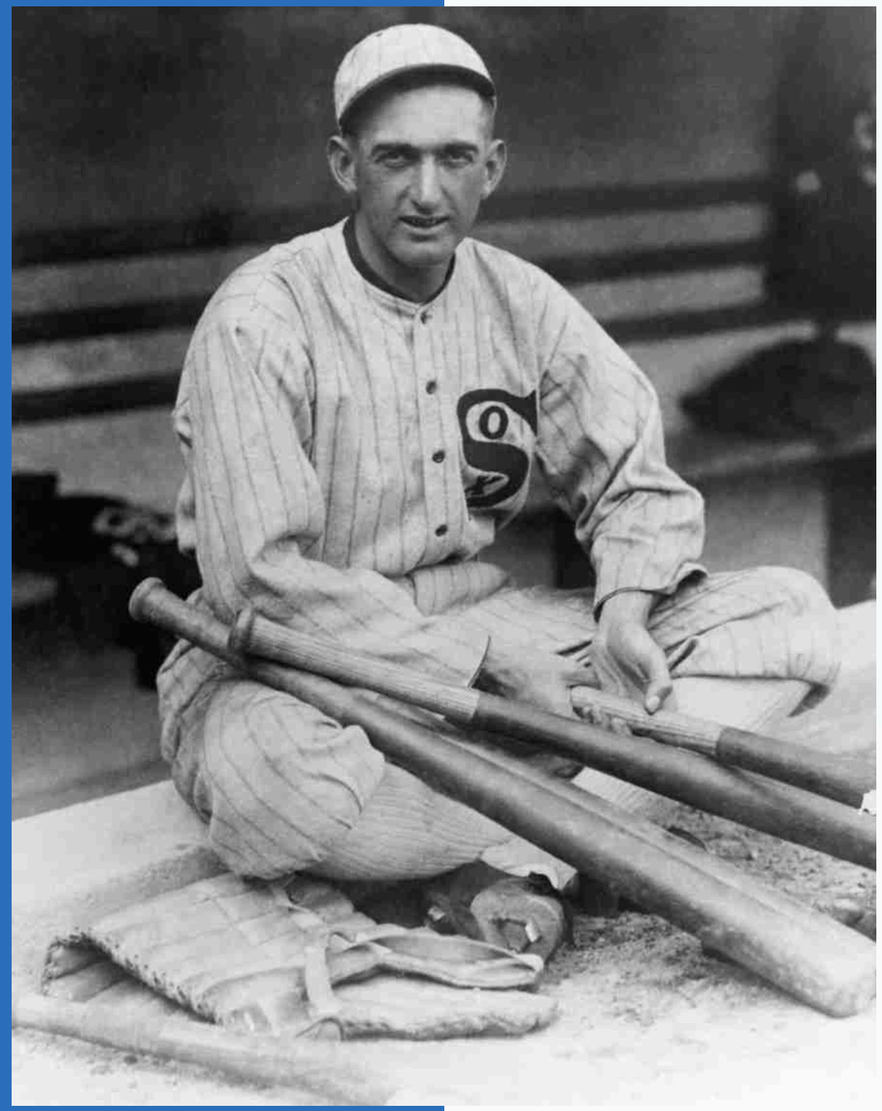
LINCOLN HEALTH

Say It Ain't So

What a small Critical Access Hospital in Colorado discovered when it dug through the data

KEVIN STANSBURY, CEO

June 10, 2025



Shoeless Joe Jackson

Say it ain’t so

Just a skinny kid from Scottsbluff...

- Scottsbluff
- Rep. Adrian Smith
- Joel Keralis, Legislative Director at U.S. House of Representatives
- HRA

LINCOLN HEALTH

- 25-bed independent County Hospital
- The only hospital between Denver & Burlington on the I-70 Corridor
- Payer Mix
  - 50% Medicare
  - 25% Medicaid
  - 20% Commercial
  - 5% Self Pay
- Negative Operating Margins

Scope of Services

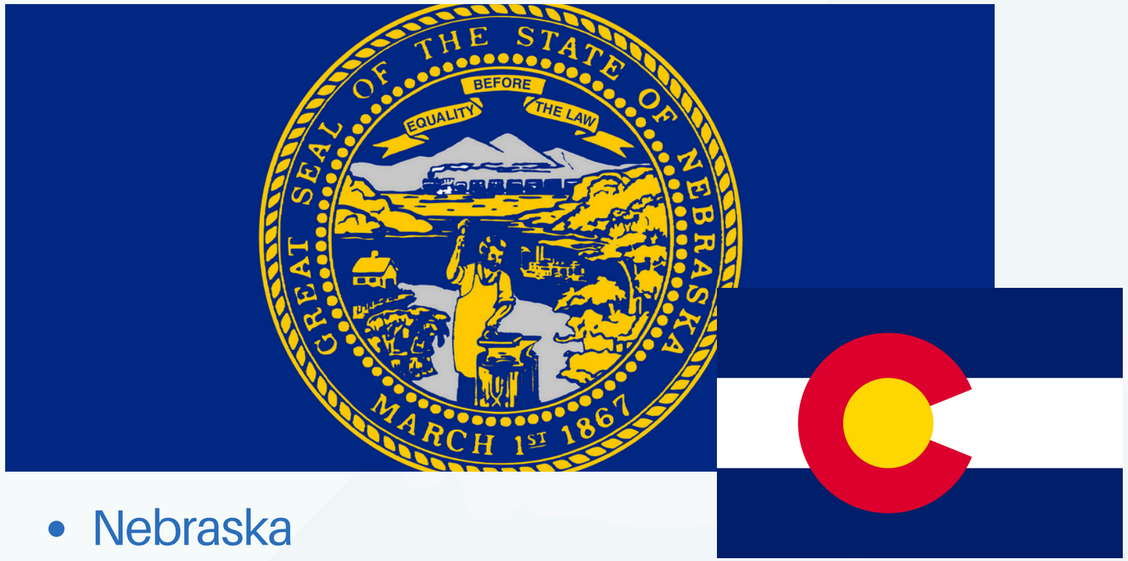
- Hospital & Ancillary Services
- Primary Care Clinics
- Specialty Services
- Extended Care Unit
- Assisted Living
- Home Health
- Hospice

The Rural Hospital Viability Challenge

National Perspective

- 46% operating in the red
- 432 vulnerable to closure
- 293 ceased OB services between 2011 - 2023
- Independent hospitals perform poorer than system-affiliated hospitals.

Nebraska & Colorado



- Nebraska
  - 54% of independent rural hospitals are operating at a loss
  - Average operating margin 1.4%
- Colorado
  - 80 % operating at an unsustainable margin
  - 48% operating at a loss

§ According to Jeremy Nordquist (NHA President) · Proposed cuts would harm rural health care • Nebraska Examiner

Payer Challenges: Medicare, Medicaid, & Commercial

A Squeeze from Payers

Medicare

- Medicare Advantage: the role and impact of these plans
- Sequestration
  - Threat of additional Sequestration

Medicaid Cuts?

- $880 Billion
- Current House estimate apx. $700 Billion

Commercial Payers

- Access to plans
- Prior Authorization: A significant hurdle

“What’s My Life Worth?”

https://youtu.be/9s3CN5EafNs?si=3zqdb9TN0xw43S2V

Independent Rural

For many small rural hospitals, the leading cause of negative margins is insufficient payment from private health insurance plans and Medicare Advantage plans. Many private health insurance plans pay rural hospitals less than the cost to deliver essential services, whereas they pay large urban hospitals more than the cost of delivering services . . .

Provider expenses increase by 18% while proposed rate increases have been 1% – 3%

Payer Attitude

- Not a negotiation
- “Shock & Awe” Approach

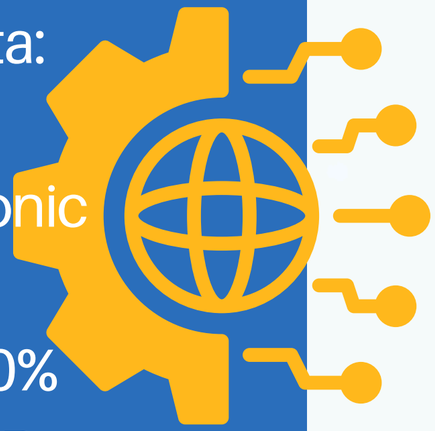
o AMA Study (Issue Brief: Payment & Delivery in Rural Hospitals | AMA

The Value of Data: Challenges to Access

Unlocking Insights: The Value and Challnges of Data

Challenges to Accessing Reliable Data:

- History of HITECH Act:
  - Created incentives for Electronic Health Record Adoption
  - Prior to adoption: less than 10%
  - By 2017: 96% of hospitals EHRs.



History of EHRs for Rural Hospitals:

- Affordability Issues
- Affordable systems often substandard
- Initial technical compliance with requirements (e.g. patient portal)
- Availability of records: often “choose the best of the worst”

LINCOLN HEALTH

ORACLE Cerner

The Value of Data: Market Data & Transparency

Leveraging Market Data and Transparency Regulations

Market Data: Garbage In/ Garbage Out

- Nebraska Data Depositories
  - Nebraska Hospital Association Data Bank
  - Partnership with UNMC
- Colorado Examples:
  - APCDB (All Payer Claims Database
  - OHDIN (Office of Health Data and Information

Transparency Requirements

- Gross Charges
- Discounted Cash Prices
- Charges negotiated between hospital & third-party payers.
- Available in a single machine-readable file
- Consumer-friendly display of standard charges for 70 CMS specified services
- Role of price estimators

Federal Mandates

- Focus on *actual prices*, not just estimates.
- Consideration of "Burden v. Benefit" in data availability.

What we Discovered

UNCOMPENSATED CARE BY PAYER CLASS

Payer	Total Charges	Contractual Write -Off	% Adjustment
Commercial Payer A	**$ 3,127,167**	**$ (1,976,713)**	**63%**
Commercial Payer B	$ 5,166,447	$ (1,697,422)	33%
Medicaid	$ 6,198,638	$ (1,385,917)	22%
Medicare	$ 13,918,114	$ (4,614,997)	33%
Medicare Advantage	$ 3,970,042	$ (1,667,817)	42%
Other	$ 1,097,334	$ (573,965)	52%
Self Pay	$ 1,333,066	$ (923,126)	69%
Grand Total	$ 34,810,809	$ (12,839,956)	37%

What We Discovered:
Market Data

Emergency Room Benchmarks						
Facility Name	**Critical Care**	**ER Level V**	**ER Level VI**	**ER Level III**	**ER Level II**	**ER Level I**
All	$9,800	$4,800	$2,700	$1,300	$1,600	$800
Lincoln	$1,700	$1,300	$1,100	$700	$400	N/A
Proposed Cap on Case Rate	$4,800	$2,100	$1,760	$1,480	$1,250	$850
Peer Group	$10,100	$4,900	$2,700	$1,300	$1,600	$800

OVERVIEW- Payer Provided Comparative Analysis

	OP- Surgery		OP- ER/Urgent		OP- Radiology		OP- Laboratory		OP- Drugs	
Facility Name	**Alwd/Case**	**Cases**	**Alwd/Case**	**Cases**	**Alwd/Case**	**Cases**	**Alwd/Case**	**Cases**	**Alwd/Case**	**Cases**
All	$7,700	5,800	$2,500	14,600	$800	22,300	$70	140,200	$28	269,200
Lincoln Health	$3,700	100	$1,000	200	$400	300	$8	3,500	$7	1,800
Peer Group	$7,700	5,700	$2,500	14,400	$800	22,000	$72	136,700	$28	267,400

ER/URGENT ALLOWED / CASE

PAYER PROVIDED COMPARATIVE ANALYSIS- CONT.

Facility Name	CRITICAL CARE	ER LEVEL V	ER LEVEL IV	ER LEVEL III	ER LEVEL II	ER LEVEL I
All	$9,800	$4,800	$2,700	$1,300	$1,600	$800
Lincoln Health	$1,700	$1,300	$1,100	$700	$400	N/A
Proposed Cap on Case Rate	$4,800	$2,100	$1,760	$1,480	$1,250	$850
Peer Group	$10,100	$4,900	$2,700	$1,300	$1,600	$800

RADIOLOGY ALLOWED / CASE

PAYER PROVIDED COMPARATIVE ANALYSIS- CONT.

Facility Name	MRI	ULTRASOUND	CT	ALL OTHER
All	$1,922	$703	$1,614	$344
Lincoln Health	$873	$464	$452	$316
Proposed Cap on Case Rate	$1,280	$450	$720	450% of MCR
Peer Group	$1,935	$706	$1,639	$345

Setting Our Sights: A Path Forward

- To achieve reimbursement rates at the mean of similarly situated hospitals in Colorado.
- Specifically, independent Critical Access Hospitals (CAHs).

2% Initial proposed increase

5% Updated proposed increase

- **Pending notice of term.**

Future Advocacy: Solutions & Models

Advocacy for Sustainable Solutions

State Legislation:

- Establishing a floor for essential services

Global Budgeting:

- An alternative payment model to stabilize rural hospitals

Utility Model for Healthcare:

- Treating healthcare as a public utility, ensuring access and stability,

What is Colorado Rural Futures?

Background

"Stop admiring the problem and work toward solutions"
Grassroots effort of Rural Hospital CEOs

Financial support

Financial pledges from Rural Hospitals and Urban Systems

Engagement of Farley Health Policy Center

Scope of the study – Aims
Aim 1 – Understand the root causes of distress in Colorado's Rural and Frontier Hospitals
Aim 2 – Develop a definition of core health services that meet essential health needs in rural and frontier communities
Aim 3 – Identify a range of state-level policy solutions and develop a policy road map

Essential Services

- What defines a community?
- What Services are truly essential?
- How do we sustainably pay for these services?

Thank You

Questions?

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