



# Q4 2016 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS



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# Q4 2016 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.

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

## **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.



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## OPERATING MARGIN

Median Operating Margin percentage (Figure 1) had been following a fairly consistent trend since Oregon’s Medicaid expansion in 2014. It peaks in Q2 each year, and hits its lowest point in Q4. However, in this Q4 the median margin dropped much lower than expected, down to pre-ACA levels.

When adjusting for seasonal trends, Figure 2 shows that Q4 2016 is only the second Operating Margin decrease in the past three years, and the largest in magnitude. A margin of 2-2.5% was expected based on previous years.

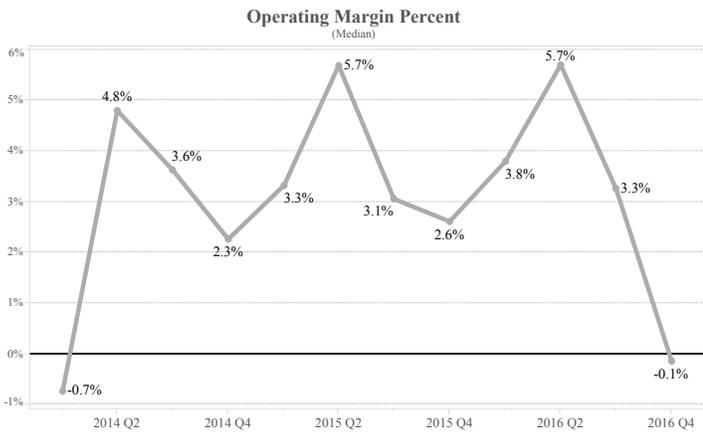


Figure 1

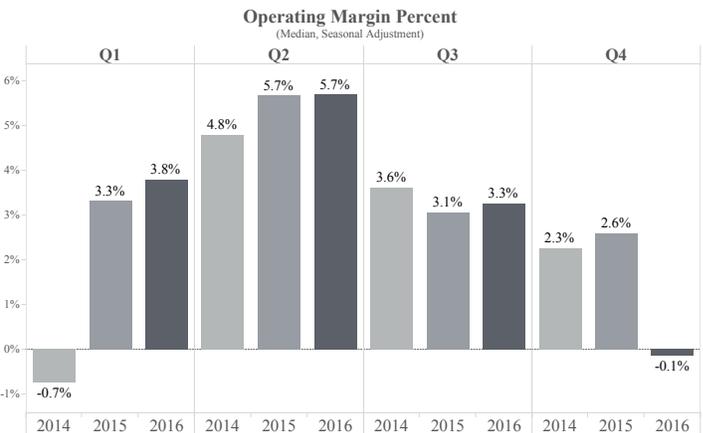


Figure 2

## NET PATIENT REVENUE

Aggregate Net Patient Revenue (NPR) continues to increase slowly, although by a much smaller amount in Q4 2016 (Figures 3 & 4).

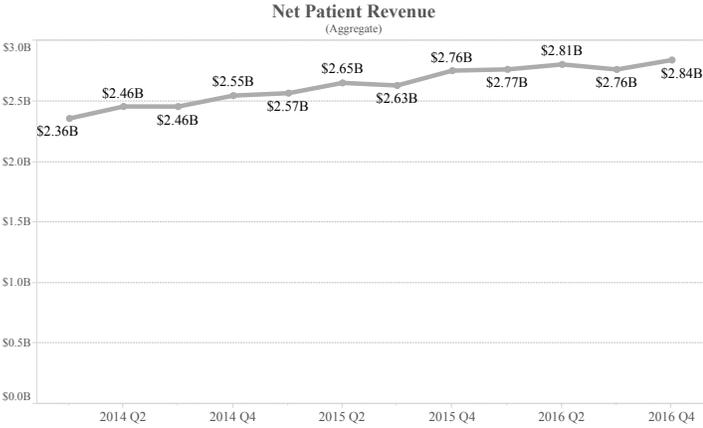


Figure 3

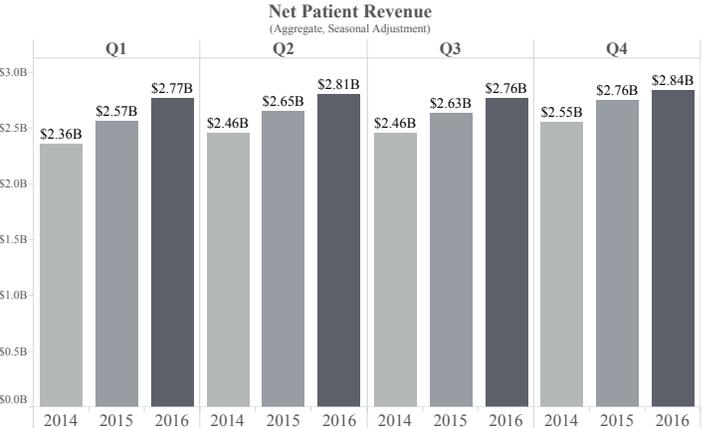


Figure 4



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## MEDICAID PAYER MIX

When controlling for seasonality, aggregate Medicaid Payer Mix continues to decrease slowly after the initial post-expansion bump (Figures 5 & 6).

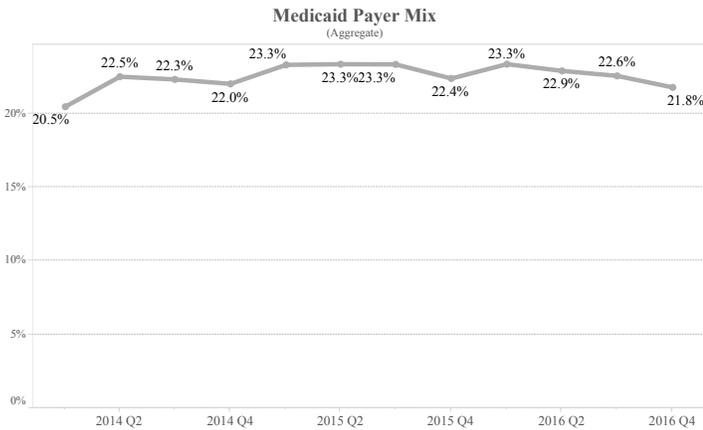


Figure 5

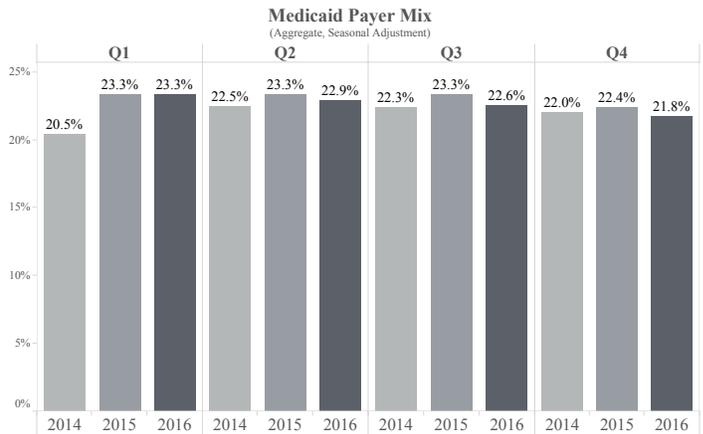


Figure 6

## MEDICARE PAYER MIX

Aggregate Medicare Payer Mix continues to look fairly stable, although recent quarters have shown a very slight increase compared to similar quarters of previous years (Figures 7 & 8).

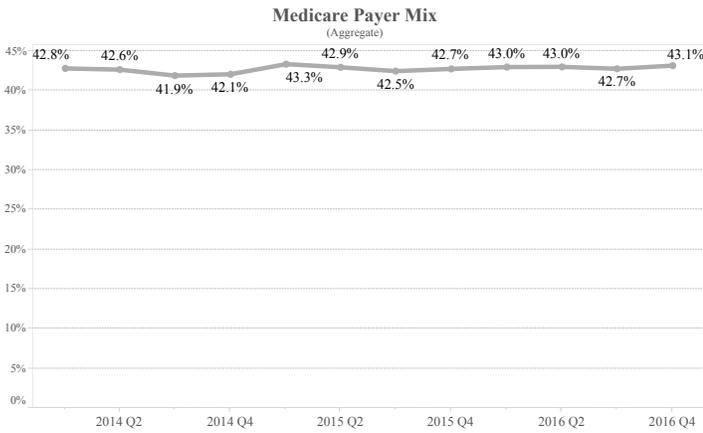


Figure 7

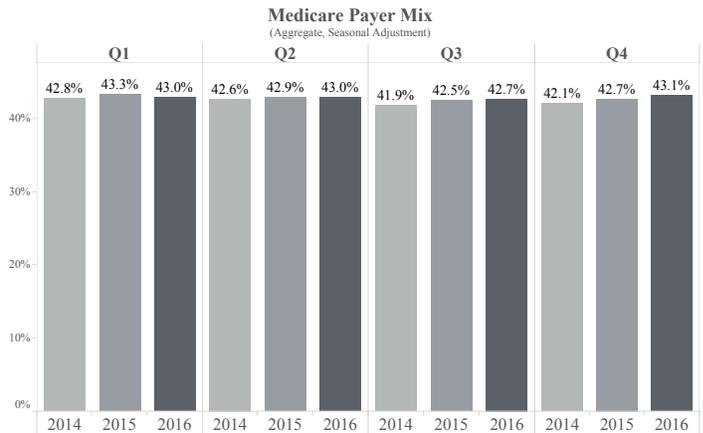


Figure 8



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## COMMERCIAL & OTHER PAYER MIX

Aggregate Commercial & Other Payer Mix is also fairly stable but has shown a very slight uptick after the drop in 2015 (Figures 9 & 10).

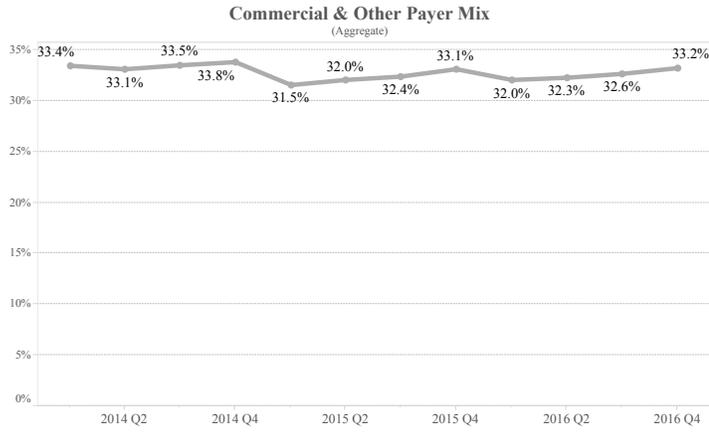


Figure 9

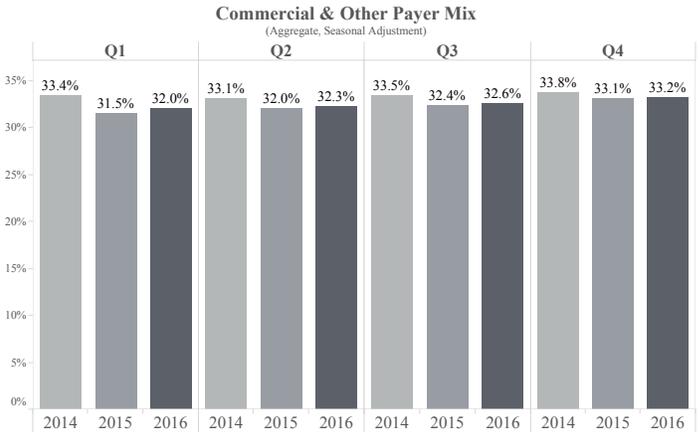


Figure 10

## SELF PAY PAYER MIX

Aggregate Self Pay Payer Mix has increased slightly for the past three quarters when controlling for seasonality (Figures 11 & 12).

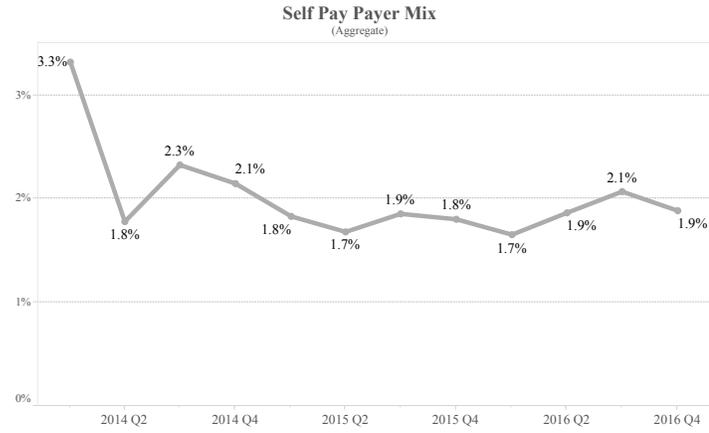


Figure 11

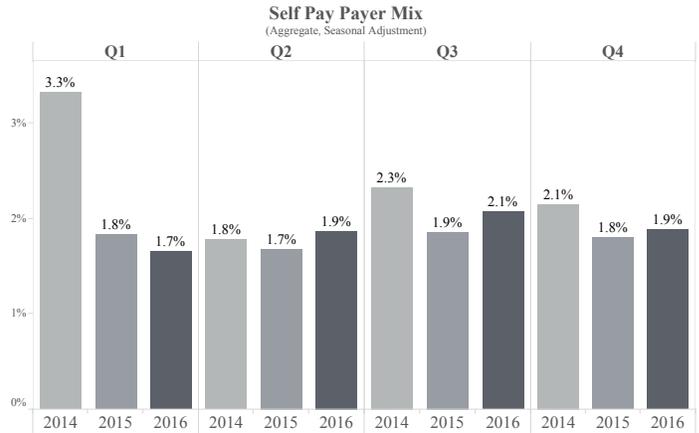


Figure 12



# Q4 2016 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## CHARITY CARE PERCENTAGE

Median Charity Care as a percentage of Total Charges has begun to increase slightly after the post-expansion drop (Figure 13 & 14).

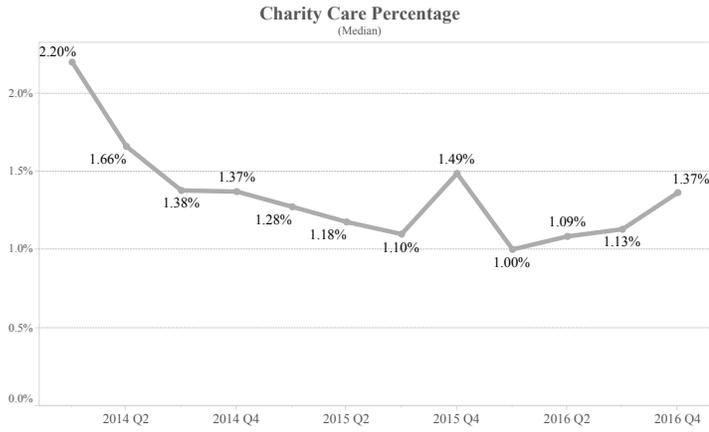


Figure 13

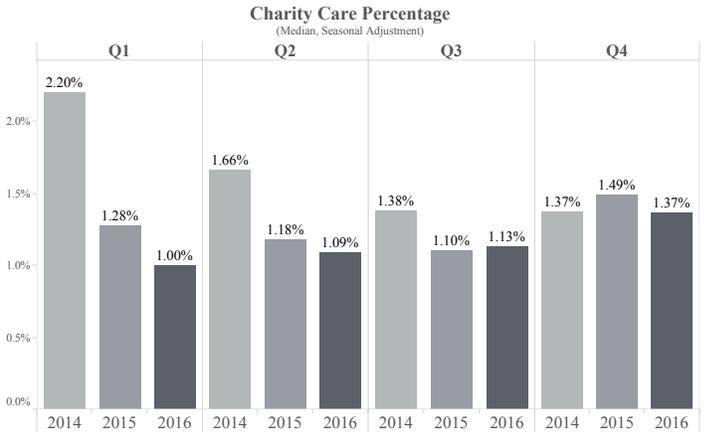


Figure 14

## BAD DEBT PERCENTAGE

Median Bad Debt continues to remain stable at around 1% of total charges after the expansion drop (Figures 15 & 16).

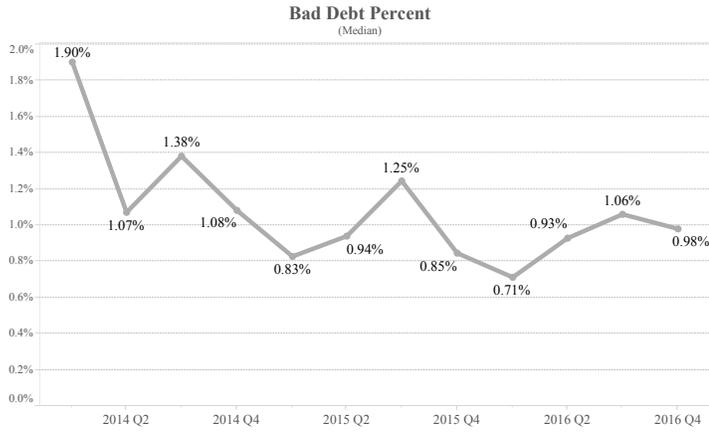


Figure 15

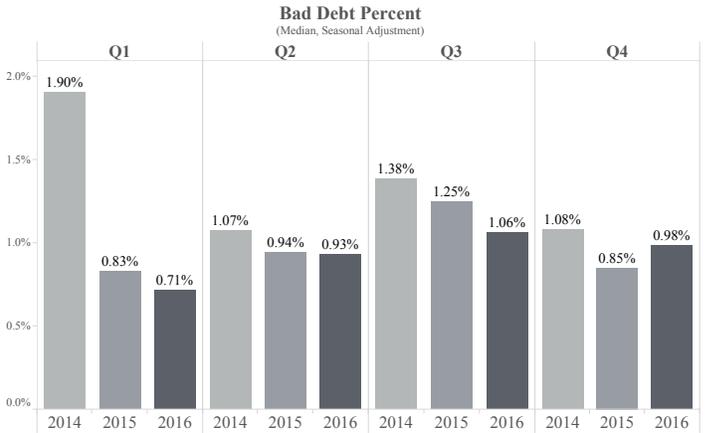


Figure 16



# Q4 2016 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## TOTAL DISCHARGES

Aggregate Inpatient Discharges remain stable at around 80,000 per quarter with some slight seasonal increases and decreases (Figures 17 & 18).

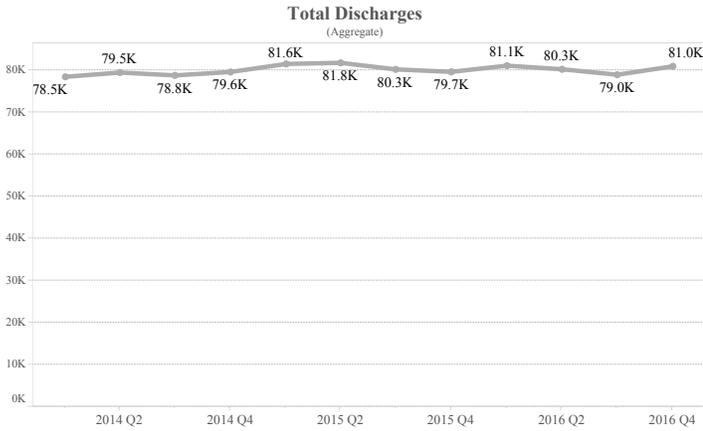


Figure 17

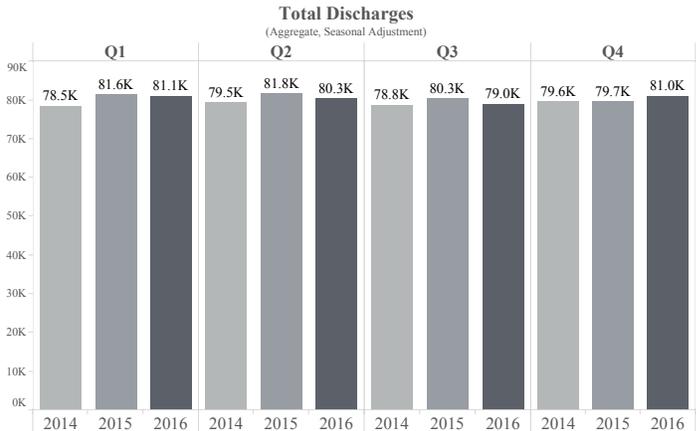


Figure 18

## TOTAL OUTPATIENT VISITS

Aggregate Total Outpatient Visits continue to increase, although the rate of increase decreased significantly in Q4 2016 (Figures 19 & 20).

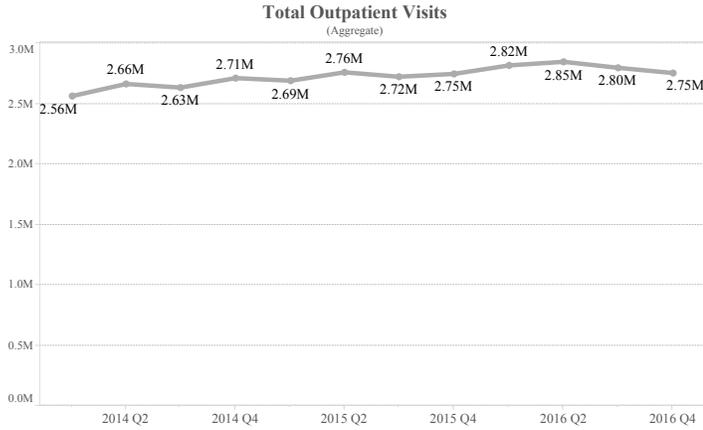


Figure 19

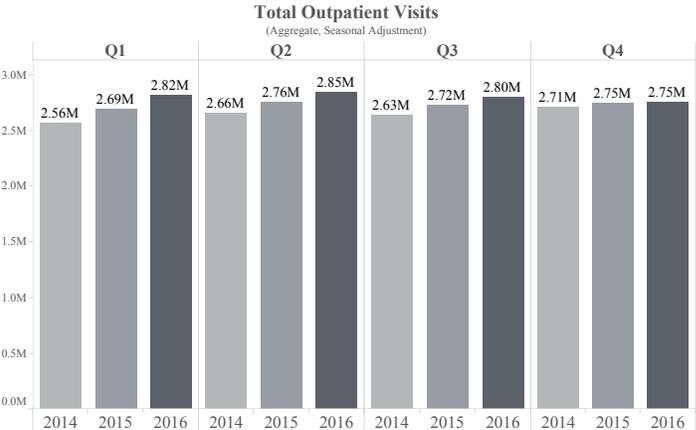


Figure 20

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## AMBULATORY SURGERY VISITS

Aggregate Ambulatory Surgery Visits are increasing after a drop in 2015 (Figures 21 & 22).

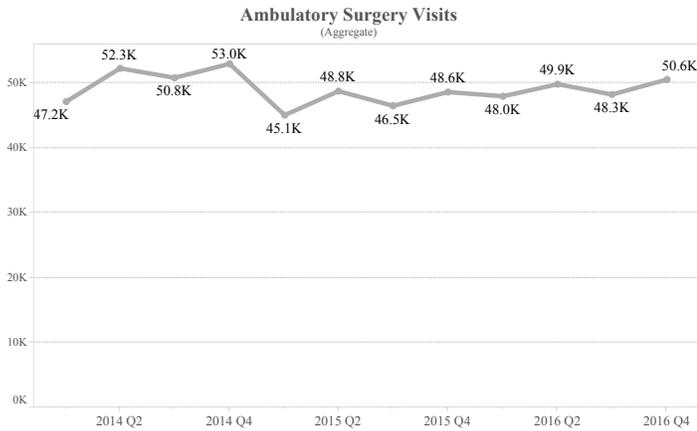


Figure 21

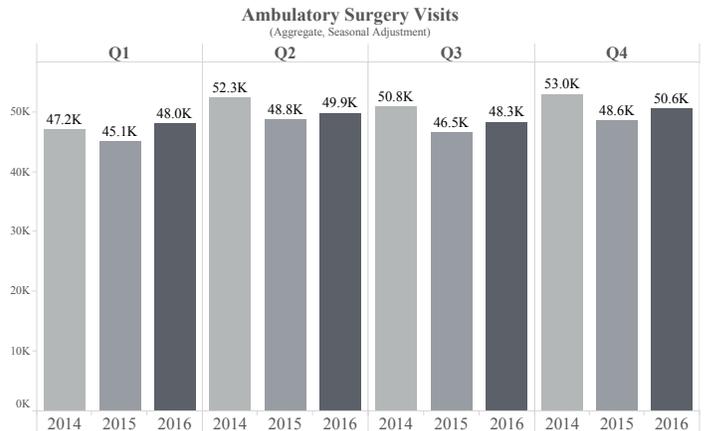


Figure 22

## EMERGENCY DEPARTMENT VISITS

Aggregate Emergency Department Visits are increasing as well, when controlling for the extreme seasonality of these visits (Figures 23 & 24).

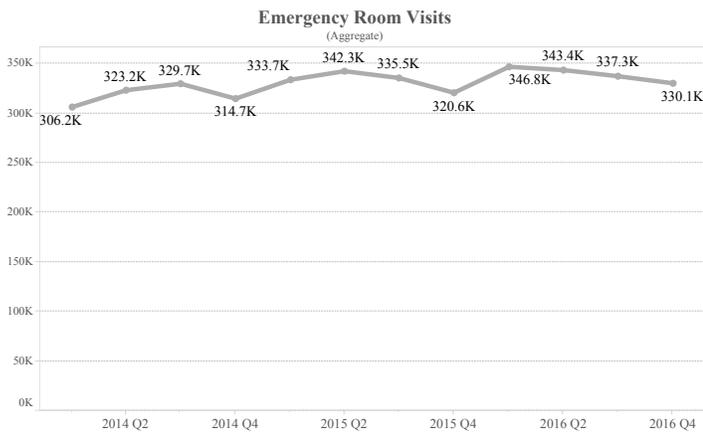


Figure 23

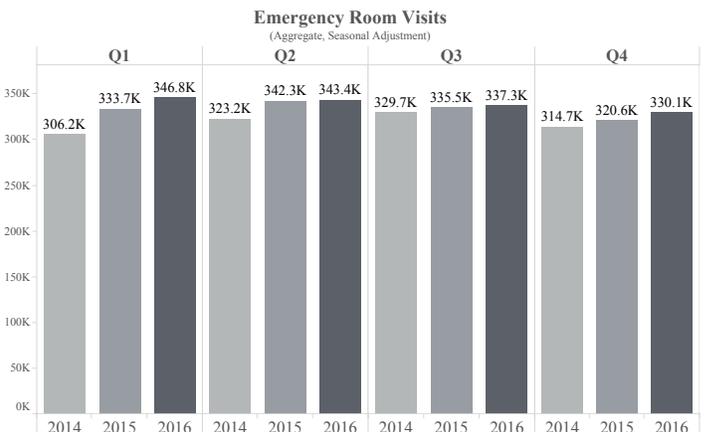
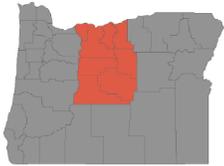


Figure 24

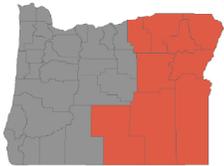


# Q4 2016 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## 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



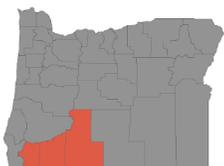
**Northwest Oregon:** Columbia Memorial Hospital, Providence Newberg Medical Center, Providence Seaside Hospital, Samaritan North Lincoln Hospital, Samaritan Pacific Communities Hospital, Tillamook Regional Medical Center, Willamette Valley Medical Center



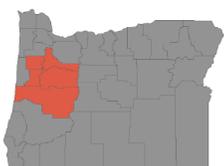
**Portland Metro Area:** Adventist Medical Center, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, OHSU, Providence Milwaukie Medical Center, Providence Portland Medical Center, Providence St. Vincent Medical 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



# Q4 2016 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

## APPENDIX B: HOSPITAL TYPES

Urban	Rural	
DRG Hospitals	Type A Hospitals	Type B Hospitals
<ul style="list-style-type: none"> <li>• Adventist Medical Center</li> <li>• Asante Rogue Regional Medical Center</li> <li>• Asante Three Rivers Medical Center</li> <li>• Bay Area Hospital</li> <li>• Good Samaritan Regional Medical Center</li> <li>• Legacy Emanuel Medical Center</li> <li>• Legacy Good Samaritan Medical Center</li> <li>• Legacy Meridian Park Medical Center</li> <li>• Legacy Mount Hood Medical Center</li> <li>• McKenzie-Willamette Medical Center</li> <li>• Mercy Medical Center</li> <li>• OHSU Hospital</li> <li>• PeaceHealth Sacred Heart Medical Center at RiverBend</li> <li>• PeaceHealth Sacred Heart Medical Center University District</li> <li>• Providence Medford Medical Center</li> <li>• Providence Milwaukie Hospital</li> <li>• Providence Portland Medical Center</li> <li>• Providence St. Vincent Medical Center</li> <li>• Providence Willamette Falls Medical Center</li> <li>• Salem Hospital</li> <li>• Samaritan Albany General Hospital</li> <li>• Shriners Hospital-Portland</li> <li>• Sky Lakes Medical Center</li> <li>• St. Charles Bend</li> <li>• Tuality Healthcare</li> <li>• Willamette Valley Medical Center</li> </ul>	<ul style="list-style-type: none"> <li>• Blue Mountain Hospital*</li> <li>• CHI St. Anthony Hospital*</li> <li>• Curry General Hospital*</li> <li>• Good Shepherd Medical Center*</li> <li>• Grande Ronde Hospital*</li> <li>• Harney District Hospital*</li> <li>• Lake District Hospital*</li> <li>• Pioneer Memorial Hospital-Heppner*</li> <li>• St. Alphonsus Medical Center-Baker City*</li> <li>• St. Alphonsus Medical Center-Ontario</li> <li>• Tillamook Regional Medical Center*</li> <li>• Willowa Memorial Hospital*</li> </ul>	<ul style="list-style-type: none"> <li>• Asante Ashland Community Hospital</li> <li>• Columbia Memorial Hospital*</li> <li>• Coquille Valley Hospital*</li> <li>• Legacy Silverton Medical Center</li> <li>• Lower Umpqua Hospital*</li> <li>• Mid-Columbia Medical Center</li> <li>• PeaceHealth Cottage Grove Community Hospital*</li> <li>• PeaceHealth Peace Harbor Medical Center*</li> <li>• Providence Hood River Memorial Hospital*</li> <li>• Providence Newberg Medical Center</li> <li>• Providence Seaside Hospital*</li> <li>• Samaritan Lebanon Community Hospital*</li> <li>• Samaritan North Lincoln Hospital*</li> <li>• Samaritan Pacific Communities Hospital*</li> <li>• Southern Coos Hospital &amp; Health Center*</li> <li>• St. Charles Prineville*</li> <li>• St. Charles Madras*</li> <li>• St. Charles Redmond</li> <li>• West Valley Hospital*</li> </ul>

**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)



## Q4 2016 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

### 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 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.



## Q4 2016 HOSPITAL UTILIZATION AND FINANCIAL ANALYSIS

### APPENDIX C: 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.