Finance in rural and urban hospitals

Introduction

This brief provides a snapshot of key financial trends in rural hospitals from 2011 to 2015, a period that saw the implementation of the Affordable Care Act (ACA). It does not provide an exhaustive analysis of rural hospital finance; rather, it focuses on those aspects that might reflect impacts of the ACA’s changes on insurance coverage and reimbursement for services.

The brief uses data from the Hospital Annual Report (HAR).

Hospitals in Minnesota were divided into three groups:

- **Critical Access Hospitals (CAHs, 78 hospitals)** is a federal designation for a rural hospital that meets certain criteria such as being non-profit and having 25 beds or less. This designation limits patients to a 96-hour inpatient stay.

- **Other rural hospitals (20 hospitals)** are also located in a rural community but do not have critical access designation. Some are similar in size to CAHs but they do not have the same limitations of 25 beds and there are no limits on the length of time a patient can stay. Other rural hospitals receive reimbursement for their services on a prospective-payment system.

- **Urban hospitals (33 hospitals)** are all other facilities; they are located in urban areas and are typically large. For the purposes of this brief, behavioral-health hospitals were excluded.

ACA changes

The period covered by this brief saw a number of important changes to the health care market. These changes include:

- **Coverage** mandates required individuals to have health insurance coverage and employers with over 50 employees to offer health insurance to their employees.

- **Medicaid expansion and other changes** increased the number of individuals that were eligible for Medical Assistance in Minnesota. See Appendix 1 for details.

- **Health insurance marketplaces** (in Minnesota, MNsure) enabled individuals who directly purchase health insurance coverage to compare coverage options.

- **Individual market subsidies** such as income-based tax credits and cost sharing supports helped to increase the affordability of individuals plans purchased on the marketplace.

See Appendix 1 for more detail on these changes.

Payer mix

Reimbursement for services that hospitals provide to patients makes up the largest percent of hospital revenue. Government and private insurance companies reimburse hospitals differently, depending on the hospital, and payment arrangements such as contracts. To receive payment, hospitals report charges for services provided to the insurance companies.
The amount reimbursed and turned into revenue varies by insurance type and hospital type. For this reason, looking at charges more accurately reflects the patient populations receiving services, while looking at revenues better indicates where dollars are coming from.

Public programs

Public insurance programs include Medicare (federal health insurance for the elderly and disabled) and two state publicly funded health programs: Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare (Minnesota's Basic Health Plan).

CAHs have a cost-based reimbursement system in which they receive close to allowable costs, although the exact percentage has varied. Due to the older population demographics of rural and most small Minnesota communities (where CAHs are located) as well as their reimbursement structure, CAHs receive a higher percentage of their total revenue from Medicare payments compared to other rural and urban hospitals.

From 2011 to 2015, the percent of total charges billed to Medicare increased among all Minnesota hospitals (Figure 2). This likely relates to the increase in Medicare enrollees over this period.

State public programs reimburse hospitals by a percentage of the payment-to-cost rate, which varies by hospital type. From 2011 to 2015, urban hospitals had a greater share of charges billed to state public programs compared to CAHs and other rural hospitals, but the percent of charges that went to state public programs increased for all types of hospitals (Figure 3). Proportionally, state public programs cover more of urban hospitals' patients than other payers do.

Private insurance

Private insurance includes commercial insurers such as employer-based insurance and insurance purchased individually. These companies negotiate the amount they reimburse hospitals. Among hospitals, urban hospitals receive the highest percent of total revenue from commercial charges.

From 2011 to 2015, the trends in the percent of charges from commercial payers decreased among all hospital groups (Figure 4).
Self-pay charges

Self-pay charges are out-of-pocket payment by individuals who do not have health insurance coverage. The percent of revenue generated by self-pay was small in 2011 and decreased still further in 2015 (Figure 5). Compared to urban hospitals, both types of rural hospitals (CAHs and other rural hospitals) continue to receive a larger percent of their revenue from self-pay.

![Figure 5. Percent of self-pay charges](image)

Source: Hospital Annual Report 2011-2015

Uncompensated care

Uncompensated care is care provided to patients where no payment is received, either expectedly (charity care) or unexpectedly (bad debt). Charity care represents discounted or free care based on patient income. Bad debt occurs when payments are expected but not received.10

![Figure 6. Uncompensated care as a percent of operating expenses](image)

Source: Hospital Annual Report 2011-2015

In 2013, following ACA implementation, uncompensated care decreased by 16.7 percent among Minnesota hospitals.11 That is, more hospitals received payment for services provided. The percentage of expenses that went to uncompensated care changed most in urban hospitals; CAHs and other rural hospitals had only a slight decrease between 2011 and 2015 (Figure 6).

In CAHs and other rural hospitals, a larger proportion of uncompensated care was from bad debt rather than charity care (Figure 7) — a trend consistent with CAHs across the nation.12 National research shows that various factors contribute to these higher rates of bad debt, including billing policies and the way CAHs set the threshold that determines if a patient will qualify for charity care.

![Figure 7. Percent of uncompensated care that is charity care and bad debt](image)

Source: Hospital Annual Report 2011-2015
Operating margins

Operating margin represents operating income calculated by excess operating revenue (income) over operating expense as a percent of operating revenue. Operating margin is a broad measure of hospital profitability because it takes into account a wide range of factors such as patient services and non-patient related operating expenses. This report uses the median value, a common way to report the average performance of a hospital.

CAHs and other rural hospitals had a lower operating margin than urban hospitals between 2011 and 2015 (Figure 8). Both CAHs and urban hospitals saw an overall increase in their operating margins during this period. This was not the case for other-rural hospitals, which saw decreased operating margins from 2011 to 2015.

Figure 8. Median hospital operating margin

The year-to-year variation from 2011 to 2015 among CAHs and other-rural hospitals would require more in-depth analysis. Factors that drive this type of variation include repeatedly low margins for the same hospital or year-to-year financial fluctuations. Differences in the presence of negative margins are another possible cause for the year-to-year variation as the median value can mask the presence of negative margins. More CAHs have negative operating margins than other hospitals, and this increased from 2011 to 2015 (Figure 9).

Figure 9: Number of hospitals with negative operating margins

Source: Hospital Annual Report 2011-2015

Minnesota hospitals report institution-wide financial data as well as hospital-only data. Many CAHs and other rural hospitals are comprehensive community health institutions that own and operate the local nursing home, medical clinic, ambulance service and other community services. Often, although not exclusively, the financial pressures on these other services result in a lower operating margin for the institution as a whole, as reflected in Figure 10, particularly for CAHs.

Figure 10. Median institution-wide operating margin

Source: Hospital Annual Report 2011-2015
Discussion

The findings in this brief demonstrate the importance of health insurance coverage to the financial stability of CAHs and other rural hospitals, among which median hospital and institution operating margins are consistently lower than urban facilities. A greater number of CAHs and other rural hospitals report negative operating margins.

Medicare and Minnesota state public program charges increased among all types of hospitals. For CAHs and rural hospitals, the percent decline in commercial insurance charges and the percent increase in public programs charges - combined with the differences in reimbursement rates between public and private insurance programs - may explain the small increase in rural hospital revenues. Critical access and other rural hospitals saw an increase in their public program insurance charges, programs that typically have a lower reimbursement rate than private insurance.15

The increase in charges to public insurance programs and decrease in the percent of self-paid charges implies that many individuals who were previously paying out of pocket for health care now have insurance, many through public programs. Further investigation into the complexity of insurance reimbursement, as well as trends in patient deductibles and copays, and their impact on hospital finance, will be important for policy makers to consider the implications that changes to health coverage will have on the availability of services and health outcomes for rural Minnesotans.
Appendix 1. Key milestones in ACA implementation in Minnesota

March 2010
- Patient Protection and Affordable Care Act (ACA) signed.

March 2011
- Minnesota expands eligibility for its Medicaid program - known as Medical Assistance (MA) - opening the program to childless adults with incomes at 75 percent of Federal Poverty Guidelines (FPG).16

November 2013-March 2014
- First open enrollment period through the state's new health insurance marketplace, MNsure.
- Tax credits and cost-sharing reductions now available for those with income between 200 percent and 400 percent FPG who enroll in private coverage through MNsure.

January 2014
- MA eligibility further expanded, now to childless adults up to 133 percent FPG. The income limit for children ages 2-18 also was raised from 150 percent to 275 percent FPG. The ACA requires that all income-eligible MinnesotaCare populations be shifted into Medical Assistance.17 18 19
- MinnesotaCare converted to an ACA "Basic Health Plan," which brings expanded benefits but reduces the maximum income allowed; eligibility now limited to those with more than 133% FPG (the new income maximum for MA) but not more than 200 percent FPG.20 Exceptions to the income floor are made for certain children under age 19 and legal noncitizens, who are not eligible for MA.
- Federal "individual mandate" kicks in, requiring all Americans to have health insurance coverage or pay a penalty.

November 2014-March 2015
- Second open enrollment period through MNsure.

November 2015-January 2016
- Third open enrollment period.

November 2016-January 2017
- Fourth open enrollment period.
Endnotes

1 The Hospital Annual Report (HAR) is part of the Minnesota Healthcare Cost Information System (HCCIS). More information is available at http://www.health.state.mn.us/divs/hpsc/dap/hccis/info.htm


3 This list is not exhaustive; the ACA included many changes to the insurance landscape, nationally and in Minnesota.


6 Prior to 2011, this was 101 percent; however, the Budget Control Act, decreased Medicare payments 2%. This type of reduction in payment is sequestration. Following this act, CAHs no longer receive the full 101% percent reimbursement for their inpatient and outpatient services. Other rural and urban hospitals have a prospective payment system (PPS) of reimbursement, where they receive a predetermined amount for a set of services related to a diagnosis from Medicare.


9 This excludes revenue by smaller payers, including Workers’ Compensation, TriCare, Indian Health Services and other federal payers.


11 MDH Health Economics Program. 2015. Uncompensated Care in Minnesota Hospitals. Available at http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/HospitalUncompensatedCare15ig.pdf


13 Defined by the Hospital Annual Report, 2015 dataset.


15 This brief does not examine how reimbursement differences between insurance types affect hospital profitability.

16 Before the ACA, adults without children were ineligible for MA. The only public options were a state-funded program (General Assistance Medical Care, or GAMC) for childless adults ineligible for MA and ≤75% FPG and MinnesotaCare for individuals up to 250% FPG. GAMC ended in February 2011 and those enrollees were automatically enrolled in MA.


20 Pre-ACA, the income maximum for MinnesotaCare was 275% FPG for children and families, and 250% for childless adults.
Challenges facing Nursing

Workforce: Regional and national issues related to staffing, labor and stability
Discussion leaders: Amanda Stefancyk Oberlies, PhD, MBA, RN, CEO ONL of MA,RI,NH,CT and VT
Patricia McFarland, MS, RN, FAAN, CEO, Association of California Nurse Leaders

Background

State of the Registered Nurse Workforce as a New Era of Health Reform Emerges by Dr. Peter Buerhaus

This article, featured in the September-October 2017 issue of Nursing Economic$, uses data compiled by the U.S. Census Bureau and the U.S. Department of Education’s National Center for Education Statistics to discuss the following key items regarding the state of the nursing workforce:

- Over the past 15 years, the RN workforce was challenged by a national nursing shortage that exceeded 100,000 RNs, two economic recessions, and implementation of health reforms beginning in 2010.
- At the same time, efforts by private and public entities sought to increase interest in nursing with the result that the number of people awarded undergraduate and graduate degrees in nursing grew dramatically from 2003 to present.
- RN employment also increased by more than 1 million full-time equivalents with growth occurring more rapidly in hospitals vs. non hospital settings; RNs with bachelor's and master's degrees earned considerably more than did those with an associate degree.
- While recent projections indicate growth in the nursing workforce through 2030 will be large enough to replace more than 1 million RNs who will retire over this period, because growth in the RN workforce will be uneven throughout the country, temporary and local shortages vs. large national shortages are expected.
- The nursing profession will need to draw upon its strengths and strong foundation as new health reforms and other challenges bear down on the nursing workforce over the next 15 years.

Nursing Ratios

The first study of the effect of nurse-to-patient ratios on care in California hospitals concludes hospitals have hired more registered nurses, but they've had little effect on two areas of care -- patient falls and bed sores.

There was no statistically significant change in either area between 2002, two years before California's strict nurse-to-patient ratio law took effect, and 2006, according to a study by the California Nursing Outcomes Coalition.

The findings -- strongly disputed by the state's largest nurses' union -- were published in of Policy, Politics & Nursing Practice, a peer-reviewed journal that explores the relationship between nursing and health
policy. The study was paid for by the Association of California Nurse Leaders and the American Nurses Association/California, the two groups that established the research coalition.

The study is significant on a national level because California serves as a bellwether on nurse-to-patient ratios. It was the first, and remains the only, state to enact this kind of law. Efforts have started in at least seven other states.

The landmark California law requires minimum nurse-to-patient ratios for units in all general acute-care

Massachusetts is now facing an initiative battle where garnering 3 percent of the eligible voting population or 70,000 voters could put the ratio question to the voters. California voters were able to defeat the ballot measures on ratios. However immediately following the failed vote, ratio legislation was introduced and passed by California legislators.

Questions

Describe your workforce environment related to the above issues.

How prepared are you to face these issues?

What can AONE do to help you?