Arkansas Healthcare Reimbursement Challenges

08.2024

Arkansas Healthcare Reimbursement Challenges

Purpose

Provide information regarding core economic factors and challenges impacting healthcare providers in Arkansas.

Why you should care

These economic factors have a significant impact on ability of Arkansas health systems to sustainably provide accessible, high-quality healthcare.

Arkansas Healthcare Reimbursement Challenges

Disclaimer

This presentation does not provide "the answer" to the problem as it is a complex situation; however, it brings to light a broader context that is important as we try to solve the funding challenge for our communities and state.

Goal

Make more stakeholders aware of certain underlying realities as if you want to make progress towards something better for tomorrow, it is important to understand where you stand today.

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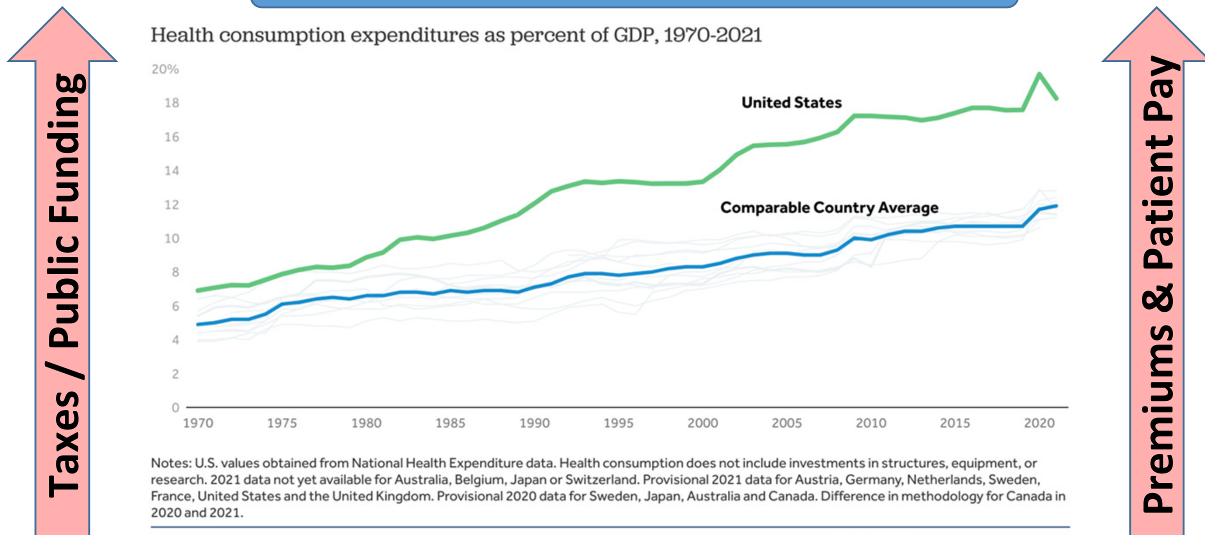
National Experience = Increasing Cost



Source: KFF analysis of National Health Expenditure (NHE) and OECD data

Peterson-KFF Health System Tracker

Is the same true for the various components?

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Operating margin slide

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Why a X% Target?

	FY 2023			
	Budget	Break-even	2%	3%
Operating Income	$ (23,558)	$ -	$ 37,391	$ 56,087
Add: Depreciation	82,803	82,803	82,803	82,803
Add: Interest	16,821	16,821	16,821	16,821
Cash Available from Operations	**$ 76,066**	**$ 99,624**	**$ 137,015**	**$ 155,711**
Less: Debt Payments	(40,300)	(40,300)	(40,300)	(40,300)
Cash Available for CapEx/Other	**$ 35,766**	**$ 59,324**	**$ 96,715**	**$ 115,411**
Cash Available as % Depr	**43%**	**72%**	**117%**	**139%**

EXAMPLE

Uses of Cash from Ops

Debt Payments

Routine Capital Needs
a.k.a. "Keep the Lights On"
Replace existing = 100%+

Mission-Focused Strategic Growth
New Technology
New Services
New Locations

Long-term Savings
Financial Stability
Cash/Invest vs Long-term Debt
Days Cash on Hand (~xxx goal)
Current OpEx = $xx/day

Important for stakeholders to understand

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Health System Payer Mix, Historic Margins & Annual Rate Lift

	% of Patients	Margins	Rate Lift
Medicare	48%	Hospital ~ Cost Physician = Loss	Less than inflation
Medicaid & Uninsured	15%	Loss / Charity	0% (some recent state efforts)
Exchange & Medicaid Expansion	9%	~ Cost	Less than inflation
Commercial & Other	28%	Margin must come from commercial & other	Commercial & Other ~overall CPI (but less than Medical CPIs)

EXAMPLE

Why are margins comparatively low?

Is cost too high?

Is revenue too low?

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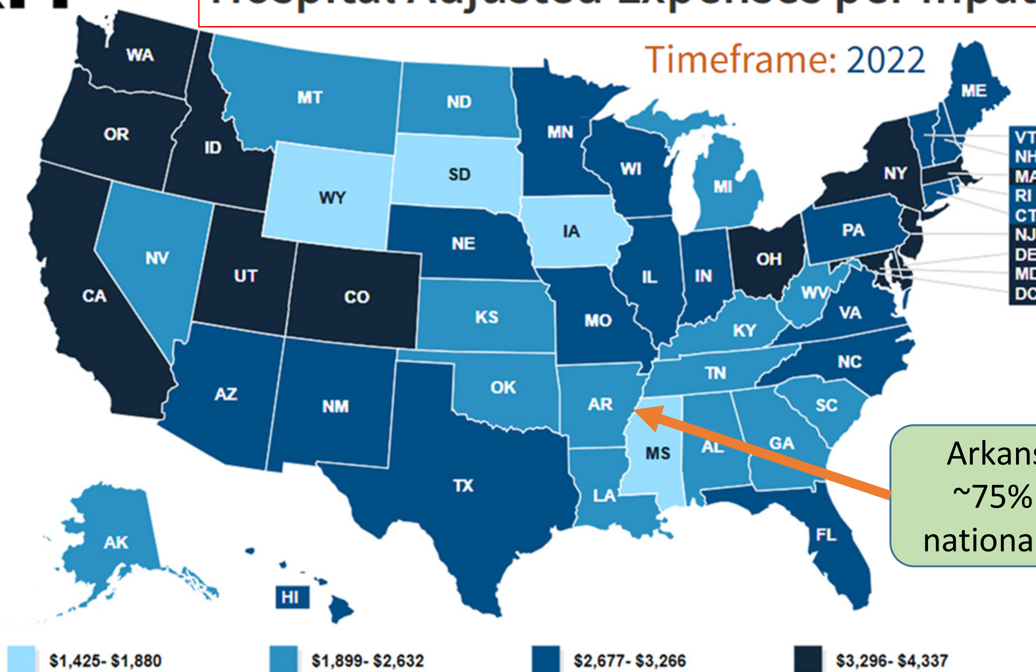

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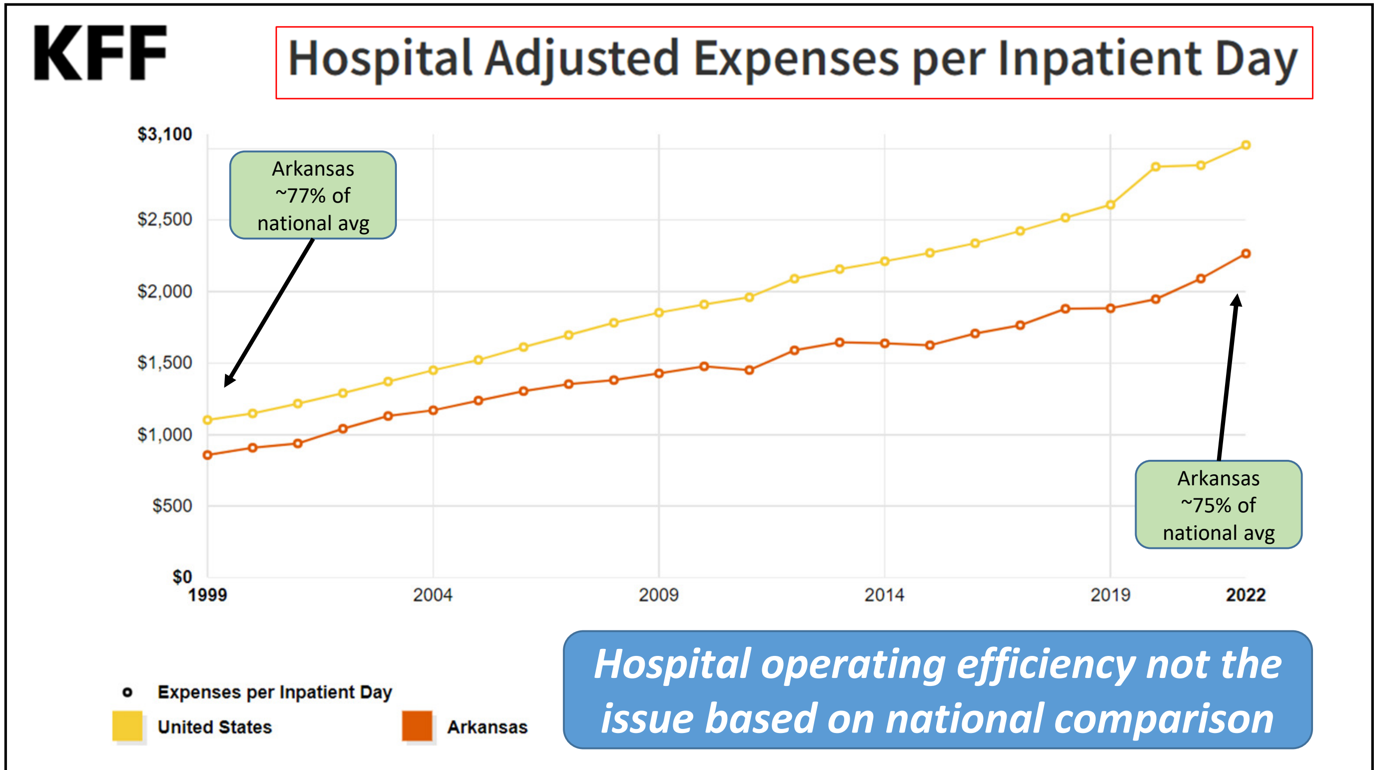

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Early “Aha Moments”

Table 3. Variation Among Metropolitan Areas in the Weighted Average Ratio of Commercial Prices and Medicare Advantage Prices to Medicare FFS Prices for Top 20 DRGs, 2013

	Weighted Average Ratio of Commercial Prices to Medicare FFS Prices for Top 20 DRGs	Weighted Average Ratio of Medicare Advantage Prices to Medicare FFS Prices for Top 20 DRGs
Percentile		
10th	1.44	0.98
25th	1.65	1.00
50th	1.88	1.01
75th	2.16	1.03
90th	2.48	1.06
Ratio		
10th to median	0.77	0.97
90th to median	1.32	1.05
75th to 25th	1.31	1.03
90th to 10th	1.72	1.08
Number of MSAs in Analysis	137	196

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Early "Aha Moments"

10 metro areas with the highest, lowest overall healthcare prices

Kelly Gooch - Tuesday, March 12th, 2019 Print | Email

San Jose, Calif., has the highest overall healthcare prices among U.S. metropolitan areas in 2016 compared to the national average, according to an interactive report from the Health Care Cost Institute.

To determine the highest and lowest overall healthcare prices, researchers examined about 1.8 billion commercial insurance claims and compared the average price paid for the same healthcare service across 112 metropolitan areas. The report used price level benchmarks from 2012 to 2016.

Ten metropolitan areas with the lowest overall healthcare prices in 2016, relative to the national median:

1. Baltimore
2. Little Rock, Ark.
3. Youngstown, Ohio
4. Pittsburgh
5. Louisville, Ky.

https://www.beckershospitalreview.com/finance/10-metro-areas-with-the-highest-lowest-o... 5/2

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Arkansas Healthcare Reimbursement Challenges

Commercial Rate Challenge *(developed over many years)*

- Reimbursement increases have lagged cost increases for many years
- Physician cost has shifted to hospital over past 15 years
- Medicare, Medicaid & Uninsured losses impact statewide system *(long-term community access challenge; Medicaid expansion helped)*
- Shift from Medicare to Medicare Advantage adds pressure
- Data shows ____ compares well on quality and cost *(local and national)*

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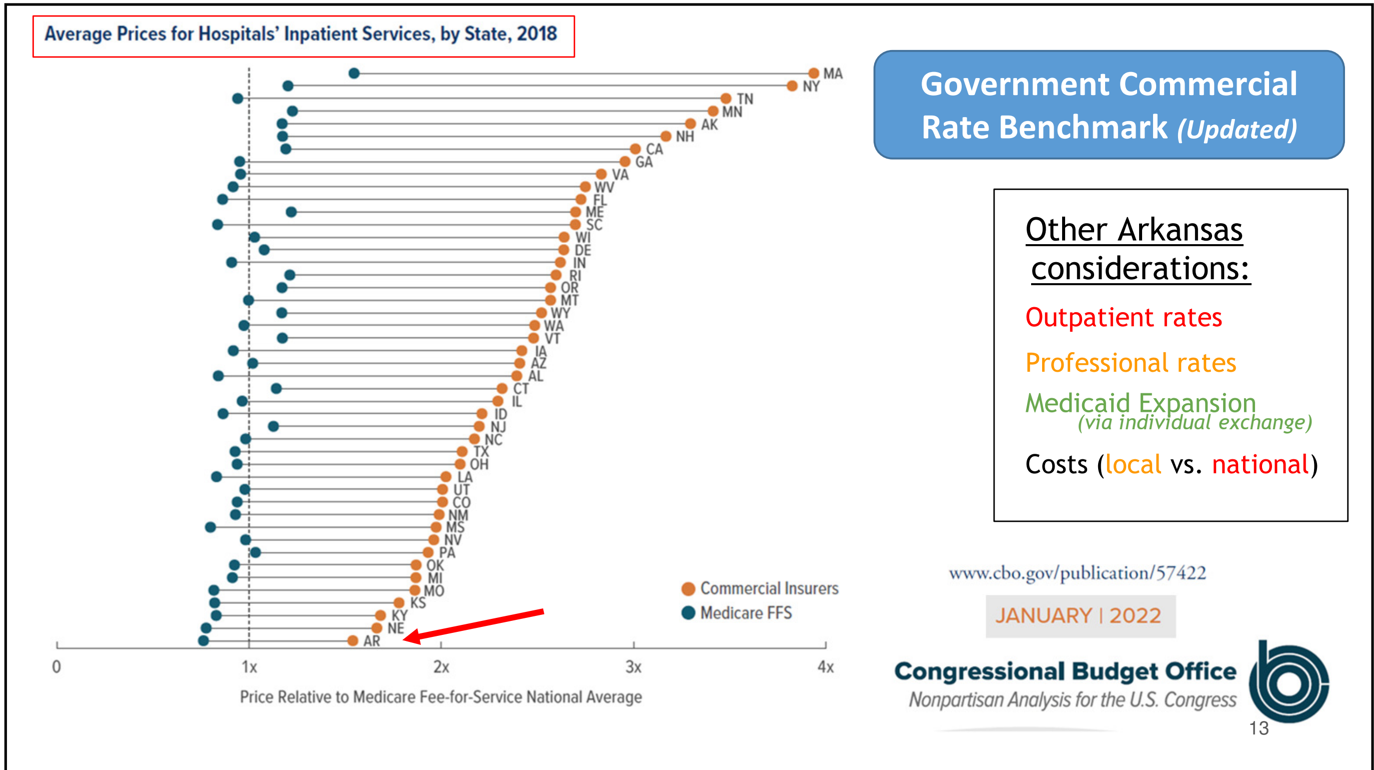

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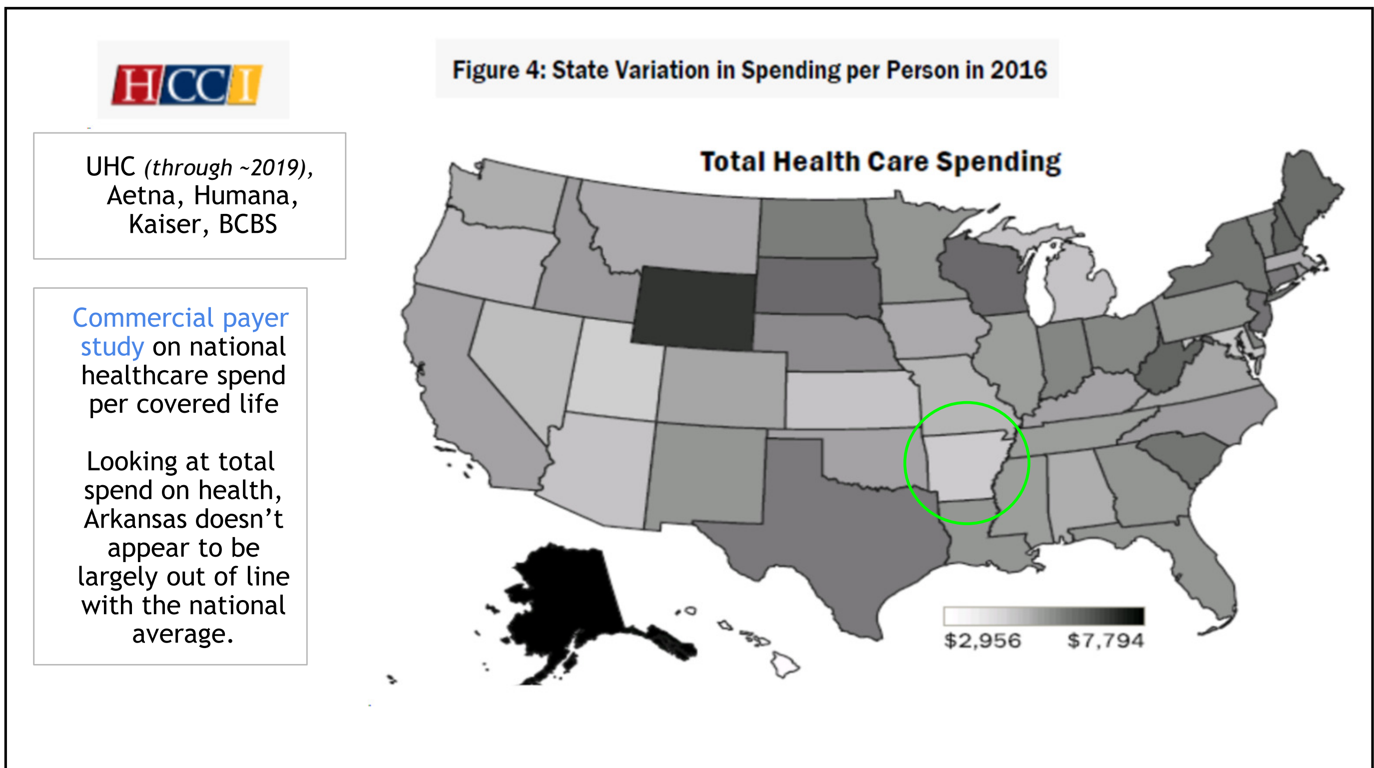

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UHC *(through ~2019)*, Aetna, Humana, Kaiser, BCBS

Commercial payer study on national healthcare spend per covered life

Looking at spend for hospital services, Arkansas rates = lowest nationally for both hospital categories

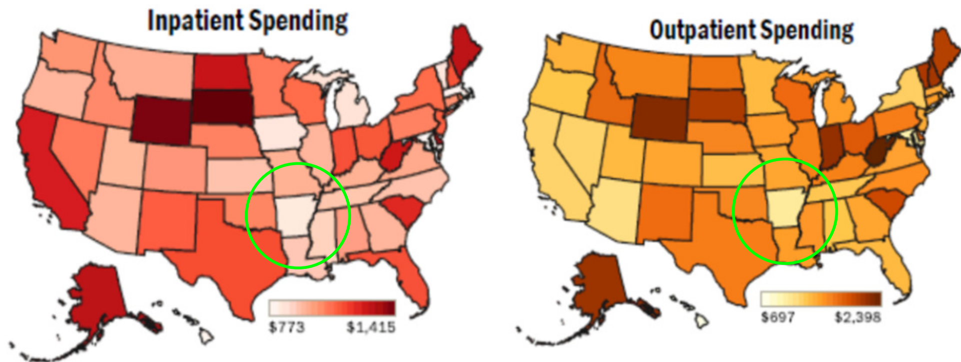

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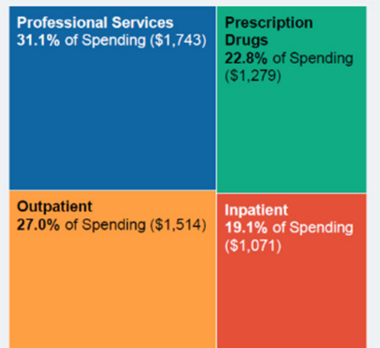
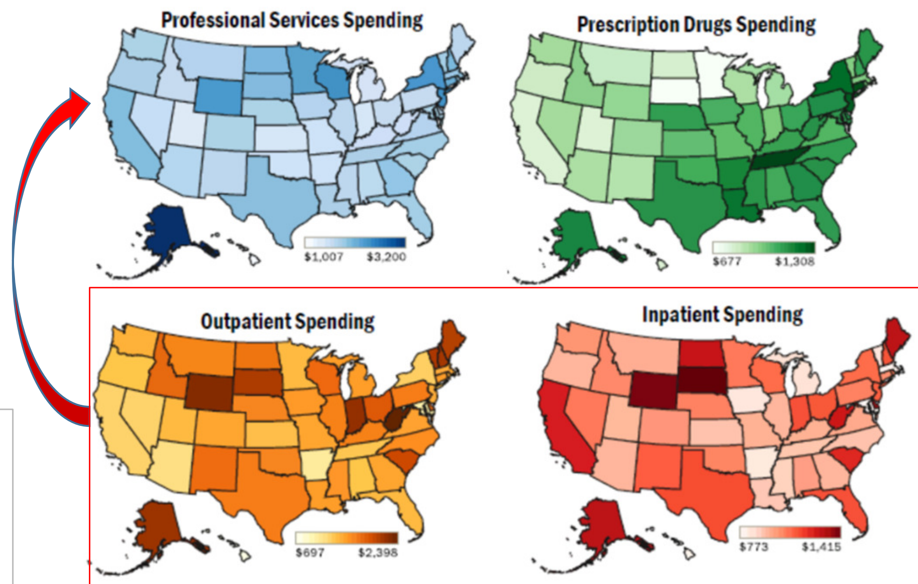
Figure 4: State Variation in Spending per Person in 2016



Hospital funds used nationally to help with community physician needs; however, Arkansas ability to do same limited

Arkansas funds higher than avg on prescription drug spend.



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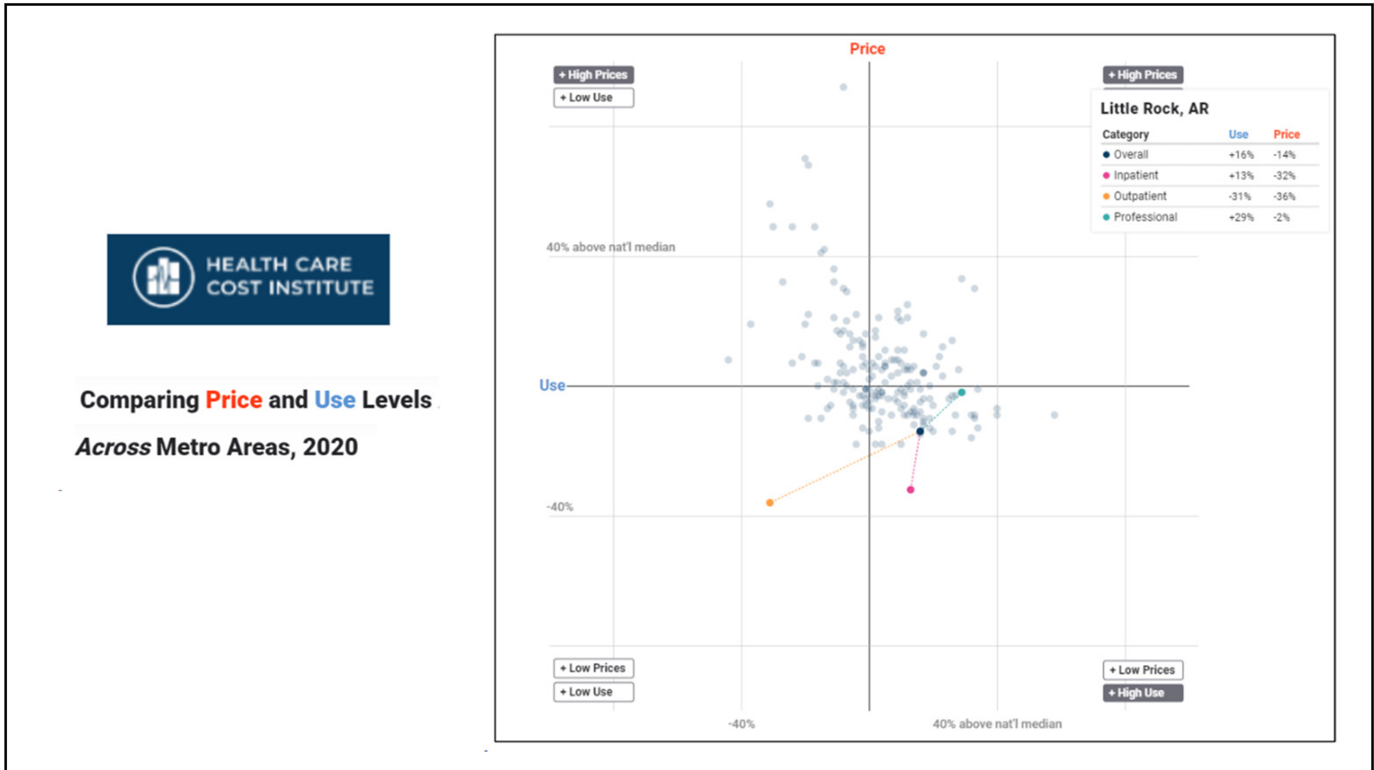

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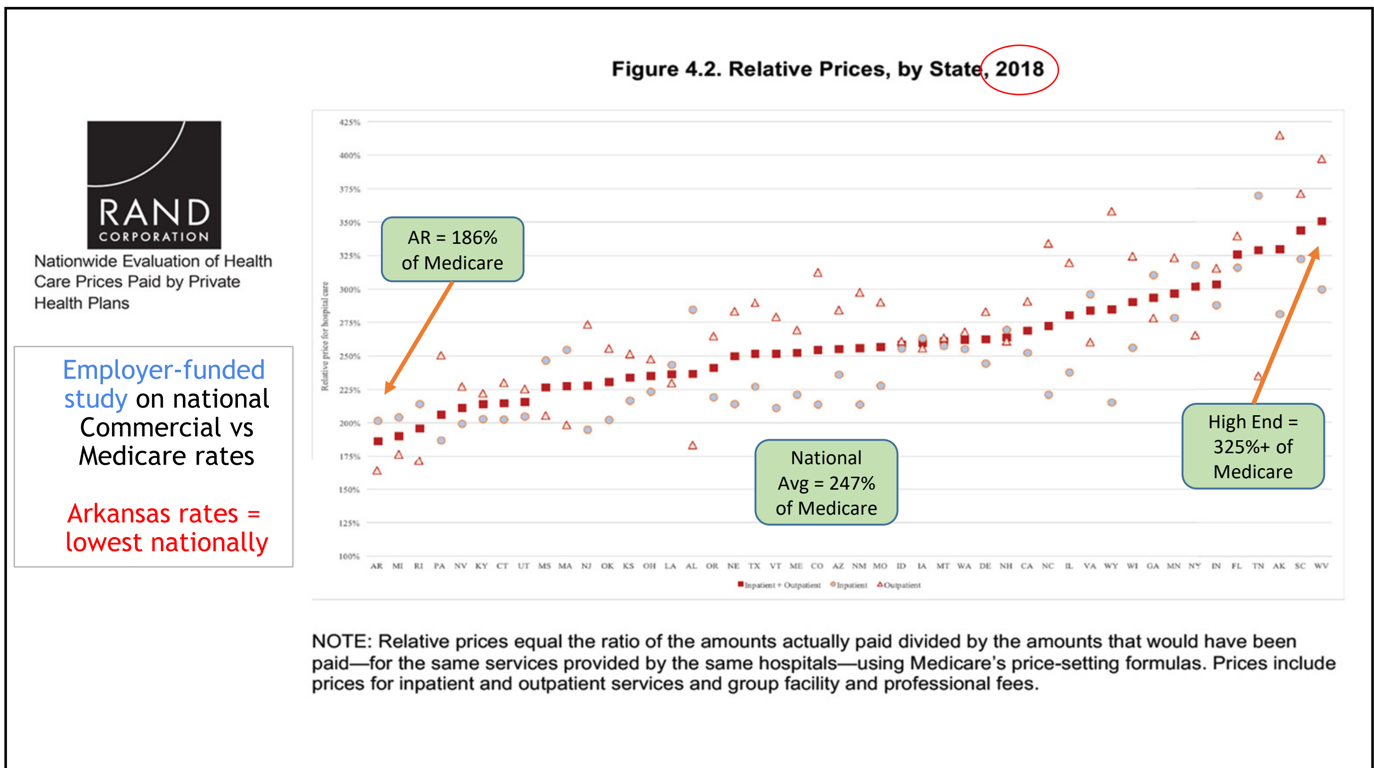

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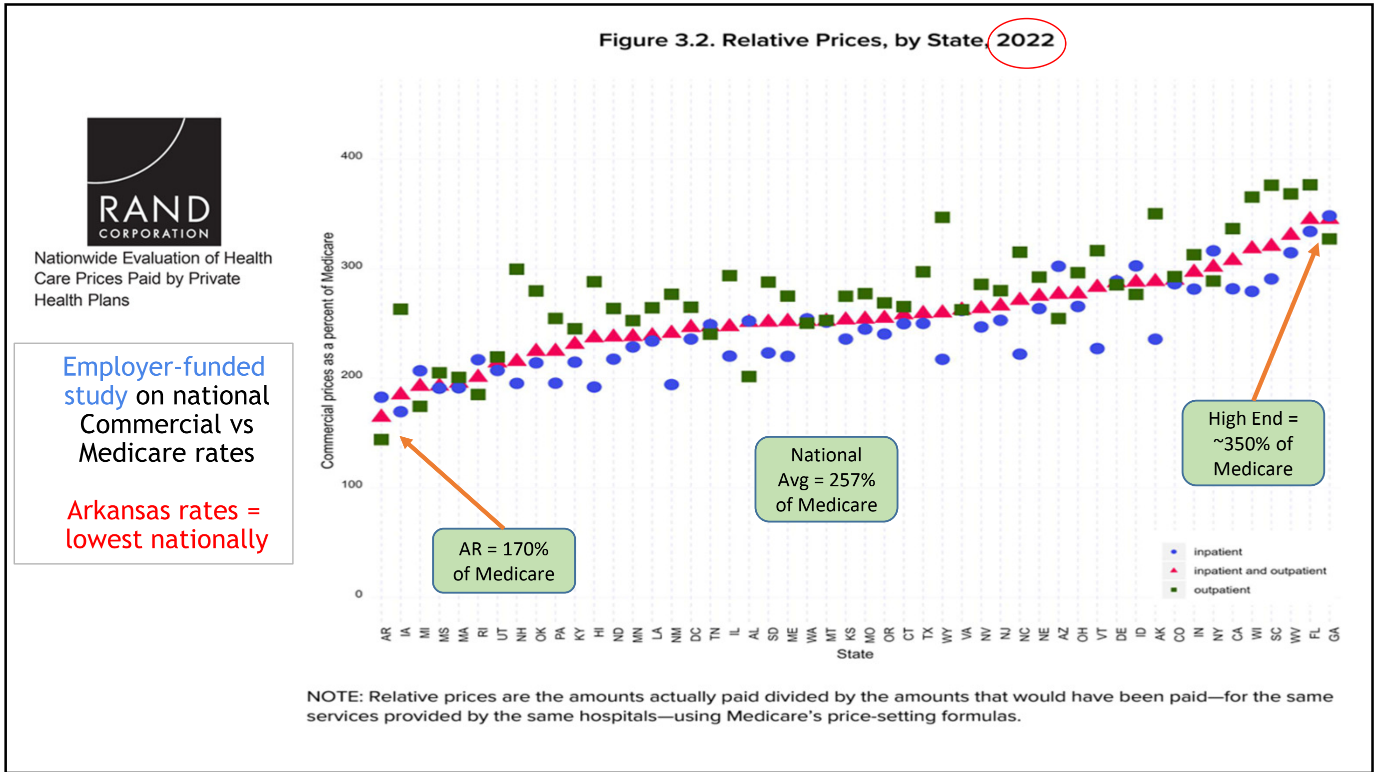

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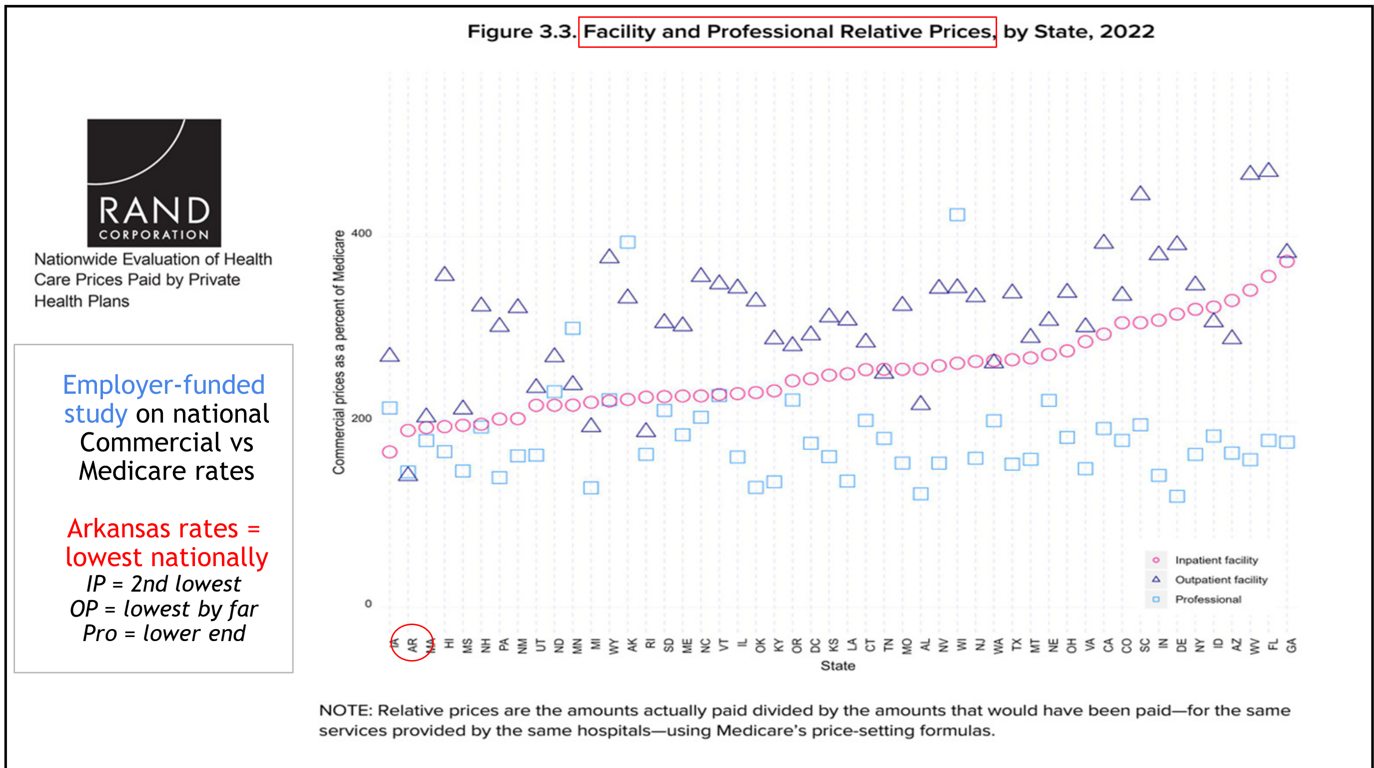

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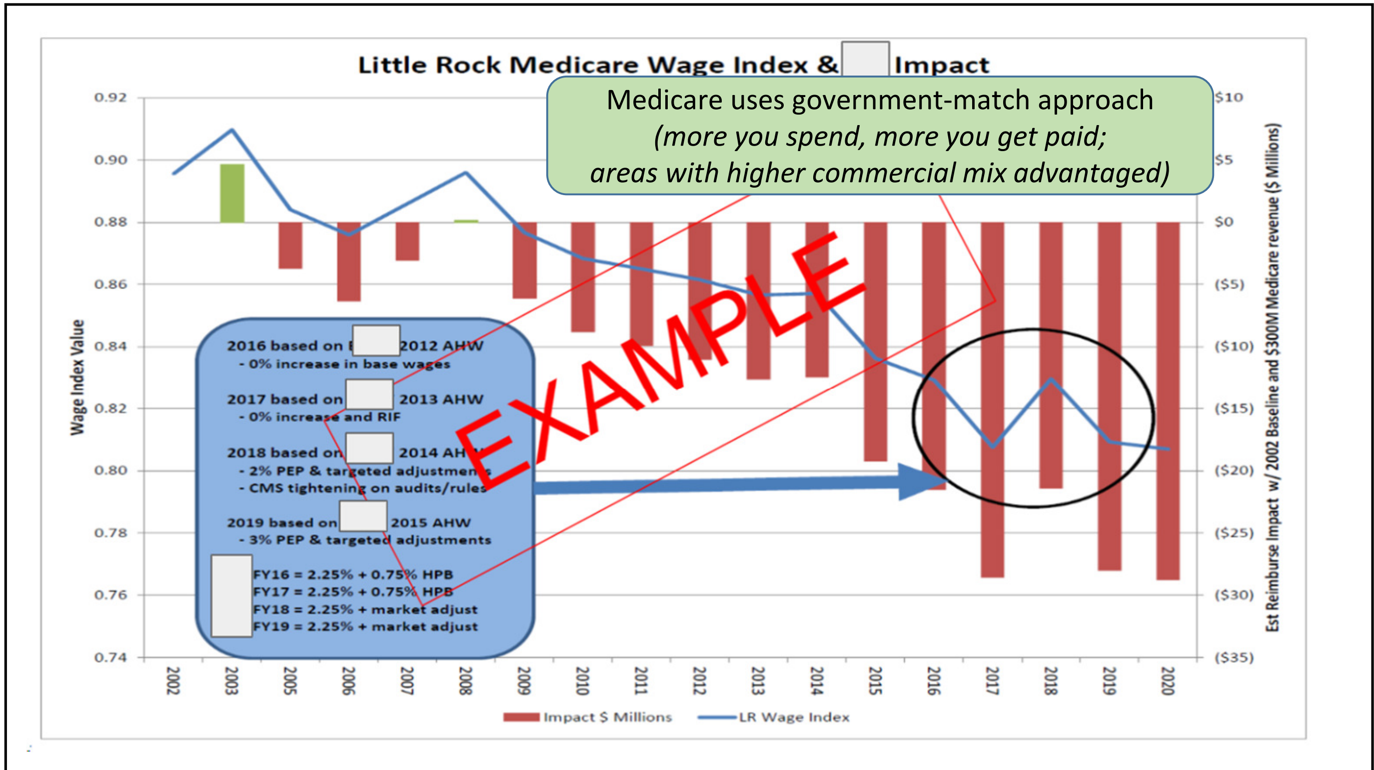

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Medicare Wage Index "Death Spiral"

	IPPS Operating Base Rate		
	FFY 1999	FFY 2019	Annual %
San Francisco, CA			
Wage Index	1.3507	1.7251	1.2%
Labor Portion	2,783	3,856	1.6%
Adj Labor Portion	3,760	6,652	2.9%
Non-Labor Portion	1,313	1,790	1.6%
Base DRG	5,073	8,442	2.6%
Little Rock, AR			
Wage Index	0.8553	0.8114	-0.3%
Labor Portion	2,739	3,501	1.2%
Adj Labor Portion	2,343	2,840	1.0%
Non-Labor Portion	1,113	2,146	3.3%
Base DRG	3,456	4,986	1.8%
Overall Inflation			
CPI-U	163.9	251.2	2.2%
CPI-U Medical Services	249.6	522.5	3.8%

San Francisco vs. Little Rock IPPS Base Rate		
Difference	1,617	3,456
% Difference	46.8%	69.3%

FederalPay.org General Schedule Pay Calculator Example Job: GS-7, Step 5	2019
Pulaski County, AR	47,661
San Francisco County, CA	57,830
Gov calculated cost-of-living diff	10,169
Gov calculated cost-of-living % diff	21.3%

Medicaid benchmarks to Medicare ***(sometimes commercial)***

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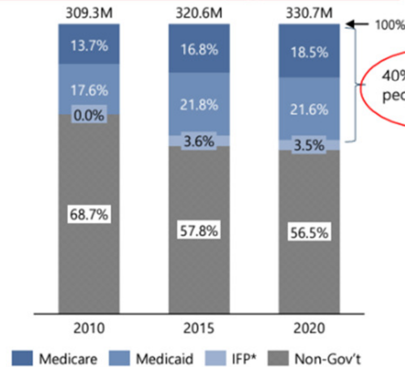
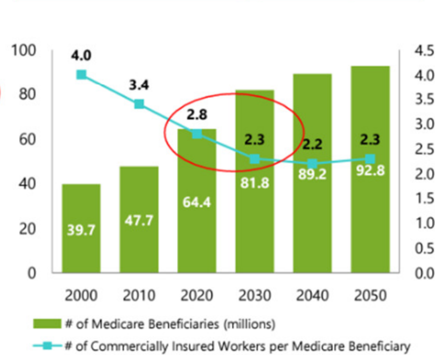
6. Demographic and Legislative Changes

40% of the US population is on Medicare or Medicaid, contributing to 65% of hospital earnings; it is becoming harder to "cost shift" to the dwindling number of commercial enrollees.





- The government will shift risk for managing the total cost of care onto providers.
- Providers with portfolios weighted to (expensive) hospital care will struggle to manage costs.
- Providing services across the care continuum – and being able to effectively manage patients across that continuum – will be necessary.
- Addressing social determinants of health will be critical to success.

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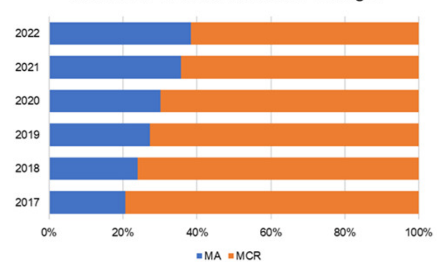
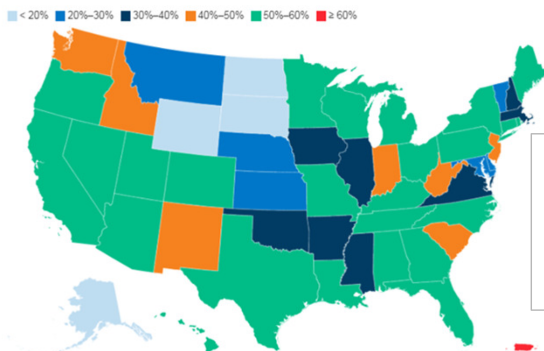
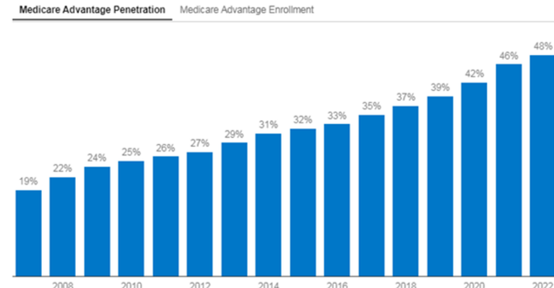
Arkansas has below average MA penetration, but growth rate is double the national average.

From 2019 to 2024, _______ needs to realize a __% increase in commercial rates due to mix changes alone.





Medicare Adv Realization ~85% of traditional Medicare



Source: Kaiser Family Foundation: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/
MA Share is Baptist total charges excluding Fort Smith and Van Buren

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Payers Influencing Patient Care

- Pre-authorization requirements (hospital, post-acute, etc)
- Coverage limitations
- Status denials and changes (unilateral downgrades)
- Coding & documentation inquiries
- Outlier and similar denials (Equian)
- Patient share (burden)

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Payer Margins

Gross Margins Per Enrollee, 2014-2023

Year	Individual Market	Group Market	Medicaid Managed Care	Medicare Advantage
2014	$60	$772	$605	$1,449
2015	–$71	$792	$638	$1,425
2016	$192	$813	$590	$1,698
2017	$835	$860	$541	$1,608
2018	$1,526	$911	$621	$1,726
2019	$1,168	$830	$584	$1,815
2020	$1,366	$958	$832	$2,266
2021	$745	$689	$768	$1,730
2022	$852	$864	$804	$1,977
2023	$1,048	$910	$753	$1,982

Note: Gross margins per enrollee are the amount by which total premium income exceeds total claims costs, divided by the number of enrollees. Gross margins include administrative costs, tax liability, and profits.

Source: KFF analysis of Exhibit of Premiums, Enrollment and Utilization data from Mark Farrah Associates Health Coverage Portal TM • Get the data • Download PNG

KFF

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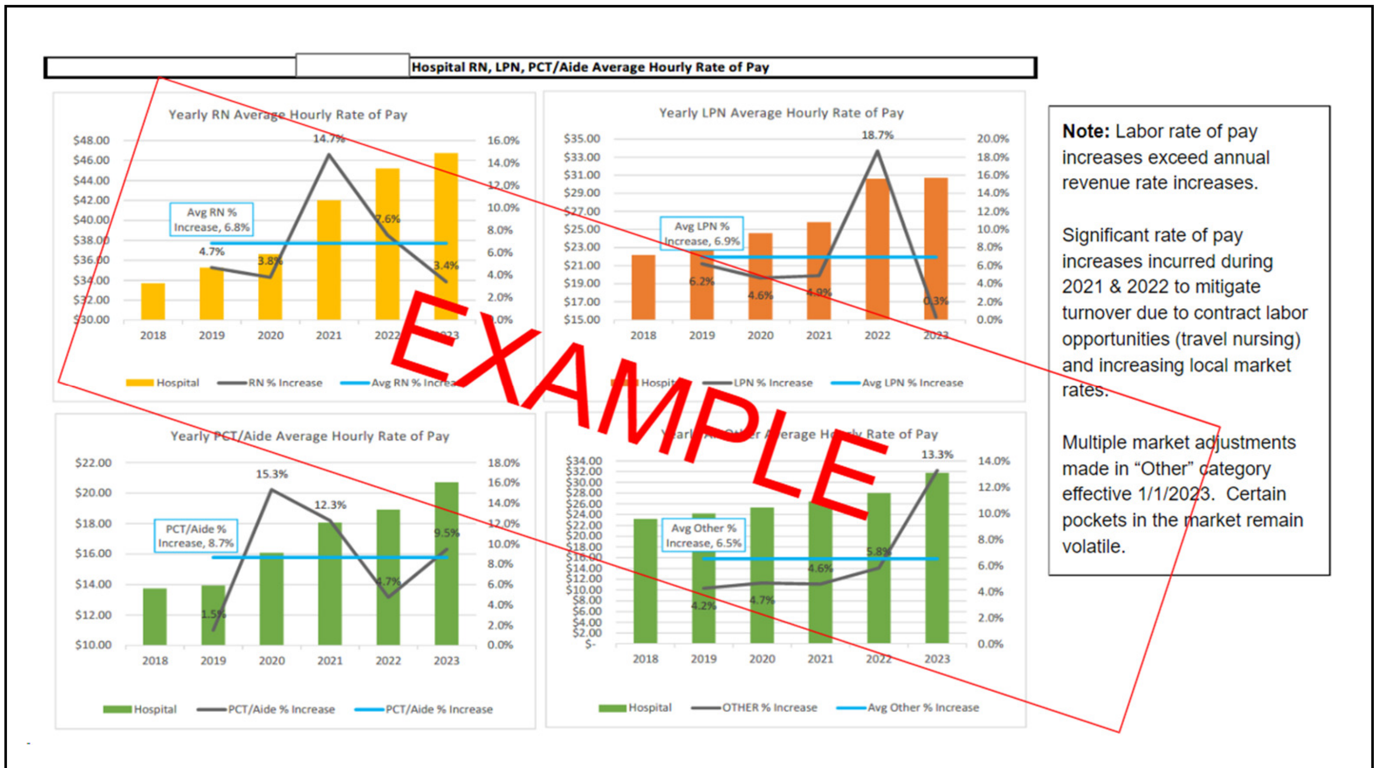

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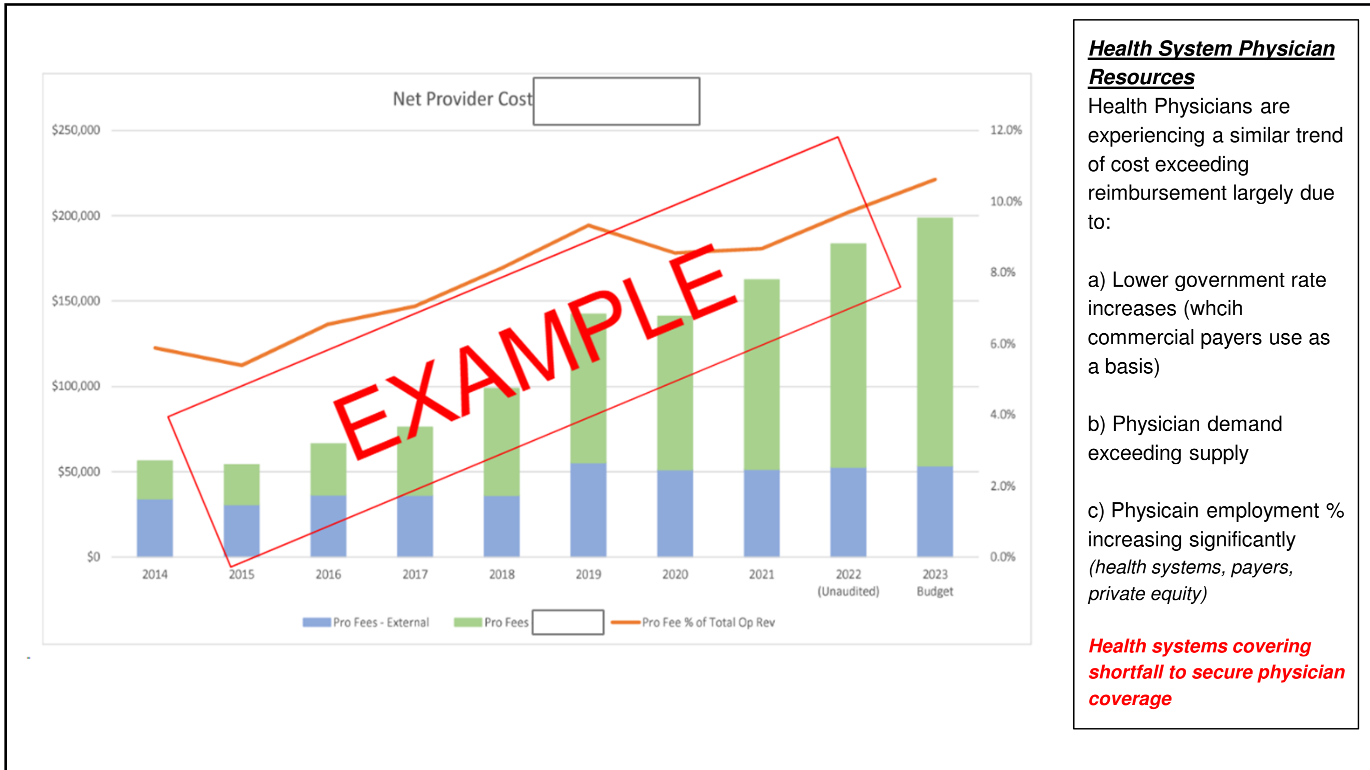

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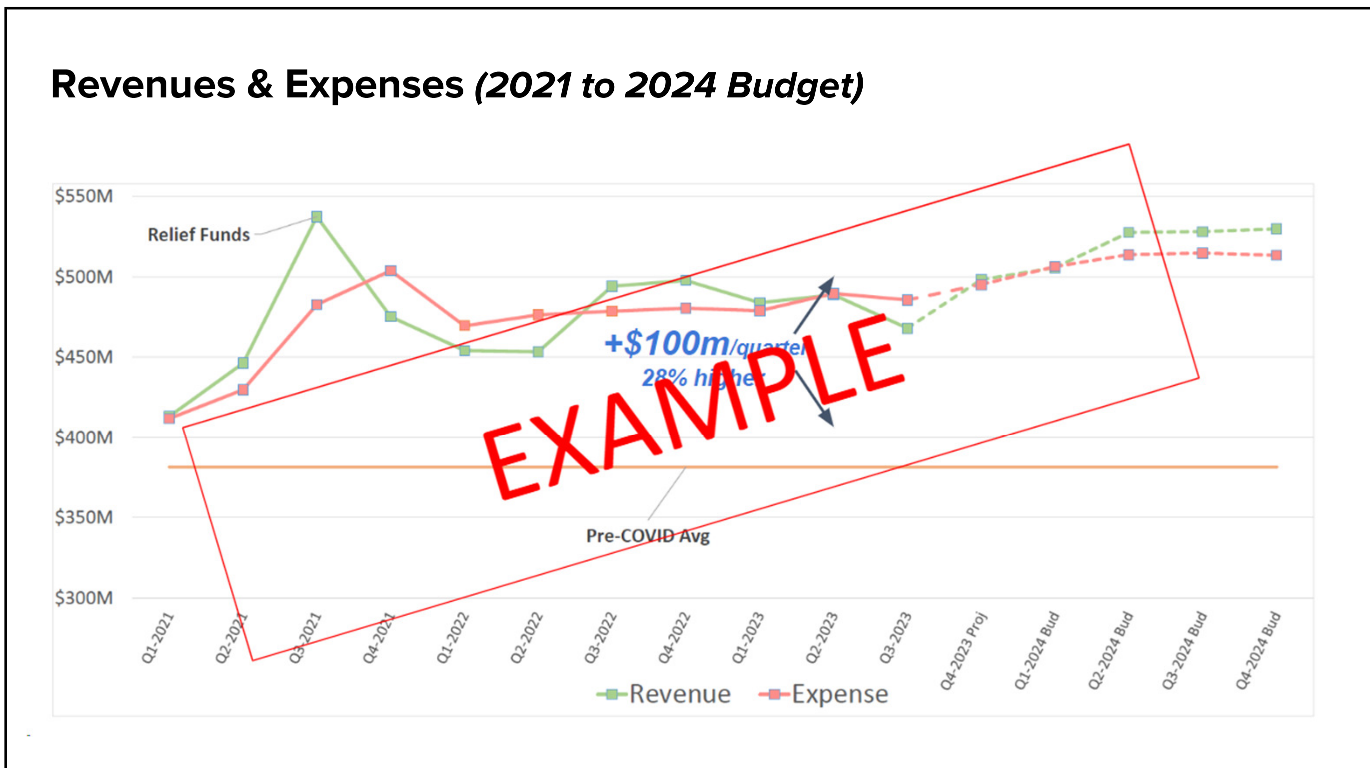

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CHI National Investor Call:

Arkansas "Low cost, but tough rate market"

Catholic Health Initiatives Operations Summary – Six Months Ended December 31, 2018 and 2017

Region *($ in thousands)*	YTD 12/31/2018 Operating EBIDA before restructuring, impairment and other losses	YTD 12/31/2017 Operating EBIDA before restructuring, impairment and other losses	YTD 12/31/2018 Operating EBIDA margin before restructuring, impairment and other losses Unaudited	YTD 12/31/2017 Operating EBIDA margin before restructuring, impairment and other losses	YTD 12/31/2018 Operating revenues percentage of CHI consolidated	YTD 12/31/2017 Operating revenues percentage of CHI consolidated
Pacific Northwest	$127,992	$155,548	9.1%	11.4%	18.6%	18.2%
Colorado	170,989	141,003	13.9%	11.8%	16.3%	15.9%
Texas	79,349	38,873	6.7%	3.6%	15.6%	14.4%
Nebraska	80,877	129,114	7.9%	12.5%	13.6%	13.7%
Iowa	36,200	29,284	6.9%	5.7%	6.9%	6.8%
Kentucky	47,932	52,449	9.2%	9.5%	6.9%	7.3%
Ohio	8,032	13,857	2.0%	2.4%	5.3%	7.5%
Arkansas	(17,165)	2,867	(4.3)%	0.8%	5.3%	5.0%
North Dakota/Minnesota	18,833	39,189	5.2%	10.4%	4.8%	5.0%
Tennessee	30,114	33,094	8.6%	10.0%	4.6%	4.4%
National business lines[1]	22,633	14,763	11.9%	10.0%	2.5%	2.0%
Other[2]	(10,172)	(41,213)	N/A	N/A	(0.4)%	(0.2)%
Total Regional	595,614	608,828	7.9%	8.1%	100.0%	100.0%
Corporate services and other business lines[3]	(108,515)	(73,762)	N/A	N/A	0.0%	0.0%
Total CHI Consolidated	$487,099	$535,066	6.4%	7.1%	100.0%	100.0%

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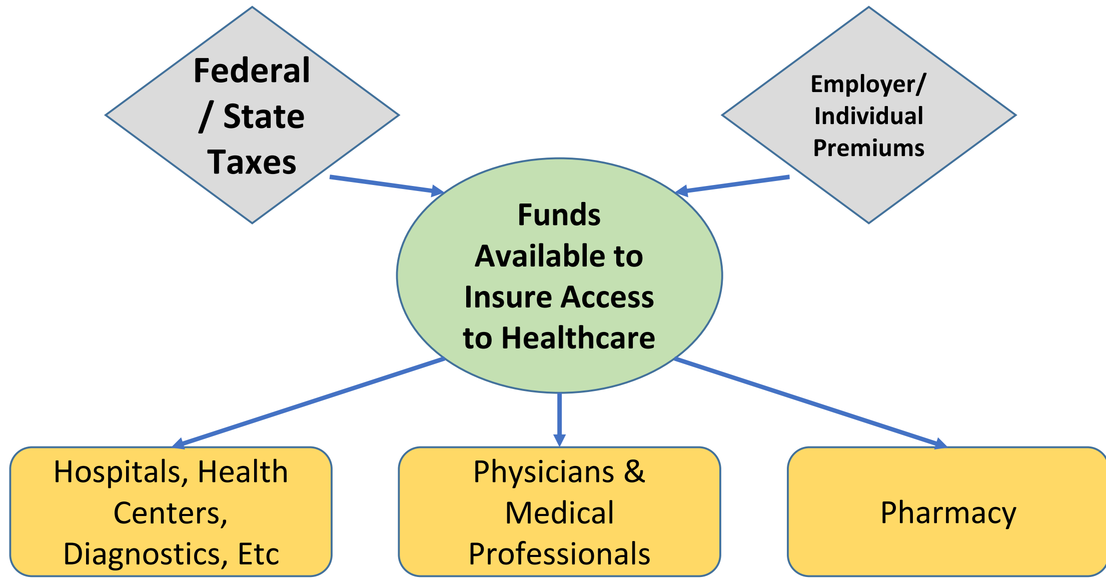

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Average Employer Premiums

Arkansas
Trends in Employer Insurance Costs, 2008–2017

The Commonwealth Fund

	2008	2011	2016	2017
Employer-Sponsored Insurance Premium Cost				
Single coverage				
Arkansas	$3,923	$4,392	$5,341	$5,722
United States	$4,386	$5,222	$6,101	$6,368
Family coverage				
Arkansas	$11,220	$12,474	$14,929	$16,663
United States	$12,298	$15,022	$17,710	$18,687

AR ~90% U.S. Avg

Annual Avg Change
CY2008 – 2017
AR = 4.5%
US = 4.8%

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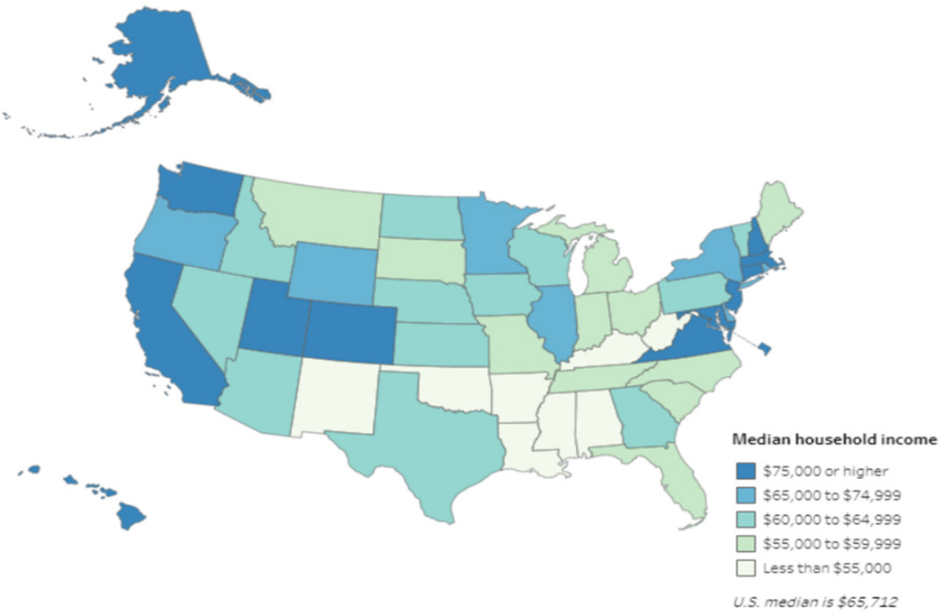
2019 Median Household Income in the United States



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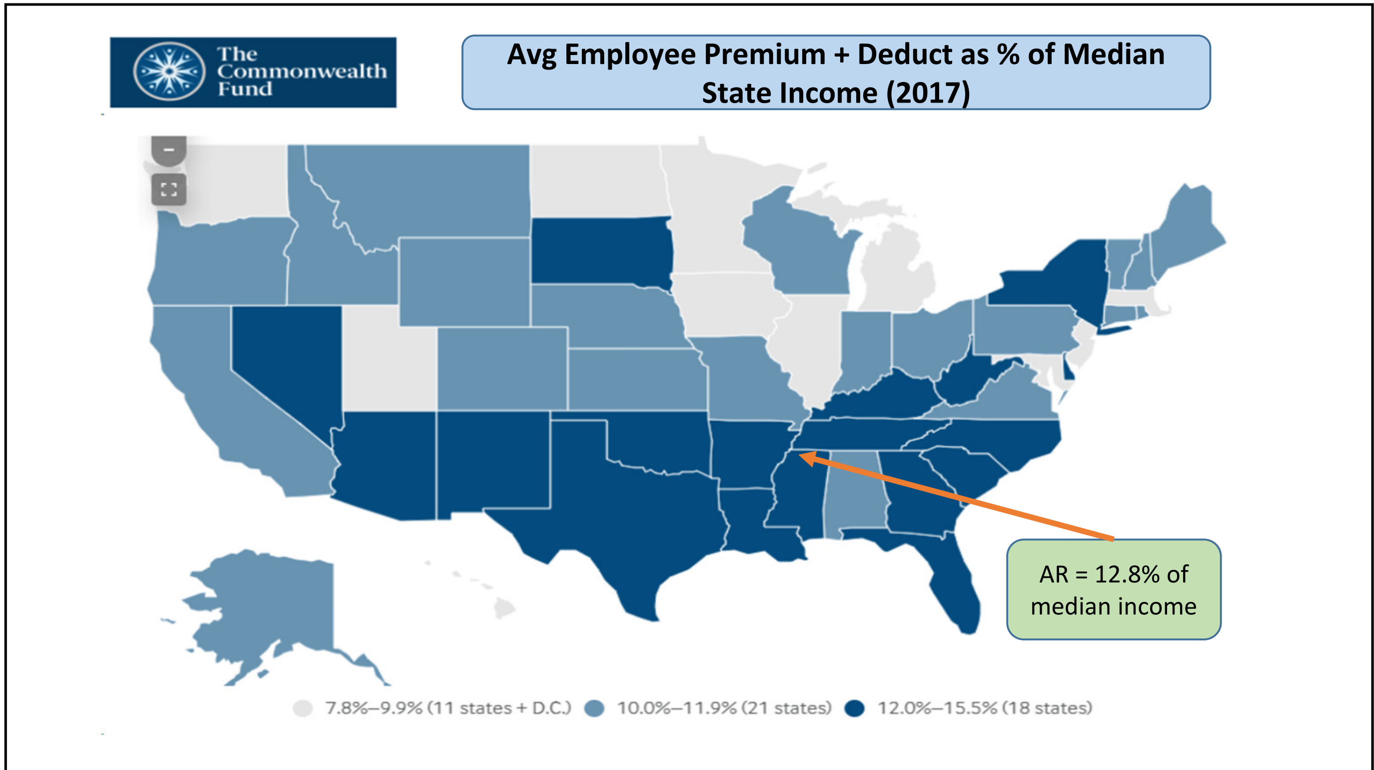

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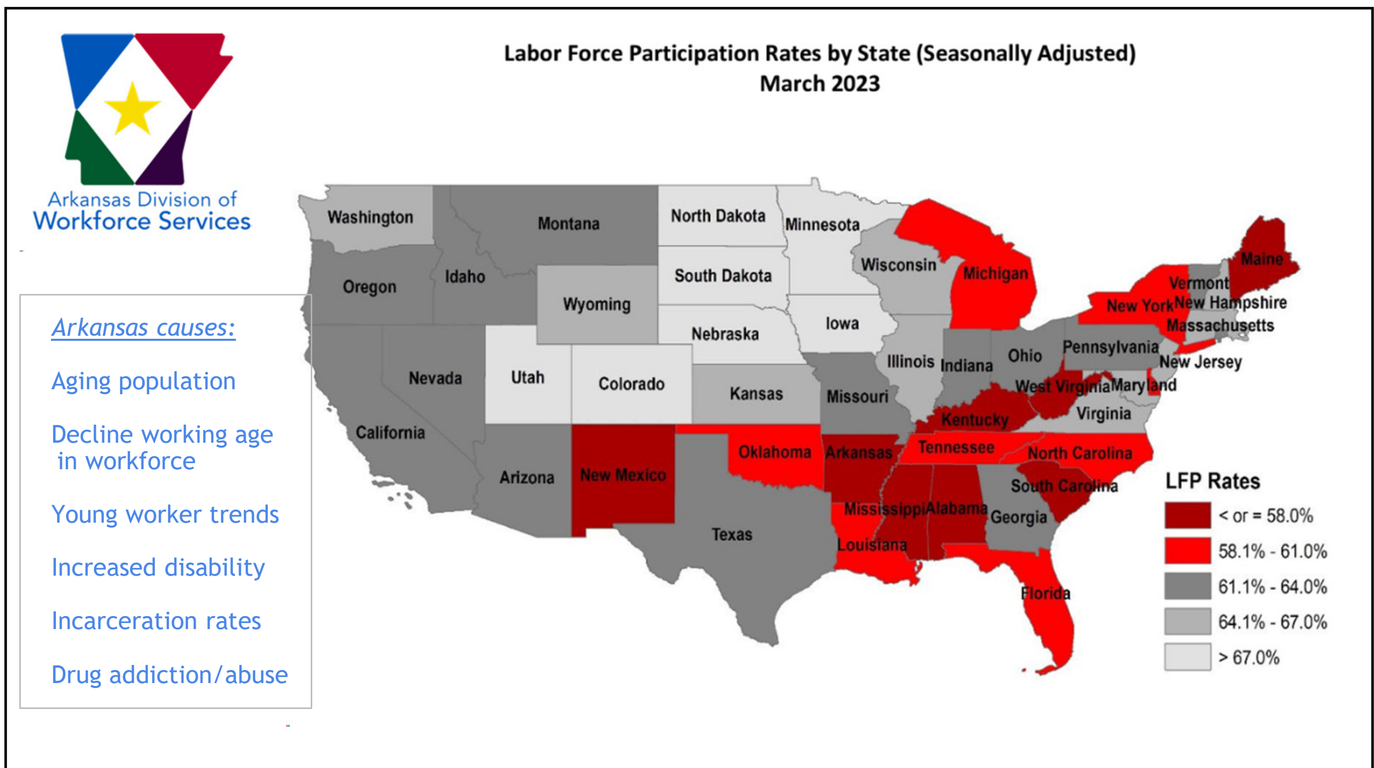

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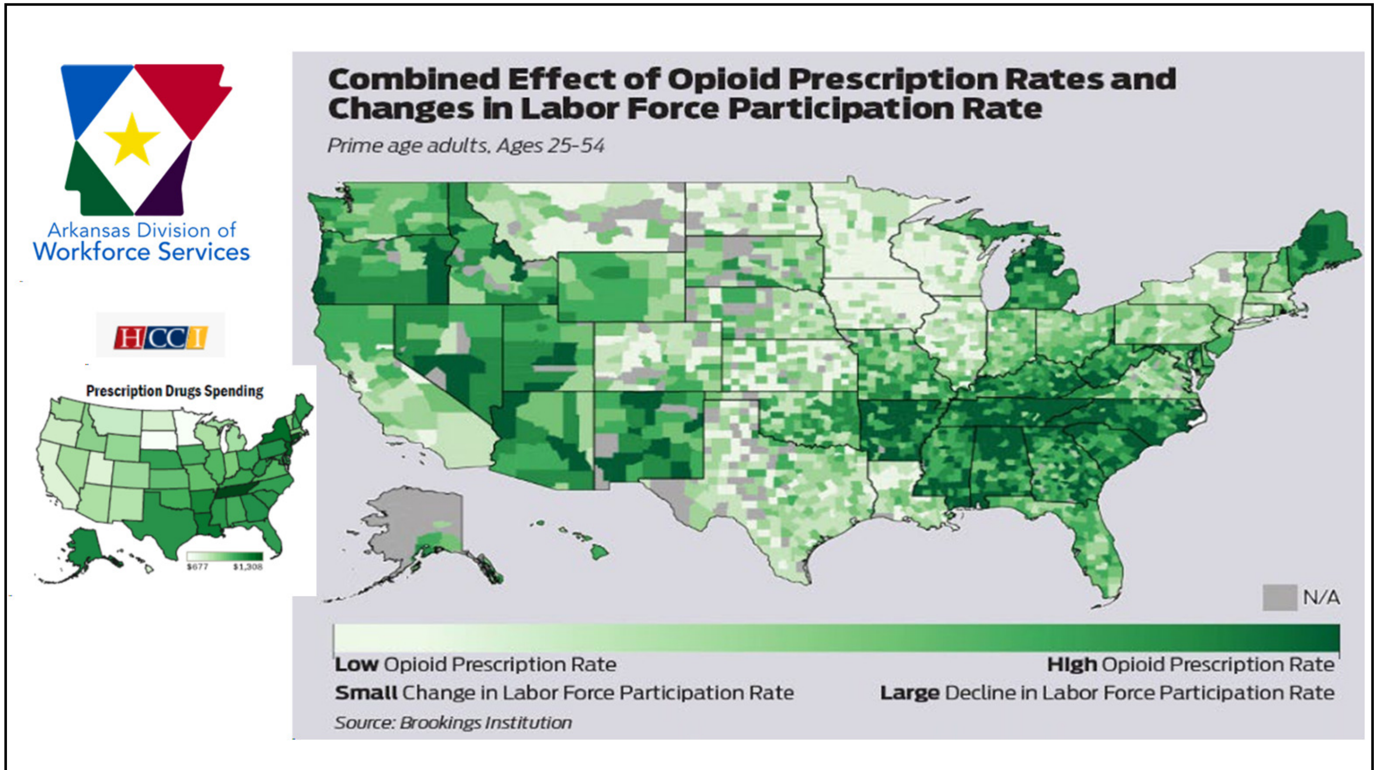

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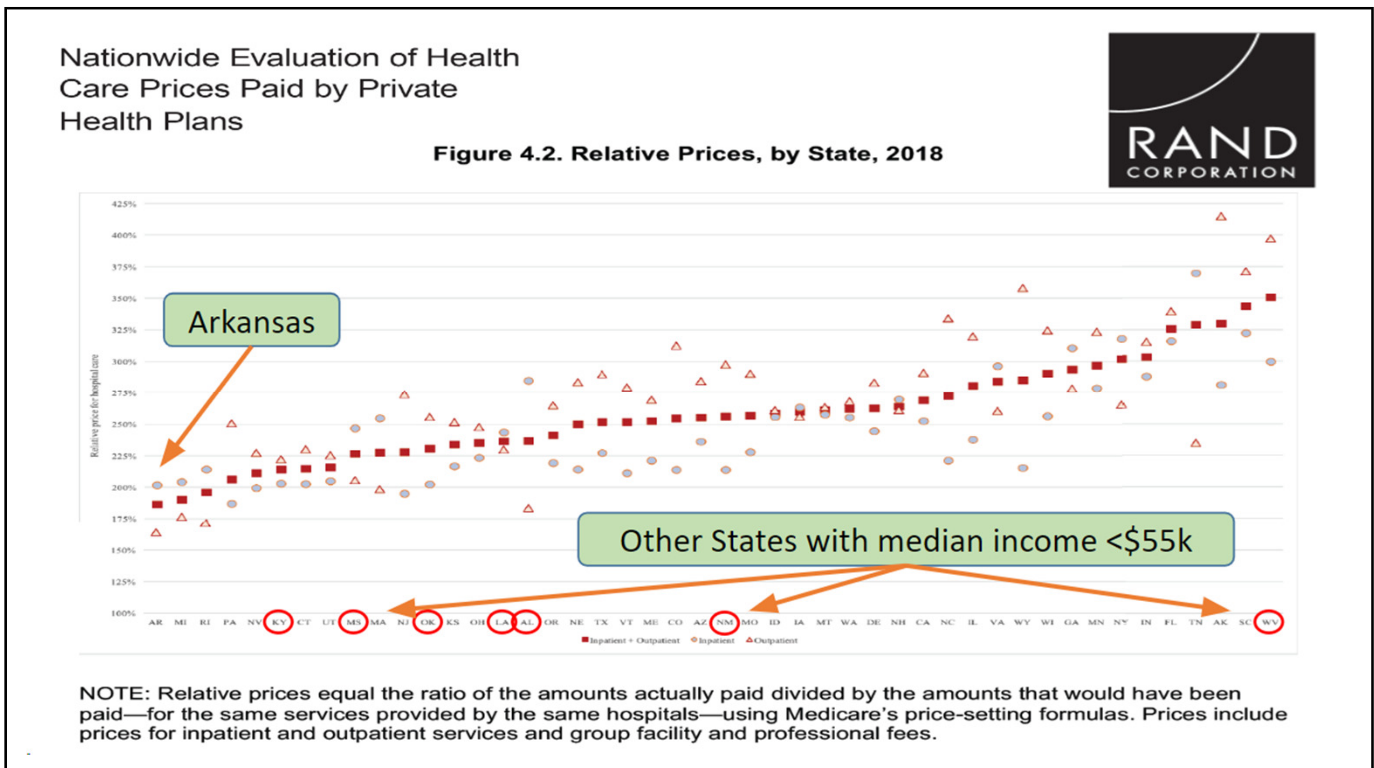

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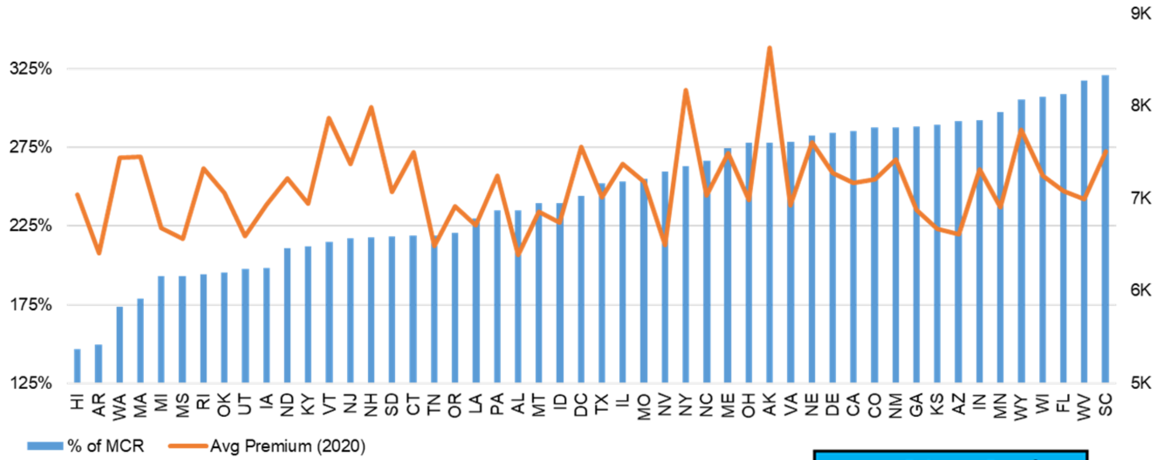
Premiums are not correlated with reimbursement rates

(when premium set using multi-state spend, Arkansas portion of premiums subsidize healthcare in other states)



	Rates	Premiums
MS	+62%	+2%
MO	+92%	+12%
TN	+70%	+1%

*Annual premiums by state from Kaiser Family Foundation
**Commercial Reimbursement from RAND

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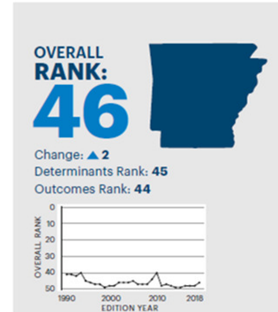
Key Take-Aways

1) *Arkansas hospitals face a unique and difficult challenge that has developed over many years*
2) *Getting to national average payer rates would be very difficult, and may not be the right big-picture goal considering national drive to reduce cost*
3) *Value-based care is very important for sustainbility, but addressing underlying service rates must also happen to remain competitive nationally, and achieve broader community goal*
4) *Will require creative strategic approach working with other providers, and we need payers to understand and participate*
5) *Different level of efficiency & effectiveness required for Arkansas to succeed*

Arkansas



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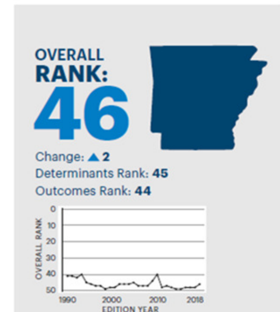
Education, Advocacy & Other Considerations

1) *Regulatory advocacy (AHA, local and national representatives)*
2) *Stakeholder education (health system board & leaders, employers, government, community leaders)*
3) *Payer Relations (finance, rev cycle, legal)*
   - *Payer education & collaboration (facility & professional pricing, structure, process, value-based focus)*
   - *Medicare Advantage efforts (experience/data transparency)*
   - *Innovative approaches to core (patient/provider/employer friendly)*
4) *Significant Value-Based Care efforts*

Arkansas



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