



HFMA Puerto Rico Chapter 2011 Medicare Update Conference

An Industry in Transition: *U.S. Healthcare Economics* (*Focus on Value!*)

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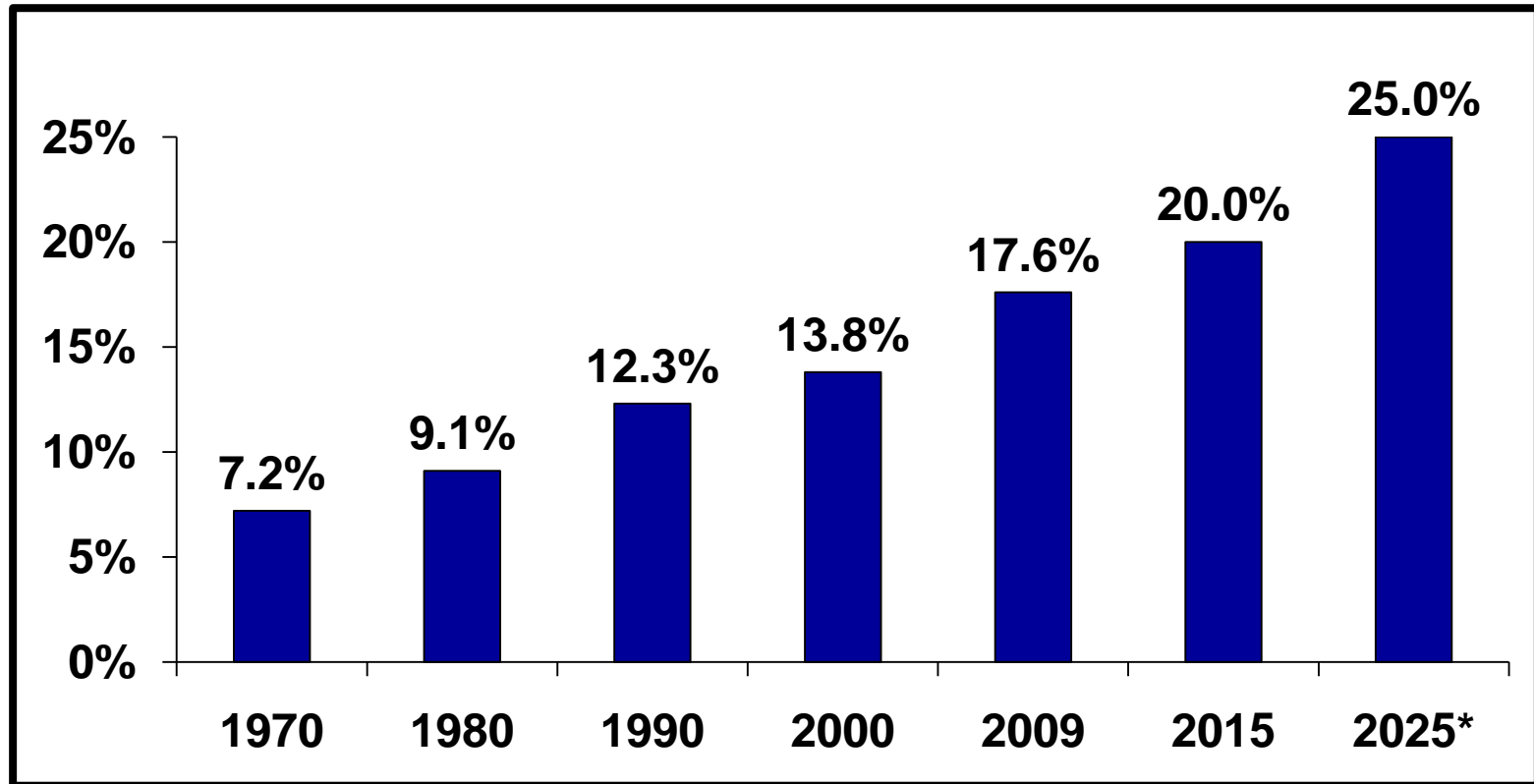
**“These are the times
that try men’s souls”**



Timeline Of Healthcare Events

- **1949: President Truman attempts to establish a national health bill**
- **1965: Establishment of the Medicare Program**
- **1970s: Passage of Federal HMO Act/ Employer Mandate**
- **1983: Implementation of the Inpatient Prospective Payment System**
 - **Diagnosis Related Groups (DRGs)**
- **1990s: Failure of the Clinton Health Security Act**
- **2000: Outpatient Prospective Payment System**
 - **Ambulatory Patient Classification Groups (APCs)**
- **2008: Implosion of financial markets and the slow recognition that financing current consumption with long term debt is unsustainable, even for sovereign governments**
- **2010: Implementation of the Affordable Care Act**
- **2010 to present: Political gridlock in Washington on how to solve the nation's financial woes**
- **August 2011: Standard & Poor's downgrades U.S. debt to AA+ with a negative outlook**

National Health Spending As A Percentage Of GDP

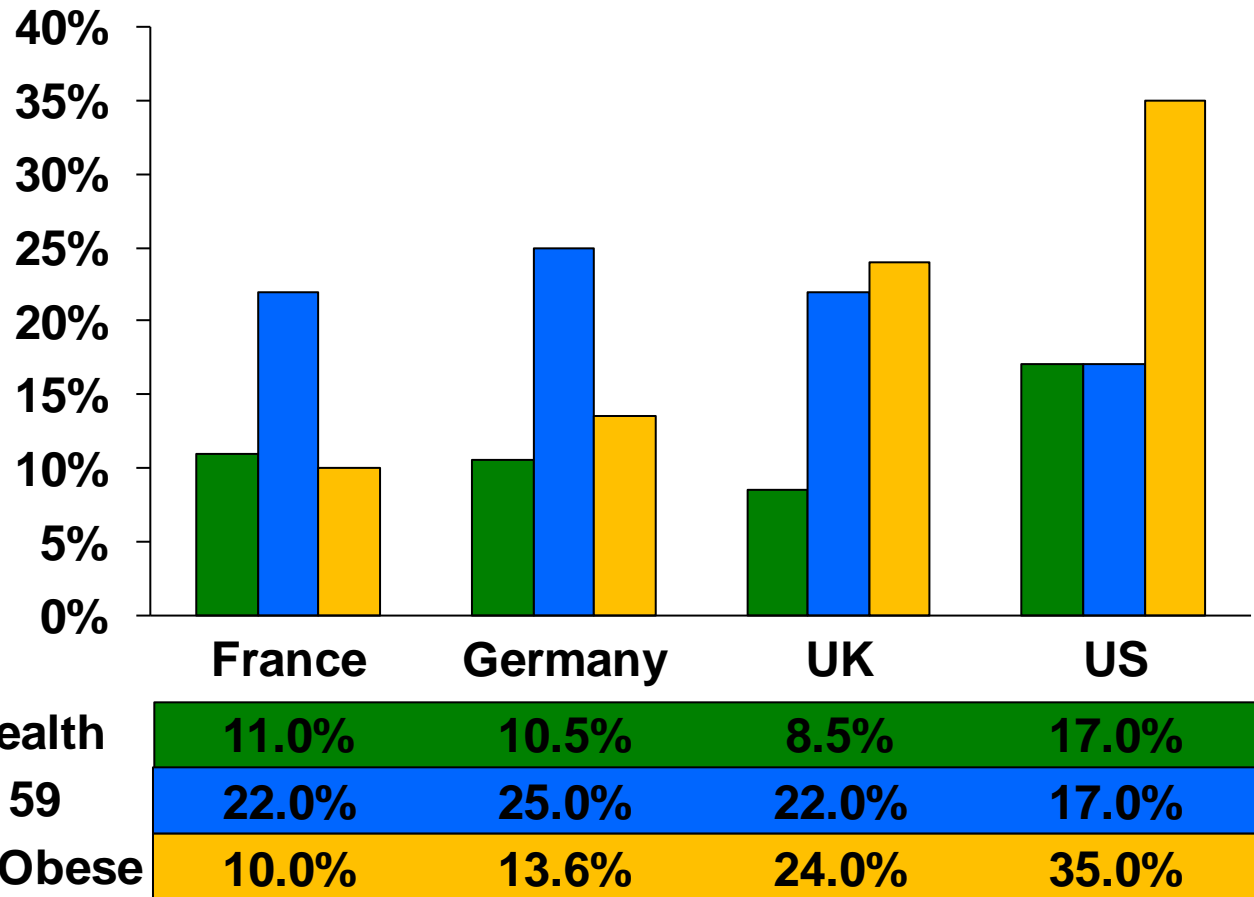


* = projection

Source: Hartman, Micah; Martin, Anne; McDonnell, Patricia et al. (2009). "National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998" Health Affairs, Jan./Feb., p. 247. (www.healthaffairs.org). See also, Orszag, Peter; Congressional Budget Office (2008). "Growth in Health Care Costs." Testimony before the Senate Budget Committee, Jan. 31, p. 1. (www.cbo.gov/doc.cfm?index-8948). Center for Medicare and Medicaid Services, January 2011.



Drivers Of Healthcare Spend



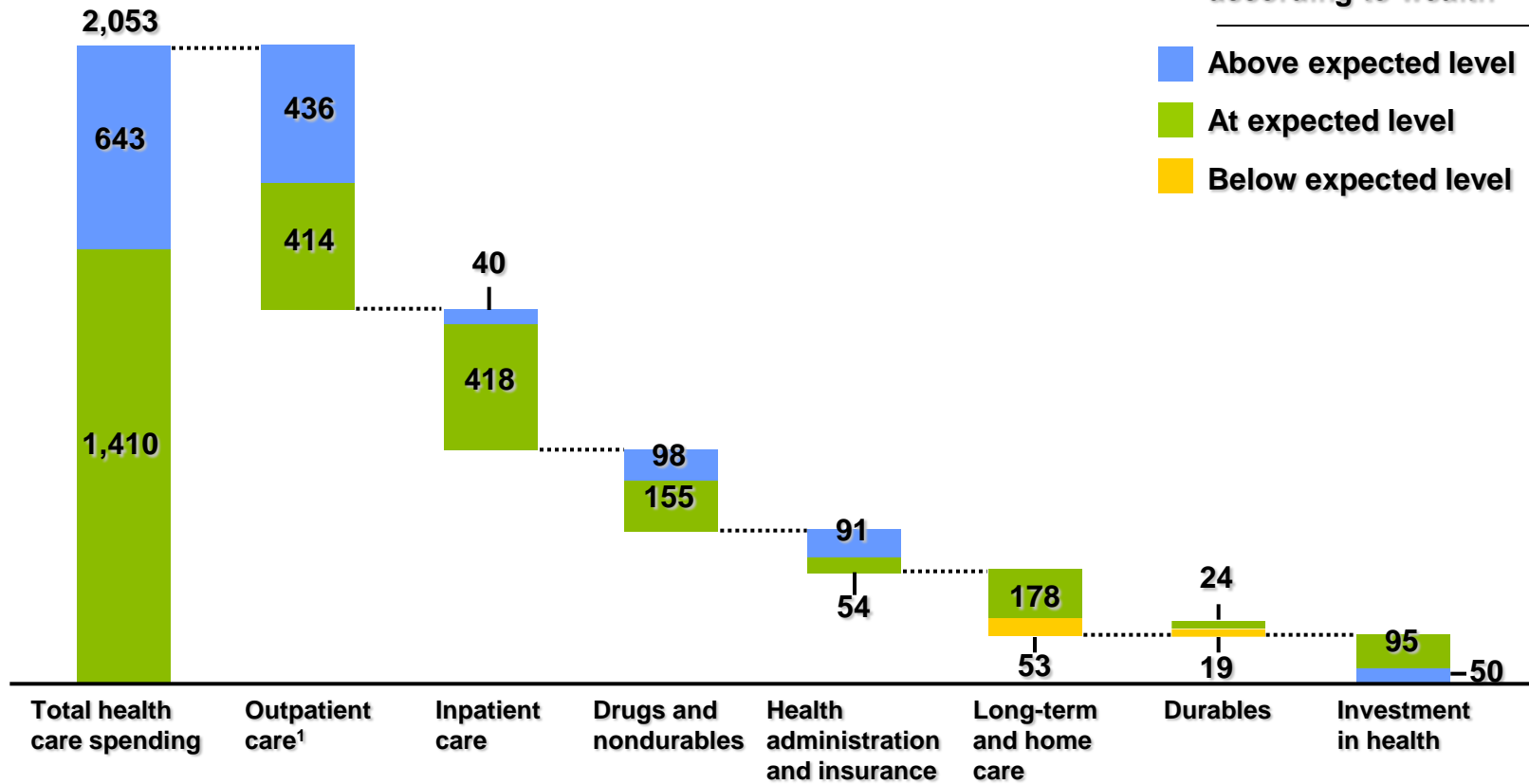
“It’s a good system but people abuse it. It’s like an open bar.”

McKinsey Study Of International Costs

2006, \$ billion

Expected spending according to wealth

- Above expected level
- At expected level
- Below expected level

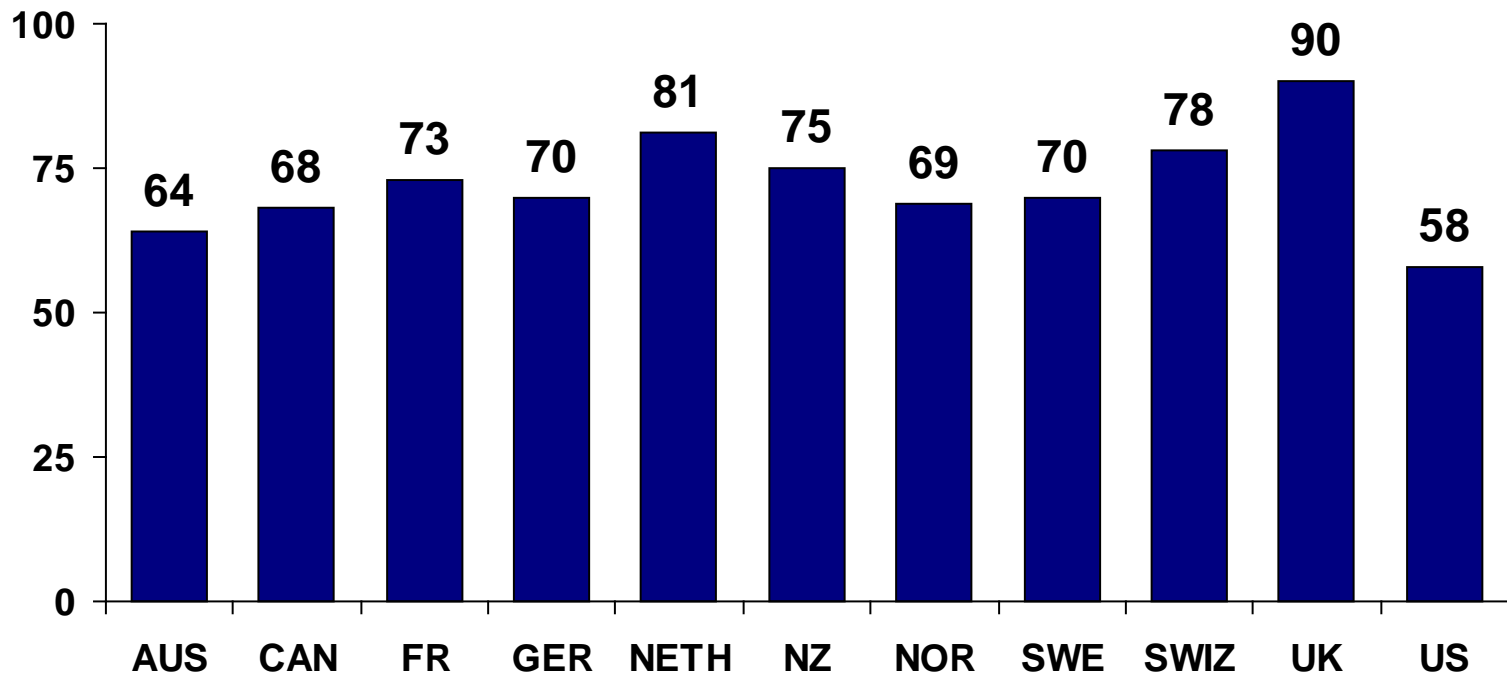


¹ Outpatient care includes care in the offices of physicians and dentists, same-day visits to hospitals (including emergency departments), ambulatory surgery, diagnostic-imaging centers and other same-day care facilities.

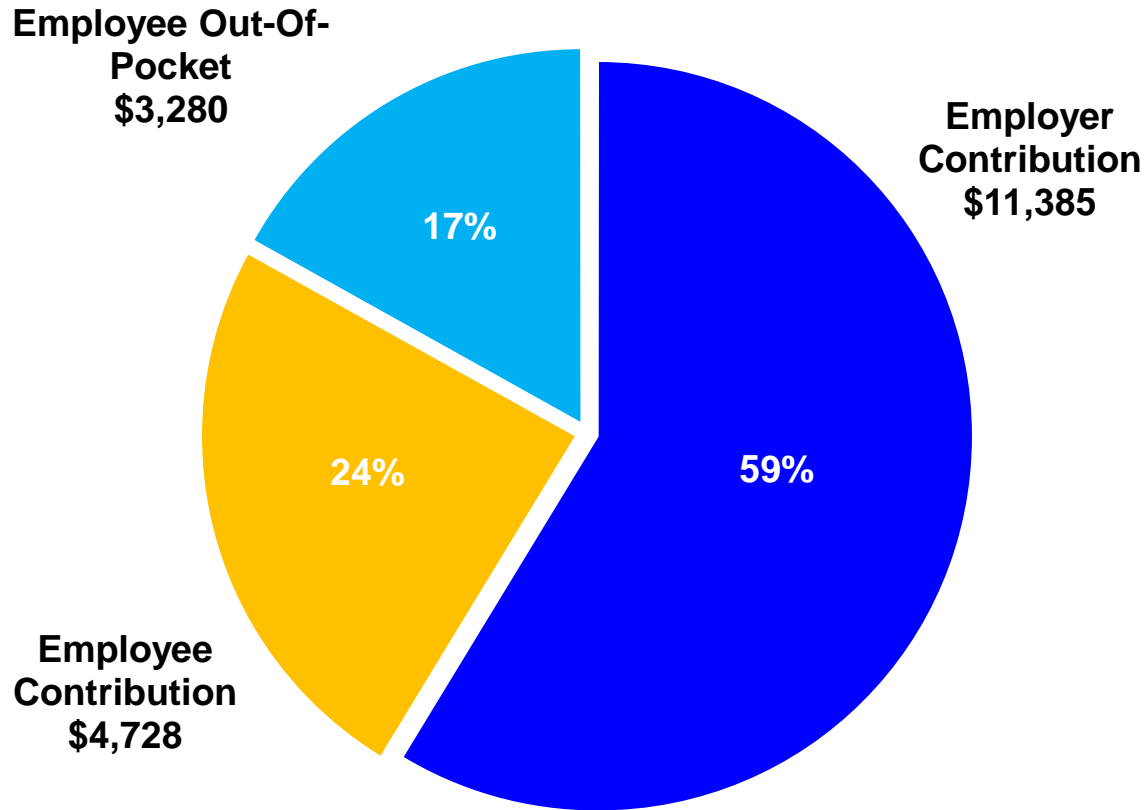


Americans Are Not Confident They Can Afford Needed Healthcare

Percent responded, if they became seriously ill, confident/very confident they would be able to afford the care they needed

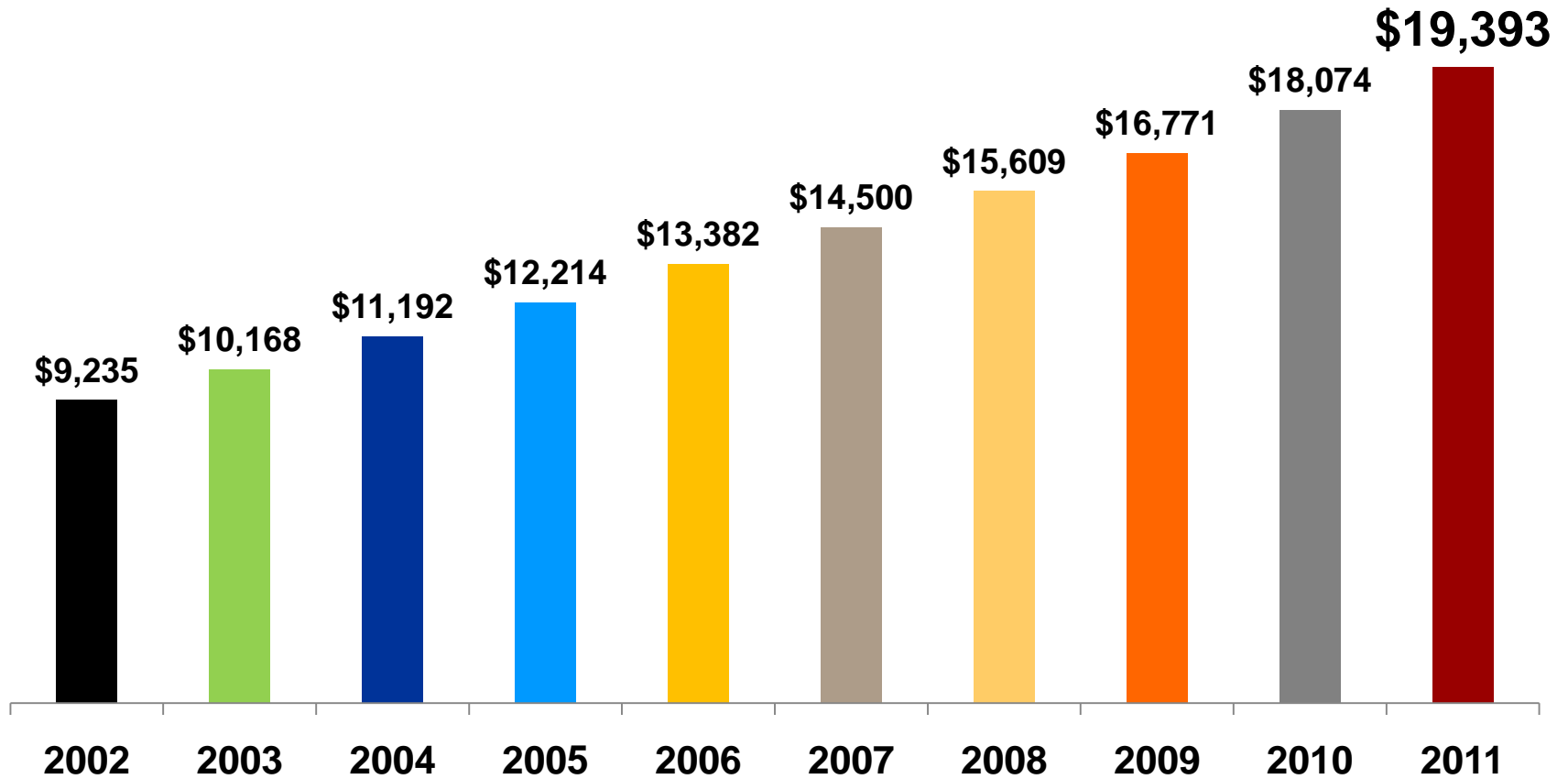


Relative Proportions Of Medical Costs

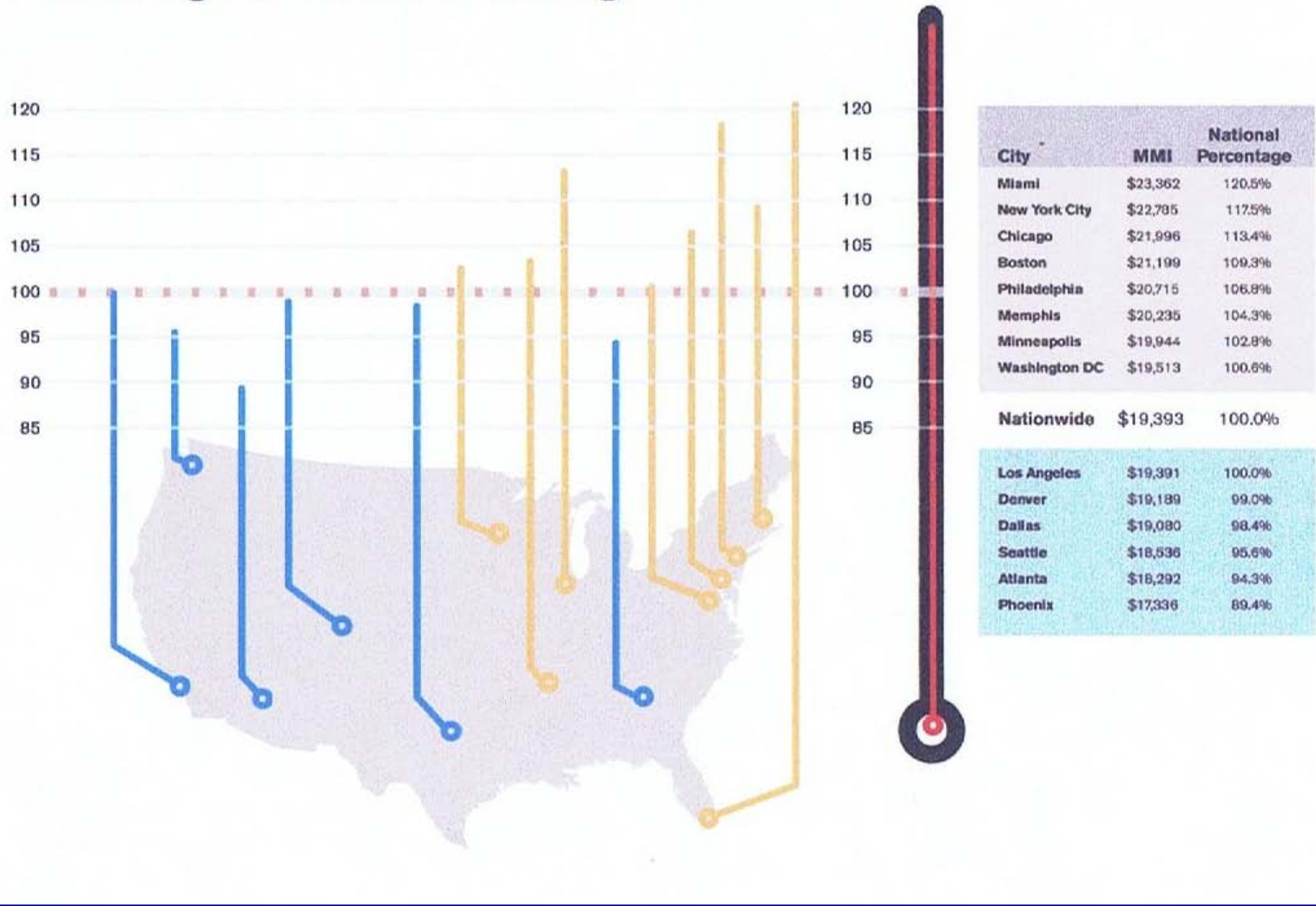


2011 Milliman Medical Index

Healthcare costs for American families double in less than nine years



Percentage of National Average



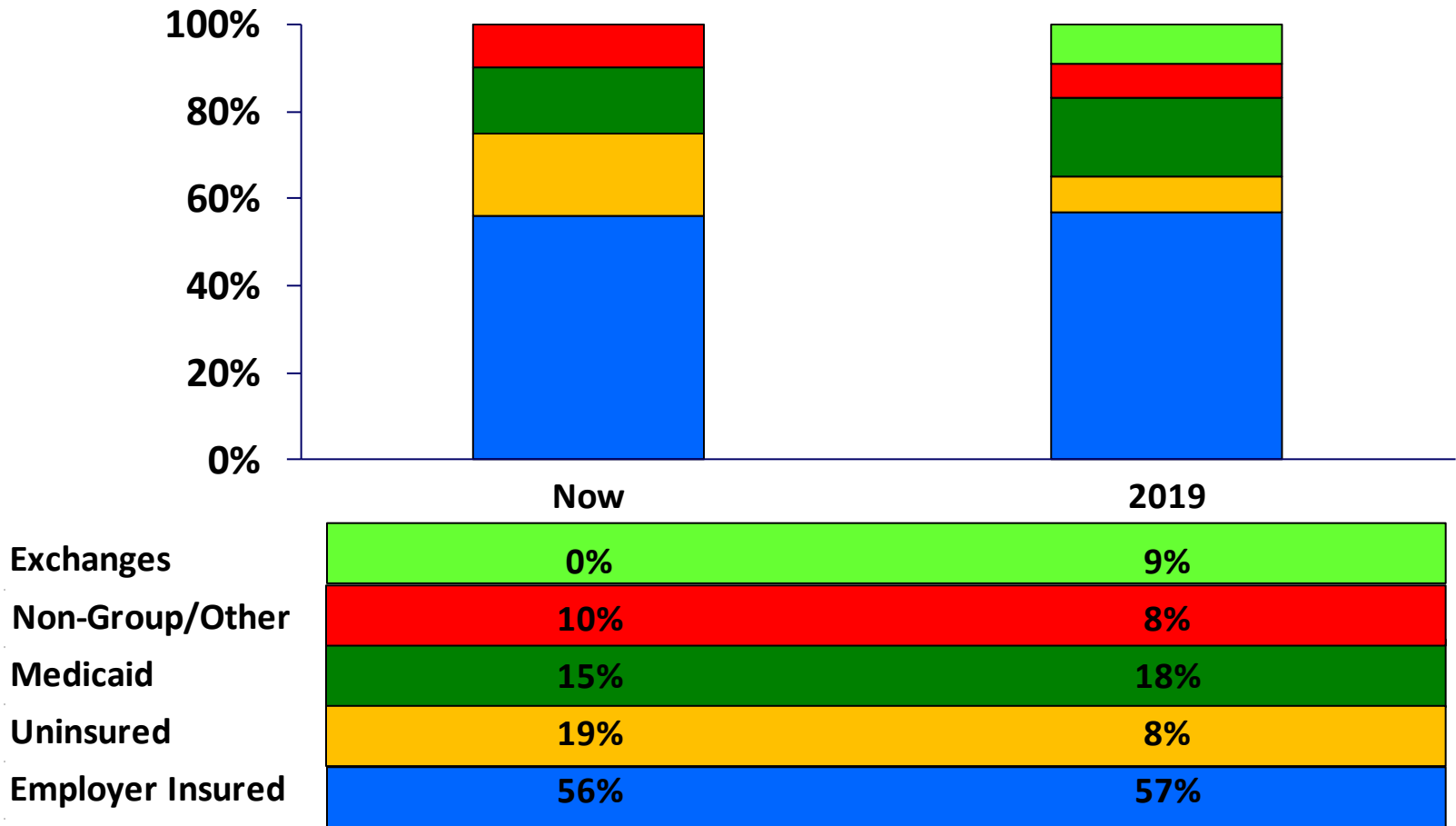


Traditional Value Equation Falls Short In Healthcare

$$\frac{\text{Quality}}{\text{Cost}} = \text{Value}$$



The Big Picture Non-Elderly Insurance Coverage

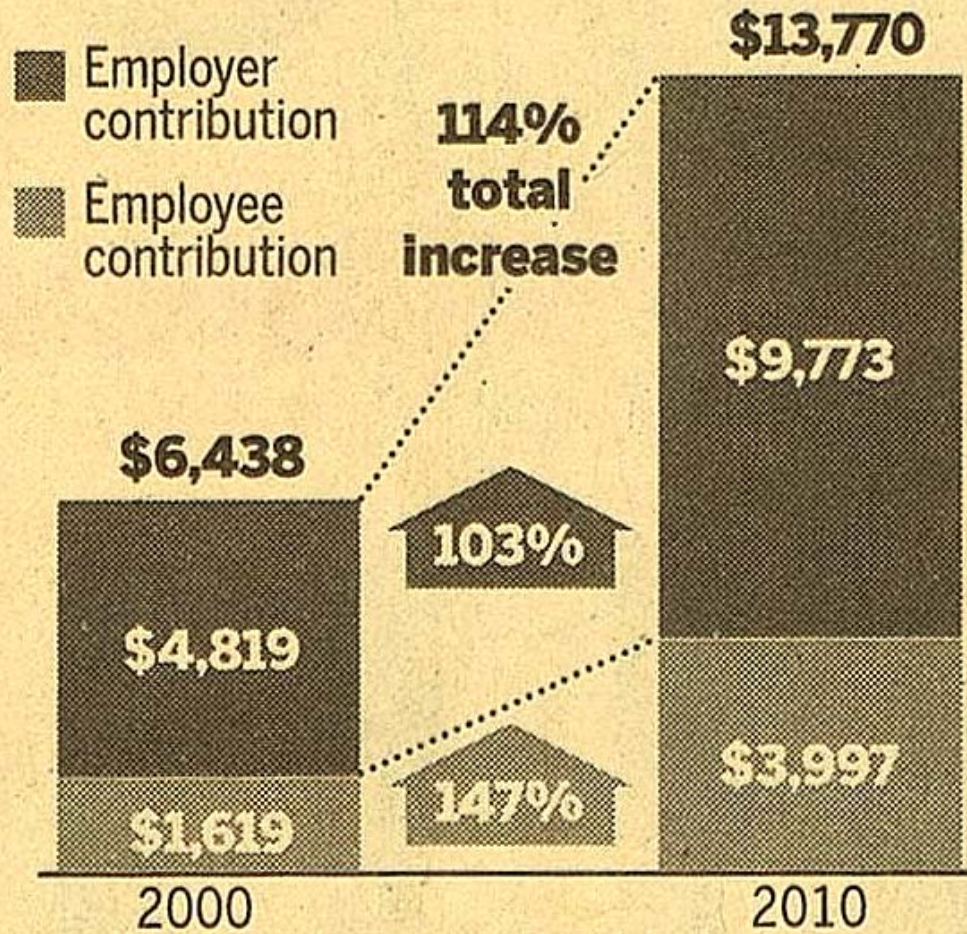


U.S. Healthcare Reform:
It's About The Money

**Fundamental economic issues
were not effectively addressed**

US health insurance premiums

Average annual cost for family coverage



**“52% of U.S. adults believe
50% or greater of the
money spent in the U.S.
health care system is
wasted.”**

Projected annual rate of increase in total U.S. healthcare spending:

Before - 6.1%

After - 6.3%

SECTOR COMMENT

From Bad to Worse: Erosion of Medicare Trust Fund Threatens Hospitals

Extracted from "Moody's Weekly Credit Outlook", dated May 23, 2011

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The 2011 report from the Medicare board of trustees released on 13 May projected that the \$270 billion Hospital Insurance Trust Fund will be depleted by 2024, five years earlier than the board projected just last year. The fund's swift decay is an unambiguous credit negative for not-for-profit hospitals, as what already was a challenging environment for America's not-for-profit hospitals is worse than we thought.

Regardless of which political party controls Congress or occupies the White House, Medicare reimbursements to hospitals are going to be under material strain. Already stressed hospitals will need to find ways to be more efficient even as they upgrade their service quality to comply with federal reform mandates.

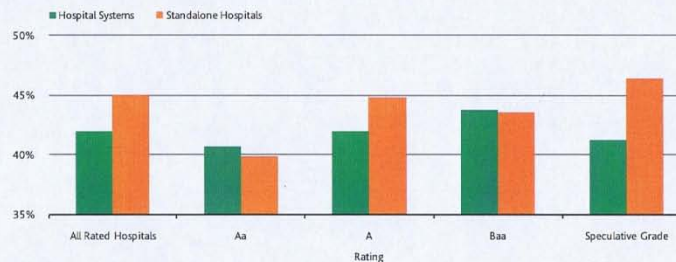
Medicare is not-for-profit hospitals' biggest source of revenue. We maintain a negative outlook on the not-for-profit healthcare sector, in part because of risks to Medicare reimbursements. As shown in Exhibit 1, among the approximately 500 not-for-profit hospitals and health systems that we rate, median Medicare revenue dependence ranges from 40% to 47% by rating category. Most at risk are low-rated hospitals, particularly those that rely disproportionately on Medicare patients for cash flow. For instance, Kuakini Health System (Ba1 stable) and Citrus Memorial Hospital (Ba2 negative) are both speculative-grade hospitals that derive more than two-thirds of their gross revenue from Medicare.

What is Moody's Weekly Credit Outlook?

Moody's [Weekly Credit Outlook](#) provides our research clients with timely opinions on breaking credit market developments and trends. Published every Monday morning, the newsletter will help you start your week informed of Moody's latest opinions from across the organization.

EXHIBIT 1
Median Dependence by Rating Category

Median % of Gross Patient Revenue



Source: Moody's

SPECIAL COMMENT

Hospital Revenues In Critical Condition; Downgrades May Follow

Not-for-Profit Hospital Revenue Growth Lowest in Two Decades

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Summary

Top-line revenue growth is falling at many not-for-profit hospitals, presenting hospital management teams with their most immediate challenge and supporting our negative outlook for the sector.¹ Hospital downgrades will likely increase in the short term unless expense reductions and productivity gains compensate for stagnant or weak revenue growth. With hospitals facing reimbursement pressure from *all* payers – Medicare, Medicaid and commercial health insurers – and declining volumes given a persistently sluggish economy, numerous hospitals are reviewing every aspect of their operations to make fundamental changes to their business model. These efforts will stave off rating downgrades at better managed hospitals, but will likely prove insufficient at others to stave off credit deterioration over the longer-term.

We expect the following challenges to revenues:

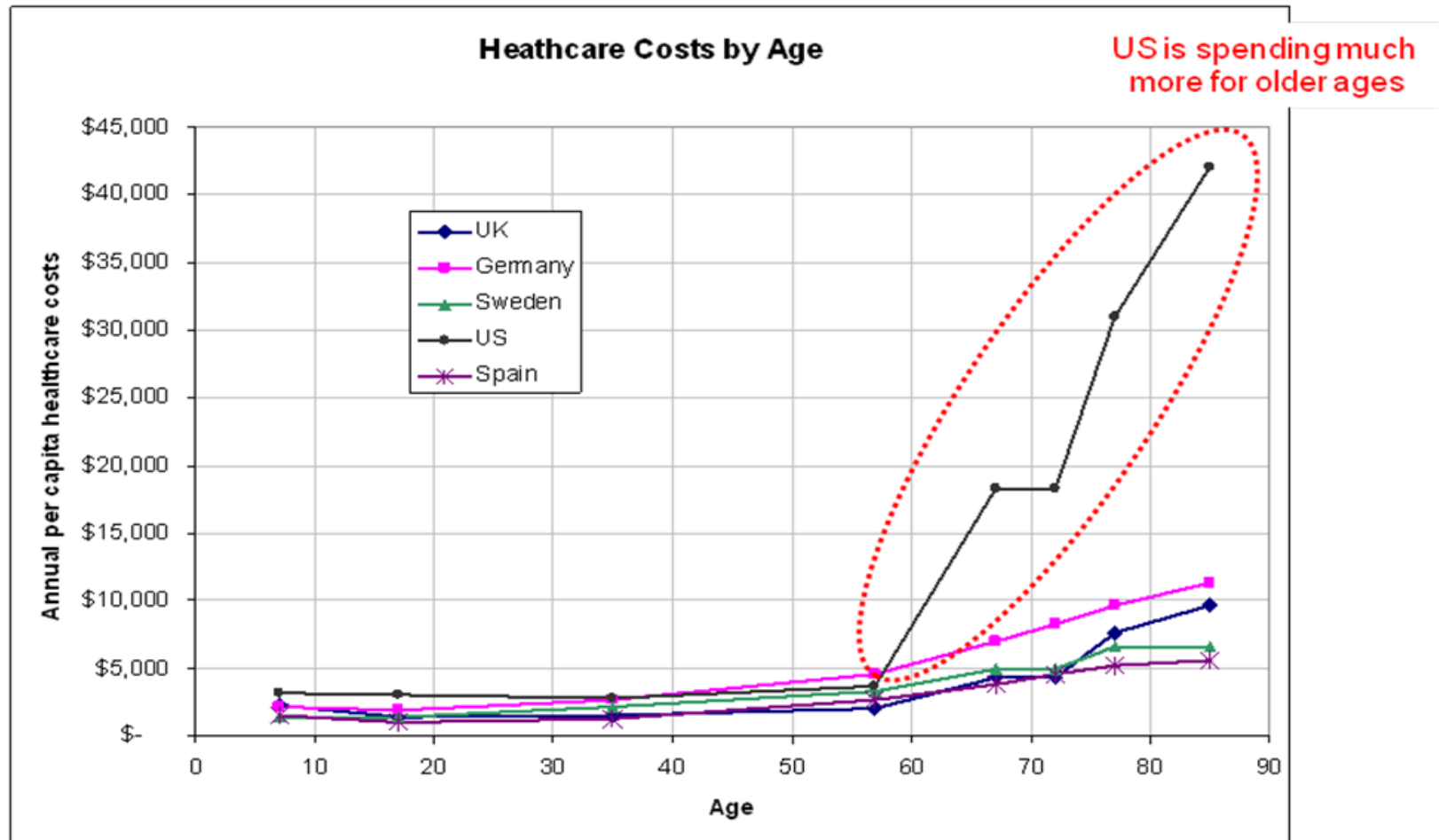
- » Medicare: Despite an uptick in reimbursement rates for 2012, funding pressures and rate reductions are inevitable in coming years as Washington seeks to reduce the deficit and reign in Medicare costs²
- » Medicaid: Widespread rate reductions caused by federal budget reforms as well as funding pressure at the state level as lawmakers continue to grapple with budget challenges
- » Commercial Payers: Lower rate increases as payers face financial challenges and increased regulation; ability to cost shift will abate
- » Patient Volumes: Flat inpatient admissions while lower-paying 24 hour observation stays increase
- » Uncompensated Care: Likely to increase given stubborn unemployment rate and employers discontinue or reduce healthcare benefits; over the longer term uncompensated care should decrease due to greater coverage under healthcare reform
- » New Disease Diagnosis Classifications (ICD-10): Will likely disrupt revenues in 2013 unless management teams start preparing now
- » Fee-for-Service and Bundled Payment: Simultaneous management of two very different reimbursement schemes will impede revenue management

¹ Please refer to [Moody's Negative Outlook for U.S. Not-For-Profit Healthcare Sector Continues for 2011](#) February 2011.

² CMS has just announced a 1% increase in rates for federal fiscal year 2012



U.S. Spends More On Healthcare For Seniors



Source: Fischbeck, Paul. "US-Europe Comparisons of Health Risk for Specific Gender-Age Groups." Carnegie Mellon University; September, 2009; and HFMA

“How many teachers are you willing to fire in order to have 78-year-olds have a procedure which will be invented five years from now that adds four months to their lives?”

**Where should we look
to reduce costs significantly?**

***“...private insurance bureaucracy
and paperwork consume one
third (31 percent) of every
healthcare dollar.”***



Healthcare Reform - The Role Of Government

- **159 new federal agencies**
- **Discretionary power is being delegated to the Secretary of the Department of Health and Human Services**
 - **“The Secretary shall” is said 1,075 times**
- **Somewhere between 5,000 and 15,000 new IRS agents**
- **Significant new reporting and administrative requirements**

“Researchers at Dartmouth have gone as far as to assert that their work on (medical cost) variation suggests that nearly 30 percent of (United States) healthcare spending could be unnecessary or wasteful”

**The change in thinking
that must occur...**

...there are no revenue centers



Example Of A Savings Opportunity

Physical Health Indicators, by Income Group

	Annual Income			Low to High Difference
	<\$24K (Low Income)	\$24K-<\$90K (Middle Class)	\$90K+ (High Income)	
% Obese	32.0	27.9	21.7	10.3
% Diabetes	16.1	10.1	6.7	9.3
% High blood pressure	36.4	29.0	23.6	12.8
% Asthma	15.9	10.5	9.2	6.7
% Diagnosed with depression	29.0	15.2	10.2	18.8



U.S. Department Of Health And Human Services Releases Its *National Strategy For Quality Improvement In Health Care*

Six Priorities

- **Make care safer by reducing harm caused in the delivery of care**
- **Promote effective communication and coordination of care**
- **Ensure each person and family is engaged as partners in their care**
- **Promote the most effective prevention and treatment practices for leading causes of mortality, starting with cardiovascular disease**
- **Work with communities to promote best practices to enable healthy living**
- **Make quality care more affordable**

***Remember, as you pursue strategies
to create additional value, focus
first on quality...***

Quality always brings down cost!



Healthcare Mega-Trends

- Healthcare providers may have difficulty accessing capital at acceptable rates
- Healthcare is getting more expensive throughout the world at a time when the world can least afford it
- Insurance restrictions are increasingly viewed as a barrier to accessing quality care
- Healthcare customers are increasingly searching for value
- Employer sponsored healthcare will increasingly demand compliance and life style changes
- Employers will likely end coverage for retirees that qualify for government sponsored insurance
- Medicare advantage will change or be completely eliminated
- Hospitals and physicians will be paid significantly less per unit of service
- Nurse practitioners and physician assistants will increasingly be your doctor
- End of life costs will be reduced by more rational provision of care
- Provider performance will become increasingly transparent and available to consumers
- Physicians will be rewarded for doing less and keeping costs down
- **Everyone believes there is a better way**

Value Based Purchasing

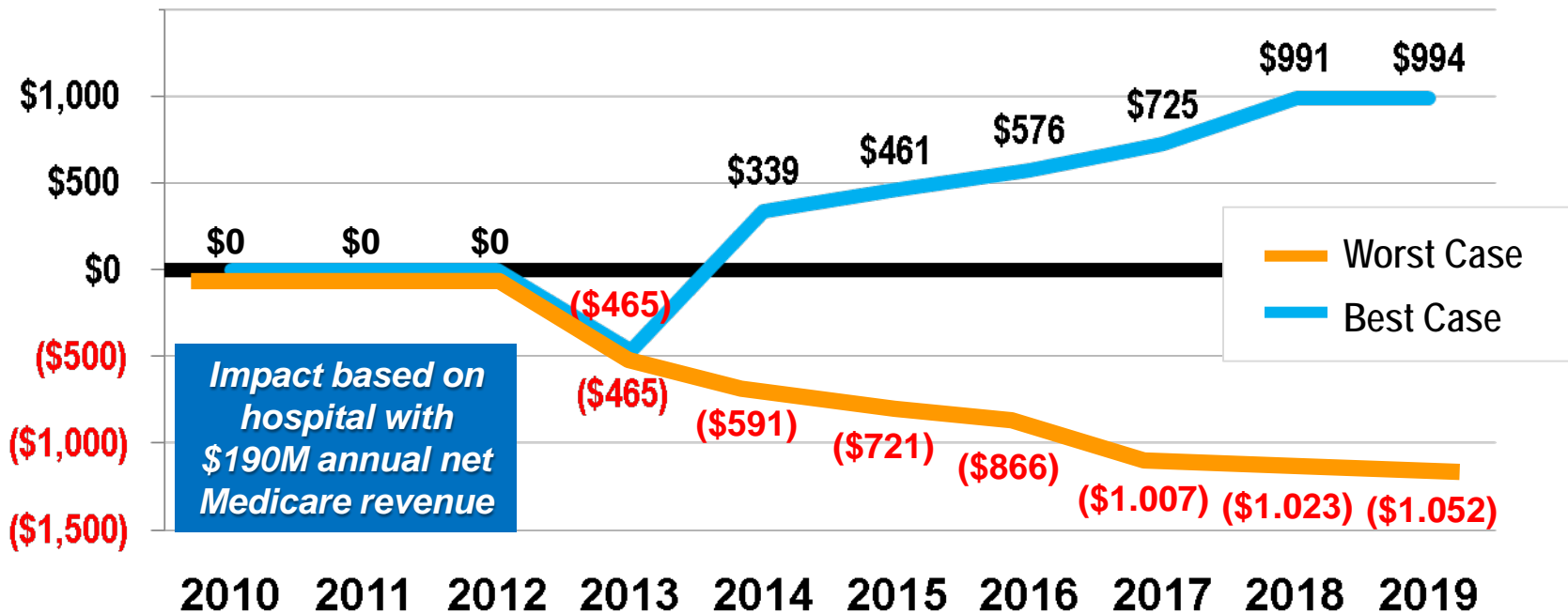


Payment Reform CMS Value-Based Purchasing Program

(\$ in 000's)

Starting in FFY 2013, base IPPS payments will be cut by 1%.
Based on performance relative to other hospitals, providers may be eligible for a bonus.

Value Based Purchasing Impact



“A group of Medicare-enrolled providers and suppliers that work together to coordinate and deliver health care services to the Medicare fee-for-service enrollees assigned to it.”



Minimum Requirements For A Functional ACO

Consist of primary care physicians, specialists and a hospital

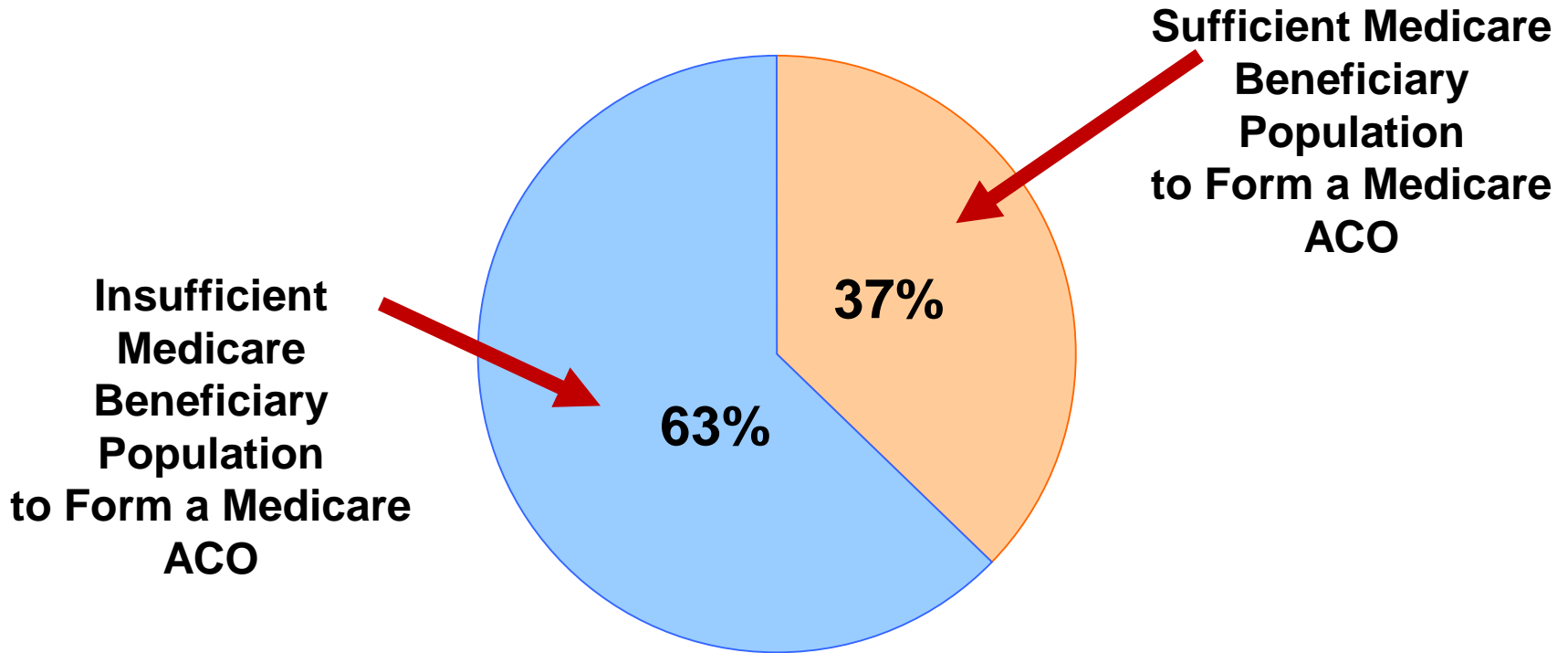
AND

Have the capability to set benchmarks, measure performance, receive and disburse payments and account for and disburse shared savings

**Hospitals will likely dominate
the ACO contracting process**



Many Hospitals Lack Critical Mass To Meet ACO Population Threshold

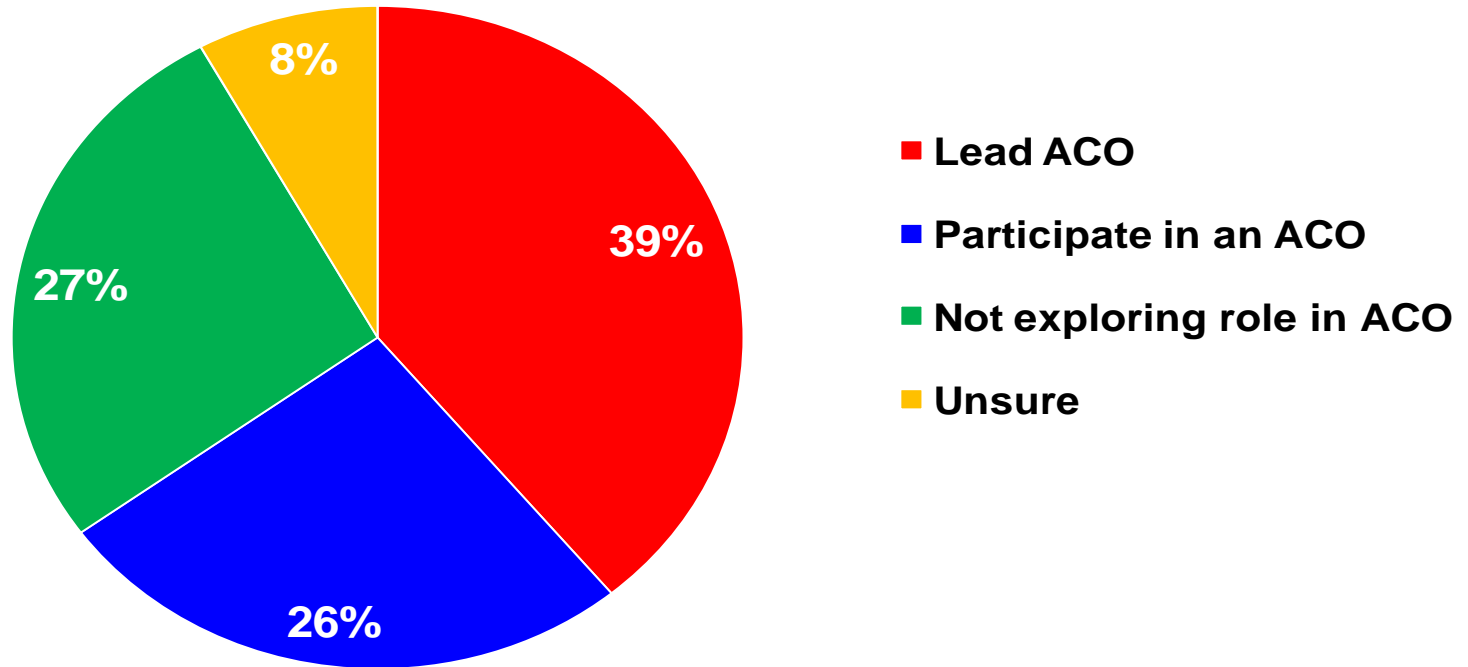


Source: MedPac June 2009 Report to Congress, Chapter 2, footnote 7: “According to the Dartmouth data analysis, 4,658 single hospital EHMSs could be defined, of which 1,736 would have an assigned patient population of 5,000 or more and could meet our definition of ACOs. . . .”
http://www.medpac.gov/documents/Jun09_EntireReport.pdf



ACO Bound?

How Would You Describe Your Organization's Accountable Care Organization (ACO) Strategy?





Concerns With CMS' Proposed ACO Rule

- **Misses an opportunity to align quality and cost incentives by ignoring the role beneficiaries play in their care**
- **Jeopardizes fairness and sustainability**
 - **Provides inadequate financial support for providers, given start-up costs and risks**
 - **Fails to reward innovative delivery systems**
- **Increases complexity by placing significant burdens on participants to qualify for and administer the program**
- **Provides inadequate legal waivers to create the necessary alignment among providers**

How the shared savings program works

A Medicare patient with 5 or more chronic conditions averages 37 physician visits, sees 14 different physicians, and fills 50 prescriptions per year

**National voluntary pilot program
on payment bundling**



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- Provider performance will become increasingly transparent and available to consumers
- Physicians will be rewarded for doing less and keeping costs down
- Everyone believes there is a better way
- **Meaningful tort reform must eventually occur to significantly lower costs**

***Providers must do more with
less, and do it better!***

Increasing Quality:

Define it

Believe it

Be accountable for it

**“We believe it is important to let customers
decide what is of value to them.”**

**First, seek to understand before you
seek to be understood**

Thirteen Potential Winners And Losers Over The Next Five Years

- 1. High cost urban hospitals (free standing or part of a small system) will lose*
- 2. Primary care physicians will finally win (but not big)...along with pediatricians*
- 3. Physicians alone or in small groups in urban areas will often lose*
- 4. Anyone who can meaningfully help hospitals significantly reduce cost will win*
- 5. Organizations that make advanced technology that increases quality, reduces cost, extends or improves life, or improves the patient experience will win*
- 6. Companies that make advanced technology that compensates for the expected shortfall of healthcare workers will win big!*
- 7. Organizations that make advanced technology more affordable to hospitals will win*
- 8. Large, highly integrated hospital systems with strong volumes and favorable payer mixes will stay in business*
- 9. Organizations that help healthcare providers define, understand, communicate and create value will win*
- 10. Large safety net hospitals will often struggle and reduce services*
- 11. Information system vendors that help hospitals and other providers adapt to new payment models will win*
- 12. Insurers that genuinely reach out to providers to collaborate and reduce cost will win*
- 13. Market consolidators will win**

***The real winners over the next
several years will be those
providers that successfully
transition from volume to value***