

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

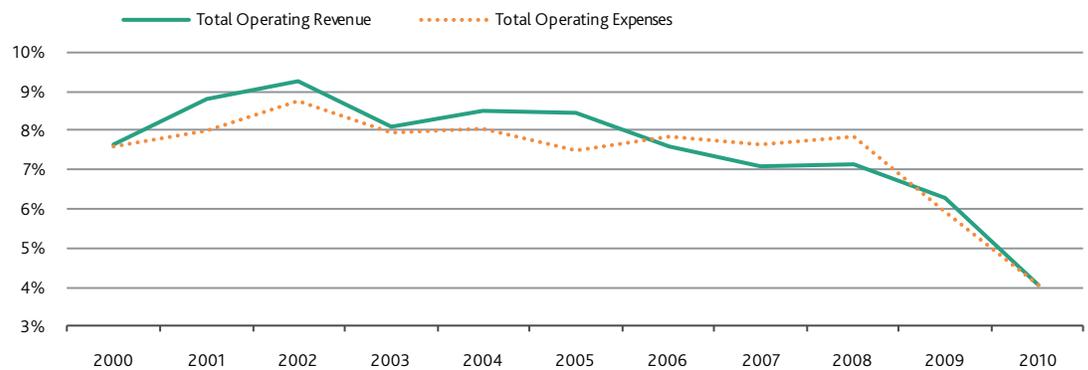
¹ Please refer to [Moody's Negative Outlook for U.S. Not-For-Profit Healthcare Sector Continues for 2011](#) February 2011

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

Median Hospital Revenue Growth Rate Falling

As depicted in Figure 1, the median hospital revenue growth rate is the lowest in two decades at 4.0% based on our FY 2010 medians³ and is unsurprising given the payer pressures and lower volumes. When reviewing a small sample of unaudited interim FY 2011 statements we are seeing some stabilization of revenue growth but expect a further decline over the long term. The median expense growth rate is also down, indicating that hospital management teams have responded to the revenue pressures thus far. However, additional expense reductions will be harder to achieve and they will depend on more difficult strategies to change fundamentally how hospitals deliver care.

FIGURE 1
Median Hospital Revenue Growth Rate Reaches Low Point of 4% in 2010*



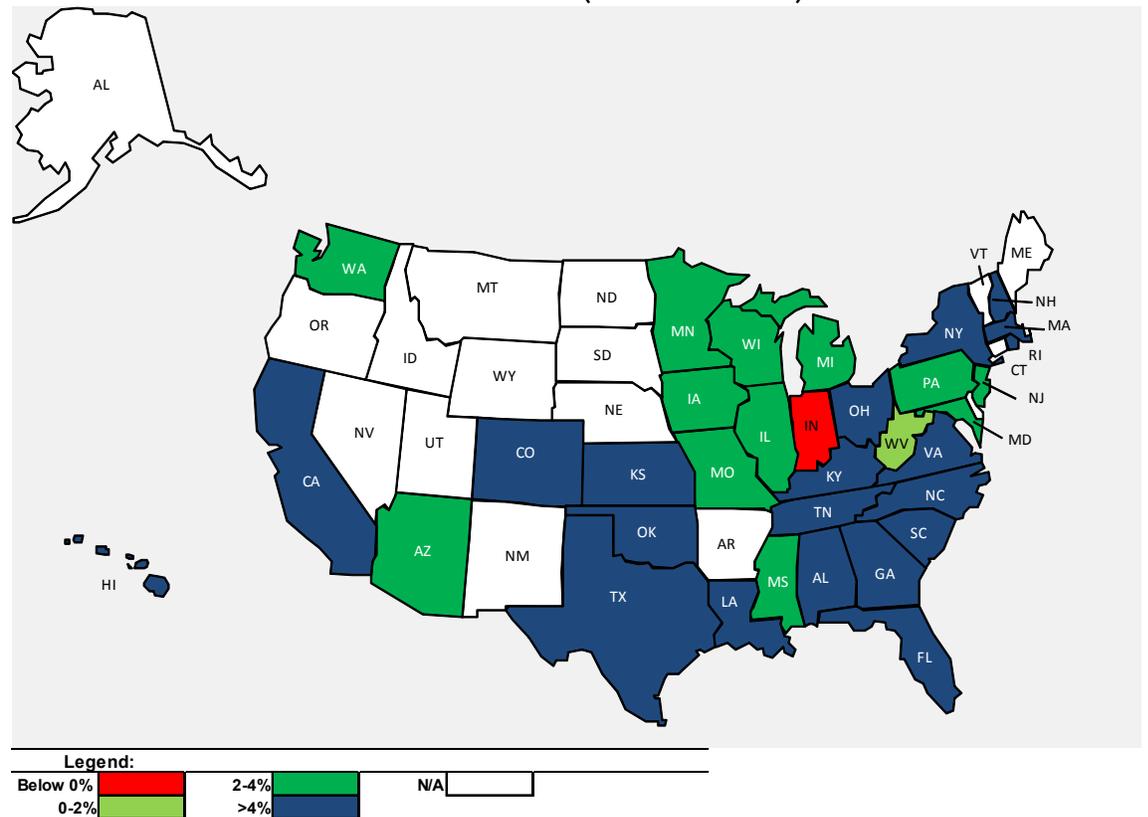
*The data prior to 2007 are from different sample sets, however the ten years of data still accurately reflect the trend in the industry over this period
Source: Moody's

Figure 2 depicts the median revenue growth rate from FY 2009 to FY 2010 for each state based on audited financial statements for each rated hospital. Fourteen states show revenue growth below the national 4.0% median⁴ and we expect that number of states falling below 4.0% to increase in FY 2011. Indiana was the only state to show an actual decline in median hospital revenue growth in FY 2010.

³ Based on 401 freestanding hospitals and health systems

⁴ We computed the median revenue growth rates for states that had four or more rated hospitals or health systems with the exception of Hawaii whose three larger rated systems encompass the majority of hospitals in that state

FIGURE 2
14 States Show Median Revenue Growth Below 4% (FY 2009 – FY 2010)*



*N/A indicates states with less than four rated hospital or healthcare systems

Source: Moody's

Medicare Reductions Inevitable Over the Long Term

The credit impact of Medicare cuts on hospital ratings is inevitably negative and will lead to more rating downgrades in the absence of significant expense reductions and productivity gains. Medicare comprises nearly half, 43%, of hospital gross revenues (see figure 3). Additionally, significant Medicare cuts to physician professional fee revenues, thus far avoided by Congress, remains a looming threat until a sustainable budget resolution is found. It is likely that as hospitals employ more physicians in preparation for health care reform and increase their professional fee revenues, they will face cuts from both hospital rate reductions and physician fee rate reductions.

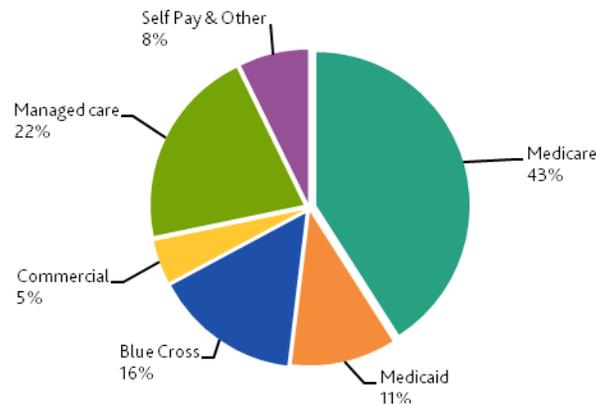
Medicare payment rates have been increased in every year from 1999 to 2010, but in federal fiscal year (FFY) 2011 Medicare rates were effectively cut because presumed overpayments in prior years were netted out. This adjustment led to a reimbursement decline in inpatient rates of 0.4%. While Medicare recently announced a 1.0% increase in FFY 2012, it includes a reduction factor legislated under healthcare reform. We expect Medicare rate reductions to hospitals in the coming years given the looming insolvency of the Medicare Trust Fund and the need to fund the mandated individual coverage stipulated under healthcare reform. Healthcare reform includes Medicare reductions of \$155 billion over ten years along with reductions to disproportionate share funding in FFY 2014.

Furthermore, Medicare funding is in the cross-hairs of Congress given the Federal deficit and more cuts may be forthcoming as early as FFY 2013.

Medicare is also reviewing potential overpayments to hospitals through the Recovery Audit Contractor (RAC) process. Numerous hospitals have been required to repay Medicare at the conclusion of the findings and appeals. RAC represents another pressure point on Medicare revenues for hospitals.

FIGURE 3

Medicare Typically Represents Largest Payer for Hospitals*



*Based on FY 2010 medians; numbers do not necessarily sum to 100% because each payer is a separate median calculation.

Source: Moody's

Medicaid under Pressure from States' Fiscal Challenges

Most U.S. state governments continue to face considerable budgetary challenges. Not-for-profit hospitals have felt the brunt of these pressures as many states have reduced hospital Medicaid reimbursement rates in order to balance their budgets, creating yet another strain on top-line revenue growth that hospital management must address. On average, Medicaid represents a moderate 11% of a hospital's revenue and therefore, Medicaid payment reductions have less of an impact on revenue than Medicare cuts for the average hospital. However, some hospitals are much more dependent on Medicaid because they treat a much higher share of Medicaid-eligible populations. Some of these providers face a higher likelihood of a rating downgrade.⁵

The American Recovery and Reinvestment Act (ARRA) of 2009 provided states with enhanced federal funding that temporarily staved off deeper Medicaid cuts, but the June 30, 2011 expiration of the enhanced funding will lead to more severe Medicaid reductions. Many states have already implemented rate reductions as most states are essentially restricted from modifying Medicaid eligibility at this time as a means to reduce costs.

Many states are introducing Medicaid managed care organizations (MCO) to control costs. Medicaid MCOs typically receive a per capita payment from the state for each individual covered by the MCO's Medicaid program. While Medicaid MCOs are not immune to the risk of reduced state payments, individual contracts between states and providers may make it difficult for states to implement mid-year rate adjustments. In addition, state attempts to cut rates may be met with federal restrictions if the reductions limit access to care for Medicaid enrollees.

⁵ Please refer to [Medicaid Funding Cuts Add to Credit Strain for U.S. Not-For-Profit Hospitals](#), July 2011

Experience has shown that there can be an adjustment period for both the state and the providers during the initial stages of a new Medicaid managed care program. Once a managed care program is established, hospitals usually receive payments on a timely basis. Still, others experience revenue challenges well after a new program is established.

Finally, similar to the RAC reviews, the Centers for Medicare and Medicaid Services (CMS) has also established Audit Medicaid Integrity Contractors (MICs). MICs perform audits of Medicaid providers to identify overpayments and inappropriate Medicaid claims. While not as widespread as RAC reviews, the MIC program may also threaten revenue growth going forward.

Commercial Payers Face Declining Membership and Increasing Regulation

Moody's maintains a negative outlook on the health insurance sector.⁶ An insurance payer's financial stress has a direct impact on hospitals' top-line revenue growth because a hospital's ability to cost-shift to commercial payers will be weaker. In past years, many hospitals have achieved higher rates from commercial insurers in order to subsidize losses on governmental payers.

While health insurers' recent financial results have been very strong, it does not appear that they can be maintained at this level. Recent earnings have been bolstered by lower than anticipated utilization as enrollees appear to have deferred medical care due to the general economic uncertainty. However, some insurers have reported a slight uptick in utilization in recent months. Adding to the pressure on the insurers' earnings are enrollment levels, which declined during the height of the recession as employers instituted layoffs or eliminated healthcare benefits. Many predict that membership will decline further as healthcare reform unfolds due the establishment of state health exchanges as private employers discontinue healthcare benefits in favor of the exchanges.

Regulatory scrutiny surrounding premium increases has also increased. The Department of Health and Human Services (HHS) has announced that all rate increases of 10% or more in the individual and small group market will be subject to analysis by HHS to determine if they are unreasonable. Also effective January 1, 2011, two key provisions of healthcare reform - minimum medical loss ratio (MLR) regulations and changes to Medicare Advantage reimbursement levels – may have a significant impact on insurers' financial results. The MLR regulations will, in effect, limit the profitability of the individual and group insured segments, while changes to Medicare Advantage reimbursement levels could reduce health plan margins and membership. These pressures will undoubtedly result in tougher rate negotiations with hospitals.

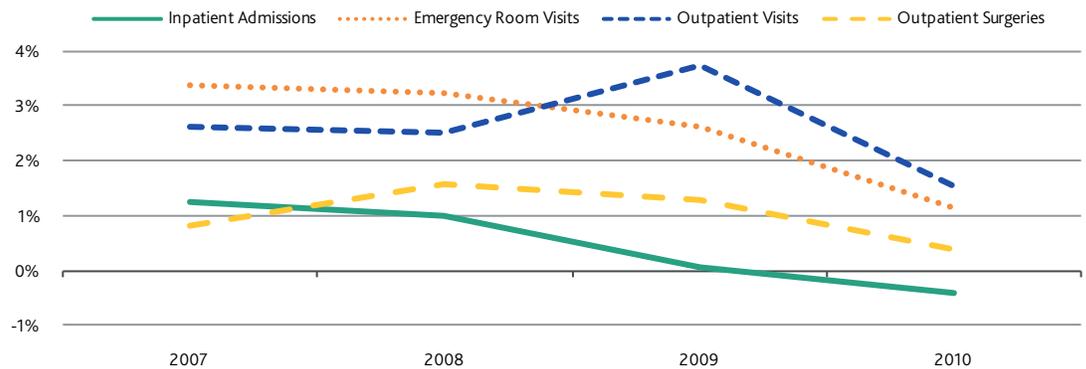
To address these pressures, many health insurers are diversifying their service lines by adding third party administrative (TPA) businesses, investing in technology to help consumers electronically navigate their benefits and expanding into patient care. Recent examples include Humana's December 2010 acquisition of Concentra (provides physical therapy, urgent care and occupational medicine) and WellPoint's announcement in June plans to acquire CareMore Health Group, a senior focused health care delivery program that includes 26 care center clinics. These strategies may put health insurers in direct competition with hospitals for outpatient revenues.

⁶ Please refer to ["U.S. Healthcare Insurers: Outlook Remains Negative"](#) December 2010

Economy Drives Volumes Down and Uncompensated Care Up

For any business, revenue growth is comprised of two variables: rates (or price) and volumes. Inpatient admission volumes for not-for-profit hospitals continue to decline (see figure 4) with the growth rate actually turning negative in FY 2010. Reasons for the decline include a patient's decision to defer elective medical procedures due to the weakened economy; higher co-pays and deductibles required by employers who still offer health insurance or are discontinuing employer-provided healthcare coverage; a less-intense flu season and a lower national birth rate.

FIGURE 4
Median Volume Growth Rates Continue to Slump



Source: Moody's

Also driving the decline in admissions is a shift in the classification of cases to observation stays that result in lower reimbursement rates. Nearly all Moody's-rated not-for-profit hospitals are reporting statistics on observation stays with large increases in recent years. Observation-stay patients typically stay in the hospital for 23 to 48 hours, depending on the illness. The difference in reimbursement rates between an inpatient admission and observation stay can be material while the costs of providing the service are, largely, the same.

The depressed economy is also producing an increase in charity care as individuals lose their healthcare benefits or COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage. Many hospitals are expanding their front-end registration process, in an effort to qualify more patients for some type of government funding or classify them as charity care rather than as a bad debt expense. Increased charity care may result in higher provider assessments for those hospitals operating in states with provider tax programs and we view this favorably.

ICD-10 Likely to Disrupt Revenues

The transition to the new International Classification of Diseases, known as ICD-10, from ICD-9 on October 1, 2013 may disrupt hospital revenues as well. ICD-10 is the most current version of the diagnostic coding system that hospitals use to label a patient's medical diagnoses and submit these claims for services provided. ICD-10 codes represent a voluminous expansion of codes -- to 69,000 from 13,600 under the current ICD-9 version. Hospitals risk delays in reimbursement if ICD-10

codes are not used for services provided on or after October 1, 2013 and will need to resubmit claims with the correct codes, which could greatly impair revenue flow.⁷

Our observations indicate that most hospitals are not ICD-10 ready at this time, and CMS has stated that it will not push back the implementation date or provide any grace period for adaptation. If not properly handled, ICD-10 will have a direct impact on a hospital's Medicare case mix index, which measures acuity and affects Medicare reimbursement. ICD-10 will also be an expense issue as hospitals will need to spend resources to train their coders in ICD-10 and may need to purchase software upgrades that are ICD-10 compliant.

Managing Two Different Reimbursement Schemes – Bundled Payment and Fee-for-Service – Will Be Challenging

Many hospitals are negotiating commercial payer contracts with fixed or “bundled” payment terms, whereby the hospital receives a lump-sum payment that will need to cover all costs of a specific service before and after hospital care is provided. Medicare will begin piloting bundled payments in 2013.

This reimbursement methodology is somewhat similar to the capitation model that many hospitals tried in the mid 1990s, which, during that period, often led to financially disastrous results. One of the main challenges hospitals faced was simultaneously managing two very different reimbursement schemes: fee-for-service and capitation, both with different incentives and requiring different business models. We envision a similar occurrence today, as hospitals will need to manage both bundled payments and fee-for-service all at once.

⁷ [Centers for Medicare and Medicaid Services.](#)

Moody's Related Research

Outlook:

- » [Negative Outlook for U.S. Not-for-Profit Healthcare Sector Continues for 2011, February 2011 \(131016\)](#)

Special Comments:

- » [Medicaid Funding Cuts Add to Credit Strain for U.S. Not-For-Profit Hospitals July 2011 \(134594\)](#)
- » [Revenue Growth Lowest in More Than a Decade for Not-For-Profit Hospitals in 2010 According to Preliminary Median Data, April 2011 \(132405\)](#)
- » [Medicare and Medicaid Proposals Are Credit Negative for Not-for-Profit Healthcare, April 2011 \(132315\)](#)

To access any of these reports, click on the entry above. Note that these references are current as of the date of publication of this report and that more recent reports may be available. All research may not be available to all clients.

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