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Lander County Hospital District

2023 Audit Results and Report to Governance

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Executive Summary

Results of Professional Services

Results of Professional Services

Significant Transactions

- Adoption of GASB 96
- Capital expenditures
- Investments

Audit Adjustments

- No material audit adjustments
- Passed adjustment (1)

Other Matters

- No significant subsequent events identified
- Significant commitment – Construction

Internal Control Results

- No material weaknesses

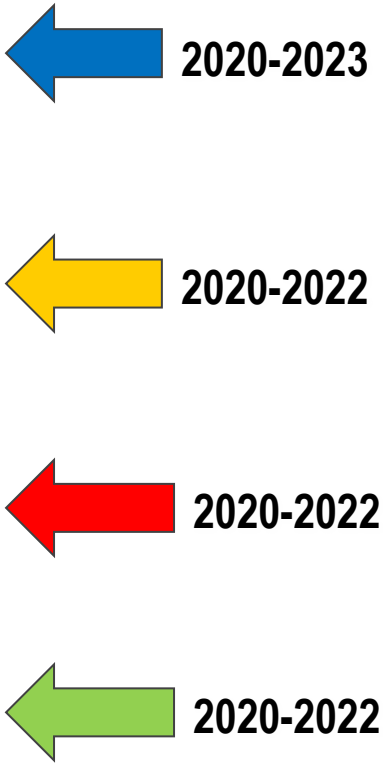
Deliverables

- Report on the Financial Statements (FY 23)
- Report on Internal Control Over Financial Reporting on Compliance and Other Matters
- Report on Compliance with Nevada Revised Statutes
- Board Packet including Required Communications and Internal Control Communications
- Preparation of the Medicare Cost report

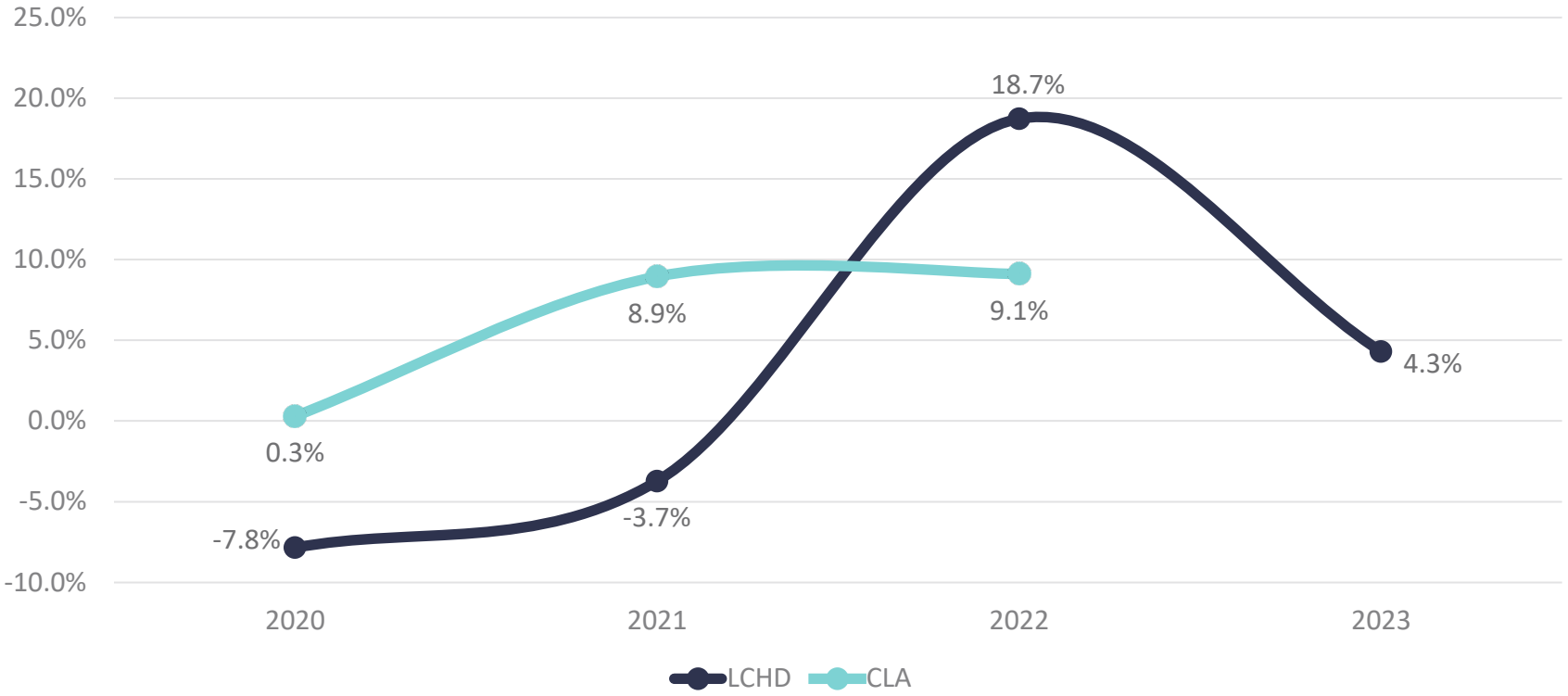
Your Business

Financial Highlights

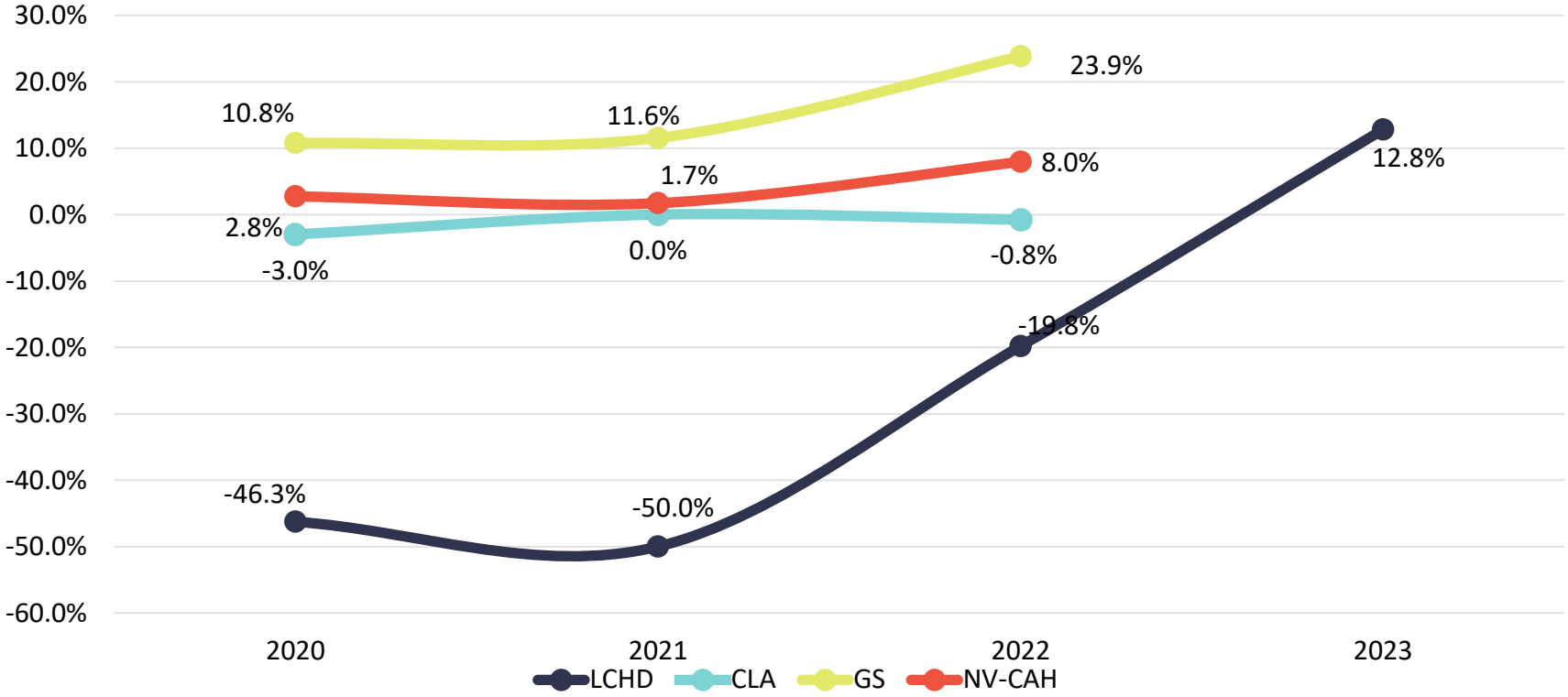
- **Lander County Hospital District dba: Battle Mountain General Hospital (LCHD)**
  - $12.5 Million Net Patient Service Revenue in FY 2023
  - Based on Audited Financial Statements
- **CliftonLarsonAllen Gold Standard**
  - 1,300 fiscal year reports analyzed and used in preparation of ratios and benchmarks
  - 44 Gold Standard Facilities
- **Nevada Critical Access Hospitals (NV-CAH)**
  - Nevada CAH data extracted as part of CliftonLarsonAllen Gold Standard Study
- **CLA Small Size CAH Clients (CLA)**
  - Hospital's with between $10 and $25 million of net patient service revenue



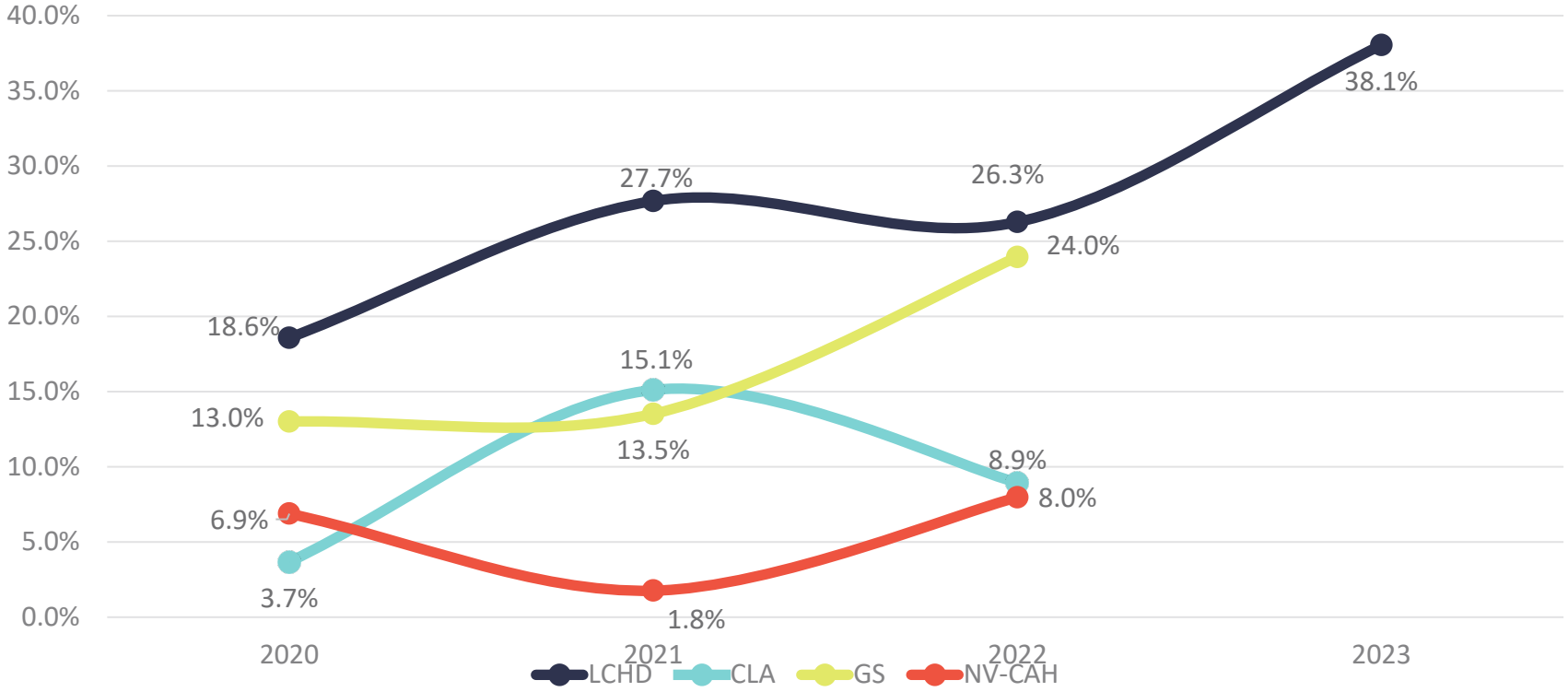
Percentage Growth in Net Patient Revenue



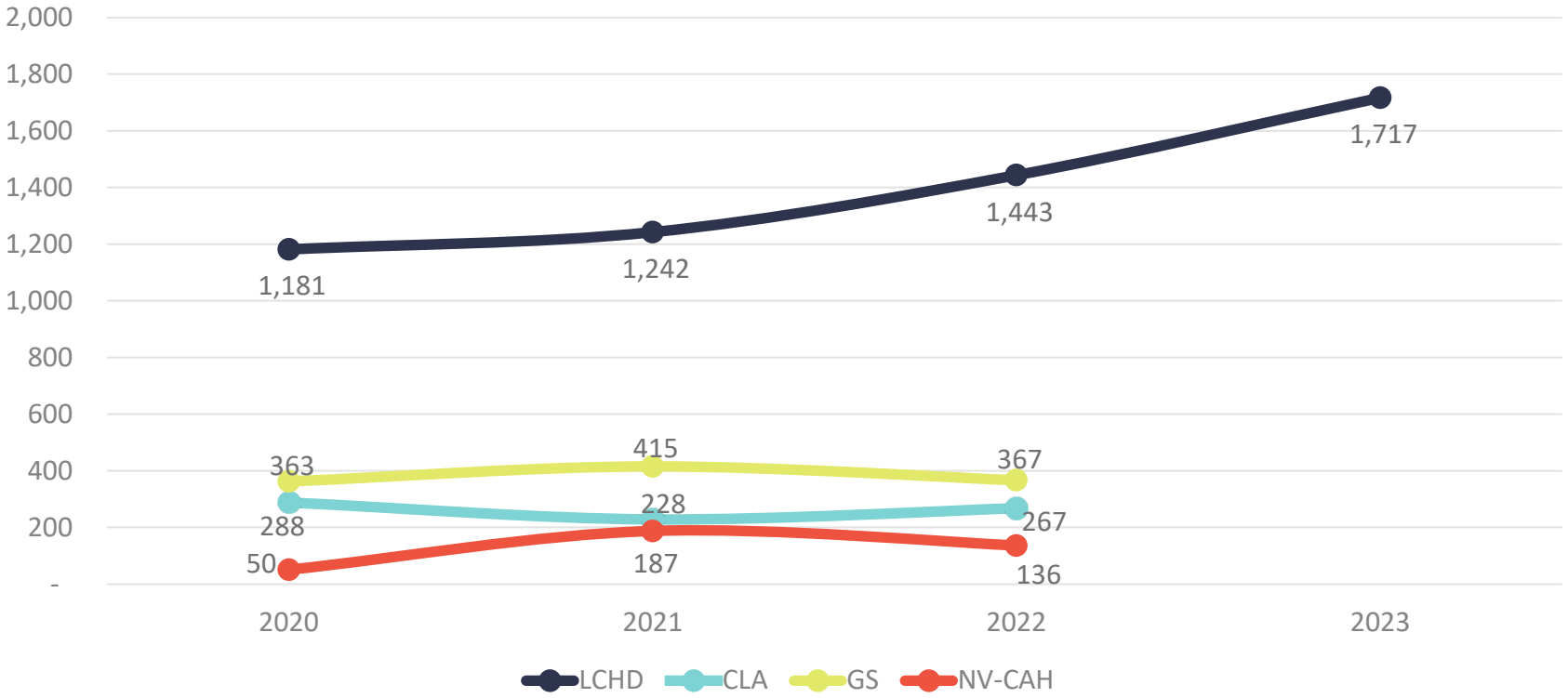
Operating Margin



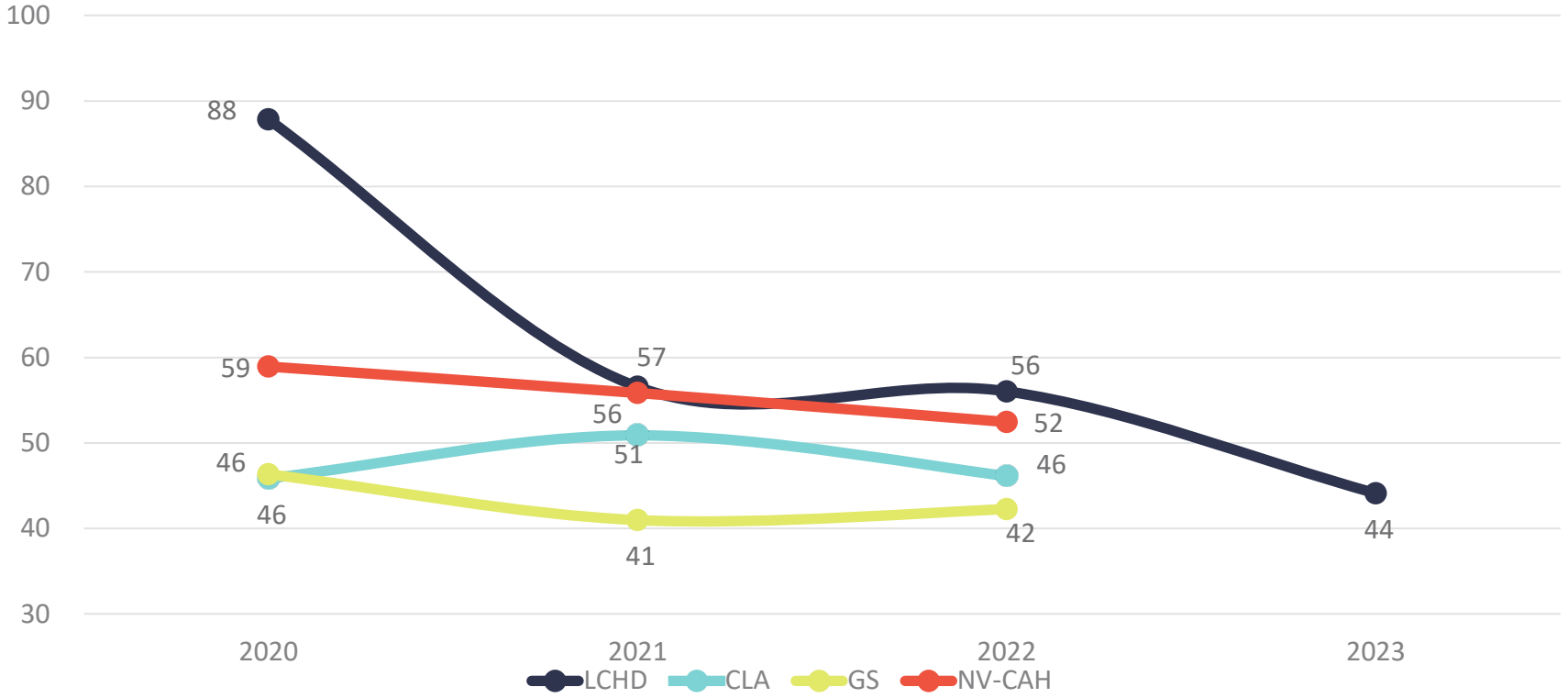
Total Margin



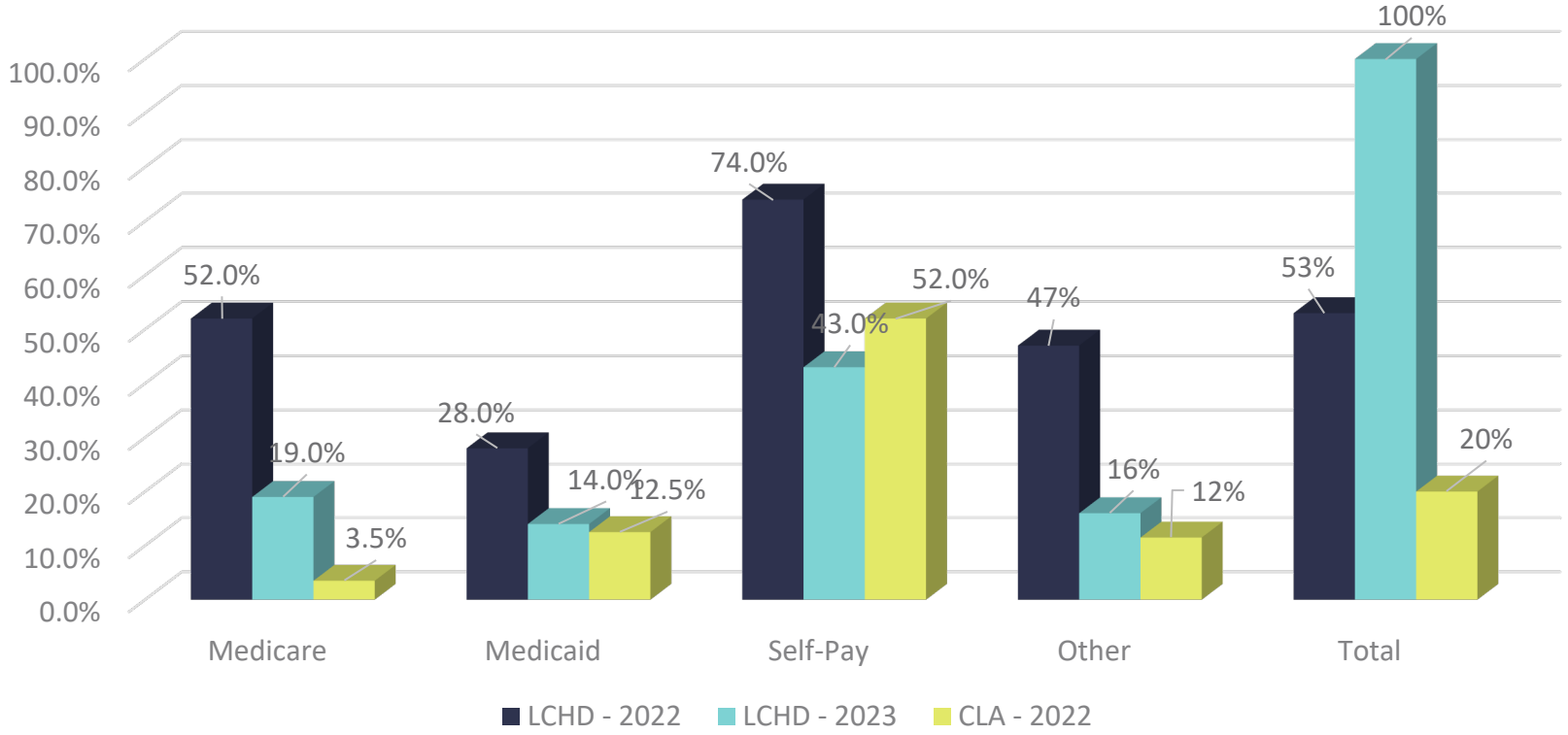
Days Cash on Hand



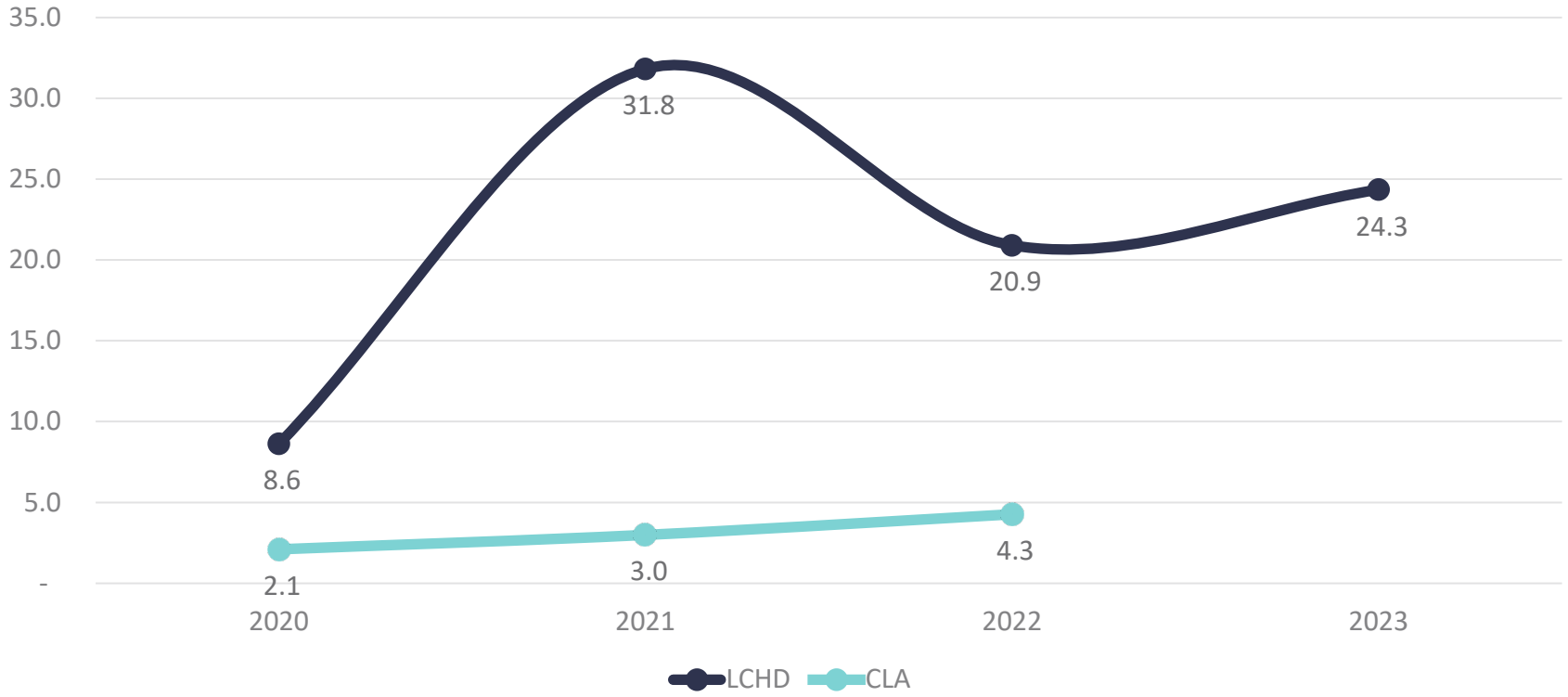
Net Days in Accounts Receivable



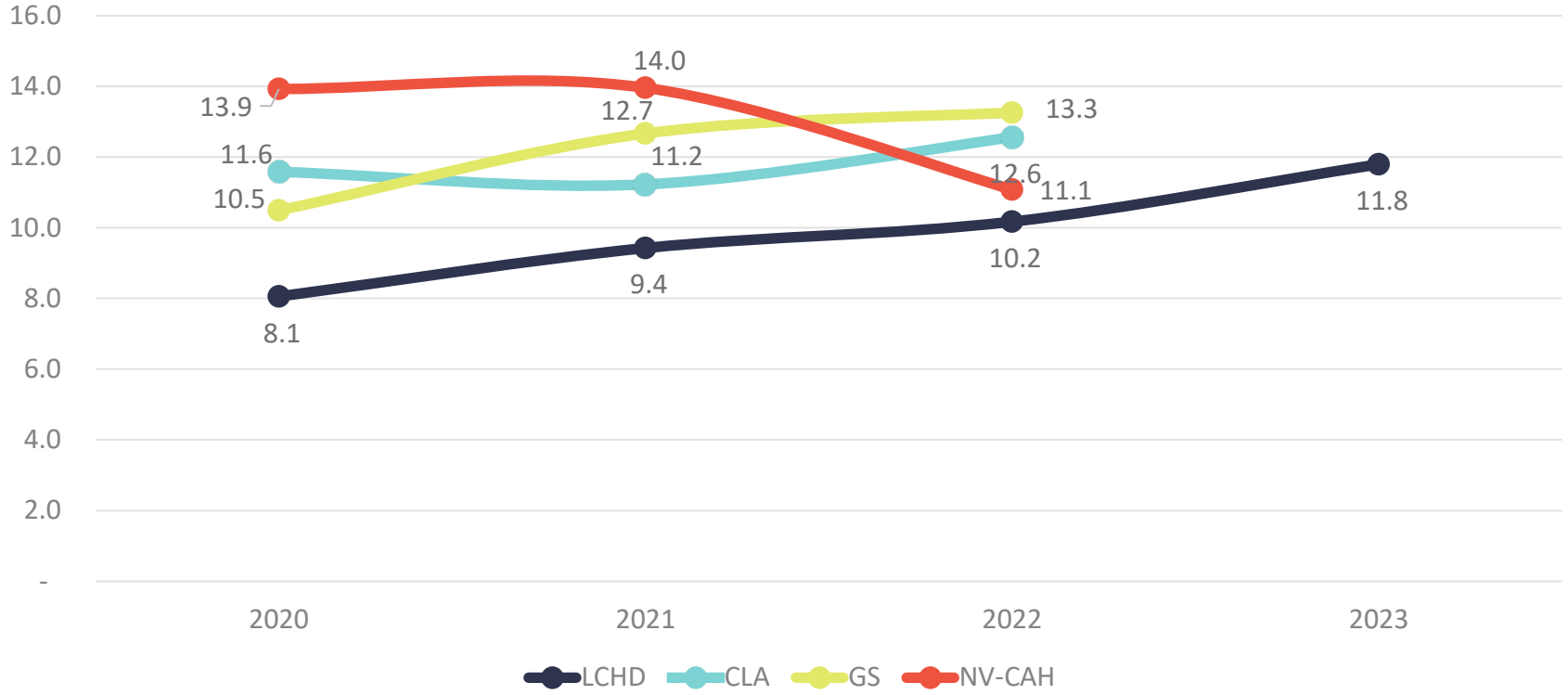
Percentage of A/R over 90 Days Old



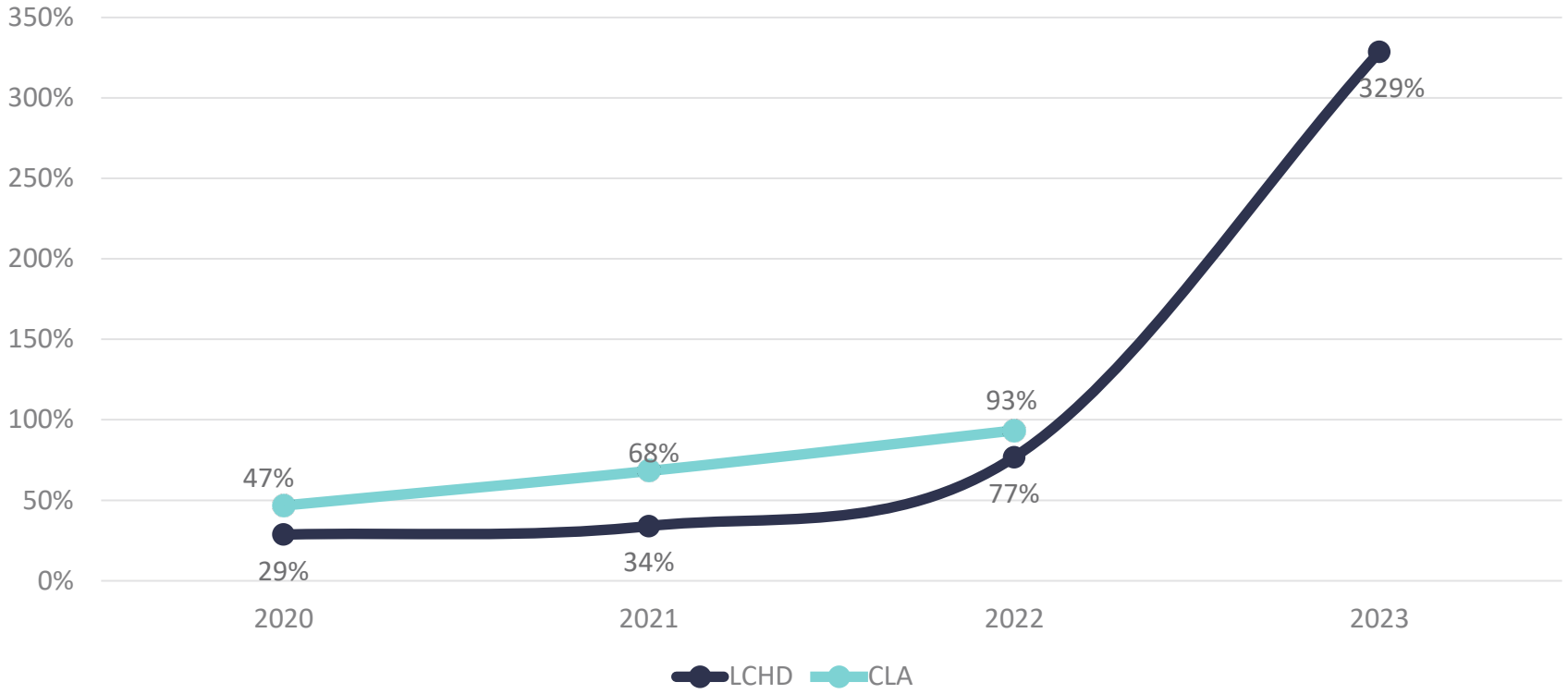
Current Ratio



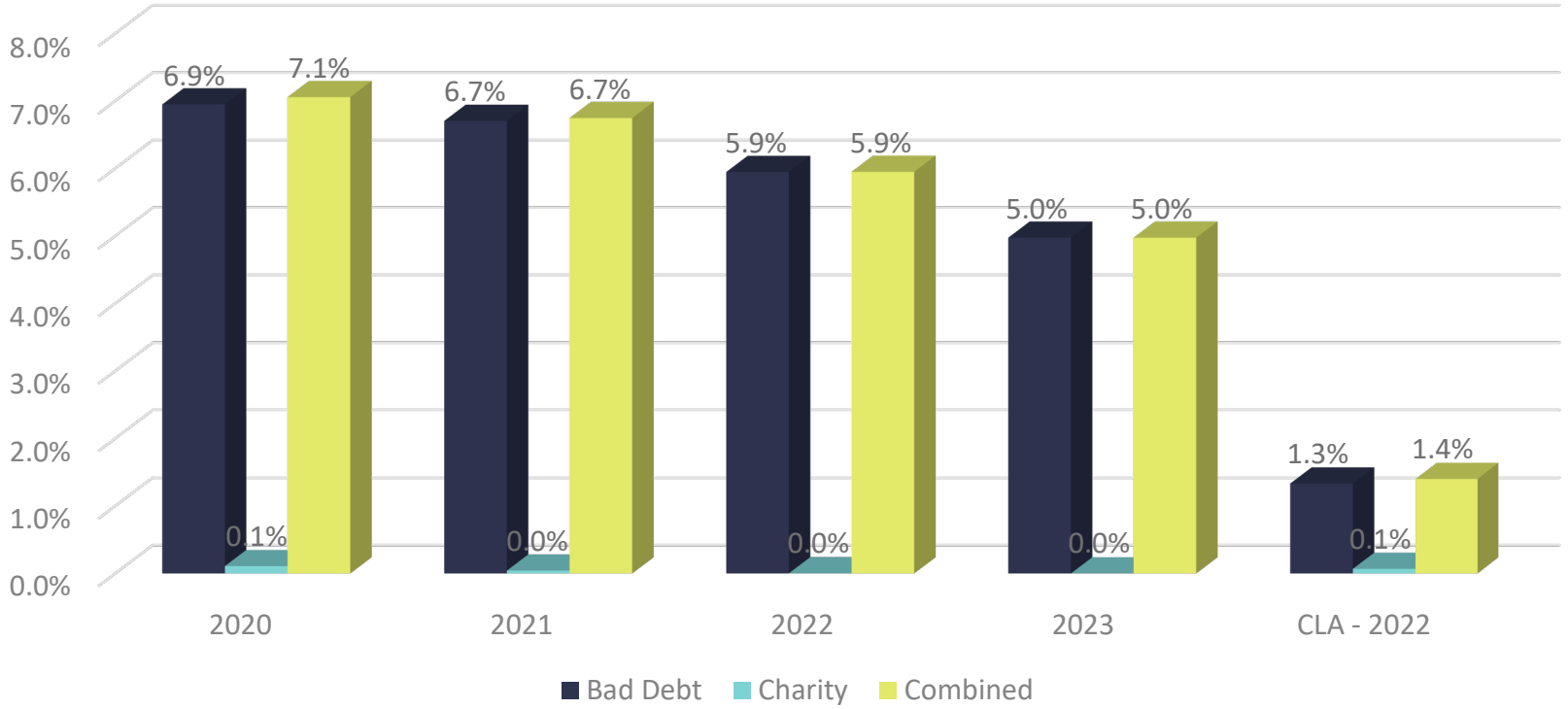
Average Age of Plant



Capital Spending as a % of Depreciation and Amortization



Bad Debt & Charity Care as a % of Revenue



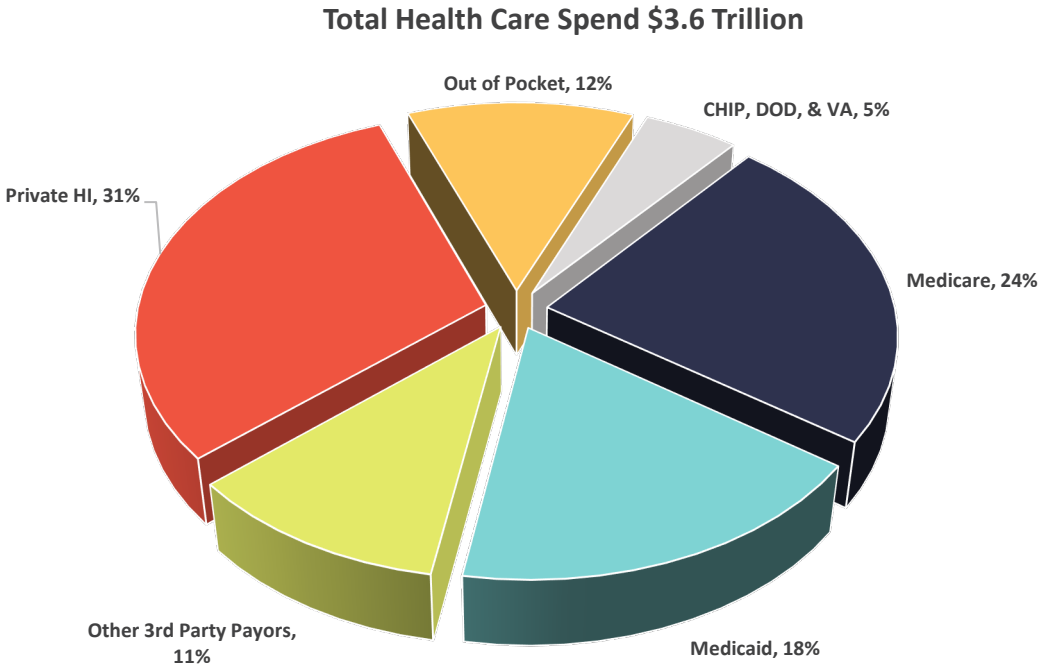
2023 Industry Trends

Understanding growth in health care spending, and what's at risk for providers in the coming year.

Trends in National Health Care & Medicare FFS Spending

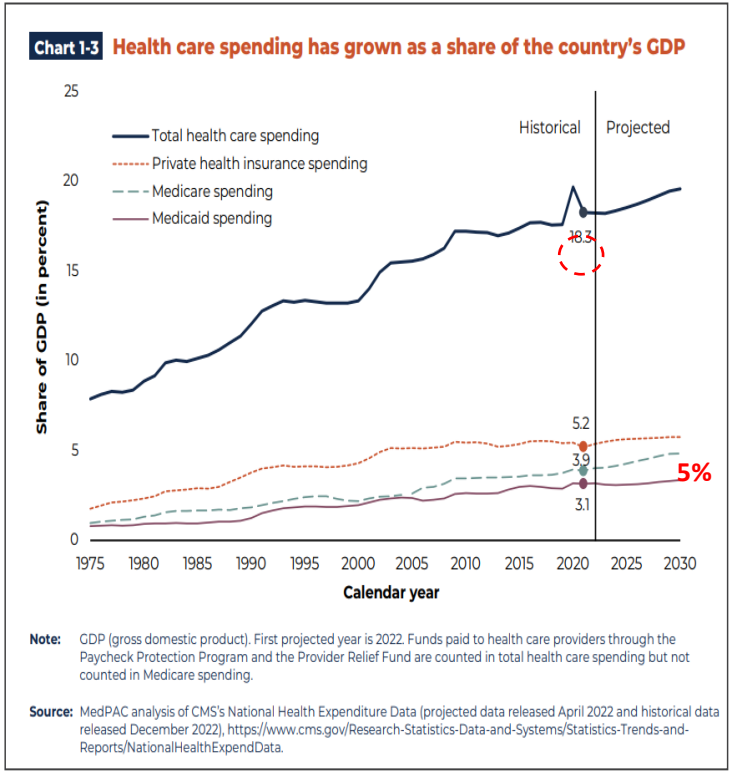
A Financial Profile of Health Care in the United States

Federal Gov't Accounts for 47% of $3.6T in Health Care Spending in 2021*



** Source: 2023 MedPAC Data Book, based on 2021 data, available at www.medpac.gov/document-type/data-book*

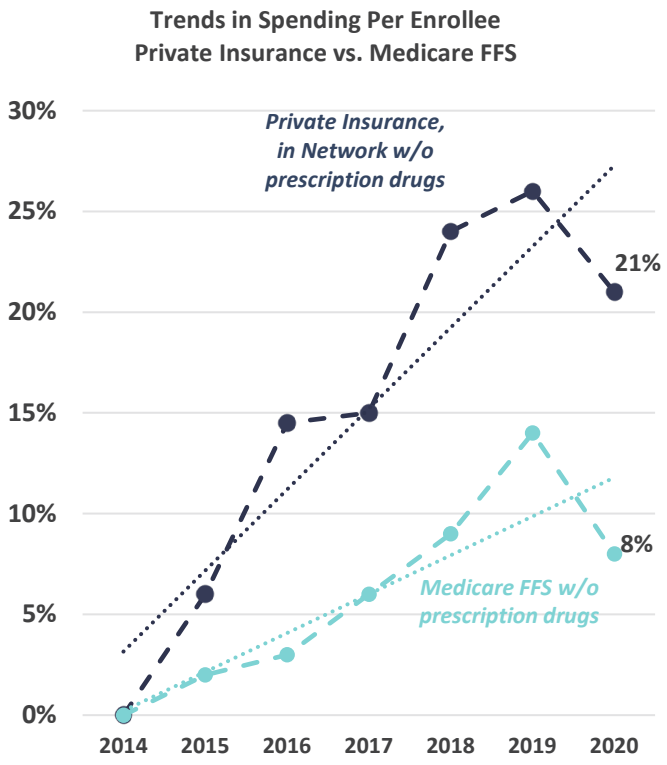
Health Care Spending as a Percent of GDP



- Health care spending hit a peak of 19.7% of GDP in 2020, due to one-time Gov't payments as a result of COVID-19 Pandemic.
- In 2021, spending dropped to an estimated 18.3% of GDP.
- Medicare spending doubled from 2008 – 2022 from $455B to $918B and is projected to double again by 2032 hitting $1.9T or 5% of GDP.
- By comparison, in 1975 Medicare spending as a percent of GDP was about 1%.
- MedPAC Trustee's estimate the average annual increase in Medicare spending will be about 7.5% over the next 10 years.

** Source: 2023 MedPAC Data Book, based on 2021 data, available at www.medpac.gov/document-type/data-book*

Health Care Spending Per Enrollee*

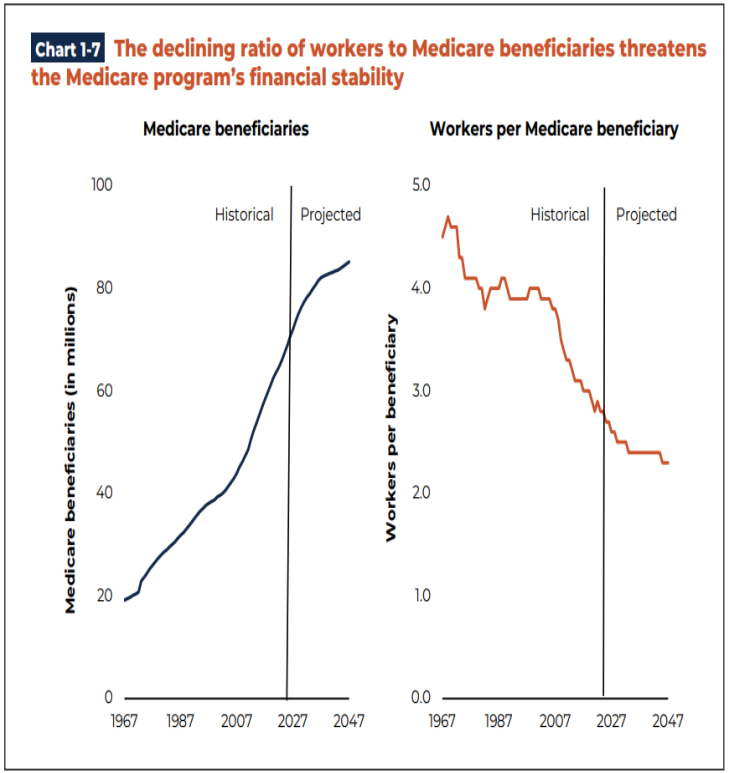


- Growth in health care spending for those with private insurance has increased proportionately faster than Medicare FFS spending.
- As depicted at left, from 2014 to 2020, private insurance spending per enrollee has grown at a rate of 21% compared to 8% for Medicare FFS**.
- Unlike Medicare FFS which has the ability to administratively set prices for many health care services, private insurance is impacted significantly by changes in price. Price increases were largely responsible for spending growth in private insurance.
- Hospital & physician consolidation is believed to be the cause for high prices as consolidation creates increased provider market power, which in turn leads to greater leverage in contract negotiations.

** Source: 2023 MedPAC Data Book, based on 2021 data, available at www.medpac.gov/document-type/data-book*

** * Spending includes payments to providers from health insurance and patients, but not from other sources (e.g. workers compensation or auto insurance. Spending for retail prescription drugs was not available and therefore not included.*

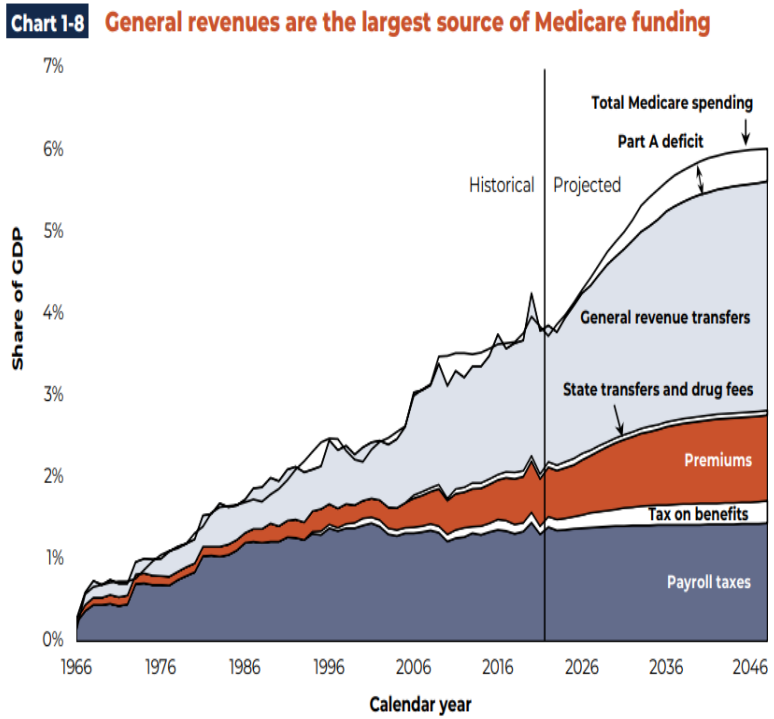
Declining Work Force vs. Growth in Medicare Population Creates Funding Challenges



** Source: 2023 MedPAC Data Book, based on 2021 data, available at www.medpac.gov/document-type/data-book*

- As the baby boomer generation ages, enrollment in the Medicare program is surging.
- By 2029, all baby boomers will have reached the age of eligibility for the Medicare program, and 75 million beneficiaries are expected to have Medicare Part A Hospital Insurance—up from 65 million beneficiaries in 2022.
- While Medicare enrollment is rising, the number of workers per beneficiary is declining rapidly.
- Per beneficiary work force has declined from 4.5 workers (1967) to 2.9 workers per beneficiary in 2022 with projections to decrease further to 2.5 workers by 2029.
- Medicare Part A Hospital Insurance is largely financed by workers' Medicare payroll taxes, so a declining workforce creates significant financial challenges for the program.

Medicare Part A Solvency Remains Concern



** Source: 2023 MedPAC Data Book, based on 2021 data, available at www.medpac.gov/document-type/data-book*

** The Congressional Budget Office (CBO) projects it will take longer for the Trust Fund to become insolvent, sometime after its 10-year budget projection window which goes through 2033.

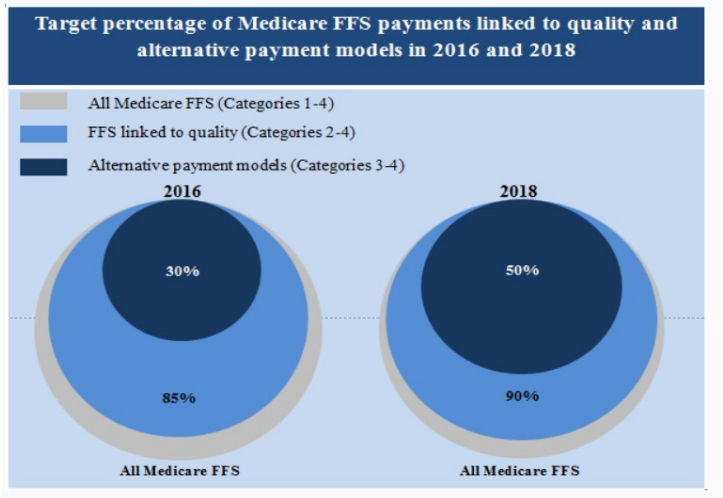
- Trend of declining workforce, growth in Medicare enrollment and spending has created gaps in funding for Medicare Part A.
- As depicted at left, the Federal Government has had to shift increasing amounts of General Fund Revenues to cover Medicare spending that out paces payroll taxes and premiums paid by beneficiaries. By 2009 these transfers became the largest funding source for Medicare Part A.
- MedPAC estimates that annual deficits in the coming years will cause the Part A Trust Fund to be zero dollars by 2031, leaving Medicare with enough funds to cover approximately 89% of incurred Part A costs in that year**.
- To keep the Trust Fund solvent for the next 25 years, MedPAC believes payroll taxes need to be increased immediately from 2.9% to 3.6% or implement permanent spending reductions of 15.6%, or some combination of the two.

Provider Implications of Rising Health Care Spending

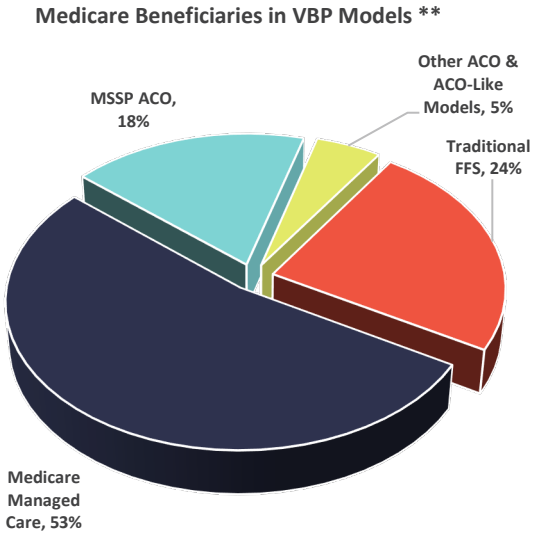
The "Levers" the Federal Government Can "Pull" to Control Spending

Evolution of Alternative Payment Models (APM)

- The passage of The Affordable Care Act (ACA) signaled a new direction for health care, with overarching goals of maintaining or improving the quality while reducing the cost of health care.
- In 2015 CMS established a goal of having 90% of Medicare payments linked to some form of "value-based payment" model, with 50% of those payments being in an APM built on FFS architecture or population-based payment.
- As of 2021, of the 59.8 million Medicare beneficiaries 76% of them are in a Medicare Managed Care or an ACO model.
- While not entirely an "apples-to-apples" comparison, it is clear CMS had significantly advanced it VBP payment model strategy since it's inception.



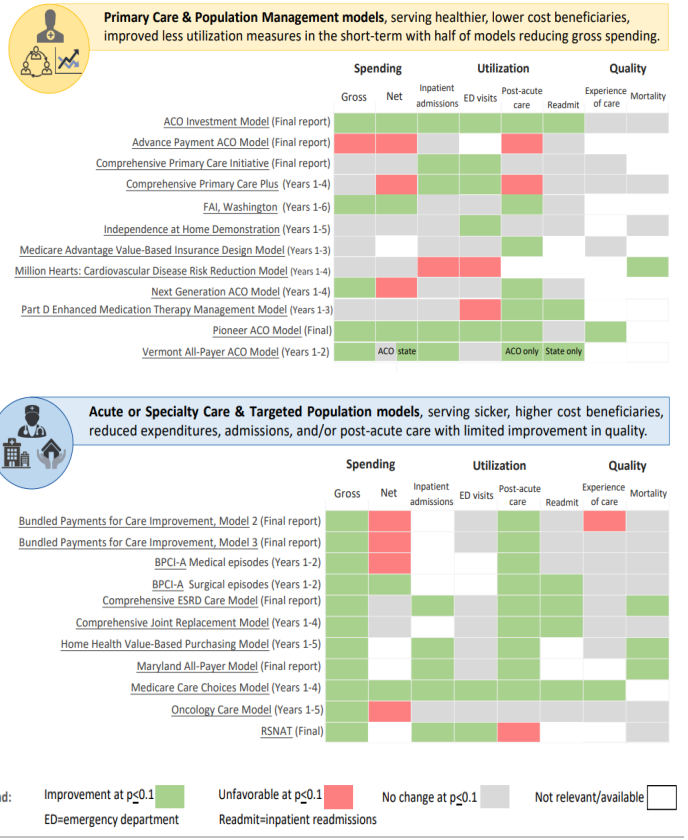
*Source: https://www.cms.gov/newsroom/fact-sheets/better-care-smarter-spending-healthier-people-paying-providers-value-not-volume



** Source: 2023 MedPAC Data Book, based on 2021 data, available at www.medpac.gov/document-type/data-book

APM Results to Date *

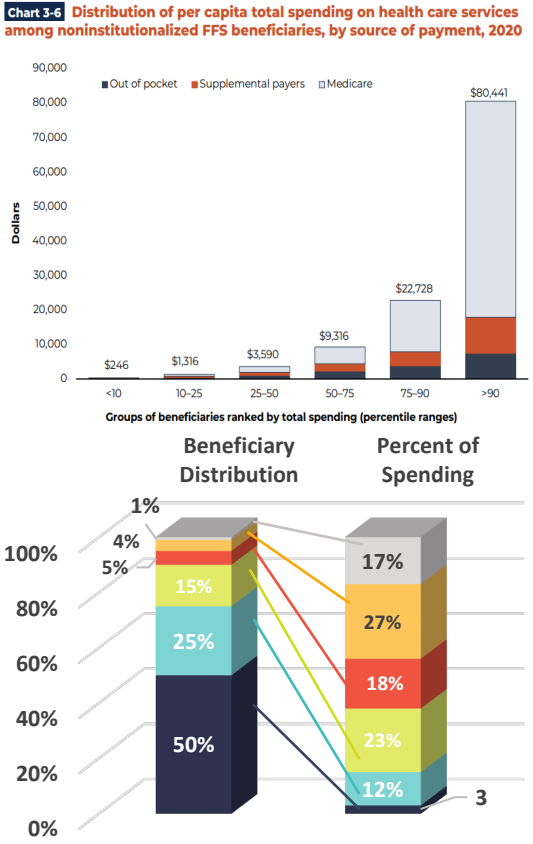
- CMS evaluation of 21 models operating from 2012 – 2020 noting across all models:
  - 14 demonstrated "gross savings" driven by reduced utilization & spending in IP admissions and/or more efficient post-acute care.
  - For models with incentives paid, 6 realized net savings, while 6 incurred net losses.
  - 10 models reduced IP admissions
  - 14 models improved post-acute care
  - 7 reduced ED visits and/or IP readmissions
  - 4 models had unfavorable increases in care
  - Quality of care has remained the same w/a few examples of improvement
  - Patient experience remained largely unchanged based on self-reported data.
- Primary Care & ACOs reflected smaller declines in spending and other outcomes.
- Acute or Specialty Care & Targeted Populations models produced large effects due to high-cost beneficiaries using targeted services.



** CMS CMMI "Synthesis of Evaluation Results across 21 Medicare Models 2012-2020" at https://innovation.cms.gov/data-and-reports/2022/wp-eval-synthesis-21models*

APMs Make Big Impact on Targeted Populations*

- The graphics at right depict Medicare spending based on beneficiary aging, and percentage of beneficiaries making up the largest spending percentages.
  - Beneficiaries > 90 years old represent ~ 10% of Medicare beneficiaries, and accounted for annual per capita costs of > $80,000, of which Medicare paid 78% of.
  - The costliest 5% of beneficiaries, account for about 44% of total Medicare spending, while the costliest 25% accounted for 85% of total Medicare spending.
- These are the population of beneficiaries that Targeted APMs are designed for. These APMs focus on improving care coordination and utilization across settings in an effort to reduce IP admissions, ED visits, post-acute utilization, and improved utilization of end-of-life services.



** Source: 2023 MedPAC Data Book, based on 2021 data, available at www.medpac.gov/document-type/data-book*

Final & Proposed 2024 Medicare Rates**

- The table below depicts CMS's proposed payment rate updates for either Federal Fiscal Year or Calendar Year 2024. With the exception of the Physician Fee Schedule, and Home Health, most sectors of health care will see modest increases in payment rates.
- While the payment rate changes are generally positive, they are not keeping pace with the current inflation trends and the end result will be continued downward pressure on operational performance for all health care providers:***
  - July 2023 3.2% inflation over July 2022
  - July 2022 8.5% inflation over July 2021

							Hospice	
Description	**Hospital IP PPS**	**Hospital OP PPS**	**LTACH's**	**Physician Fee Schedule**	**Skilled Nursing**	**Home Health**	**Meeting Quality Reporting**	**Failure to Meet Quality Reporting**
Market Basket Increase or Current Conversion Factor	3.3%	3.0%	3.1%	-	3.0%	3.0%	3.3%	3.3%
2023 PFS Conversion Factor	-	-	-	$ 33.89	-	-	-	-
2024 PFS Proposed Conversion Factor	-	-	-	$ 32.75	-	-	-	-
Other Payment Rate Adjustment*	-	-	-	-	1.2%	-5.0%	-	-4.0%
Productivity Adjustment	-0.2%	-0.2%	-0.2%	-	-0.2%	-0.2%	-0.2%	-0.2%
Net Payment Change	**3.1%**	**2.8%**	**2.9%**	**$ (1.14)**	**4.0%**	**-2.2%**	**3.1%**	**-0.9%**
Other Key Provisions	**$957M Reduction in DSH & UCP Payments**	**N/A**	**N/A**	**Increase in PC reimbursement w/Modifier; corresponding decrease in various specialties.**	**N/A**	**N/A**	**N/A**	**N/A**

** Other adjustments include Market Basket Forecast Error increase for SKF; 2nd Phase PDPM Payment Phase-In Decrease for SNF; Proposed Prospective Behavior Adjustment for Home Health and failure to meet quality reporting penalty for Hospice.*

*** CMS proposed payment regulations updates accessed at www.cms.gov*

**** U.S. Bureau of Bureau of Labor Statistics "12-Month Percentage Change, Consumer Price Index" at www.bls.gov/charts/consumer-price-index-by-category-line-chart.*

Other Regulatory "Levers":
"Site Neutral Payments" A Hot Topic!*

Site Neutral Provision	Legislation
Medicare site-neutral for all off-campus HOPDs ($30-$40 billion)	• Health Care Fairness for All Act • SITE Act
Medicare site-neutral for all off-campus HOPD drug administration ($4 billion)	• Health Care Price Transparency Act • PATIENT Act
Separate NPI for each off-campus HOPD ($2 billion)	• Primary Care and Healthcare Workforce Expansion Act • Transparency in Billing Act
Commercial market site-neutral HOPD payment caps ($120 billion)	• Primary Care and Healthcare Workforce Expansion Act

** Source: Health Policy Source, Inc., Washington, D.C. 8/1/2023*

Other Legislative/Regulatory "Levers"

Tax Exempt Designation in the Crosshairs!

"We are alarmed by reports that despite their tax-exempt status, certain nonprofit hospitals may be taking advantage of this overly broad definition of "community benefit" and engaging in practices that are not in the best interest of the patient.6 These practices – along with lax federal oversight7 – have allowed some nonprofit hospitals to avoid providing essential care in the community for those who need it most."

- Letter from Senators Warren (D-MA.), Warnock (D-GA.), Cassidy (R-LA), Grassley (R-IA)*

Example Cited in Letter:

- 56 NY hospitals filed liens on nearly 5,000 people's homes w/nearly 80% of liens occurring in counties with incomes < 300% of FPL.
- Mosiac Life, MO, charging full fees for patients who should have received free or reduced fee care.
- Methodist Le Bonheur Hospital, TN brought > 8,300 lawsuits against patients or employees for unpaid medical bills.
- UV Health System filed 36,000 lawsuits for > $106M over a 6-year period that involved "relentless" debt collection efforts.
- NY Times article reporting that:
  - Providence Health pursued a strategy to "wring money" out of patients to "pressure them to pay" for services when those patients were eligible for free care.
  - Allina Health System, MN reportedly receives $209M > than was spent on providing charity care, having a policy of denying medical care from patients with unpaid medical bills.

** Source: Bi-Partisan letter to The Honorable Daniel Werfel, Commissioner Internal Revenue Service & The Honorable Edward T. Killen, Commissioner Tax Exempt & Government Entities Division dated August 7, 2023 at www.warren.senate.gov/imo/media/doc/letters.*

Other Legislative/Regulatory "Levers"

13 New Merger Guidelines from DOJ & FTC *

Health care mergers will get greater scrutiny!

1. Mergers should not significantly increase concentration in highly concentrated markets
2. Mergers should not eliminate substantial competition between firms
3. Mergers should not increase the risk of coordination
4. Mergers should not eliminate a potential entrant in a concentrated market
5. Mergers should substantially lessen competition by creating a firm that controls products or services that its rivals may use to compete
6. Vertical mergers should not create market structures that foreclose competition
7. Mergers should not entrench or extend a dominant position
8. Mergers should not further a trend toward concentration
9. When a merger is part of a series of multiple acquisitions, the Agencies may examine the whole series
10. When a merger involves a multi-sided platform, the Agencies examine competition between platforms, on a platform, or to displace a platform
11. When a merger involves competing buyers, the Agencies examine whether it may substantially lessen competition for workers or other sellers
12. When an acquisition involves partial ownership or minority interests, the Agencies examine its impact on competition
13. Mergers should not otherwise substantially lessen competition or tend to create a monopoly

**** U.S. DOJ & FTC Draft Memo with 13 guidelines for Merger & Acquisition Activity dated July 19, 2023 at** www.ftc.gov/news-events/news-press-releases*

Summary Conclusions

- Total health care spending, including Medicare, is projected to continue to grow substantially over the next decade.
- By 2029 100% of baby boomers will be fully transitioned into Medicare; with this surge and declining ratio of workers to Beneficiaries, revenue streams that support the program will be in a shortfall position.
- The Federal Government will have to "shore-up" these finances, and it has several "levers" that can be pulled to accomplish that:
  - Immediate 24% increase in payroll taxes from 2.9% to 3.6%
  - Permanent spending reductions of 15.6%
  - Some combination of these two
  - Other regulatory/legislative levers
- Given the success with reducing spending in higher risk/higher use rate populations – expect Medicare to double down on these APMs in the coming years.
- Providers ***should expect*** to see stepped up scrutiny of M&A activity from the FTC, scrutiny of tax-exempt status from the IRS, as well as strong bi-partisan support to accelerate site-neutral payment legislation.

Appendix

Required Communications

Topic	Communication
Our responsibility under Generally Accepted Auditing Standards	• **Express an opinion** on the fair presentation of the financial statements in conformity with GAAP • Plan and perform the audit to obtain **reasonable, non absolute** assurance that the financial statements are free of material misstatement • **Evaluate internal control** over financial reporting • Utilize a **risk based** audit approach • **Communicate significant matters** to appropriate parties
Planned Scope and Timing of the Audit	• Performed the audit **according to the planned scope and timing** previously communicated.
Other Information in Documents Containing the Audited Financial Statements	• Financial statements may only be used in **their entirety** • **Our approval** is required to use our audit report in a client prepared document • We have **no responsibility to perform procedures** beyond those related to the financial statements
Significant Accounting Policies	• **Management is responsible** for the accounting policies of the organization • Accounting policies are outlined in **Note 1** to the consolidated financial statements • Adoption of GASB 96 in fiscal year 2023 • **No significant changes** to the accounting policies during the year • Accounting policies **deemed appropriate** • No unusual transactions occurred
Significant Financial Statement Disclosures	• No sensitive disclosures • No significant risks, exposures, or uncertainties • No unusual transactions • Disclosures are neutral, consistent, and clear

Required Communications

Topic	Communication
Significant Accounting Estimates	• **An area of focus** under a risk based audit approach • Significant estimates include: **allowance for bad debts, contractual allowances, third-party payor settlements pension and other postemployment benefit obligations.** • **Estimates determined by management** based on their knowledge and experience • **No management bias** indicated • Estimates were deemed **reasonable** • Estimate uncertainty is disclosed in the financial statements
Supplemental Information	• Schedule of Proportionate Share of PERS Net Pension Liability and PERS Schedule of Contributions • Schedule of Changes in Total OPEB Obligations and Related Ratios • Budget Comparison to Actual • Management Schedules – Net Patient Service Revenue, Other Revenue, Tax Revenue, and Operating Expenses • Engaged to report in relation to the financial statements as a whole • Method of preparing has not changed from the prior year, supplemental information reconciles to consolidated statements • Supplemental information is appropriate and complete in relation to our audit
Management Representation Letter	• Management will provide signed representation letters prior to finalization of the audit reports
Other	• **No difficulties** encountered in performing the audit • **No issues** discussed prior to retention as independent auditors • **No disagreements** with management regarding accounting, reporting, or other matters • No Consultations with **other independent auditors** • No other findings or issues were discussed with, or communicated to, management

Required Communications

Topic	Communication
Corrected and Uncorrected Adjustments	• **Corrected adjustments identified –** no significant auditor proposed adjustments • **One uncorrected adjustments** – • To recognize PEBP obligations

Internal Control Matters

Topic	Communication
Purpose	• Express an opinion on the financial statements, not on the effectiveness of internal controls. • Our consideration of internal controls was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore material weaknesses or significant deficiencies may exist that were not identified. In addition, because of inherent limitations in internal control, including the possibility of management override of controls, misstatements due to fraud or error may occur and not be detected by such controls.
Material Weakness	• Reasonable possibility that a material misstatement would not be prevented, or detected and corrected on a timely basis.
Significant Deficiencies	• Less significant than a material weakness, yet important enough to merit the attention of governance.
Restricted Use	• This communication is intended solely for the information and use of management, the audit committee, and others within the Organization, and is not intended to be, and should not be, used by anyone other than these specified parties.
Results	• **No material weaknesses.**

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