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Local County Hospital: A Review of Challenges and Opportunities

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There are multiple factors regarding current health care delivery in the U.S. These factors include the high-priced medical care, hospitals, equipment, and pharmaceutical charges, and the private system of health insurance.

This discussion looks at these factors' impact on Local County Hospital ranging from Obamacare to a host of other challenges. The hospital is going through difficult times as it struggles to make ends meet. Although it will take time to adjust to an inconsistent environment and changing health care industry, Local County Hospital continues to focus on the patients first and attempts to keep the region healthy.

INTRODUCTION

In the United States, there is not a system of socialized medicine in which the government manages the health care system. Rather multiple factors set the United States' health care at a higher quality and efficiency. These factors include the higher priced medical care where patients are offered multiple treatments as well as pay their doctors, hospitals and pharmaceutical higher amounts than in other countries (Smith et al., 2009). Americans have access to facilities, like Local County Hospital (LCH), with beautiful architecture, terrazzo floors, and comfortable rooms containing art work and plants. These benefits come at a price to patients.

LCH's service area covers 35 Texas counties with a population of 1.5 million people in a predominately rural region. Services provided by LCH are delivered by home health care facilities located in all 35 counties, 18 clinics, 12 rehabilitation centers and seven hospitals including one trauma center.

Research finds that healthcare patients in the region are older, more obese, poorer, less educated and have a higher mortality than the average healthcare patient in the State (Lakey, 2016). Lakey also reports that in addition to accidents, the leading causes of death in the region include heart disease, cancer, stroke and respiratory issues.

The following discussion covers several specific items, processes and funding sources that impact American health care costs using LCH as an illustration.

HEALTH CARE SERVICES

President Obama signed the Affordable Care Act (ACA) bill, known as Obamacare in 2010. Obamacare introduced comprehensive health insurance reforms that were put into effect gradually with some provision implemented immediately but with most changes implemented by 2014 (HealthCare, 2011). Benefits gained by LCH were raises in Medicaid as well as Medicare payment rates for primary care (HealthCare, 2011) that allowed a greater utilization of primary care providers rather than specialists.

Because the ACA included third-party reimbursement system reform, insurance providers have requirements regarding the utilization of their profits (HealthCare, 2011). Under the Act, insurance providers are not able to turn away patients due to pre-existing conditions (Smith et al., 2009). The ACA also provides tax credits for small businesses and not-for-profit organizations that provide insurance to their employees (HealthCare, 2011). The small businesses and organizations use these funds to supply additional coverage for retired workers (Scott, 2017). However, should Congress repeal the ACA, 23 to 32 million fewer people will have health insurance (Angerer, 2017).

Sixty-eight percent of medically underserved communities in the nation are in rural areas known as Rural Health Care Clinics (RHC) (Schulte et al., 2017). LCH is a large medical provider located in an extended area including subsidiary RHC affiliates of which several are suffering financial stress. These RHCs are not facilities that can or should be closed because they supply medical care to people in rural areas that are too far away from comprehensive facilities to obtain treatment. Due to the lack of resources, LCH's rural hospitals have cut back on their emergency services and reduced previously provided services. This makes it difficult for rural communities to have access to health care providers because patients tend to be older and less able to travel. Due to lack of specialty and funding, RHCs also have become less marketable to qualified doctors and certified staff. In prior years, LCH spent a significant amount paying ER doctors for loss salary allocation because the doctors could not earn a competitive salary at the RHC facilities. LCH abandoned these practices because it is less expensive to transport patients to the main Hospital's trauma facility than subsidizing doctors at the RHCs.

Under the Obamacare Act, more than 40 million Americans have access to affordable health care coverage (RHRP, 2017). With this benefit, Americans need not avoid health care because of unaffordability. This benefits LCH substantially because less than 1% of the current service costs are recovered from uninsured, self-paying patients. Most of these service charges are written off to charity (see Exhibit 2).

Despite the numerous benefits from Obamacare, there are many concerns with the current discussion of change or repeal of the ACA. Rural hospitals are struggling with budgets that are based on the massive influx of poor people. Since 2010, 81 of the more than 1800 rural hospitals in the U. S. closed (Schulte et al., 2017). An increase of uncompensated care may not be stainable for rural health care facilities should the ACA provisions be reduced as more rural hospitals would cease providing services (Schulte et al., 2017; Angerer, 2017; Armour, 2017)

ACA alleviated the hardship on rural hospitals by supplying additional Medicare and Medicaid reimbursements. Borochin and Golec (2016) claim the ACA services cost the government billions of dollars. If the ACA services continue to be funded, the federal U.S. deficit will increase (Armour, 2017).

Another concern is the *luxury treatment* of patients together with the record keeping and funding systems used to classify patient illnesses (Zelman et al., 2014).

DIAGNOSIS RELATED GROUP (DRG) ISSUES

The diagnosis-related group (DRG) is a system used by Medicare and private insurers to classify patients based on their diagnoses (Zelman et al., 2014). DRG charges represent the average resources needed to treat patients in that DRG group (Zelman et al., 2014). Currently approximately 1,000 DRGs are used by LCH and other health care providers to bill for their services.

DRGs are fixed fees determined by Medicare based on the actual procedures, expected length of stay, age of patient, and the principal diagnosis. They are assigned *weights* that are used by a third-party insurance to provide reimbursement allocations. Although these allocations are helpful, LCH still loses money on Medicare and Medicaid patients. The amount recovered from Medicare and Medicaid patients covers only the direct costs and partial indirect costs but not the total health care costs (Tarantino, 2002).

LCH is constantly on the alert for changing Medicare reclassification. One of the effects of the 2014 classification changes was increased Medicare DRG payments (Baicker et al., 2013). However, since Medicare and Medicaid patients represent 49% of LCH's current patient base, any additional reimbursement should be substantial but not sufficient to offset unpaid health care services.

UNPAID HEALTH CARE SERVICES

According to Childs (2008) unpaid health care bills are the single leading cause of personal bankruptcy in the United States. The combination of personal bankruptcy, unemployment and outstanding medical debt is enough to capsize some major health care organizations even though the industry contributes only 18% of the country's gross domestic product (GDP) (Neumann et al., 2017).

Millions of workers are unemployed or underemployed since the 2007 economic downturn (Rodrigues & Weijermars, 2016). Research estimates that for each percentage point increase in unemployment, the number of uninsured people increases by 1.1 million (Sommers et al., 2015).

At LCH, the current payer mix is primarily Medicare and Medicaid. When unemployment increases or continues, there are more self-pay and Medicaid patients which has a direct impact on LCH's net revenue. The effects of unemployment are becoming more obvious to LCH. The percent of charges recouped from current uninsured/self-pay patients is less than 1% or .957% compared to prior fiscal year's recovery of 1.310%. Converting the uninsured/self-pay into revenue numbers, the prior fiscal year service revenue was $29 million compared to $34 million in the current fiscal year (see Exhibit 2). As a not-for-profit, LCH recognized these losses as charity to support its not-for-profit status even though the recognized amounts exceed the requirement needed to maintain the not-for-profit status. There is also the negative effect of patients cancelling elective services and surgeries because they cannot afford the procedure. These specialized procedures tend to net more revenue than the basic preventative care; so again, LCH suffers a loss.

Given there are less people with insurance in the region, there are a larger number of patients seeking medical care at LCH because only a not-for-profit hospital can provide charity care. An increase of patients for the hospital is usually a good thing, but these additional patients have no insurance, cannot self-pay, and do not qualify for Medicare or Medicaid. A not-for-profit

typically should devote a minimum of 8% of its services to charity. LCH recognizes approximately 12% annually as charity services (see Exhibit 2).

The main commercial payer to LCH is Blue Cross and Blue Shield (BCBS). Only 13% of the current year's patient mix had BCBS but the BCBS payments accounted for $30 million which offset some of the $74 million of the loss resulting from self-pay, Medicare, and Medicaid patients.

Frequently insurance companies audit their reimbursements to hospitals and reclass the amount they will pay hospitals as service reimbursement. In June of the current year, BCBS completed an audit and drastically cut LCH's reimbursement rates impacting inpatient payments. Before the reclass, LCH received $15,545 per inpatient but after the reclass, the amount was reduced to $4,584 significantly effecting financial management. LCH's net income dropped from $49.5 million in the prior fiscal year to $23.9 million in the current fiscal year (see Exhibit 2). Since the reclass did not occur until mid-fiscal year, LCH is predicting a net income of only $8 million for the forthcoming year.

The reclass was detrimental to LCH because an amount less than operating costs is being reimbursed by the insurance company. The reclass caused a relatively healthy hospital to drop into an unhealthy financial condition. As a result, radical cost-saving efforts throughout the system are being identified and employed specifically in the area of staffing and labor costs.

LABOR COST ISSUES

The Medicare statute requires that per-discharge payments to hospitals in the inpatient prospective payment system (IPPS) reflect geographic differences in the cost of labor. As a result, Medicare's IPPS payments are adjusted by a hospital wage index that reflects the average price of labor at each hospital. To construct the index, Medicare clusters hospitals into metropolitan statistical areas (MSAs) and residual areas (balance-of-state or rest-of-state). These geographical areas approximate hospital labor markets, and average wages are calculated for each using wage data from an annual survey of IPPS hospitals' labor costs (CMS, 2015).

The occupational mix is based on the hospital IPPS designed to standardize payments for inpatient care where there is a base and capital payment for each Medicare case. The base operating payment contains two components; a labor-related amount which is essentially the labor costs and a nonlabor related amount. These amounts are submitted in the Medicare annual cost report which adds the market rate of labor to the DRG calculation (Holmes et al., 2006).

The wage rate submitted in the cost report is the total wages paid by hospitals divided by the total hours worked. The wage index captures the prices for area labor. Depending on its relation to the market average, the index compensates or reduces payment for treatments (Holmes et al., 2006). If the wages are higher than the national average, the wage index automatically compensates for the reduction (CMS, 2015). This creates issues when hospitals use a more expensive payer mix that results in receiving excess funds. A solution to the problem was the introduction of the occupational mix. The mix developed by Center for Medicare & Medicaid Services (CMS) removed the effects of the skill mix to allow only the price difference between a market and the national rate. Hospitals that had a more expensive occupational mix would have their average hourly wage calculation decreased while the hospitals with the less expensive average hourly wage would receive an increase (CMS, 2015).

The occupational mix calculation occurs every three years (CMS, 2015). This year, LCH is going through an occupational mix review. Three years ago, the mix calculation found many

flaws in the Hospital's staffing configuration. LCH had nursing departments where in one nursing unit there were 4 managers and 5 employees, while the national average is 1 manager to 4 employees. This was beneficial because LCH management provided affiliated units illustrations of how LCH was receiving less funds from Medicare due to inefficient staff mix. Improvements have been made to the occupational mixes, but there is still excessive overhead at LCH to be cost efficient.

Since the mix is recalculated every three years, it allows the hospital to make gradual changes. LCH has made an effort to reallocate human resources as positions became vacant. Previously LCH employed a CEO and CFO at each rural entity. LCH utilized the mix recalculation to promote efficiency and reduce overhead costs.

DRUG AND SUPPLY COSTS

For a cost-conscious healthcare provider, having an extensive inventory of medical pharmaceuticals and medical supplies is an involved process. Hospitals work under a different cost structure compared to pharmacies and drug companies that receive preferential cost based on a desired quantity. The cost structure is beneficial for a hospital because the savings can be passed on to patients and the hospital's financial stability maintained. Unfortunately, drug costs have significantly increased over the past decade. They are expected to increase even more based on items such as advertising, FDA regulations, R&D costs, more prescriptions being written, and higher priced drugs replacing existing drugs (Neumann et al., 2017).

LCH has a pharmacy and therapeutics group called drug formularies comprised of pharmacists and specialists to determine which drugs to acquire for the hospital. There may be dozens of drugs available to treat cholesterol, but the formularies select what they believe to be the best 1 or 2 cholesterol drugs to have in stock at the hospital. These drugs are then approved as medical costs. Having these formularies greatly affect the hospital's costs by employing quantity contract purchases.

A major controversy in pharmaceuticals costs stems from the introduction of Direct-to-Consumer (DTC) Advertising (USC, 2011). Recently, the advertising for prescription drugs has escalated. Many believe this advertising is beneficial by reminding patients they need to schedule health checkups and presents an easy way to resolve their health problems. However, these advertising campaigns add billions of dollars to drug costs (Neumann et al., 2017). In an economy where efficiencies are critical, this is a cost that hospitals would rather not afford.

As health care continues to improve, so does the type and mix of drugs used, especially in a hospital setting where the treatment is often more of an acute nature than treating a chronic illness. LCH is constantly being asked for medications and procedures that are substantially more expensive than what is needed for the patient's care. However, when a cancer drug is developed that travels to the area of the body where the cancer is found and affects only the cancerous cells rather than the normal cells, that drug will be desirable because the costs of treating the old protocol consequences will be avoided (Finley, 2017; Neumann et al., 2017

Another drug cost increase for LCH is the FDA regulation that disallows all medications that are not FDA approved. The FDA 2011 Food Safety Modernization Act (FSMA) was passed to ensure the U.S. food supply is safe by shifting the focus of federal regulators away from responding to contamination but instead preventing it (Neumann et al., 2017). While this is beneficial for the safety of the patients, it removed many older, less expensive but effective drugs from the pharmaceutical market.

The FDA has a significant influence on the costs of approved drugs. It can easily take up to seven years to develop a drug and complete FDA clinical trials before being put on the market (Neumann et al., 2017). The drug company may only have a limited time to recoup and make a profit on the costly R & D expenses along with the costs of clinical trials and other tests that are required by the FDA in the approval process. This means that while the pharmaceutical companies still have control of the market share, they must earn a profit before the patent expires.

AREA DEMOGRAPHICS

Given the region's attraction to retirees, LCH's Medicare patients are expected to increase. Having an increased number of Medicare patients also puts a strain on the financial health of LCH because Medicare reimbursement does not generally cover the total service costs.

Since 2012, there has been an approximate 11% increase in the Hospital's Medicaid patients. This results in a financial loss because Medicaid patients are generally more ill than other patients. The Medicaid patients also tend to not eat correctly, are overweight, have poor hygiene, and do not maintain preventative health care.

As a percentage of cost recovery, Medicaid is the lowest other than self- pay. In the current year, LCH suffered an operating loss of $900 per Medicaid patient.

A demographic concern for LCH and the area is the number of undocumented workers. These people need medical treatment although they cannot get insurance, so they turn to LCH for health service. Since the state has one of the largest populations of undocumented workers (12%), this is a significant financial toll on LCH. The Hospital records their names and ages, but the prospective patient has no social security number, medical records, or any formal documentation. Thus, any health care service provided is recorded as charity. Over the past 10 years, the quantity of these undocumented patients has doubled.

FINANCIAL CONSTRAINTS

LCH's balance sheet displays an 8% asset growth from Prior FY to Current FY (see Exhibit 1) due to an increase in fixed assets and cash equivalents. During the same time, the liabilities increased over 10% due to new debt and other current liabilities. Given the current projected decrease in future years' net income, long-term debt and lease obligations will consume more than 10% of net income which is considered a fiscal red flag.

Labor and benefit cost represent the largest component of LCH's expenses (see Exhibit 2). Charity and bad debt expenses escalated in the current year as a result of the DRG audit. Extensive cost containments are currently under way to achieve labor efficiencies and identify cost reductions.

Analysis of LCH's ratios indicates that although there are multiple fiscal constraints, most of the ratios are favorable (see Exhibit 3). Based on the ratios, the organization is liquid. The activity and capital structure ratios are presently favorable but decreasing. The profitability ratio return on net asset is the only measure that is unfavorable (Holcombe & Hillman, 2012).

Overall, the profitability ratios are low indicating LCH is dependent on patient revenue. Since patient revenue is the main revenue source, LCH is initiating expense reductions and economies to improve the performance measure. Although the salary and benefit expense as a

percent of operating expense is much less than the national norm, it is comparable to area salary and benefits packages paid by area health care providers.

Not apparent in the ratio analysis is LCH's capital asset expansion (see Exhibit 1 property and equipment). To add capital assets, LCH assumed new debt and debt convents that may prohibit any near-term expansion. With favorable short-term liquidity, the debt obligations will impact future periods' favorable measurement.

To resolve a financial constraint, LCH is closing a distant auxiliary facility due to declining Medicare and Medicaid reimbursements. This illustrates how the financial future may be compromised by external forces such as regional economic performance and national health care legislation.

CONCLUSION

Although the U. S. economy has largely healed since the Great Economic Downturn of 2007, LCH is going through a difficult time, struggling to make ends meet in a poor economy with numerous challenges including ACA payer reclassification, national political activities to revise ACA, new governmental regulation, and budget cuts to gain efficiencies. Even with these challenges, LCH continues to be one of the leading health care providers in the region and prides itself in providing the highest quality of patient care. Although it will take some time to adjust to the inconsistent environment and changing health care industry, LCH continues to focus on their patients and implement decisions to help keep the region healthy.

Changing Events

During the current fiscal year, a for-profit healthcare entity approached LCH with a buy-out proposal assuming all LCH debt and contractual obligations to form a new health system in collaboration with the local State supported teaching hospital and physician clinical operation. The new combined entity creates a 10-hospital system with 41 clinics, a high-rise physician office facility, 13 regional rehabilitation facilities, two freestanding emergency centers, regional home health services covering 41 counties, and a behavioral health center together with a comprehensive 7-trauma center care network including a Level 1 (Ardent, 2018).

The newly created health system allows the former LCH to grow and thrive in the region and to expand medical education, research and community health services. It is envisioned that the affiliation will add up to 200 medical residency positions to the region's health service mix. The new entity plans to invest $150 million for improvements over the next five years and provide other resources to support the operation of the newly created health system.

A great national for-profit healthcare system integrating with a regional leader in healthcare delivery and a leader in health education and research makes a dramatic contribution and solution to the region's health service challenges and concerns. Future research should revisit the new healthcare system to determine what changes and improvements, if any, are accomplished.

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APPENDIX

EXHIBIT 1
LOCAL COUNTY HOSPITAL
CONSOLIDATED BALANCE SHEET

	Prior FY	Current FY	Growth %
Assets			
Current Assets:	$	$	
Cash and Cash Equivalents	123,747	134,231	0.08
Assets whose use is limited			
Patient accounts receivable, net	54,215	50,715	-0.06
Estimated third party settlement	-		
Inventory	9,016	9,448	0.05
Prepaid expenses and other	2,678	3,347	0.25
Total Current Assets	189,656	197,741	0.04
Noncurrent Limited Assets	2,977	628	-0.79
Property and Equipment, Net	47,607	57,879	0.22
Other Assets:			
Due from affiliates	191,549	208,210	0.09
Due from leased hospitals	694	1,208	0.74
Due from outside entities	117	102	-0.13
Other Assets	-692	-577	-0.17
Total Assets	$ 431,908	$ 465,191	0.08
Liabilities and Fund Balance			
Current Liabilities:	$	$	
Accounts Payable	10,989	13,846	0.26
Accrued Expenses	10,604	12,570	0.19
Estimated third party settlement	3,110	6,119	0.97
Current portion of long-term debt	750	450	-0.40
Current portion of capital leases	2,578	2,880	0.12
Deferred revenue	985	953	-0.03
Total Current Liabilities	29,016	36,818	0.3
Capital Leases net of current portion	7,483	7,654	0.02
Due to Affiliates			
Long term debt net of current portion	44,914	44,555	0.02
Total Liabilities	81,413	89,027	0.1
Net Assets	300,961	352,246	0.17
Year to Date net income	49,534	23,918	-0.52
Total Net Assets	350,495	376,164	0.07
Total Liabilities and Net Assets	$ 431,908	$ 465,191	0.08

Amounts in $ millions

EXHIBIT 2
LOCAL COUNTY HOSPITAL
CONSOLIDATED STATEMENT OF REVENUES AND EXPENSES

	Prior FY	-	Current FY
Patient Service Revenue		$	
Routine revenue	384,038		462,887
Inpatient-Ancillary	892,921		921,316
Outpatient-Ancillary	636,373		726,540
Total Patient Service Revenue	1,913,332		2,110,743
Deductions			
Medicare Contractual	802,540		891,287
Prior Year-Medicare	-17,591		
Medicaid Contractual	151,105		199,715
Other Third Party Contractual	308,742		320,698
Charity	140,542		143,847
Administrative	82,332		96,943
Total Deductions	1,467,670		1,652,490
Net Patient Service Revenue	445,662		458,253
Other Operating Revenue	13,335		14,301
Total Revenue	458,997		472,554
Expenses:			
Salaries and Wages	118,678		127,918
Contract Labor	8,295		4,853
Employee Benefits	27,617		36,139
Professional Fees	23,857		24,099
Supplies	78,955		79,507
Utilities	5,372		5,275
Purchased Services	24,234		24,361
Other	9,999		10,852
Insurance	2,184		1,288
Provision for Bad Debts	59,161		77,102
Depreciation	12,684		14,323
Interest	5,116		5,825
Rent	6,342		7,330
System Fee	27,416		30,297
Total Operating Expenses	409,910		449,169
Income (Loss) from operations	49,087		23,385
Non-Operating Revenue	448		533
Net Income (loss)	49,535		$ 23,918

Amounts in $ millions

EXHIBIT 3
LOCAL COUNTY HOSPITAL ANALYSIS FOR PRIOR AND CURRENT FY VERSUS INDUSTRY BENCHMARKS

Ratios	Industry Benchmark[1]	Cur FY	Prior FY $			Favorable/ Unfavorable		Trend Position
Liquidity Ratios								
Current Ratio	1.88	5.37	6.71			F		Dec
Quick Ratio	1.58	5.02	6.30			F		Dec
Acid Test Ratio	0.29	3.65	4.38			F		Dec
Days in Accounts Receivable	50	40.40	44.40			F		Inc
Expense, and Profitability Ratios								
Operating Revenue per Adjusted Discharge	$11,771							
Operating Expense Per Adjusted Discharge	$11,353							
Salary and Benefit Expense as a Percentage of Operating Expense	44%	28%	29%			F		Inc
Operating Margin	0.04	0.05	0.11			F		Dec
Non-Operating Revenue	0.07	0.03	0.03			F		Inc
Return on Total Assets	0.05	0.05	0.11			F		Dec
Return on Net Assets	0.09		0.14			U		Dec
Activity Ratios								
Total Asset Turnover Ratio	0.94	1.02	1.06			F		Dec
Net Fixed Asset Turnover Ratio	2.49	8.16	9.64			F		Dec
Capital Structure Ratios								
Long Term Debt to Net Assets ratio	0.64	0.12	0.13			F		Inc
Net Assets to Total Assets Ratio	0.5	0.81	0.81			F		No Chg
Times Interest Earned Ratio	4.31	5.01	10.59			F		Dec

[1] Source: Zelman 2014

Note: Local County Hospital data used for this analysis are not publicly available based on a confidentiality agreement that names and related parties remain anonymous.