Special Committee on Financial Institutions and Insurance

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About KHA

The Kansas Hospital Association is a voluntary, non-profit organization existing to be the leading advocate and resource for members.

KHA membership includes 222 member facilities, of which 125 are full-service, community hospitals.

Founded in 1910, KHA's vision is Optimal Health for Kansas.

KHA's Mission: To be the leading advocate and resource for members

Understanding Healthcare Reimbursement

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Sources of Hospital Revenues

- Patient Revenue
- Non-Patient Revenue
  - Gift shop
  - Cafeteria sales
  - Vending machine commissions
- Tax Subsidies
- Donations and Grants
- Investments

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Net Patient Revenue

- Income Earned by Delivering Patient Care
- Adjustments to Revenue
  - Charity Care
    - Financial assistance based on hospital's policy
  - Bad Debt
    - Uncollectible – Patient is unwilling or unable to make payments and does not respond to hospital's request to work out payment arrangements or to apply for financial assistance
  - Contractual Adjustments (write-offs)
    - Difference between hospital charges and allowed amounts

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Key Revenue Drivers

<u>Internal</u>

- Patient mix and growth
- Physician mix
- Service center mix
- Contract reimbursement rates
- Business office performance
- Volume
- Seasonal changes
- Target markets
- New equipment

<u>External</u>

- Local competitive pricing
- Inflation rate
- Facility expansion plans
- Local population growth
- Payer market shares
- Advertising/promotion spend
- Natural disasters
- Government policy shifts
- Patient satisfaction surveys
- Socio-economic factors

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Payment Sources

- **Medicare**
- **Other Private Insurance**
- **Patient Self-pay**
- **Employer-sponsored insurance**
- **Christian Ministries**
- **Medicare Advantage**
- **Workers' Comp**
- **TRICARE**
- **Veteran's Administration**
- **Medicaid**

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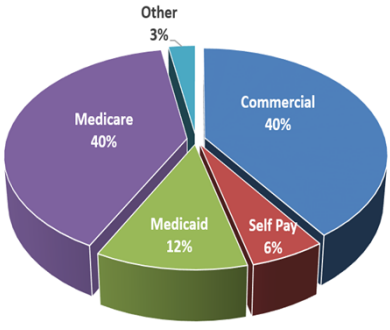
Payer Mix

- Most Kansas hospitals depend heavily on payments for services provided to Medicare and Medicaid patients.
- As reflected in the pie chart, these two programs provide 52% of the typical hospital's net patient revenue.
- These governmental programs pay less than the costs to provide care.
- In addition, around 6% is self-pay or charity care



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Medicare

- Hospitals Are NOT Paid the Same
- There are Multiple Payment Methodologies Based on Type of Service Rendered

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Critical Access Hospitals (CAHs)

- Eligibility:
  - Located in a federal or state defined rural area
  - More than 35 road miles from a similar hospital (15 miles in certain conditions)
  - Necessary Provider Designation by Governor
  - Provides 24-hour emergency services
  - No more than 25 inpatient beds
  - Annual average length-of-stay of no more than 96 hours
- Reimbursement
  - 101% of allowable costs (as defined by Medicare)
  - Optional methods for reimbursement for outpatient services

NOTE: Kansas has 82 CAHs

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How Critical Access Hospitals (CAHs) are Paid

- Medicare pays 101% of "allowable" costs for most services
  - Medicare defines what is allowable (excludes patient telephones, TV, advertising, lobbying, etc.)
- Cost is estimated using cost accounting data from Medicare cost reports
- CAHs are paid "interim" rates based on costs from previous cost reporting year and then "settled"

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Rural Hospitals

- Sole Community Hospitals (SCH)
  - Reimbursement:
    - Paid the higher of trended 1982, 1987, 1996, or 2006 of their Hospital Specific Rate or the federal inpatient operating amount
    - Receive a 7.1% add-on to outpatient payments
    - May also qualify for other payment adjustments such as a Low Volume Hospital Payment Adjustment
- Medicare Dependent Hospitals (MDH)
  - Reimbursement
    - Paid the higher of the federal rate or a 25%/75% blend of the federal rate and the Hospital Specific Rate for inpatient services
    - Receive transitional adjustments to outpatient payments

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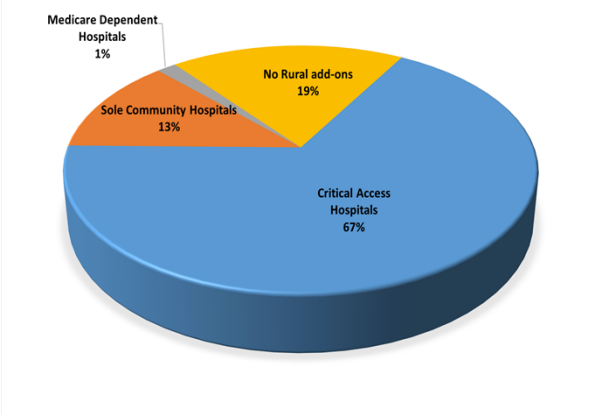
Special Medicare Rural Payments

- 103 of Kansas Hospitals receive special Medicare payments for serving patients in rural, isolated or underserved areas.



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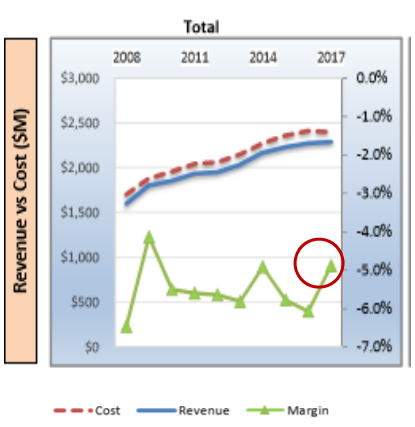
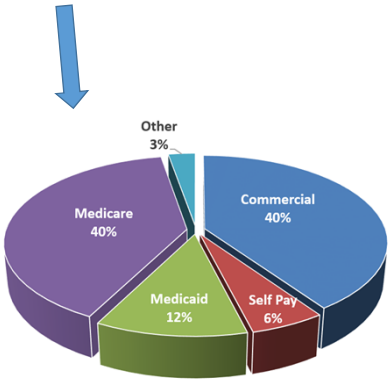
Medicare Margins

- In 2017, the average Medicare margin for Kansas hospitals was a negative 4.88%
- Only 18% of hospitals had a positive bottom margin
- Health economists consider a positive 4% margin as the minimum necessary to ensure hospitals have sufficient funds to improve patient care and to reinvest in modernization.





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Enacted Medicare Cuts Analysis

Relative Magnitude of Enacted Medicare Cuts

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			Impact of Enacted Cuts (2010-2018)	Impact of Enacted Cuts (2019-2028)	Total Impact (2010-2028)
Legislative (1)	ACA Marketbasket Cuts	IPPS Marketbasket Reduction	($304,173,300)	($1,514,691,500)	($1,818,864,800)
		OPPS Marketbasket Reduction	($150,035,200)	($769,788,200)	($919,823,400)
		IPF Marketbasket Reduction	($7,965,800)	($55,379,800)	($63,345,600)
		Post-Acute Marketbasket Reductions	($52,378,900)	($255,961,700)	($308,340,600)
	Other Cuts	Sequestration (2.0% reduction to payments)	($235,065,000)	($428,127,700)	($663,192,700)
		Medicare DSH Cuts	($98,104,900)	($258,709,200)	($356,814,100)
		Medicaid DSH Cuts	$0	$0	$0
		ATRA IPPS Retrospective Coding Adjustment	($102,122,800)	($138,749,800)	($240,872,600)
		Post-Acute Marketbasket Caps	($696,800)	($8,617,000)	($9,313,800)
		PAMA CLFS Adjustment	($931,800)	($31,791,200)	($32,723,000)
		OPPS SN (PN)	($30,330,400)	($189,452,300)	($219,782,700)
		Hospice Transfer Adjustment	$0	($45,243,700)	($45,243,700)
		Reimbursable Bad Debt reduced to 65%	($23,115,400)	($53,960,000)	($77,075,400)
New		New Legislative Cut 1	$0	$0	$0
		New Legislative Cut 2	$0	$0	$0
		New Legislative Cut 3	$0	$0	$0
		New Legislative Cut 4	$0	$0	$0
		New Legislative Cut 5	$0	$0	$0
Regulatory (2)	Coding	IPPS Coding Adjustments	($327,991,000)	($602,803,800)	($930,794,800)
		OPPS Packaging Inflation Adjustment	($32,238,700)	($130,540,800)	($162,779,500)
		LTCH Prospective Budget Neutrality Adjustment	($18,161,500)	($48,502,300)	($66,663,800)
		HH Prospective Coding Reduction	($27,767,700)	($67,341,800)	($95,109,500)
	Other	LTCH Site-Neutral Adjustment	($4,490,500)	($30,095,300)	($34,585,800)
		340B Reduction	($5,877,600)	($71,764,400)	($77,642,000)
		WAC Drug Payments Reduced to 103%	$0	($939,800)	($939,800)
		OPPS Clinic SN (PO)	$0	($43,530,100)	($43,530,100)
QBPR (3)		Readmissions Reduction Program	($13,079,000)	($48,896,900)	($61,975,900)
		Hospital Acquired Condition Reduction Program	($7,344,900)	($19,754,600)	($27,099,500)
		Value-based Purchasing	$3,378,000	$1,107,600	$4,485,600
Total Enacted Cuts			**($1,438,493,200)**	**($4,813,534,300)**	**($6,252,027,500)**

Medicaid (KanCare)

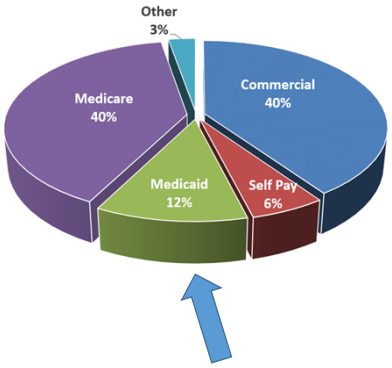
Amerigroup RealSolutions in healthcare

aetna Aetna Better Health of Kansas

sunflower health plan

UnitedHealthcare Community Plan

Kansas Hospitals are paid less than cost for Medicaid (KanCare)



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Definitions……..Charge vs Payment vs Cost

• A **charge** is the amount the hospital lists as the price for services. In today's world, it is the starting point for negotiation of payment for services.

• **Payment** is the amount the hospital actually receives in cash for its services.
  - Private insurers, public insurers, and the uninsured all pay different amounts for the same services based on contracts, fee schedules, etc.

• **Cost** is what it actually costs the hospital to provide the services.
  - Costs include utilities, housekeeping, depreciation, equipment costs, labor, general overhead, etc.

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Hospital Finance is Challenging

Hospitals ***CHARGE*** everyone the same rates…BUT

- No two payers ***PAY*** the same rates
- Government payers pay ***BELOW*** costs
- Commercial payers ***NEGOTIATE*** rates based on market share
- Charity care and underpayment impacts overall costs for everyone else

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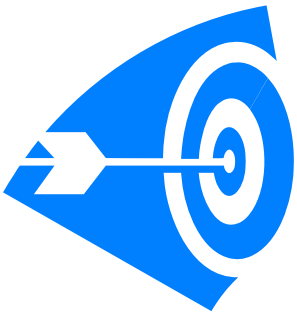
EXAMPLE: X-Ray

- Hospital Cost = $75
- Hospital Charge = $110
- Medicare = $45
- Medicaid = $24
- Blue Cross = $35
- Commercial Ins = $93



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Impact on Reimbursement

- Cost shifting
  - Negotiate higher prices with private payers to offset losses from Medicare, Medicaid, and the uninsured
  - Higher prices are passed on to employers and individuals via higher premiums, deductibles, etc.

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Impact of Shortfalls/Losses

- Impacts ability to:
  - Attract physicians and other medical staff
  - Retain nurses, clinical staff
  - Health care costs for private sector
  - Devote financial resources to update to technology/infrastructure/facility
- Impact on communities
  - Diminishes hospital economic impact (jobs, taxes, etc.)

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Specific Challenges in Rural Hospitals

1. Negative Margins
2. Higher patient mix of Medicare and Medicaid
3. Hospitals designed for inpatient care
4. Small and aging populations
5. Workforce recruitment
6. Patients seek care elsewhere
7. Health care and community futures tied together

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Kansas Hospitals at a Glance

- 5 hospitals have closed since 2010
  - Central Kansas Medical Center – Great Bend
  - Mercy Hospital – Independence
  - Mercy Hospital – Fort Scott
  - Oswego Community Hospital – Oswego
  - Horton Community Hospital - Horton
- 73% KS hospitals are operating at a loss
- Median days cash on hand for KS CAHs is 46.57
- 66 counties have fewer than 10 persons per square mile

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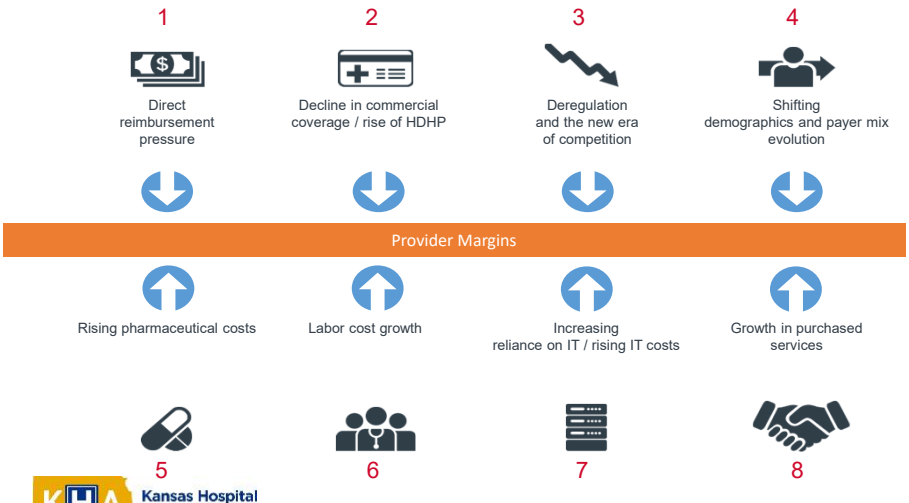
Eight Price and Cost Pressures Squeezing Margins



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Why Is Healthcare So Expensive?

1. Administrative Costs
   (According to Harvard economist David Cutler)
   a) Compliance with Medicare and other payer regulations
   b) Billing requirements
   c) Collection efforts
   d) Quality reporting
   e) Rising costs of IT
   f) Heavily regulated

Medicare Prospective Payment Systems

Provider Component	Hospital Inpatient Operating	Hospital Inpatient Capital	Hospital Outpatient	Skilled Nursing	Home Health	Inpatient Rehabilitation	Long term Acute*	Inpatient Psych
Federal Rate	Standard amount per discharge	Federal rate per discharge	Conversion factor per procedure	Federal rate per diem	National 60 day episode rate	Standard amount per discharge	Standard amount per discharge	Per diem base rate
Rate Year	Oct-Sept	Oct-Sept	Jan-Dec	Oct-Sept	Jan-Dec	Oct-Sept	Oct-Sept	Oct-Sept
Area Salary Adjustment/Labor Share	Wage index 69.6% or 62%	Geographic adjustment factor (GAF) 60%	Wage index 60%	Wage index w/o reclassifications 68.8%	Wage index 78.53%	Wage index w/o reclassifications 70.9%	Wage index w/o reclassifications 66.5%	Prior year's pre-floor, pre-reclassification IPPS wage index. 75.1%
Urban/Rural Adjustment	None	None	Temporary hold harmless for small rurals 7.1% add on for SCH	Urban and rural rates	Temporary 5% rural add-on	14.9% rural add-on	None	17% rural add-on
Medical Education	Indirect medical education (IME) adjustments	IME adjustment	None	None	None	Teaching variable	None	Teaching variable
Disproportionate Volume of Low Income Patients	Disproportionate share hospital (DSH) adjustment	DSH adjustment	None	None	None	Low income patient (LIP) adjustment	None	None
Intensity of Services	Medicare Severity diagnosis related groups (MS-DRGs)	MS-DRGs	Ambulatory payment classifications (APCs)	Resource utilization groups (RUGs)	Home health resource groups (HHRGs)	Case mix groups (CMGs) with comorbidities	Medicare Severity Long-term care DRGs (MS-LTC-DRGs)	MS-DRGs with day weights and comorbidities
Excessive Costs	Cost outliers	Cost outliers	Cost outliers	None	Cost outliers	Cost outliers	Cost outliers	Cost outliers; ECT, increase in Day 1 per diem for hospitals with an ED
Partial Treatment	Short stay transfers	Short stay transfers	None	None	Partial episodes low utilization	Short stay CMGs	Short stay outliers/ interruption of stay	Interrupted stays

Updated September 2016 *Note: Services provided to patients not meeting LTCH criteria under the DRACT Act are paid under IPPS.

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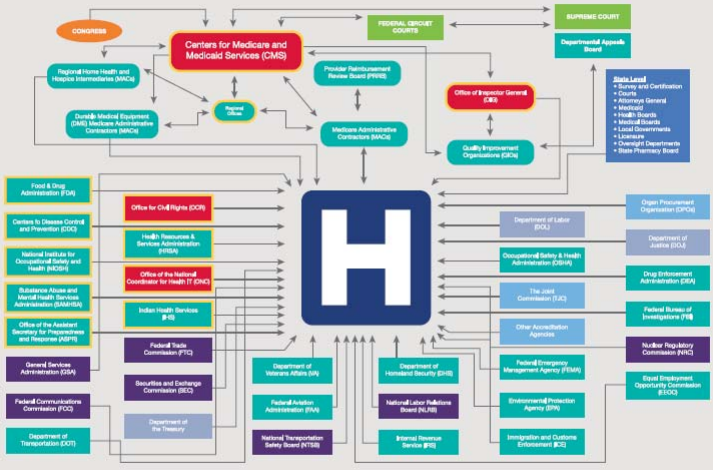
Figure A. Federal Agencies with Regulatory Authority Impacting Health Systems, Hospitals and PAC Providers



Adapted and updated from: American Hospital Association. Patients or Paperwork? The Regulatory Burden Facing America's Hospitals.

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Why Is Healthcare So Expensive?

2. Drug Costs
3. Defensive Medicine (fear of being sued)
4. Expensive Mix of Treatment (use of specialists)
5. Wages (highly specialized workforce)
6. Branding (reimbursement varies by payer)

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