

**Healthcare Organizations: [Financial Management Strategies]**  
**November 2008 Newsletter**



**Health Economists and the Economy**  
**- “The Not-So-Dismal Science” -**

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Economics was labeled the “dismal-science” by Thomas Carlyle a century ago. Since then, its tradition of negativity carries into the present. As the corporate credit crisis escalates, the pharmaceutical industry implodes and the population ages, hospitals are shuttered, re-sized or merely struggle onward with trepidation. And, daily the media focuses on the increasing number of our uninsured citizens.

Such media coverage is expected entering into a general economic contraction, or depression for the healthcare sector. But, in their zeal to “afflict the comfortable and comfort the afflicted”, the media victimizes the for-profit class, while it champions public hospitals, not-for-profit clinics and nanny-state medical care. The news is pre-occupied with calamity even when the economy is fundamentally strong.

OK, premium print guides like **Healthcare Organizations [Financial Management Strategies]** know that bad news draws more subscribers than good news. When all is well, physicians, executives and administrators are not keen on constructive change. There are also fewer reasons to log-on to our companion blog, the *Executive-Post* at [www.HealthcareFinancials.wordpress.com](http://www.HealthcareFinancials.wordpress.com). It’s all a matter of perspective.

But, why is the media’s take on economic issues so important? Because it has significant impact on how patients view the entire healthcare industrial complex! It influences how doctors, insurers and politicians adjust their own lobbying and legislative initiatives. And, it governs how CFOs invest in capital expenditures, as well.

Yet, media glare on our industry is not new. It began in 1963 with the article “Uncertainty and the Welfare of Medical Care,” and again in 1972 when Nobel Laureate Kenneth J. Arrow PhD shocked academe by identifying health-economics as a separate and distinct field. He codified seemingly disparate insurance, econometric, statistical, business and financial management principles for us all. And, he argued that the marketplace was incapable of insuring against the uncertainties we face in the healthcare arena. Of course, the opposing viewpoint argues that, without the existence of a competitive market, individuals lose their freedom to choose, or are allowed to consume medical care for “free.” Therefore, the marketplace cannot learn what an individual values most. Nevertheless, to informed executives, Arrow served as progenitor to the modern strategic health advisory era. In 2004, he was awarded the National Medal of Science for his innovative views.

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Unfortunately for some hospitals, disinformation and exaggeration about health economics is just the excuse needed for self-pity, or to reduce or cease operations. "It's not our fault, we can't compete in a free-market economy and our patient satisfaction rates are falling. The malaise is sapping our morale."

For others, there is the more positive proactive track of your editors, contributing authors and enlightened consultants. For example, in a recent budget meeting, one young hospital CFO cautioned physician-executives and healthcare administrators to watch every dollar in anticipation of a softening economy. Yet, his more seasoned CEO responded: Fiscal prudence is important, but if you are asking me to take my foot off the gas pedal, my position is that we should choose not to participate in this recession.

He further opined that we all must anticipate changing cycles, recessions and adverse demographics. But, let's not make it a self-fulfilling prophecy. It is the astute CEO who realizes that strong financial statements lie in effective negotiation skills and the management of revenue cycles. And conversely, that strong management and informed decision-making is the basis of an enhanced revenue cycle. In practical terms, this means understanding the process and targeting core aspects revenue growth to fine-tune and support the entire healthcare enterprise.

And so, as a quarterly subscriber, we trust you will review, communicate, use and profit from our guide, as well as the 2007 CMS payment services benefits report and hospital system trend summary listed below. Let **Healthcare Organizations** [Financial Management Strategies] enhance your knowledge of health-economics and avoid its confusion with the traditional dismal-science.

**PS:** *Don't forget to review-read-rave and rant online at our web-blog and new communications forum.*

Fraternally,

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### CMS PAYMENT SERVICES AND BENEFITS REPORT FOR 2007

Benefit payments for all parts of Medicare totaled \$426 billion, allocated as follows:

**Part A:** Hospital Insurance = 41% (includes home health partially funded under Part B)

- Hospital Inpatient = 30%
- Skilled Nursing Facilities = 5%
  - Home Health = 4%
  - Hospice = 2%

**Part B:** Supplemental Medicare Insurance = 28%

- Physicians and other suppliers = 20%
  - Hospital Outpatient = 4%
  - Other Part B benefits = 4%

**Part C:** Medicare Advantage (private health plans) = 18%

**Part D:** Prescription Drug Benefit = 12%

- Payments to Drug Plans = 7%
- Low-Income Subsidy Payments = 4%
- Payments to Union/Employer-Sponsored Plans = 1%

Note: Does not include administrative expenses such as spending for implementation of the Medicare drug benefit and the Medicare Advantage program. Total is net of \$8.1 billion in recoveries for 2007.

Data Source: Congressional Budget Office, Medicare Baseline, March 2008.

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### HOSPITAL AND INTEGRATED HEALTH SYSTEMS MID-YEAR TREND SUMMARY FOR 2008\*

*By Richard Frye; PhD*

*Forte Information Resources, Denver, Co.*

#### Hospital Industry Summary

- In 2006, 52.4% of the 4,956 short-term, acute-care, nonfederal hospitals in the U.S. were affiliated with MHSs, up from 51.8% of the 4,911 in 2005.
- The average number of hospital days per 1,000 members of HMOs not owned by MHSs grew 6.6% in 2006, to 302.2 from 283.6 in 2005, the fifth consecutive annual increase.
- The average number of prescriptions dispensed to non-Medicare members of MHS-owned HMOs decreased slightly in 2006, to 8.5 from 8.7 the previous year.
- In 2006, total hospital outpatient revenue was \$103.6 million, up 9.9% from \$94.3 million in 2005. As a consequence, the outpatient revenue percentage of total hospital revenue increased to 38.1% from 37.4% the prior year.
- Between 2005 (11,485.8) and 2006 (11,292.9), the average number of admissions fell at hospitals in MHSs that owned HMOs, the first such decline in this measure since 2001 (9,799.7).
- Between 2005 and 2006, the ratio of FTE registered nurses (RNs) to occupied beds rose both at hospitals in MHSs that owned HMOs (to 2.08 from 2.05) and at hospitals in MHSs that did not own HMOs (to 2.02 from 2.00).
- In 2006, total costs per occupied bed were just over \$1.0 million at hospitals that were part of MHSs that owned HMOs, up 4.7% from \$987,827 in 2005. Since 2001 (\$821,194), these costs have risen by more than one-quarter (26.0%).

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- Non-MHS hospitals averaged 164.7 outpatient visits per day, up 5.2% from 156.6 in 2005, the fourth consecutive annual rise.
- After rising notably between 2004 (60.2%) and 2005 (66.4%), the average intensive care unit (ICU) occupancy rate for MHS hospitals fell slightly in 2006, to 65.3%.
- Pharmaceutical expenses per discharge at hospitals tied to government-run MHSs fell 27.9% in 2006, to \$1,380 from \$1,915 in 2005, reversing two straight years of double-digit growth.

### Integrated Health Systems Summary

- Between 2006 (12,674) and 2007 (12,852), the number of distinct facilities in the most highly integrated systems rose slightly. The number of freestanding outpatient surgery centers (FOSCs) grew 16.1% during this period, to 483 from 416 the previous year.
- For the first time since 2003, the number of highly integrated systems with six or more delivery components dropped, to 65 in 2007 from 68 in 2006. These systems accounted for 20.2% of all highly integrated systems, down from 21.3% the year before.
- The total number of equity relationships between diagnostic imaging centers (DICs) and highly integrated systems rose 11.7% in 2007, to 764 from 684 in 2006.
- In 2006, the average number of emergency department (ED) visits per staffed bed at nonsystem hospitals climbed 5.3%, to 224.3 from 213.1 in 2005, the fifth consecutive annual increase. Since 2001 (177.3), the number of ED visits per staffed bed has jumped 26.5% at these nonsystem hospitals.
- The number of HMOs tied to highly integrated systems in the Midwest region dropped a notable 15.6% in 2006, to 27 from 32 in 2005. In spite of this decline, the Midwest region was again home to the most system HMOs.

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- The number of hospital days per 1,000 non-Medicare members of HMOs affiliated with highly integrated systems increased a substantial 9.0% in 2006, to 225.9 from 207.2 the year before.
- For the fourth straight year, the pharmacy expenditure share of total operating expenses at HMOs tied to systems fell, to 13.5% in 2006 from 13.6% in 2005.

Conversely, nonsystem HMOs saw this ratio rise during this time, to 14.5% from 14.4% the prior year.

- The number of multispecialty medical group practices that were part of integrated health systems rose to 1,679 in 2007 from 1,674 in 2006, the sixth straight annual increase. Since 2001 (1,195), the number of system-affiliated multispecialty group practices has jumped by more than 40%.

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