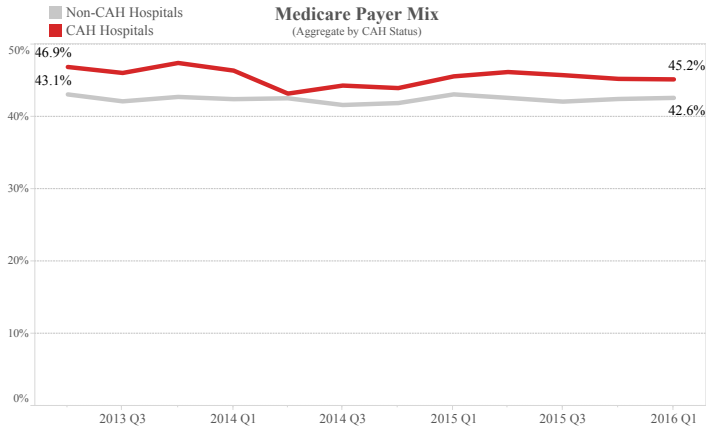

Figure 7

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COMMERCIAL PAYER MIX

The overall trend in Commercial payer mix is a decrease post-ACA, but this quarter marks a slight upturn compared to previous Q1's. Commercial payer mix could be stabilizing around 32% (Figure 8).

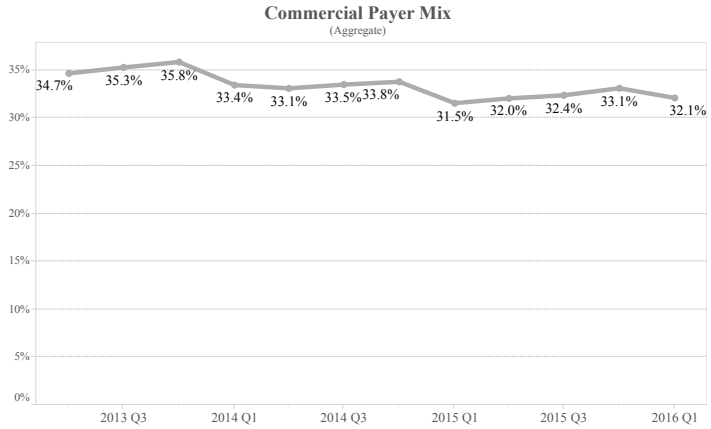

Figure 8

SELF PAY PAYER MIX

Self Pay payer mix is still decreasing and is now at an all-time low of 1.7% (Figure 9). Rural hospitals are still seeing a larger percentage of Self Pay charges than DRG hospitals (Figure 10).

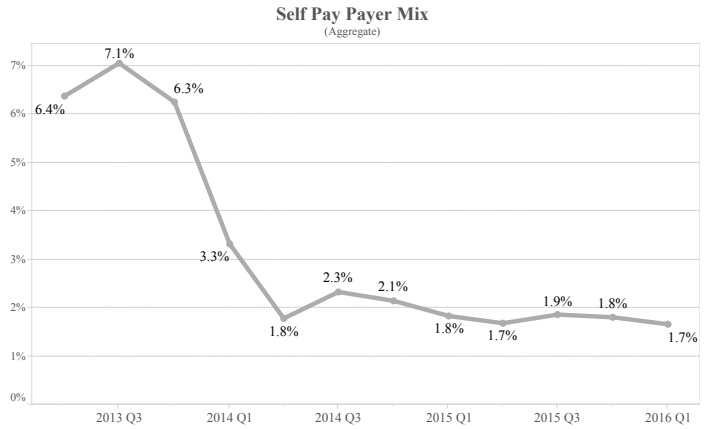

Figure 9

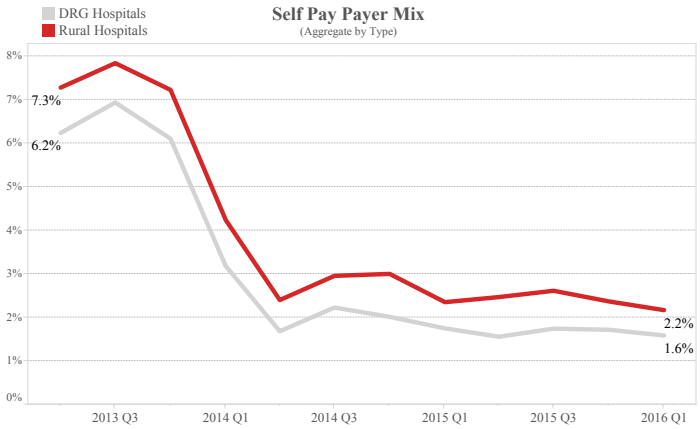

Figure 10

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CHARITY CARE PERCENTAGE

Median charity care percentage is now at around 1% after being near 4% pre-ACA (Figure 11).

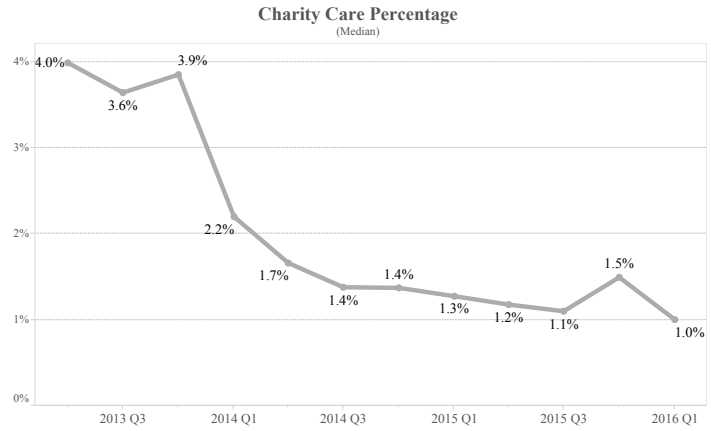

Figure 11

BAD DEBT PERCENTAGE

Median bad debt continues to decrease as more Oregonians utilize their new coverage (Figure 12).

The Southern Coast region had the highest median bad debt percentage for the past seven quarters (Figure 13).

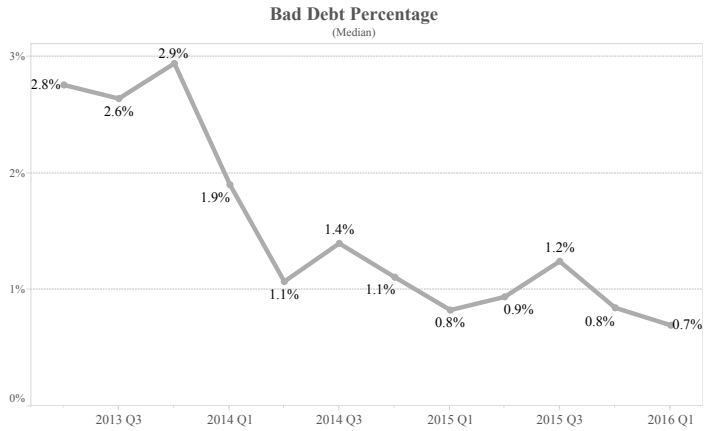

Figure 12

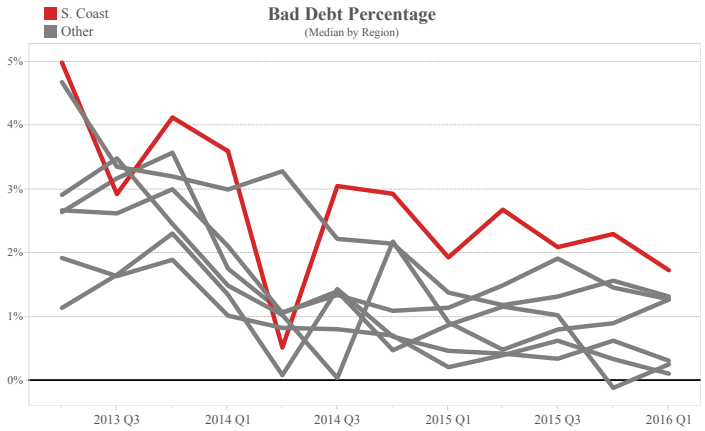

Figure 13

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TOTAL DISCHARGES

The total inpatient discharge count across Oregon seems fairly stable for the past three years (Figure 14).

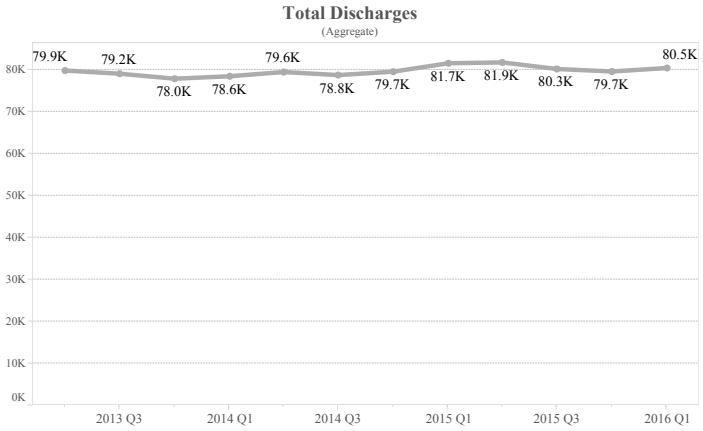

Figure 14

When you break out the discharge count by payer a clear shift has occurred (Figure 15). This graph looks similar to the payer mix graphs that have been numerous since the ACA implementation. It appears that the effect of Medicaid expansion on inpatient visits was most effective in shifting the previous Self Pay patients to being Medicaid patients. The expansion has not significantly affected the total number of Oregonians receiving inpatient care.

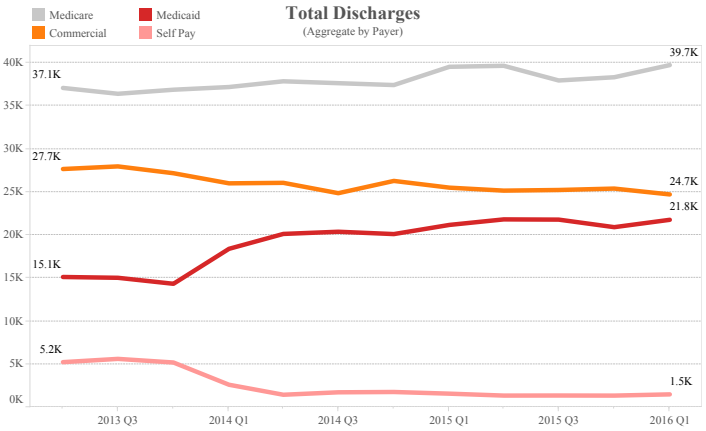

Figure 15

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EMERGENCY DEPARTMENT VISITS

Although ED visits are cyclical by nature (Figure 16), a continued increase can be shown across quarters for the past three years (Figure 17). The visit count for Q1 2016 was the highest in Oregon history at 342,738 visits.

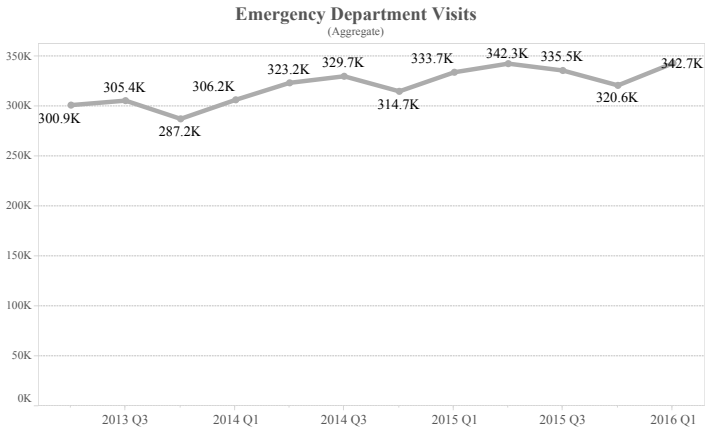

Figure 16

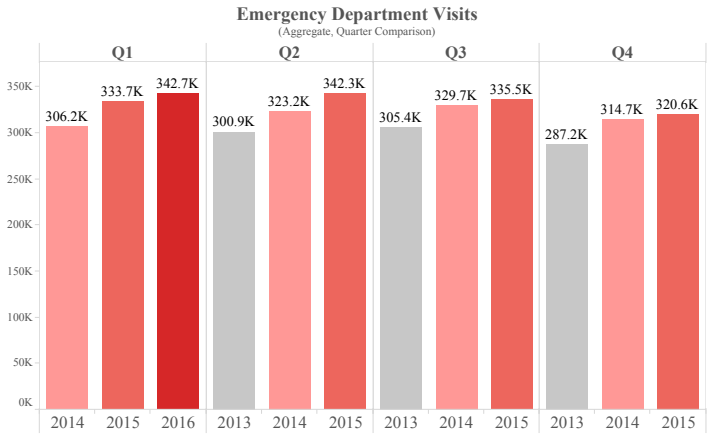

Figure 17

TOTAL OUTPATIENT VISITS

Total outpatient visits continue to increase seemingly independent of the ACA 2014 implementation (Figures 18 & 19).

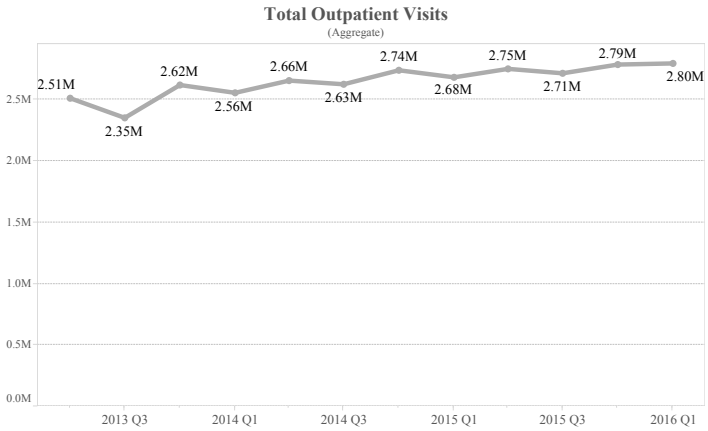

Figure 18

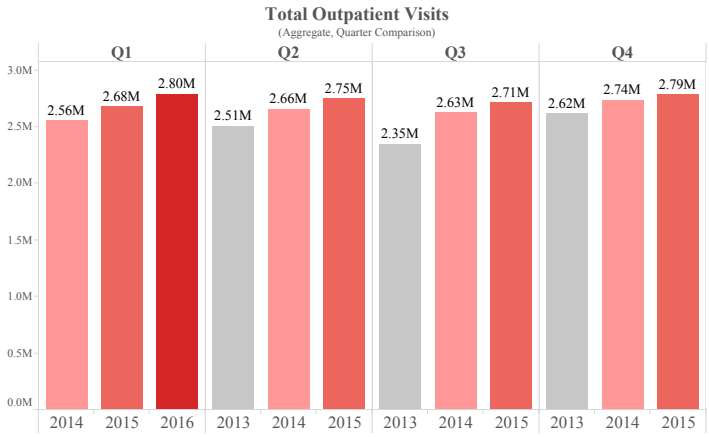

Figure 19

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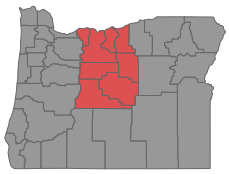
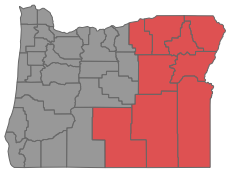
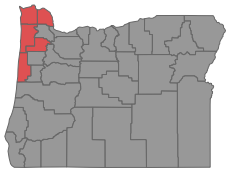
APPENDIX A: REGIONS



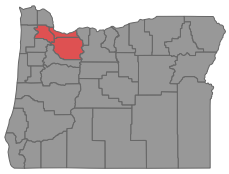
Central Oregon: Mid-Columbia Medical Center, Providence Hood River Memorial Hospital, St. Charles Bend, St. Charles Madras, St. Charles Prineville, St. Charles Redmond



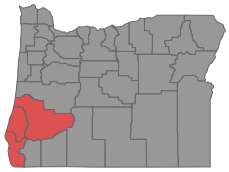
Eastern Oregon: Blue Mountain Hospital, CHI St. Anthony Hospital, Good Shepherd Medical Center, Grande Ronde Hospital, Harney District Hospital, Lake District Hospital, Pioneer Memorial Hospital-Heppner, St. Alphonsus Medical Center-Baker City, St. Alphonsus Medical Center-Ontario, Wallowa Memorial Hospital



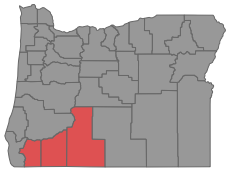
Northwest Oregon: Columbia Memorial Hospital, Providence Newberg Medical Center, Providence Seaside Hospital, Samaritan North Lincoln Hospital, Samaritan Pacific Communities Hospital, Tillamook Regional Medical Center, Willamette Valley Medical Center



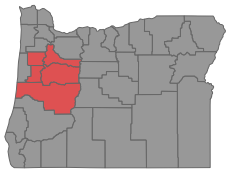
Portland Metro Area: Adventist Medical Center, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, OHSU, Providence Milwaukie Medical Center, Providence Portland Medical Center, Providence St. Vincent Medical Center, Providence Willamette Falls Medical Center, Shriners Hospital-Portland, Tuality Healthcare



Southern Coast: Bay Area Hospital, Coquille Valley Hospital, Curry General Hospital, Lower Umpqua Hospital, Southern Coos Hospital & Health Center



Southern Oregon: Asante Ashland Community Hospital, Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center, Mercy Medical Center, Providence Medford Medical Center, Sky Lakes Medical Center



Valley: Good Samaritan Regional Medical Center, Legacy Silverton Medical Center, McKenzie-Willamette Medical Center, PeaceHealth Cottage Grove Community Hospital, PeaceHealth Peace Harbor Hospital, PeaceHealth Sacred Heart Medical Center at RiverBend, PeaceHealth Sacred Heart Medical Center University District, Salem Hospital, Samaritan Albany General Hospital, Samaritan Lebanon Community Hospital, Santiam Memorial Hospital, West Valley Hospital

APPENDIX B: HOSPITAL TYPES

Urban	Rural	
DRG Hospitals	**Type A Hospitals**	**Type B Hospitals**
• Adventist Medical Center • Asante Rogue Regional Medical Center • Asante Three Rivers Medical Center • Bay Area Hospital • Good Samaritan Regional 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 • Provicence 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 • Willamette Valley Medical Center	• Blue Mountain Hospital* • CHI St. Anthony Hospital* • Curry General Hospital* • Good Shepherd Medical Center* • 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*	• 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* • Samaritan Lebanon Community Hospital* • Samaritan North Lincoln Hospital* • Samaritan Pacific Communities Hospital* • Southern Coos Hospital & Health Center* • St. Charles Prineville* • St. Charles Madras* • St. Charles Redmond • West Valley Hospital*

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)

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APPENDIX C: 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 requsted financial assistance or does not qualify for financial assistance. In these cases the hospital will generate a bill for services providec. 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 expsed 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 of 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.

APPENDIX C: DEFINITIONS (CONT.)

Tax Subsidies: Tax revenues from cities, counties or special hospital districts, which assess mill levies to subsidize the report-ing 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. In-cludes 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.