SAFETY NET HOSPITALS AT RISK

RE-THINKING THE BUSINESS MODEL

ALVAREZ & MARSAL HEALTHCARE

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the crosshairs of economic distress
and healthcare reform.
They have historically been challenged
by high levels of uncompensated care,
a Medicaid payor mix and minimal
commercial pay cost shifting.
Growing fiscal constraints,
combined with the unintended
consequences of the PPACA
requires a new business model
to ensure sustainability.

For all inquiries, please contact:
+1 212 763 9801
dgruber@alvarezandmarsal.com

Authored by:

David Gruber, MD, MBA
Director of Research
Alvarez & Marsal Healthcare Industry Group

Special thanks to Benjamin Nassau, Analyst, for contributing to this report

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FOREWORD

In May 2012, Alvarez & Marsal published a report entitled "Getting Much Closer to the Cost Precipice," which analyzed the Patient Protection and Affordable Care Act (PPACA), as well as the inefficiency and ineffectiveness of care delivery. Whereas, the PPACA increases insurance coverage, it does little to bend the cost curve driven by an aging population and a fee-for-service (volume-based) reimbursement system.

This report, entitled "Safety Net Hospitals at Risk: Re-thinking the Business Model," analyzes the complex healthcare ecosystem involved in serving Medicaid and uninsured populations, as well as the impact of federal, state and local financial constraints. Paradoxically, the PPACA, despite its intentions, may actually worsen the status of many safety net hospitals; a tsunami of financial challenges secondary to Medicare value purchasing, reduced Medicare hospital market basket payment updates, lower disproportionate share payments and increased Medicaid coverage mobility is likely.

A&M believes a new business model leading to the development of integrated delivery systems, or hospital ventures with "super-urban" Federally Qualified Healthcare Centers (FQHCs) offers the best opportunity for sustainable cost-effective, quality-oriented care for those using the safety net. The report not only assesses national trends, but also profiles several large states. The local nature of care delivery requires tailored solutions.

I am also pleased to announce that Larry Gage, founder and former President of the National Association of Public Hospitals and Health Systems (NAPH) has joined A&M as a Senior Advisor. Larry serves as Senior Counsel at Alston & Bird LLP in the firm's Washington, D.C. office, focused on public sector and nonprofit health law and policy. In 1981, Larry founded NAPH, and served as its president for over 30 years. He has had extensive experience working with major teaching hospitals, medical schools, integrated health and hospital systems, and state and local governments across the country.

The goal of A&M research is to provide strategic and actionable insights to the ongoing transformation of healthcare. Fundamental changes are necessary to stem the inexorable rise in costs.

Guy Sansone
Managing Director
Head of A&M Healthcare Industry Group

INTRODUCTION

Safety net hospitals and health systems play a crucial role in America's healthcare delivery system. As this important new report indicates, safety net hospitals overwhelmingly rely on governmental funding sources, as a result of their commitment to provide care for people who would otherwise have limited or no access to necessary hospital care.

Some observers believe that the need for safety net providers will disappear with the implementation of expanded coverage under health reform. But this is simply not true, and the role of safety net hospitals is unlikely to diminish any time soon. Opportunities will stem from the expansion of coverage to many millions of previously uninsured patients who are used to relying on safety net hospitals. At the same time, there are likely to remain sizeable populations, including immigrants and working class families too well-off to qualify for Medicaid, who are outside the various mechanisms being established to expand coverage.

Irrespective of coverage status, a shortage of primary care providers, combined with inadequate funding of community health services, limited access to capital and a failure to resolve the many social determinants that also impact the health status of low income patients – such as poor nutrition, sub-standard housing, lower educational levels and lack of available jobs – mandate a need to re-think the safety net hospital business model.

The demand for reforms like vertically integrated delivery systems that can coordinate patient care more effectively and efficiently offer opportunities to safety net providers. Some systems already employ a substantial number of their physicians and provide a high volume of outpatient and primary care, whereas others have not yet made the necessary structural and delivery system reforms to develop fully integrated systems. This report underscores how essential it will be for safety net hospitals to develop integrated systems in order to compete effectively in an industry where all payors will one day emphasize value rather than volume.

Against this backdrop of opportunity and challenge, this special report should be welcomed by safety net providers and the patients and communities that rely on them. It carefully and thoughtfully summarizes a considerable volume of recent research on the current situation of safety net hospitals, and also provides a number of solid and creative potential solutions. It should be required reading for anyone who cares about preserving and strengthening the nation's health safety net.

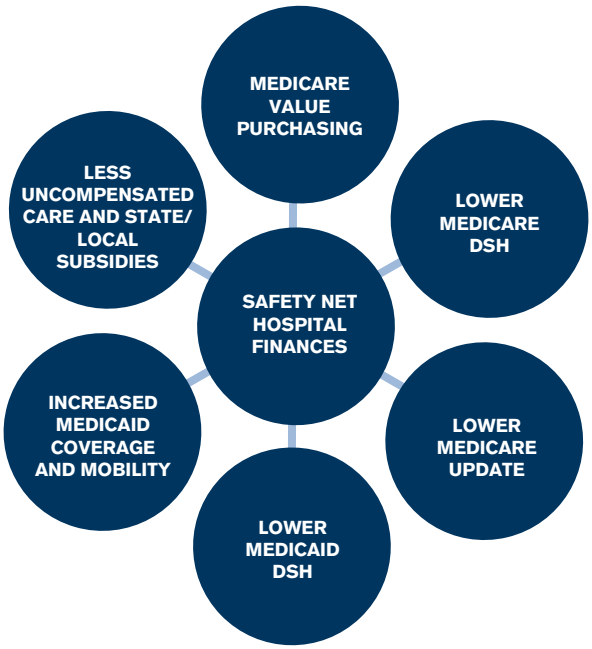
Larry Gage
Founder and Former President
National Association of Public Hospitals and Health Systems
Senior Advisor, Alvarez & Marsal

Executive Summary

Safety net hospitals are in the crosshairs of economic distress and healthcare reform. They have been historically challenged by high levels of uncompensated care, a Medicaid payor mix and a limited ability to shift costs toward commercial payors. Direct and indirect federal, state and municipal subsidies have historically funded their mission.

Growing fiscal constraints at the federal, state and municipal level, as well as the unintended consequences of the Patient Protection and Affordable Care Act (PPACA), are likely to alter the historical safety net hospital business model. State cuts to Medicaid budgets are increasing despite the growing demand for services. Medicare value purchasing programs, combined with PPACA mandated reductions in disproportionate share hospital payments and Medicare market basket payment updates are likely to exacerbate financial constraints, particularly in states that do not plan on expanding Medicaid coverage. The PPACA will also provide newly insured Medicaid recipients a choice to shop elsewhere, potentially choosing non-safety net hospitals and their associated care delivery systems.

FIGURE 1. TSUNAMI OF FINANCIAL CHALLENGES

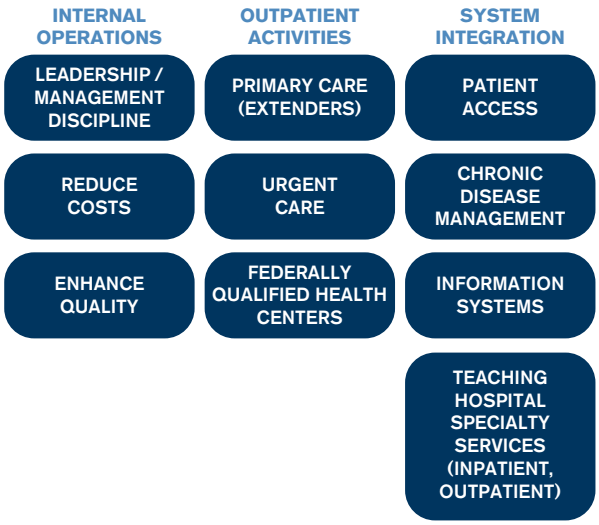


The economic challenges facing safety net hospitals are compounded by the socially disadvantaged and clinically vulnerable profile of their patients. Safety net hospitals are but a single component of a larger ecosystem that includes social, physical and other determinants of health. These include income levels, living conditions and consistent access to primary care services.

The prescription for healthcare reform is well known and equally well represented by Kaiser Permanente, Geisinger Health System, Group Health of Puget Sound, Healthcare Partners and Denver Health. Common elements include a focus on primary and secondary prevention, team-based case management, evidence-based medicine, whole person treatment, consumer / caregiver engagement and continuity of care services (coordination, collaboration, transition management). The replacement of fee-for-service reimbursement with fixed fee capitation for the full continuum of care is essential to shift provider focus from volume to value.

Opportunities exist for safety net hospitals to develop closer and more meaningful relationships with profitable academic medical centers or teaching hospital systems. Integration would facilitate scale economies, operational efficiencies and information liquidity, and enhance clinical effectiveness. Access to specialist care would also increase. Safety net hospitals could also affiliate with Federally Qualified Healthcare Centers (FQHCs), shown to increase primary care access and cost-effective care delivery. A few safety net hospitals already operate FQHCs directly. Expert specialty care, combined with increased primary care access, could emerge as a new business model.

FIGURE 2. SAFETY NET HOSPITAL STRATEGIC ALTERNATIVES



Steward Health Care, comprised of eleven New England hospitals and owned by Cerebrus Capital Management, is focused on serving the underserved, addressing the social determinants of health, increasing prevention and delivering affordable care. Private equity firms such as Cerebrus represent a potential source of capital to safety net hospitals.

Irrespective of whether a safety net hospital becomes part of a care delivery integrated system or affiliates with an FQHC, the safety net system has the opportunity to develop and maintain a distinct and competitive brand in the market(s) it serves. To become competitive, it will have to reduce costs, provide increased care access, enhance real and perceived quality and compete for its patient volume. Further, the safety net hospital will have to manage a range or evolving determinants of Medicare reimbursement: hospital re-admissions, prevention of hospital-acquired conditions and patient satisfaction. Transforming these facilities to focus on clinical and operational effectiveness will require significant and meaningful commitment by funding sources, governance systems and senior management, along with the discipline required for effective implementation.

As the primary sources of funding, the federal government and states will have a critical role in shaping the future of safety net hospitals. In many cases, significant changes in funding and / or the introduction of independent governance and leadership might be required to facilitate the necessary disruptive transformation. A new business model is required to ensure sustainability.

Situation Analysis

The stated mission of safety net hospitals is to provide healthcare services to people irrespective of their ability to pay; i.e., primarily Medicaid recipients and the uninsured. Safety net hospitals are often required to offer expensive specialty services including trauma care, neonatal intensive care (NICU), burn care and emergency psychiatry. Emergency Department overuse is common and reflects limited primary care and specialist access for indigent populations.

Safety net hospitals are challenged by their served population, and a series of operational factors, including:

POPULATION CHALLENGES

- Attributes of their served population: baseline health inequities, limited patient / caregiver health literacy and inadequate engagement in preventative and basic health services
- A systemic failure to identify, address and treat the social determinants of health
- The impact of dual eligible patients that dispro-portionately utilize healthcare resources across Medicare (Federal) and Medicaid (state) programs with limited, if any, care coordination [1]

OPERATIONAL CHALLENGES

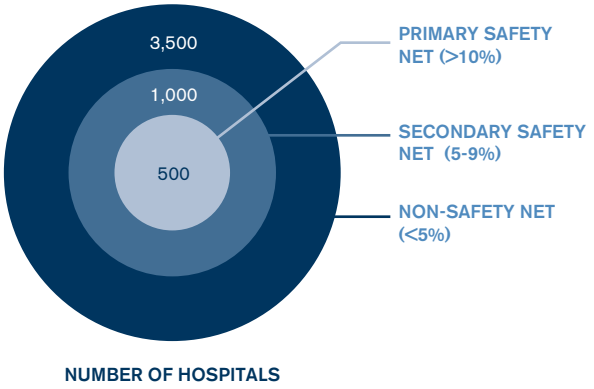
- Emergency Department overuse reflecting limited access to primary care physicians and specialists and, to a lesser extent, patient dumping [2]
- Financial and programmatic support for critical, though unprofitable, service lines – trauma centers, NICU, burn care and inpatient psychiatric services
- Lagging IT and capital infrastructure investment
- A higher rate of unionized labor

The safety net hospital mission and service are at risk

According to the National Association of Public Health Hospitals and Health Systems (NAPH), a "safety net hospital or health system provides a significant level of care to low-income, uninsured, and vulnerable populations." Its mission includes an open door policy offering healthcare services irrespective of an ability to pay. Specific safety net hospital criteria have not been defined, although the Center for Medicare and Medicaid Services (CMS) and others have attempted to identify quantitative thresholds for low income utilization, Medicaid utilization (i.e., more than one standard deviation from the mean) and uncompensated care.

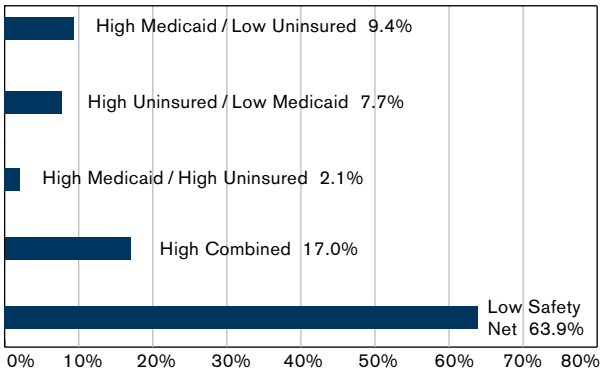
The Agency for Health Research & Quality (AHRQ) defines safety net hospitals based on the proportion of hospital stays for the uninsured population.[3]

FIGURE 3: HOSPITAL STAYS BY UNINSURED



Source: Phil Oliff, Chris Mai, Vincent Palacios. "States Continue to Feel Recession's Impact", Center for Budget and Policy Priorities. 6/27/2012

FIGURE 4: % DISTRIBUTION OF HOSPITAL EMERGENCY DEPARTMENTS BY SAFETY NET CRITERIA, 2000



Source: Center for Disease Control and Prevention. Characteristics of Emergency Departments Serving High Volumes of Safety Net patients: United States, 2000. U.S. Department of Health and Services. Series 13, Number 155. 5/2004.

Alternatively, the Center for Disease Control and Prevention (CDC) defined the criteria for safety net hospitals as Medicaid or uninsured patients who account for 30% or more of visits to the Emergency Department (ED). ED visits by Medicaid and uninsured patients that represent more than 40% of total visits is found in 17% of hospitals (n=850). Based on the AHRQ definition, an additional 650 hospitals could be construed as secondary safety net hospitals. Including both of these definitions, we estimate that there are approximately 1,500 to 1,800 primary and secondary safety net hospitals in the U.S.

Safety net hospitals span all locations, sizes and ownership groups. 56% are located within urban areas, while the remaining 44% are rural.[3] 50% of safety net hospitals have less than 100 beds, the majority in rural areas. 43% are publicly-owned government hospitals, whereas 45% are not-for-profit. Safety net hospitals admit fewer patients for specialized surgery and more for substance abuse and mental health services (e.g., depression, bipolar disease).

Safety net hospitals are an integral component of the healthcare delivery system, as nearly one-third of the U.S. population under the age of 65 is either a recipient of Medicaid or uninsured. Louisiana (41%) and Texas (40%) are among the states with the highest percentage of the population with Medicaid coverage or being uninsured; conversely, Pennsylvania (25%) is among the lowest.[4] [5]

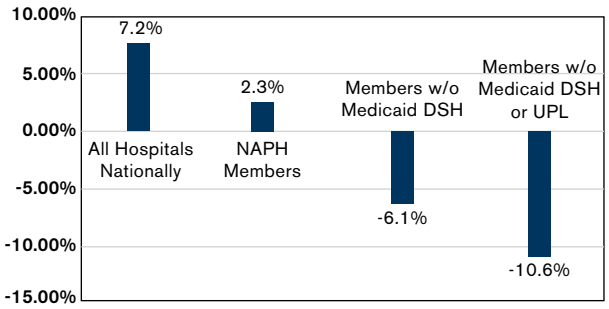
FIGURE 5: MEDICAID AND UNINSURED BY STATE

	Population	% Medicaid	% Uninsured	Total
California	37,370,144	18.9%	19.6%	38.5%
Florida	18,843,880	14.3	20.3	34.6
Illinois	12,734,256	16.9	14.8	31.7
Louisiana	4,455,154	20.2	20.4	40.5
New Jersey	8,686,786	12.4	15.5	27.9
New York	19,217,679	21.6	13.6	35.2
Pennsylvania	12,620781	14.5	10.9	25.4
Texas	25,339,910	15.6	24.2	39.8
U.S. Average	307,891,500	16.1%	16.0%	32.1%

Sources: Health Insurance Coverage of Nonelderly 0-64, 2011. Kaiser Family Foundation. 1/9/2013. <http://statehealthfacts.org/comparetable.jsp?ind=126&cat=3>

Operational challenges faced by safety net hospitals include the medical, behavior and social health status of the served populations, aging plant infrastructure and labor issues. Safety net hospitals face further financial challenges considering the payor mix of the population served (Medicaid, uninsured) and less profitable service line offerings (e.g., trauma, neonatal intensive care, burn care and emergency mental health). Small, rural safety net hospitals with less than 100 beds are negatively impacted by low occupancy rates in the range of 34% to 53%. [6]

FIGURE 6: NAPH HOSPITAL MARGINS, 2010



Source: National Association of Public Hospitals. 2010 Characteristics Survey. 5/2012

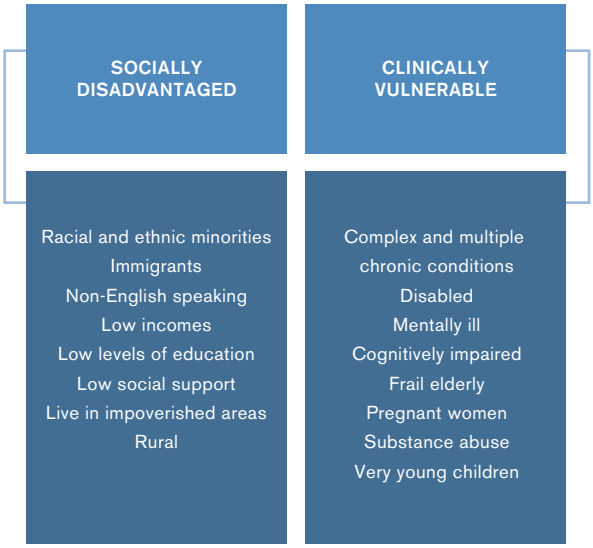
An unstated mission of many safety net hospitals is local employment and the generation of surrounding economic activity. According to the Illinois Association of Safety Net Hospitals, "safety net hospitals see more than half a million Medicaid patients each year, employ 12,000 people, and drive more than $700 million in economic stimulus in their communities."[7] Alan Avilas, President of the Health & Hospitals Corporation in New York City said it in an easily understood manner: "We make an impact because we create jobs and purchase services, supplies and equipment from vendors, but we also make an impact because every day the doctors, nurses, and staff who work in our hospitals and community health centers stop on the way to work to buy coffee and a bagel, they drop off clothes at the dry cleaner or shoes at the shoe repair. They shop at nearby stores and walk across the street to have lunch at local restaurants, bringing life and vitality to local business communities."[8]

POPULATION CHALLENGES

Safety net hospitals are challenged by their served population and baseline health inequities

Safety net hospitals disproportionately treat socioeconomic and clinically vulnerable populations. These populations include racial and ethnic minorities, undocumented individuals and those residing within impoverished and rural areas. Clinically vulnerable populations include those with complex co-morbidities (i.e., multiple chronic medical conditions), the disabled, patients with acute and chronic behavioral health issues and substance abusers.

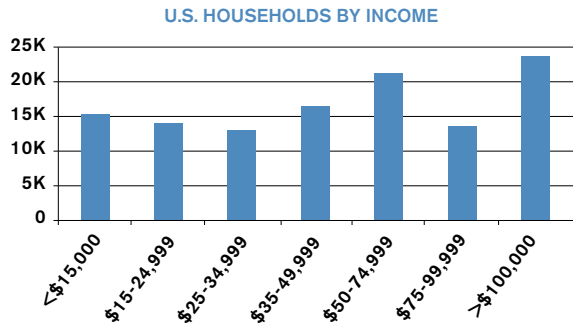
FIGURE 7: CATEGORIES AND OVERLAP OF VULNERABLE POPULATIONS



Source: V. Lewis, et al. "The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles". Health Affairs, Volume 31(8), 1777-1785. 8/2012

Vulnerable populations often reside in low income households. The Federal Poverty Limit in 2012 was $11,170 for an individual and $23,050 for a family of four. These calculations do not include noncash benefits such as: public housing, Medicaid, employer provided health insurance and food stamps. In 2010, the poverty rate was 15.1% - a significant increase from the 11.3% reported in 2000. Nearly 50 million Americans live in poverty. Children account for 24% of the U.S. population, but 36% of the poor population. African-Americans (27%) and Hispanics (27%) are also disproportionately represented among the poor. [9]

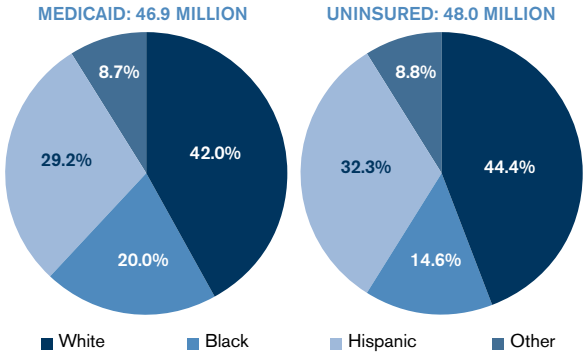
FIGURE 8: DISTRIBUTION OF HOUSEHOLDS BY INCOME (IN THOUSANDS)



Source: United States Census Bureau. Money Income of Households-Distribution by Income Level and Selected Characteristics 2009. Statistical Abstract of the United States 2012. 453. PDF File

Safety net hospitals provide care to a disproportionate number of African-Americans and Hispanics due to socio-economic and historical access issues. Approximately 18% (40.8M) of white Americans receive Medicaid or are uninsured; they account for 43% of the total. Nearly 50% of African-Americans receive Medicaid (28%) or are uninsured (21%), whereas for Hispanics, the comparable percentages are 28% and 32%, respectively. Children account for 58% of Medicaid recipients. The mothers of these aforementioned children account for a large percentage of adult Medicaid recipients. An additional 6.3 million children are covered by CHIP, the Children's Health Insurance Plan, in families with incomes too high to qualify for Medicaid, but inadequate to afford private coverage. The vast majority of uninsured (84%) are adults. [10]

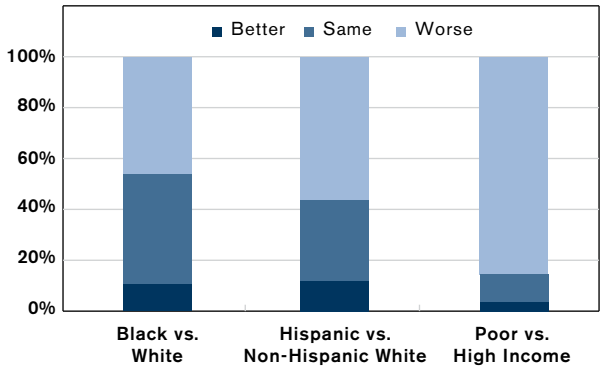
FIGURE 9: MEDICAID AND UNINSURED BY RACE AND ETHNICITY IN NON-ELDERLY < 65 YEARS OLD



Source: Medicaid and Uninsured Coverage Rates for the Non-Elderly by Race/Ethnicity, states (2010-2011). Kaiser Family Foundation. 1/9/2013 <http://statehealthfacts.org/comparetable.jsp?ind=163&cat=3>

According to a recent National Healthcare Quality and Disparities Report, African-Americans, Hispanics and low income people, have a worse quality of care than white Americans and those with high income.[11] Measured diseases, conditions and / or care processes include: cancer, diabetes, end-stage renal disease, heart disease, HIV/AIDS, maternal and child health, mental health, substance abuse, respiratory diseases, lifestyle modification, functional status preservation and rehabilitation, supportive and palliative care, and patient safety. Eliminating, or even reducing, the healthcare inequity represents an important strategic goal.

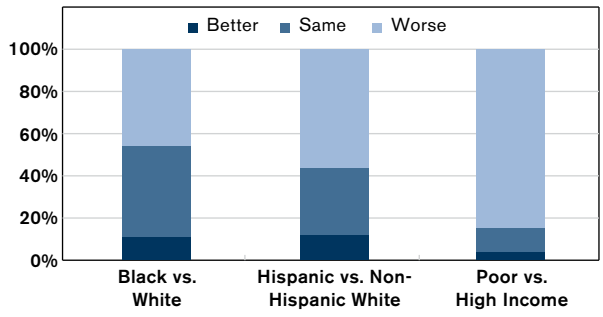
FIGURE 10: COMPARATIVE QUALITY OF CARE



Source: Agency for Healthcare Research and Quality. 2010 National Healthcare Disparities Report. U.S. Department of Health and Human Services. 3/2011.

Access to primary and specialist care is also an issue for minority populations and the poor; it contributes to worse clinical outcomes.[12] Access issues are compounded by a shortage of primary care physicians and inadequate Medicaid reimbursement. As a result, Emergency Departments have become the primary site of care for many patients with non-urgent conditions.

FIGURE 11: COMPARATIVE ACCESS TO CARE

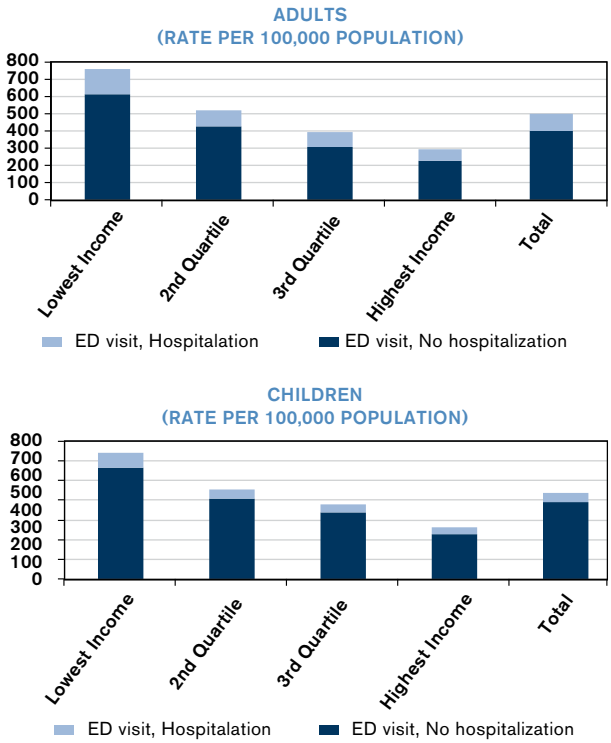


Source: National Healthcare Quality and Disparities Report, 2010. Figure H.1. Distribution of core quality measures for which members of selected groups experienced better, same or worse quality of care compared with reference group. www.ahrq.gov/qual/nhdr10/nhdr10.pdf

Asthma care is a prime example of how lack of primary care access can lead to increased Emergency Department volume. Improved primary care, combined with parent / patient education, can reduce the number of asthma hospitalizations by 12 to 50%.[13] A physician has told nearly 30 million Americans they have asthma; two-thirds have either had an asthma episode or have been told they have asthma within the past 12 months.[14]

In 2009, asthma accounted for 2.1 million Emergency Department (ED) visits, 479,000 hospitalizations and 3,404 deaths.[15] Asthma also resulted in 10.5 million missed school days and 14.2 million missed work days among employed workers.[16] Proper self-management and medical treatment allows most people with asthma to lead normal lives. Avoiding known triggers and substances that irritate the airways can substantially reduce symptoms. Avoidable ED encounters are highest for adults and children in the lowest income quartile.[13] Increased primary care access makes a difference.[17]

FIGURE 12: AVOIDABLE ED ENCOUNTERS FOR ASTHMA



Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Nationwide Emergency Department Sample, 2007. Figure 6.5 http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf

Safety net hospitals are challenged by limited patient / caregiver health literacy and engagement

Health literacy is essential for consumer (patient) engagement; i.e., building a relationship, ensuring understanding, making informed decisions and changing behavior. The U.S. Department of Health and Human Services defines health literacy as "the ability to obtain, process, and understand basic health information and services to make appropriate health decisions." [18]

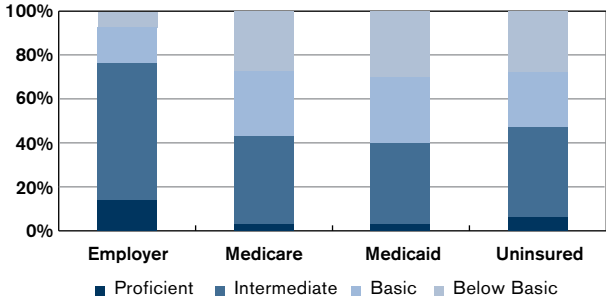
FIGURE 13: DESCRIPTION OF HEALTH LITERACY

Health Literacy Level	Task Examples	% of Adults	Number of Adults (MM)
Proficient	Using a table, calculate an employee's share of health insurance costs for a year.	12%	27.6
Intermediate	Read instructions on a prescription label, and determine what time a person can take the medication.	53%	121.7
Basic	Read a pamphlet, and give two reasons a person with no symptoms should be tested for a disease.	21%	48.3
Below Basic	Read a set of short instructions, and identify what is permissible to drink before a medical test.	14%	32.0

Source: America's Health Literacy: Why We Need Accessible Health Information. An Issue Brief From the U.S. Department of Health and Human Services. 2008.)

Health literacy is historically challenged in the Medicaid and uninsured population. This may lead to less treatment adherence and increased healthcare resource utilization.

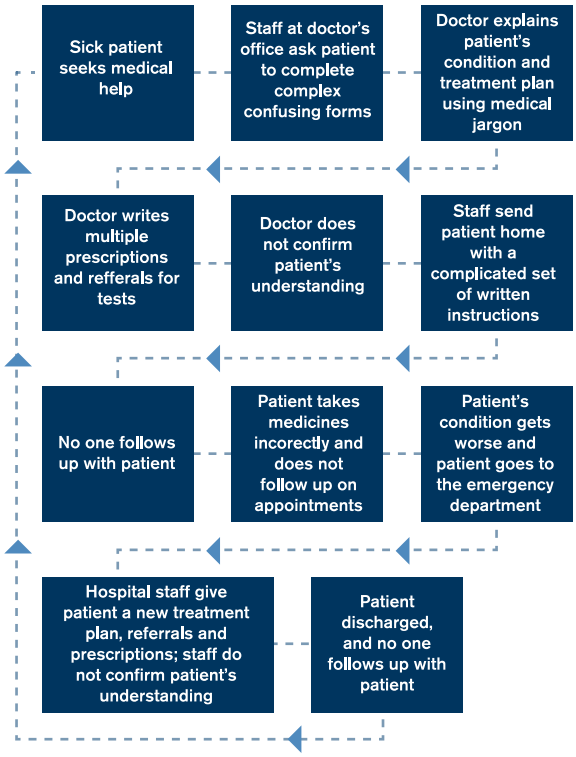
FIGURE 14: HEALTH LITERACY BY INSURANCE STATUS



Source: U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy.

The Department of Health and Human Services recently generated a National Action Plan to Improve Health Literacy that identified seven goals and related strategies to close the communication gap between provider knowledge and consumer understanding.[19] Although health literacy is often unacknowledged as a determinant of health outcomes, its importance cannot be understated for improving care equality. Symptom awareness, treatment adherence, prescription compliance, self-care and lifestyle changes are all dependent upon a basic understanding of health matters.

FIGURE 15: THE CYCLE OF CRISIS CARE: A PATIENT'S EXPERIENCE



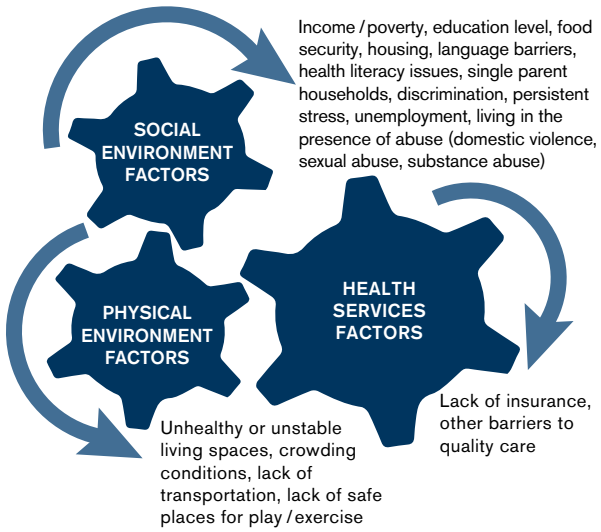
Source: Koh H, Berwick D, et al. "New federal policy initiatives to boost health literacy can help the nation move beyond the cycle of costly crises care." Health Affairs, Volume 31(12), 434-443. 12/2012.

Safety net hospitals do not effectively address or "treat" the social determinants of health

The World Health Organization (WHO) has defined the social determinants of health as the "conditions in which people are born, grow, live, work and age, including the health system." [20] Social determinants contribute to an individual's health status. Safety net hospitals represent one component of a larger environmental ecosystem that affects clinical outcomes. Federal Qualified Heath

Centers increasingly recognize the need to address areas outside the traditional domain of healthcare, such as nutrition, housing, education and job training.[21]

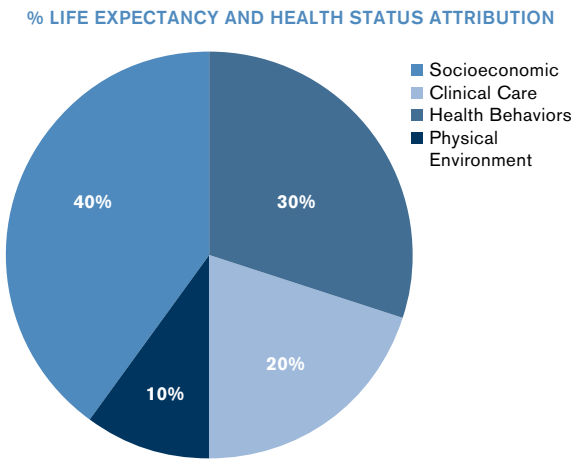
FIGURE 16: SOCIAL DETERMINANTS OF HEALTH



Source: Centers for Disease Control and Prevention. Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. U.S. Department of Health and Human Services. 10/2010.

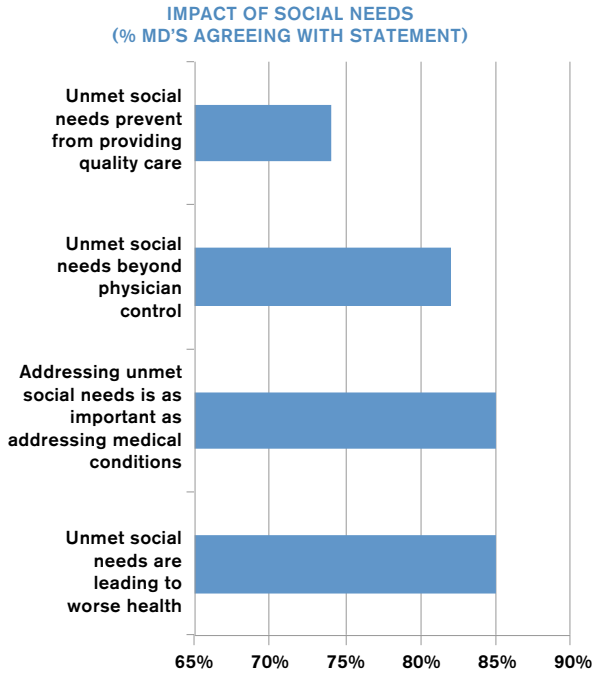
Socioeconomic status and health seeking behaviors have a major impact on population health outcomes. Genes and biology, though not included in the chart below, are mentioned by others to account for only 5-10% of health outcomes.[22]

FIGURE 17A: HEALTH STATUS ATTRIBUTION TO LIFE EXPECTANCY



Source: National Association of Community Health Centers. "Community health centers address the social determinants of health". Issue Brief, 8/2012. NACHC.

FIGURE 17B: RISK FACTORS FOR COMPLICATIONS AMONG DIABETICS

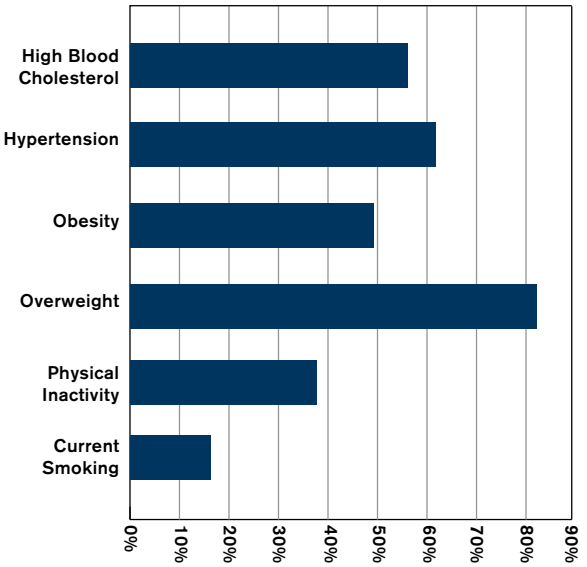


Source: Behavioral Risk Factor Surveillance System. Prevalence and Trends Data. Centers for Disease Control and Prevention.

Quality care can address social determinants of health. In its seminal report, "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." [23] Positive health outcomes require treatment staff to increase patients' skills and confidence in managing their health problems. Patients may be required to, for example, closely monitor symptoms, respond with appropriate interventions (e.g., adjust medications, initiate calls to healthcare resources, schedule MD visits), effect and sustain major lifestyle changes, adhere to medication regimens and fulfill required follow up visits for lab tests, physical exams and clinical consultations.

Lifestyle and medication adherence potentially have a major impact on health outcomes. Most people with diabetes are overweight or obese, have hypertension and elevated blood cholesterol. Many are physically inactive. Opportunities exist to reduce the occurrence of cardiovascular disease, stroke, renal failure, blindness and peripheral neuropathy through improved self-management.

FIGURE 18: RISK FACTORS FOR COMPLICATIONS AMONG DIABETICS



Source: CDC Behavioral Risk Factor Surveillance System from Division of Diabetes Translation personnel

Safety net hospitals treat dual eligible patients that disproportionately utilize healthcare resources across Medicare (federal) and Medicaid (state) programs with limited, if any, care coordination

The dual eligible population includes low income individuals, 5.6 million over the age of 65 and 3.6 million with disabilities under the age of 65. They must qualify for Medicare and Medicaid separately. Medicare is the primary payor; Medicaid covers most out-of-pocket costs, dental, vision and long-term care benefits. Medicare does not cover long-term care services, except home care and short-term SNF utilization following acute hospitalization.

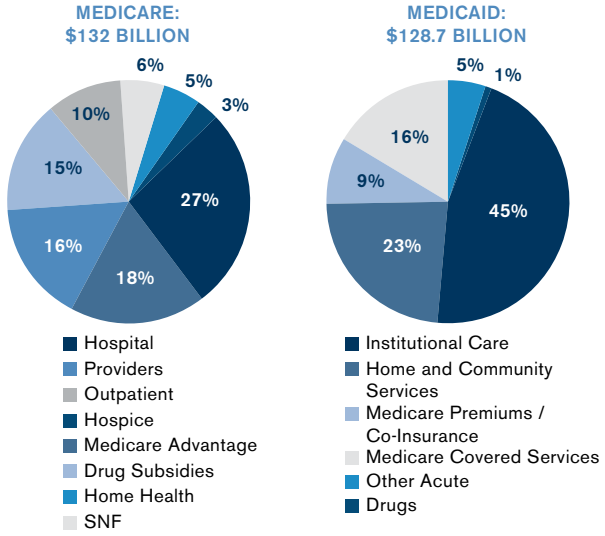
Dual-eligible Medicare beneficiaries, compared to other Medicare recipients, tend to be female and / or a racial / ethnic minority, have far lower incomes, in fair-to-poor health and are cognitively impaired. They are older and sicker. Nearly 1.5 million are long-term care residents.[24] Their "gaps in care" are significant and compounded by the lack of an integrated financing approach between Medicare and Medicaid.

FIGURE 19: CHRONIC DISEASE MANAGEMENT "GAPS IN CARE"

Source: Center for Information Technology Leadership (CITL), Partners Healthcare. NRHI: Network for Regional Healthcare Improvement

In 2008, 20% of dual eligible Medicare recipients accounted for 32% of total spending. Comparable figures for Medicaid were 15% of recipients and 39% of spending. Combined, dual eligible recipients account for nearly $261 billion in Medicare and Medicaid spending or $28,000-30,000 per person. Spending by Medicare on dual eligible recipients is only slightly higher than that of Medicaid. The Federal government accounts for approximately 75% of dual-eligible spending (assuming a Medicaid Federal Matching Assistance Percentage of 57%).[25]

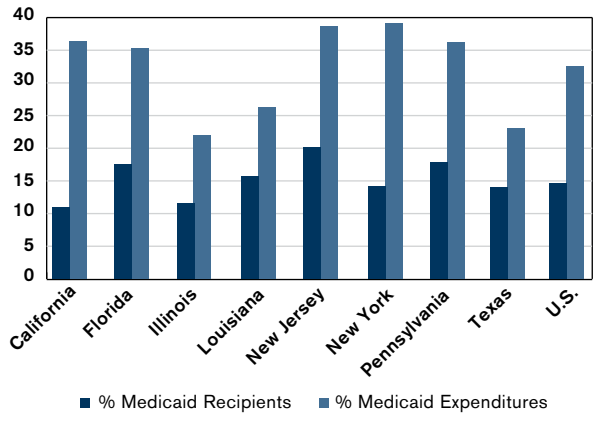
FIGURE 20: DUAL ELIGIBLE EXPENDITURES, FY2008



Sources: Kaiser Family Foundation "Dual eligible beneficiaries account for a disproportionate share of Medicare and Medicaid spending 2008." Microsoft PowerPoint File.

The amount of Medicaid spending per state varies with the size of the dual-eligible population, as well as their allocation to long-term care spending. For example, New Jersey, Illinois and Florida exceed the U.S. dual eligible percentage of 15% of the total Medicaid population, whereas Illinois and Texas are below average at 11-12% of Medicaid recipients. Fifteen states have received planning grants to develop new models of care delivery for dual eligibles.

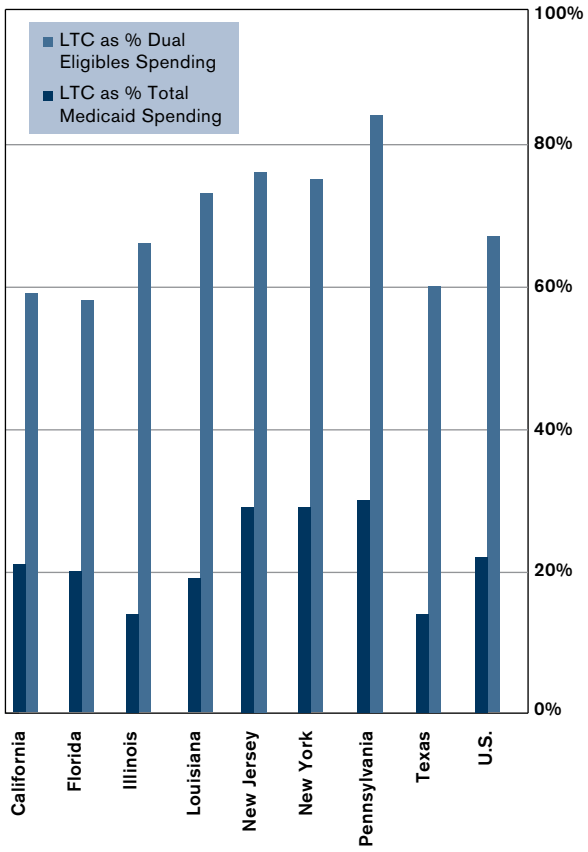
FIGURE 21: DISPROPORTIONATE SPENDING ON DUAL ELIGIBLE



Source: Distribution of Medicaid Spending for Dual Eligibles by Service, 2009. Kaiser Family Foundation. 1/8/2013. < http://state-healthfacts.org/comparetable.jsp?ind=661&cat=6&sub=76>

Long-term care (LTC) spending includes institutional care, as well as home and community-based services. As expected, states with the lowest number of dual-eligible patients spend the least on LTC. The cost of LTC is far higher in New York and New Jersey as compared to other states.

FIGURE 22: MEDICAID LONG-TERM CARE SPENDING



Source: Distribution of Medicaid Spending for Dual Eligibles by Service, 2009. Kaiser Family Foundation. 1/8/2013. < http://state-healthfacts.org/comparetable.jsp?ind=661&cat=6&sub=76>

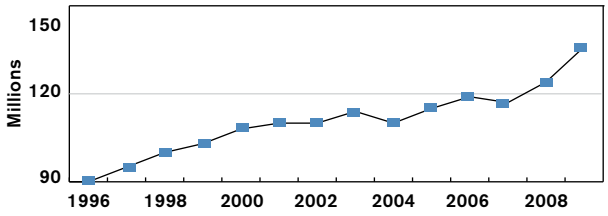
Medicare and Medicaid are distinct entitlement programs with limited, if any, integration. Eligibility, enrollment, benefits and billing systems are different. Care coordination is minimal as program spending supersedes patient outcomes. The Program of All-Inclusive Care for the Elderly (PACE) has limited enrollment. The creation of a new Medicare-Medicaid Coordination Office is likely to require many years to become effective.

OPERATIONAL CHALLENGES

Safety net hospital Emergency Department overuse reflects a lack of access to primary care physicians and specialists and to a lesser extent, patient dumping.

Visits to Emergency Departments (ED) have risen 51% in less than 15 years from 90.3 million in 1996 to 136.1 million in 2009. Mild to moderate injuries caused by falls, motor vehicle accidents, being struck or cut, over-exertion and other activities account for nearly one-third of ED visits.[26] Other leading causes of visits include respiratory infections (5.5 million), abdominal pain (5.4M), nonspecific chest pain (4.3M), back pain (3.7M), skin and subcutaneous infections (3.4M) and headache, including migraines (3.1M).[27]

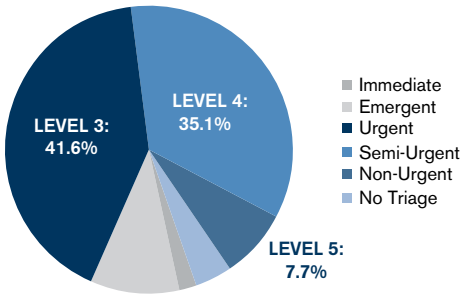
FIGURE 23: EMERGENCY DEPARTMENT VISITS



Source: Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2009 Emergency Department Summary Tables. PDF File.

Many visits to Emergency Departments are semi-urgent (Level 4) or non-urgent (Level 5). Semi-urgent visits, accounting for 35% of ED visits, are usually seen within 1-2 hours, whereas non-urgent cases are seen within 2-24 hours, if ever. Delays for psychiatric evaluation are longest. According to a consumer survey, one-half of consumers visited an ED for reasons other than an emergency during the past 12 months. [28]

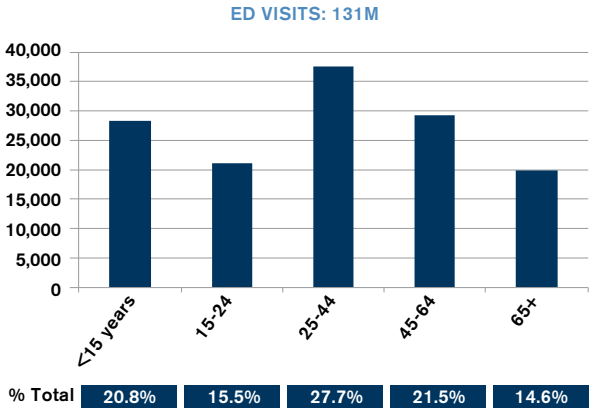
FIGURE 24: TRIAGE STATUS OF EMERGENCY DEPARTMENT VISITS



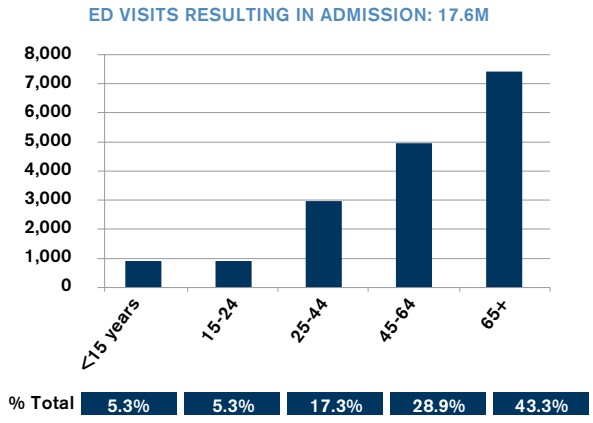
Source: Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2009 Emergency Department Summary Tables. PDF File.

Less than 13% of Emergency Department visits result in a hospital admission. Patients <24 years old are admitted to the hospital 4% of the time; comparable figures for the 25-44 (8%), 45-64 (17%) and 65+ (37%). Medicare patients account for 15% of ED visits but 43% of ED-driven admissions.

FIGURE 25: DISTRIBUTION OF ED VISITS AND HOSPITAL ADMISSIONS

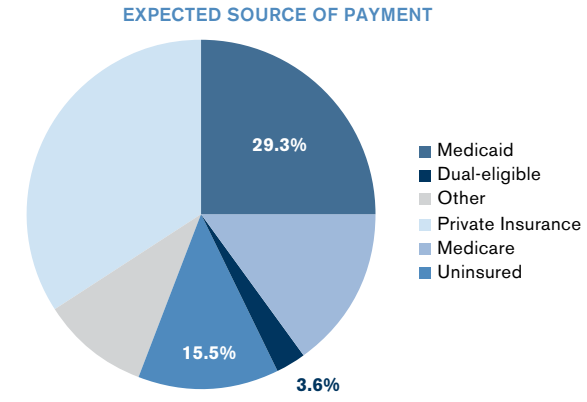


Source: Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2009 Emergency Department Summary Tables. PDF File.

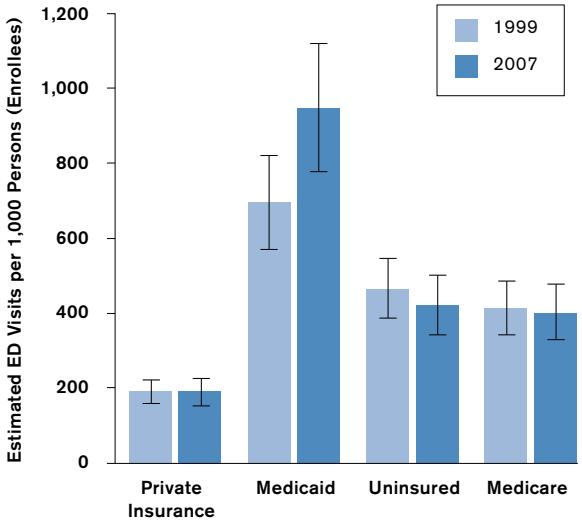


Medicaid recipients and the uninsured account for 45% of ED visits, but represent only 31% of the population. Given the age distribution of this cohort, the number of visits should be far lower. The number of ED visits per 1,000 persons in the Medicaid population is 2 to 5 times higher than the privately-insured population, suggesting the Medicaid population generally views the emergency room as a source of routine primary care.

FIGURE 26: EMERGENCY DEPARTMENT USE BY MEDICAID RECIPIENTS AND THE UNINSURED



Source: Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2009 Emergency Department Summary Tables. PDF File.

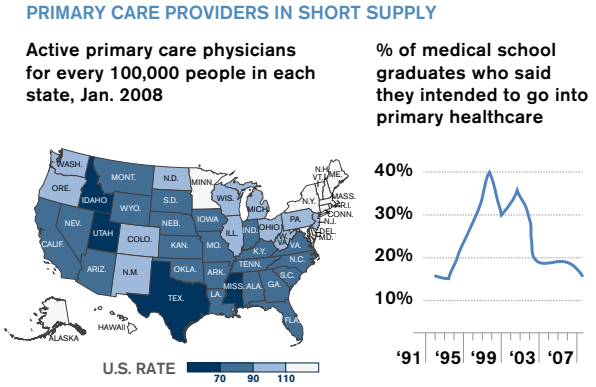


Source: Ning Tang et al. Trends and Characteristics of U.S. Emergency Department Visits, 1997-2007. JAMA, 304 (6), 664-670. 8/2012.

In 1986, the Emergency Medical Treatment and Labor Act (EMTALA) was implemented to prevent patient dumping; i.e., the denial of care to uninsured emergency patients. The Act requires hospitals to provide a screening examination and stabilize the patient prior to transfer to another hospital. Despite EMTALA, hospitals have taken liberty in their definition of an "appropriate" screening examination for the detection of an "emergency medical condition" as well as the meaning of patient "stabilization." Uncompensated care at Denver Health, an integrated safety net health system with a large hospital and several outpatient clinics has seen its uncompensated care burden increase fourfold over 20 years, partially driven by emergency patients sent from other facilities.[29]

Primary care physicians (PCPs), a term that includes internists, family practitioners and pediatricians, typically function as the initial source of diagnosis and treatment. They also function as "gatekeeper" to specialist consultation under some insurance coverage programs. PCPs collaborate with specialists and attempt to coordinate care delivery. In 2005, there were 264,086 PCPs distributed unevenly throughout the U.S. Relatively few medical graduates are becoming PCPs given the high debt load and comparatively low salaries; the mean wage of $189,480 is substantially below that of procedure-oriented medical specialists and surgeons.[30]

FIGURE 27: PRIMARY CARE SHORTAGE WILL REQUIRE INCREASING USE OF ALTERNATIVE, LOWER COST PROVIDERS AND TECHNOLOGY ADJUNCTS

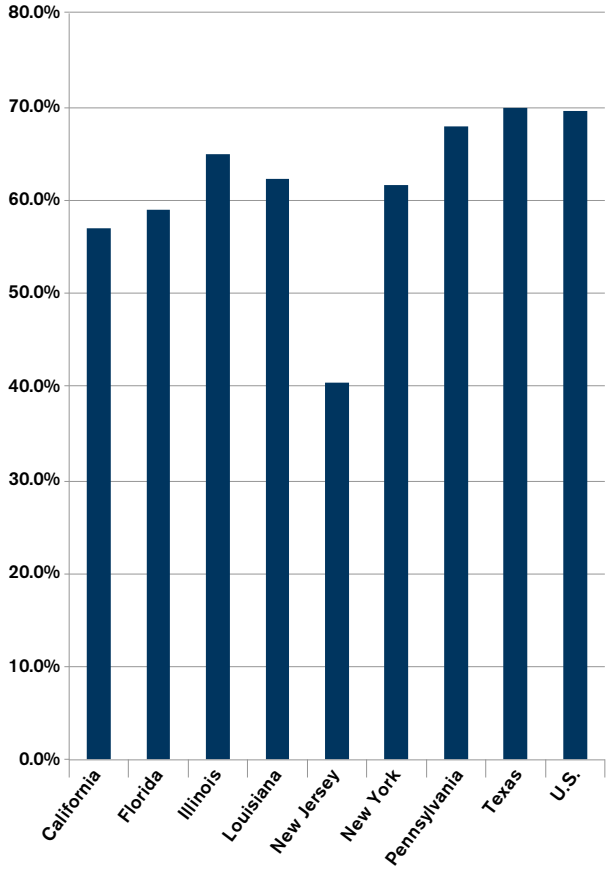


Source: Hasley III, Ashley. "Primary Care-Doctor Shortage May Undermine Reform Efforts". Washington Post. 6/20/2009

Due to existing supply and reimbursement constraints, primary care physicians have a limited amount of time to address the chronic care needs of most patients, i.e., lifestyle issues, risk factors, co-morbidities, medications and mental health concerns. The actual time spent by primary care physicians in face-to-face consultation and on visit-specific work outside the examination room has been reported to range from 13.3 to 18.7 minutes.[31] Alleviating these extreme time constraints via the use of care extenders, such as nurse practitioners and physician assistants, could result in enhanced patient management and self-care, and fewer ED visits.

The willingness of office-based primary care and specialist physicians to see Medicaid patients varies by state. Physicians who practice in semi-rural and rural areas outside of Metropolitan Statistical Areas, are 19% more likely to accept new Medicaid patients than physicians in metropolitan areas.[32]

FIGURE 28: % OF OFFICE-BASED PHYSICIANS ACCEPTING NEW MEDICAID PATIENTS, 2011



Source: Decker S. "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help", Health Affairs Volume 31(8), Page 1676. Exhibit 2. 8/2012

Inadequate Medicaid reimbursement is a major contributor to the access barrier in primary care. The Medicaid-to-Medicare fee index, as calculated by the Kaiser Family Foundation, for all services is 0.72, meaning physicians treating Medicaid patients receive $0.72 for every $1.00 they receive for treating Medicare patients in the same manner for the same condition.[33] Reimbursement for primary care is substantially below that for obstetric care. New York, New Jersey and California are among the states with the lowest Medicaid-to-Medicare Fee Index.

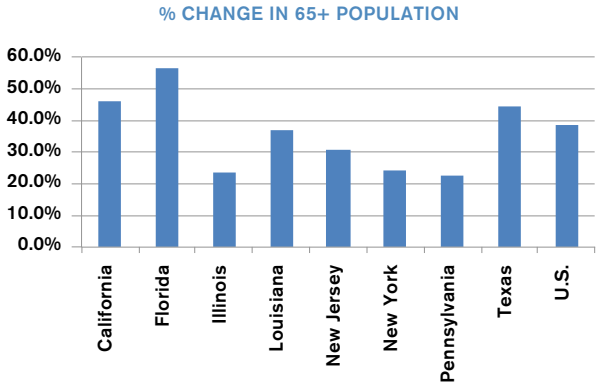
FIGURE 29: MEDICAID-TO-MEDICARE FEE INDEX

	All Services	Primary Care	Obstetric Care
California	0.56	0.47	0.64
Florida	0.63	0.55	0.99
Illinois	0.63	0.57	0.82
Louisiana	0.92	0.90	0.95
New Jersey	0.37	0.41	0.30
New York	0.43	0.36	0.67
Pennsylvania	0.73	0.62	1.73
Texas	0.74	0.68	0.87
U.S. AVERAGE	0.72	0.66	0.93

Source: Stephen Zuckerman et al. "Trends in Medicare Physician Fees 2003-2008" Health Affairs Volume 28 (3), 510-519. 4/2009.

Primary care access issues are likely to be compounded by an aging population and their need for chronic disease management. The U.S. Department of Health and Human Services, prior to the PPACA, forecasted the number of primary care physicians to reach 271,440 by 2020, compared to a projected need of 337,400.[34] The growing shortage will worsen access issues, and likely lead to additional Emergency Department overuse.

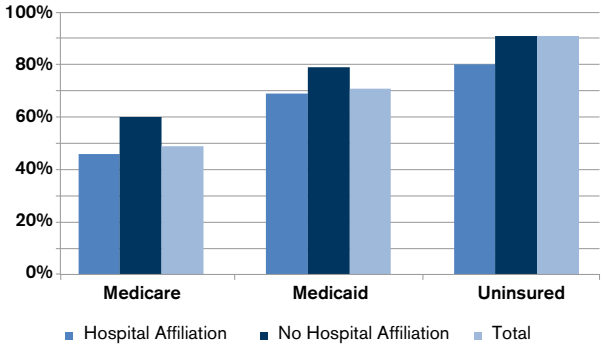
FIGURE 30: AGING POPULATION BY STATE, 2010 - 2020



Source: U.S. Census Bureau. Guide to State and Local Geography Selected Data from the 2010 Census. U.S. Department of Commerce. 10/2011.

Barriers to accessing specialists are an issue for all government-funded programs, including Medicare and Medicaid. Delays in treatment may worsen prognosis. A study of Federally Qualified Health Centers reported higher levels of accessibility to hospital-affiliated specialists as compared to their office-based peers.[35] The uninsured often visit the Emergency Department for specialist care.

FIGURE 31: PERCENT OF FQHC'S REPORTING DIFFICULTIES OBTAINING SPECIALIST PROCEDURES

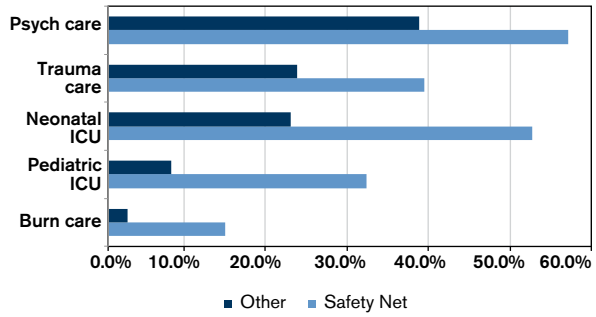


Source: The Common Wealth Fund, Harris Interactive, Inc. The 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers. United States 5/27/2009

`Safety net hospitals offer critical, though unprofitable service lines – trauma centers, NICU, burn care and psychiatric services

The Emergency Department is not the only unprofitable service line offered by safety net hospitals to the surrounding community. Most low income areas require the availability of high intensity and costly services for critically injured or ill patients with trauma, premature birth, burns or infectious conditions. Psychiatric emergency department services, though less expensive, provide access to vulnerable, mentally ill patients such as those with schizophrenia, bipolar disease, depression and other conditions.

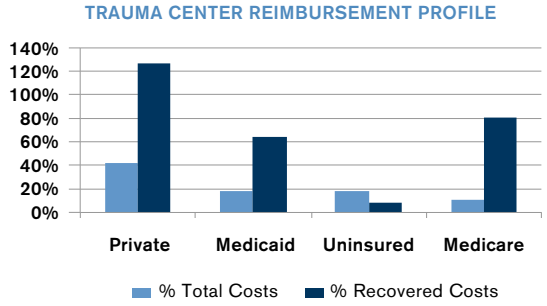
FIGURE 32: SERVICE LINE OFFERINGS



Source: Gaskin, Darrell. "Safety Net Hospitals: Essential Providers of Public Health and Specialty Services". The Common Wealth Fund. 2/1999.

There are 1,590 certified trauma centers in the U.S., of which 790 are defined as Levels I-III and capable of handling emergency resuscitation, surgery, and intensive care. Of the latter, 173 (22%) are Level I trauma centers, staffed 24/7 with the required specialists (orthopedics, neurosurgery, etc.), whereas 244 (31%) are Level II and the remainder, 373 (47%) are level III.[36] An unfavorable payor mix combined with inadequate reimbursement typically makes trauma centers unprofitable. Medicaid and the uninsured account for 36% of trauma center patients, but a far smaller percentage of revenue collections. [37] Since 1992, 20-25 trauma centers have, on average, closed each year increasing the strain on existing trauma centers.[38]

FIGURE 33: TRAUMA CENTER REIMBURSEMENT BY INSURANCE STATUS



Source: Trauma Center Reimbursement Profile. Bishop & Company. 12/10/2012. <http://traumacare.com/reimbusement-profile.php>

Many safety net hospitals have neonatal intensive care units. Despite typically higher reimbursement from Medicaid and other third-party payors, the contribution margin of this occasionally high-yield area is insufficient to fund other costly safety net service lines. Since 1982, the incidence of pre-mature births prior to 37 weeks gestation has increased by one-third to 12%. [39] Approximately half of pre-term births occur in patients with no known risk factors.

FIGURE 34: PREMATURE BIRTHS ACCOUNT FOR 12% OF ALL BIRTHS, BUT CONSTITUTE GREATEST COST

Delivery (gestational age in weeks)	# Preterm Births [1,2]	Average length of stay per patient (days)	Avg. Annual 2005 Cost per case in dollars	Aggregate Cost in 2005 dollars
<28	34,536 (0.8%)	67.4	190,467	$6.6B
28 - 32	94,976 (2.2%)	44.4	94,785	$9.0B
32 - 36	384,223 (*8.9%)	6.7	13,621	$5.2B
> 37	3,803,384	1.5	3,325	$12.6B

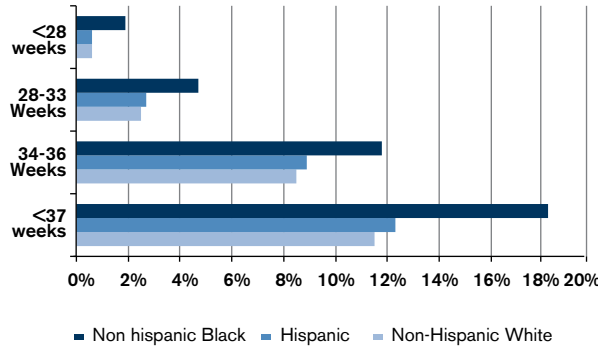
Aggregate annual indirect cost (2005)	
Early intervention services	$611 million
Special Education	$1.1 billion
Lost household and labor market productivity	$5.7 billion
Maternal delivery	$1.9 billion
Total indirect cost	$9.3 billion

- **Births < 28 weeks of gestation constituted 0.8% of all births**
- **Extreme prematurity accounts for more than 40% cerebral palsy, 23% mental retardation, 23% hearing loss, and 47% visual impairment cases per year**

Source: (1) Committee on Understanding Premature Birth and Assuring Healthy Outcomes. "Front Matter." Preterm Birth: Causes, Consequences, and Prevention. Washington, DC: The National Academies Press, 2007. (2) Jiaquan Xu et Al. "Deaths: Final Data for 2007" National Health Statistics Reports. Volume 58(19). 5/20/2010.

African-Americans account for a disproportionate number of pre-term births. Contributing factors include obesity, diabetes, heart disease, smoking, lack of prenatal care, poor maternal health and drug and alcohol use. The black infant mortality rate is 2.4 times that of white infants, largely driven by prematurity. [40]

FIGURE 35: RISK OF PRETERM BIRTH BY RACE AND ETHNICITY



Source: Brady Hamilton et Al. "Births: Preliminary Data for 2007" National Health Statistics Reports. Volume 57(12). 3/18/2009.

Burn centers represent another very expensive service line. Approximately 45,000 patients are admitted to hospitals for burns each year, with 55% of the total or 25,000 patients admitted to 125 specialized burn centers. [41] Less than 1,000 admitted patients die each year for a survival rate of 96.1%. [42] Burn care is exceedingly expensive due to long lengths of stay, the need for highly specialized staff and the investment in equipment and drugs to minimize pain, promote healing and reduce the risk of infection. Due to an increase in safety programs and smoke detector use, burn centers are seeing fewer patients.

A March 2008 report by the Treatment Advocacy Center found a "deficit of nearly 100,000 inpatient [psychiatric] beds…[the] result is increased homelessness, emergency room overcrowding, and use of jails and prisons as de-facto psychiatric hospitals…In 1955 there were 340 public psychiatric beds available per 100,000 U.S. citizens. By 2005, the number plummeted to a staggering 17 beds per 100,000 persons." A consensus panel of experts believes 50 beds per 100,000 is the absolute minimum.[43] Safety net hospital Emergency Departments have become the clearinghouse for unstable patients with schizophrenia (2.4 million), bipolar disorders (5.7 million) and other mental health conditions.[44] The relative abandonment of psychiatric services by most public payors is among the most critical issues facing safety net hospitals. Programs of Assertive Community Treatment (PACT), where the care delivery providers visit a patients home, and assisted outpatient treatment have been shown to reduce the need for psychiatric hospitalization.

Safety net hospitals lag other providers in IT and capital infrastructure investment

Electronic medical records are critical to increasing staff productivity: allowing access to multiple users, improving patient tracking, supporting decision making, and facilitating reporting. The majority of hospitals have already implemented, or are in the process of implementing, enterprise wide information systems able to link ancillaries (lab, radiology, pharmacy) with clinical documentation, decision support systems and images (PACS). Adoption is complex, and may require the development of interfaces with pre-existing systems; several years may be required for implementation. Systems are also expensive and typically cost between $10-100 million, if not more.

FIGURE 36: ADOPTION OF ENTERPRISE-WIDE ELECTRONIC MEDICAL RECORDS

EMR ADOPTION MODEL

Stage	Cumulative Capabilities
7	Medical record fully electronic; HCO able to contribute CCD as byproduct of EMR; data warehousing in use
6	Physician documentation (structured templates), full CDSS (variance, compliance), full R-PACS
5	Closed loop medication administration
4	CPOE, CDSS (clinical protocols)
3	Clinical documentation (flow sheets), CDSS (error checking), PACS outside radiology
2	Clinical data repository, Controlled medical vocabulary, Clinical decision support system, may have document imaging
1	Ancillaries – Lab, Radiology, Pharmacy - installed
0	All three ancillaries not installed

EMR ENTERPRISE ADOPTION RATE

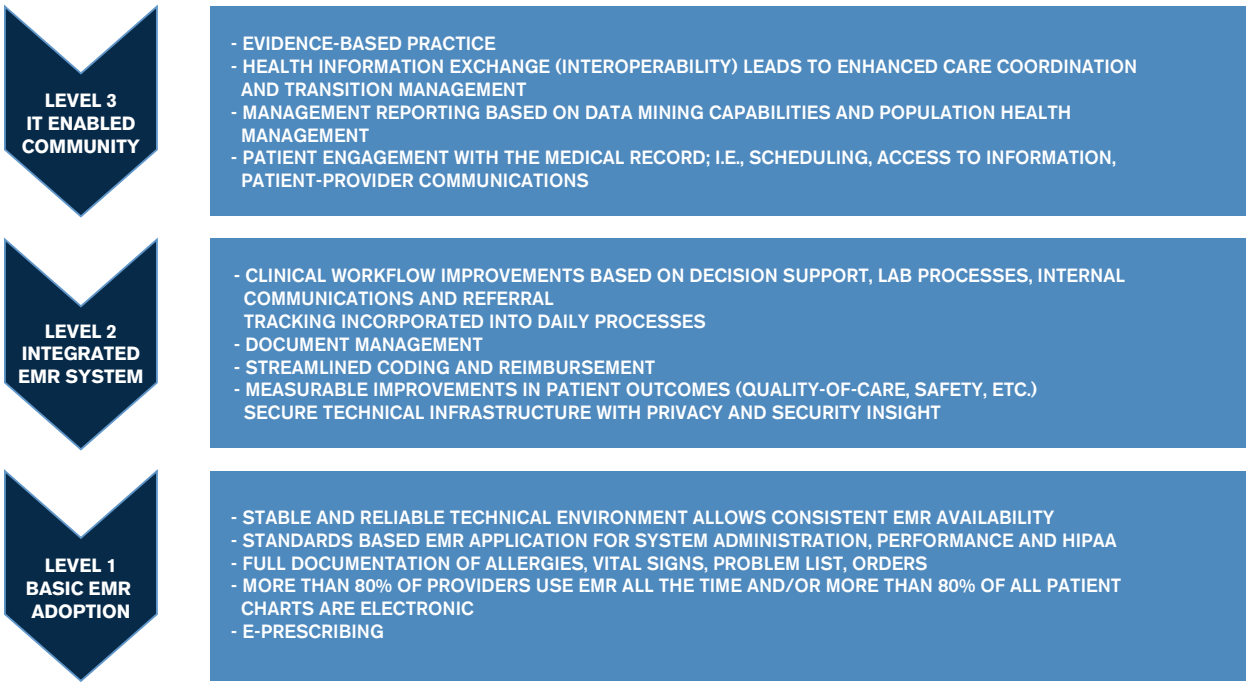
Stage	2007	2008	2009	2010	2011	2012
7	0.0%	0.3%	0.7%	1.0%	1.1%	1.8%
6	0.3	0.5	1.6	2.8	4.4	7.3
5	1.9	2.5	3.8	3.7	7.1	12.0
4	2.2	2.5	7.4	10.3	13.2	14.2
3	25.1	35.7	50.9	49.7	46.1	41.3
2	37.2	31.4	16.9	15.4	12.6	11.2
1	14.0	11.5	7.2	6.7	5.9	4.8
0	19.3	15.6	11.5	10.5	9.6	7.4
Survey Hospital	**5,073**	**5,166**	**5,235**	**5,233**	**5,299**	**5,319**

Source: Electronic Medical Record Adoption Model. HIMSS Analytics. 1/11/2013. <http://www.himssanalytics.org/emram/index.aspx>

Information liquidity – the free flow of information among multiple stakeholders including hospitals, physicians, other providers and patients – is required to ensure care coordination, minimize the duplication of services and facilitate consumer engagement. The Health Information Technology for Economic and Clinical Health Act (HITECH Act), included in the American Recovery and Reinvestment Act (ARRA) of 2009, contained financial incentives for the creation of a national healthcare infrastructure, as well as specific incentives designed to accelerate the adoption of electronic health records among providers. It also broadens data security and privacy protections.

The government has begun to address the need for electronic health records. Meaningful use "is the set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria." [45] Stage 1 is focused on the electronic capture and sharing of data in a standardized format, whereas Stage 2 and Stage 3 emphasize electronic transmission across settings and improving health outcomes (quality, safety and efficiency), respectively. Patient access to self-management tools is included in Stage 3. Incentive payments will be made in 2011-2016 for specific stages of meaningful use. Community-wide health information exchange is critical to care coordination and reducing costs.

FIGURE 37: AMBULATORY "MEANINGFUL USE" OPPORTUNITIES



It is worth noting that safety net hospitals may not only be limited in their ability to invest heavily in information systems, but also in facilities and capital equipment due to cash flow and credit issues.[46] [47] An inadequate physical and technology infrastructure may worsen employee morale, affect staff recruitment and potentially represent a competitive disadvantage for insured patients requiring "sophisticated surgical, diagnostic and therapeutic services." [48]

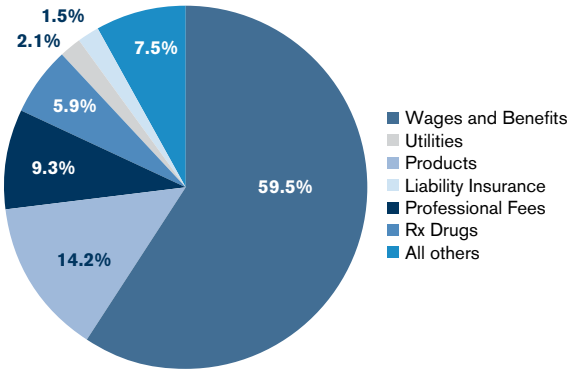
Safety net hospitals are more often unionized, raising costs and lowering operating margins

In 2009, membership in public sector unions surpassed membership in private sector unions for the first time in U.S. history. Hospital membership has increased by almost a third over the last decade, from 687,000 in 2000 to 907,000 today.[49] In 2010, there were 5.4 million part-time and full-time hospital employees; the reported union penetration rate is 21.0% – far above the 11.8% national rate.[50] [51] Public sector workers had a 37% union membership rate, compared to the private sector at 6.9%. Government workers had the highest union membership rate at 43.2%.[52]

There are 1,068 state and local government hospitals in the U.S., the majority of which serve as safety net hospitals.[53] Government institutions, irrespective of their unionization status, are often subject to a range of operating requirements that typically increase the cost of care. For example, civil service requirements may increase, as promotions are typically based on seniority (and not performance), and wage compression for the best employees may occur. In addition, detailed job classifications, time and motion measurements and extensive grievance procedures often limit management's ability to make process or position changes. Firing at will is more difficult. Legal proceedings are common and expensive. Increased interaction with regulatory agencies such as OSHA, the EEOC and others may occur. The risk of work stoppage is greater.

Labor costs, on average account for nearly 60% of hospital expenses. The cost of running a unionized operation across all industries has been estimated by the Bureau of Labor Statistics (BLS) to be higher – 28.3% more for median usual weekly earnings.[52] Assuming incremental union labor costs of 15%, or slightly more than one half the BLS estimate, implies labor costs of 66.6%, or 7.1% (710 basis points) higher than the average hospital. The potential impact is material given low operating margins.

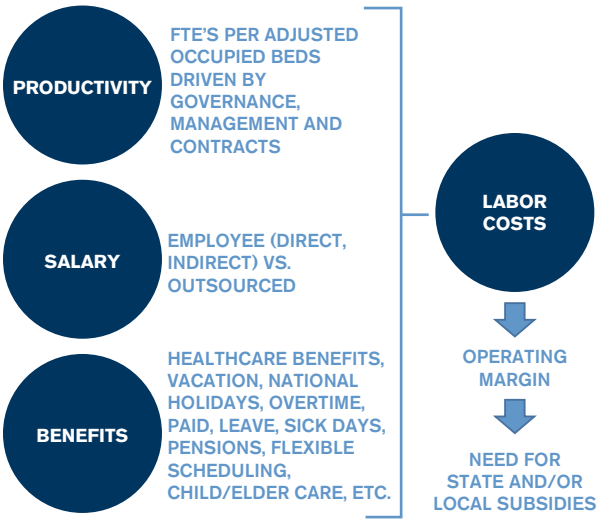
FIGURE 38: PERCENT OF HOSPITAL COSTS BY TYPE OF EXPENSE, 4Q09



Source: Trendwatch, The Cost of Caring: Drivers of Spending on Hospital Care. Avalere Health – AHA. 3/2011

According to the Service Employees International Union (SEIU), healthcare workers in unions earn higher salaries than their non-union counterparts: registered nurses (+16%), nursing aides (+22%), diagnostic technicians (+31%) and other healthcare support occupations (+33%).[49] [54] A confounding variable may be the fact that unionized hospitals and health systems tend to be in urban areas with higher living costs. They are also more likely than non-union workers to have healthcare benefits, employer-paid pensions, more days of paid vacation and sick days, and pay less out-of-pocket costs for their benefits.[52]

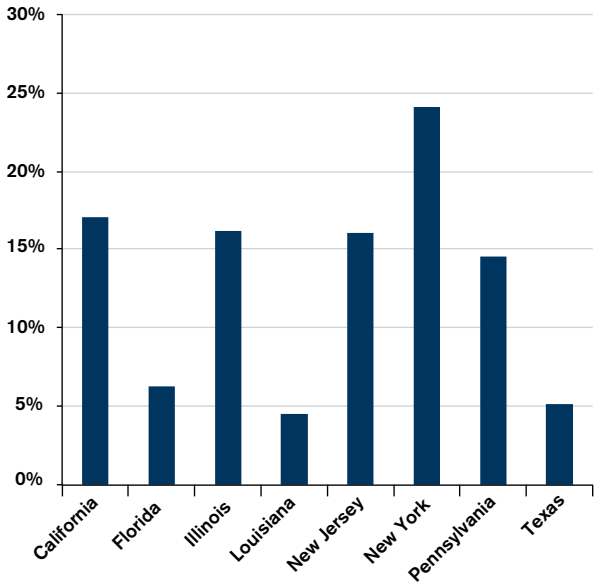
FIGURE 39: HOSPITAL LABOR COSTS



Union penetration rates across all industries are highest

in the Northeast, Midwest and California; a specific rate for hospital workers by state is unknown. Union contracts may be with a single hospital or spread across many institutions. The latter case is exemplified by the Service Employees International Union ("SEIU") master contract covering tens of thousands of hospital workers in New York City and Long Island. This contract was negotiated with a collective bargaining organization, the League of Voluntary Hospitals and Homes. Negotiations are frequently subject to direct political involvement and municipal subsidies as exemplified by New York's Health & Hospitals Corporation (HHC), an organization that generated $6.7 billion in revenue in 2011 and served 1.4 million patients, including 475,000 uninsured. HHC staff is represented by several unions including the SEIU, District Council 37, the NY State Nurses Association and others. [55] Salaries and wages ($2.6 billion), other employee benefits ($1.2 billion) and professional services contracts ($1.4 billion) account for 71.1% of total operating expenditures, a figure inclusive of wages and benefits and professional fees, and above the average of 68.8% reported for U.S. hospitals.[50] [56] The Health & Hospitals Corporation received municipal subsidies and grants of $183.6 million, and other state and federal subsidies totaling $93.7 million to help fund its higher labor costs in 2011.

FIGURE 40: UNION AFFILIATION OF EMPLOYED WORKERS



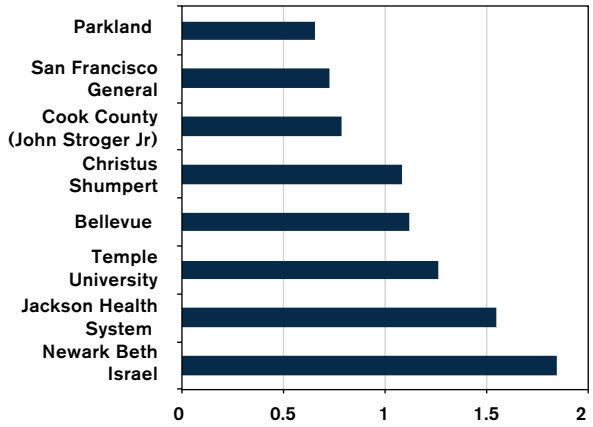
Source: Union Membership (annual) (press release) Bureau of Labor Statistics. 1/27/2012

Stuart H. Altman, Professor of National Health Policy at Brandeis University summarized the situation: "Healthcare has become a higher priority for the union movement, and Massachusetts unions have become part of more aggressive national unions. On the other side is the pressure on hospitals to cut costs at the same time the unions are asking for more." [57] Collaboration is essential in an increasingly cost-constrained environment.

Safety net hospitals, like the majority of community hospitals, exhibit an excessive local variation in healthcare delivery, cost and quality

The Dartmouth Atlas of Health Care uses "Medicare data to provide information and analysis about national, regional and local markets, as well as hospitals and their affiliated physicians." Investigators have identified significant regional and local variation in the cost of treating Medicare patients.[58] Resource utilization, rather than pricing, is the primary cause for the variation. The Hospital Care Intensity Index, a metric incorporating hospital length of stay and the number of inpatient physician consultations, is 1.85 for Newark Beth Israel (NJ), 1.0 for the average U.S. hospital and 0.65 for Parkland Hospital (TX). Total Medicare reimbursement during the last two years of life, based on a population of beneficiaries with one of nine chronic conditions, range from $57,112 to $99,771.

FIGURE 41: VARIATION IN CARE INTENSITY AMONG SAFETY NET HOSPITALS



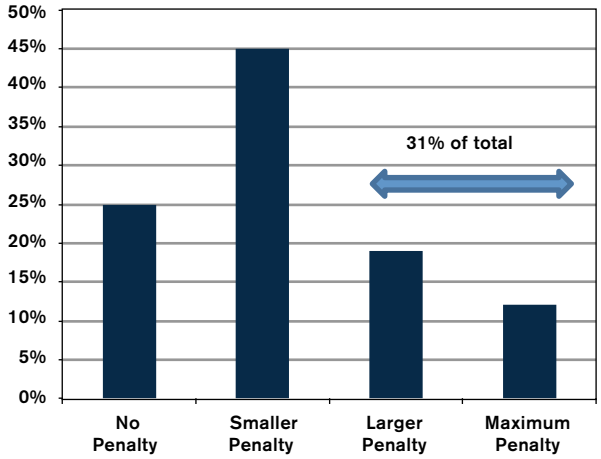
Source: Hospital care intensity. Dartmouth Atlas of Healthcare. 12/20/2012 <http://www.dartmouthatlas.org/tools/care.aspx >

Prominent physicians such as John Stobo MD and Tom Rosenthal MD of the UCLA Medical Center disagree with the foundational premise of the Dartmouth Atlas "that policymakers can extrapolate research data from one region to arrive at conclusions regarding another, very different region." The authors added, "healthcare costs are significantly higher in areas of poverty and in core poverty corridors, such as South and Central L.A., where there is no excess capacity in terms of beds, emergency departments, nurses and primary-care practitioners. Patients are suffering because they have received too little care for too long and arrive at hospitals with multiple health conditions, requiring more extensive, and thus more expensive, care." [59]

This analysis, from different geographic regions, is based on safety net hospitals with similar socioeconomic and demographic profiles. They are all likely to treat dual eligible, trauma and other complex patient populations. The significant variation in care and cost highlighted by the Dartmouth Atlas is suggestive of a benchmarking opportunity.

A recent analysis of hospitals receiving Medicare Disproportionate Share Hospital (DSH) funding highlighted a wide variation in re-admission financial penalties among hospitals treating the highest number of low-income patients.[60] Nearly one-third of (safety net) hospitals received large or maximal penalties.

FIGURE 42: MEDICARE RE-ADMISSION PENALTIES AMONG HOSPITALS WITH HIGHEST QUARTILE OF LOW INCOME PATIENTS



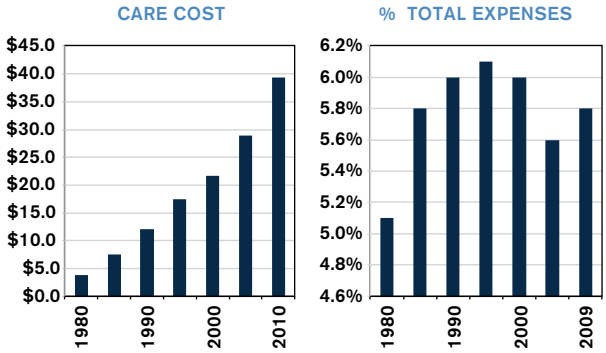
Source: Rau Jordan, "Hospitals Treating the Poor Hardest Hit by Readmission penalties" Kaiser Health News. 10/12/2012

Funding Sources

Safety net hospital funding remains an operational challenge, is not always transparent, and subject to political influence

Safety net hospitals are, by definition, challenged by their payor mix and the required services they provide. Uncompensated care, including bad debt and charity care, provided by a hospital without payment from an insurer or patient approached $40 billion in 2010, consuming approximately 5.8% of total safety net hospital operating expenses. Uncompensated care is highly concentrated; 57% of hospitals report uncompensated care less than 5% of total costs, 35% reported uncompensated care at 5 to 10% of total costs and 8% of hospitals reported uncompensated care of greater than 10% of total cost.[61] The National Association of Public Hospital and Health System (NAPH) member hospitals provide far higher levels of uncompensated care estimated at 16%, a figure nearly triple that of the average hospital. Among NAPH members, uninsured patients account for 18% of hospital discharges and 30% of outpatient visits, contributing to the high level of uncompensated care.[62]

FIGURE 43: UNCOMPENSATED CARE TRENDS



Source: Avalere Heatlh Analysis of American Hospital Association Annual Survey Data, Avalere Health. 2009

The NAPH has identified Medicaid (DSH, supplemental), Medicare DSH, Graduate Medical Education subsidies (DME, IME) and Federal / state / local payments as funding sources that contribute to the underwriting of otherwise unreimbursed care.[63]

FIGURE 44: SUPPLEMENTAL PAYMENTS TO HOSPITAL FOR UNCOMPENSATED CARE

Type of Payment	Description
Medicaid Disproportionate Share Hospital Payments (DSH). FY09: $11.3 billion	Represents Federal financial assistance to hospitals providing care to a large number of low income Medicaid and uninsured patients. States are required to make supplemental payments or adjustments to the payment rates of DSH hospitals. The Federal government distributes DSH payments to each state to a maximum of 12% of total Medicaid spending. The states then allocate DSH payments to qualifying hospitals. 14% of hospitals receive Medicaid DSH payments (n=700)
Medicaid Upper Payment Limit (UPL)	Upper Payment Limits are based on the amount of money a state is allowed to pay for Medicare claims based upon the types of providers and the medical services rendered. The upper limit represents the maximum allowable amount for obtaining matching Federal funds.
Medicare Disproportionate Share Hospital Payments (DSH). FY09: $9.8 billion	Medicare DSH is based on hospital's DSH patient percentage (DPP) or the sum of (a) the % of total Medicare patient days attribute to Medicare patients who are also SSI recipients AND (b) the % of total patient days attributable to Medicaid beneficiaries. If DPP>15%, eligible for DSH payment adjustment. Approximately 65% of community hospitals receive Medicare DSH payments (n=3,200)
Medicare Graduate Medical Education (GME) payments: Direct (DME) and Indirect (IME) payments	Teaching hospitals receive direct payments associated with resident training (DME). Indirect payments (IME) reflects not only the education mission of teaching hospitals, but also the provision of 24/7 access to specialized services and treatment available to all patients irrespective of their ability to pay. Approximately 1,000 teaching hospitals receive GME payments.

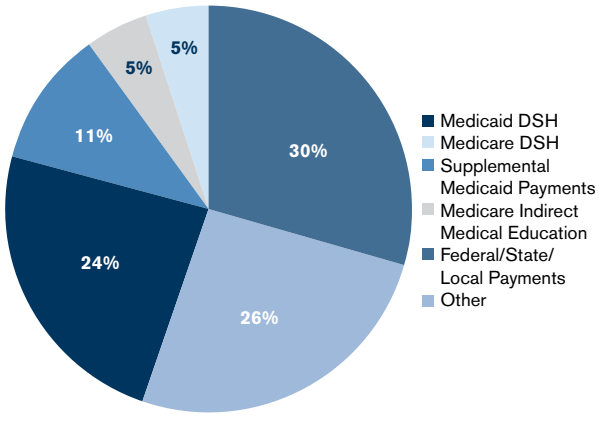
Source: National Healthy Policy Forum. The Basics Medicaid DSH Payments. 6/15/2009

Medicaid Disproportionate Share Hospital (DSH) payments are allocated to hospitals that either have a low income utilization rate (LIUR) of 25% or have a Medicaid utilization rate more than one standard deviation above the mean for that state.[64]

The Medicaid Upper Payment Limits (UPL) program provides supplemental payments to hospitals to make up for the lower reimbursement rates paid by Medicaid for impatient services. UPL payments represent the difference between Medicaid reimbursement rates and Medicare's reasonable rates for similar services. UPL payments may exceed Medicaid DSH payments in some cases. In most states, UPL payments are funded through a complex process that involves contributions from the states flowing to the federal government and returning through the states, having been matched by federal funds at a pre-determined matching rate.

Medicaid DSH and supplemental programs account for 35% of the financing for unreimbursed care; Federal, state and local payments account for 30%. Other payments, Medicare DSH and Indirect Medical Expenses account for the remainder. *A lack of identifiable, transparent, and consistent funding sources, combined with complex politically derived funding mechanisms constitute a continuous challenge for safety net hospitals.*

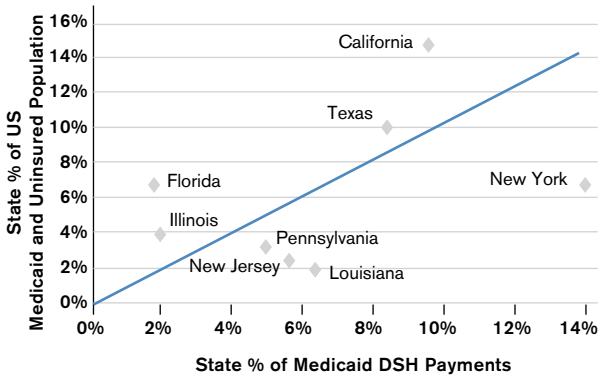
FIGURE 45: NAPH MEMBER SOURCES OF FINANCING FOR UNREIMBURSED CARE, 2010



Source: "Hospital Characteristics Report", National Association of Public Hospitals and Health Systems. 6/2012).

A&M assessed the relationship between the state percentage of the U.S. Medicaid and uninsured population, and the state percentage of the total Federal Medicaid DSH payments. New York received more than 14% of Federal Medicaid DSH payments, nearly twice its percentage of the total Medicaid and uninsured population. Other disproportionate recipients include Louisiana, New Jersey, and Pennsylvania. Florida, Illinois and California receive disproportionately less Federal DSH payments than its Medicaid and uninsured population suggests.

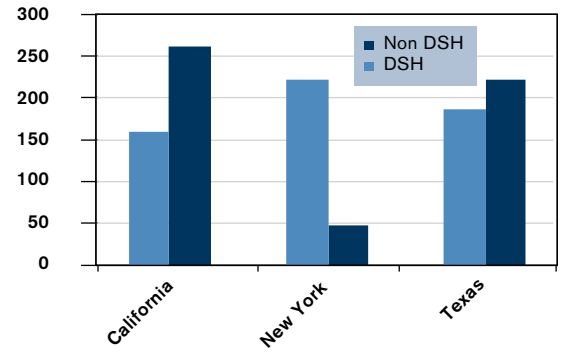
FIGURE 46: ALLOCATION OF FEDERAL DSH PAYMENTS BY STATE



Source: Federal Medicaid Disproportionate Share Hospital (DSH) Allotments. Kaiser Family Foundation. 12/10/2012. <http://statehealthfacts.org/comparemaptable.jsp?ind=185&cat=4>

States allocate the Federal Medicaid DSH payments to qualifying hospitals; the basis for DSH distribution differs from state to state. The General Accounting Office surveyed five states reporting Medicaid Supplemental Payments in FY2006 and determined that "payments were concentrated on a small proportion of providers, and some providers received payments through multiple programs." Distribution was often based on "broadly stated purposes, often to local government hospitals." [65] The criteria utilized for state allocation decisions are statutory, formulaic and complex.

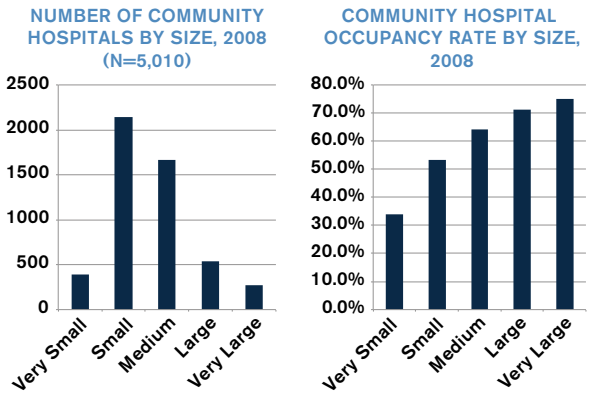
FIGURE 47: NUMBER OF PROVIDERS RECEIVING MEDICAID DSH AND NON-DSH PAYMENTS, 2006



Funding provided by State.
Source: "Medicaid: Cms Needs More Information On The Billions Of Dollars Spent On Supplemental Payments", U.S. Government Accountability Office. Gao-08-614. 5/2008

According to AHRQ, 50% of safety net hospitals are smaller than 100 beds with many located in rural areas. They may be defined as "sole community" or "essential access" hospitals if located 35 miles from other like-hospitals.[3] [66] Smaller hospitals have lower occupancy rates and are often less profitable due to limited economies of scale and a higher cost of capital. Medium sized hospitals, those with 100-299 beds may also be negatively affected by the same factors.

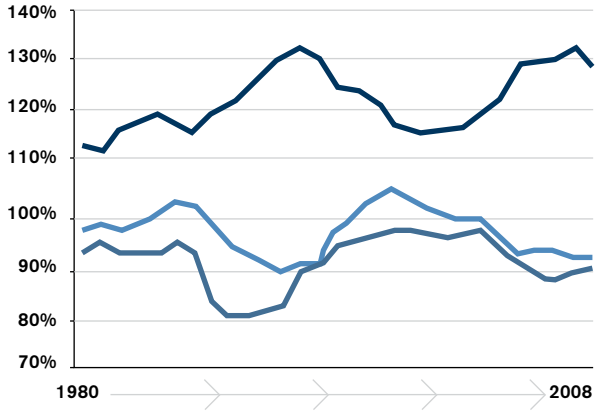
FIGURE 48: HOSPITAL SIZE AND OCCUPANCY RATES



Source: (1)Centers for Disease Control. Hospitals, beds, and occupancy rates, by type of ownership and size of hospital: United States, selected years 1975–2008.
(2) National Center for Health Statistics. Trend Tables, 113. PDF File.

Safety net hospitals generally maintain a discharge payor mix with high Medicaid (36%), Medicare (25%), and uninsured (18%), and comparatively low private insurance (19%) components.[67] The payment-to-cost ratio for Medicaid has ranged from 85-90%, whereas for Medicare it has approximated or been slightly below 100%. Private payors have indirectly subsidized these costs, though with safety net hospital reimbursement levels somewhat below the 120% to 130% of costs reported as the average by Avalere Health for all U.S. hospitals.[68] [69]

FIGURE 49: PAYMENT-TO-COST RATIO BY SOURCE OF HOSPITAL REVENUE



Note: Payment-to-cost ratios show the degree to which payments from each payor cover the costs of treating its patients. They cannot be used to compare payment levels across payors, however, because the service mix and intensity vary. Data are for community hospitals. Medicaid includes Medicaid Disproportionate Share payments.

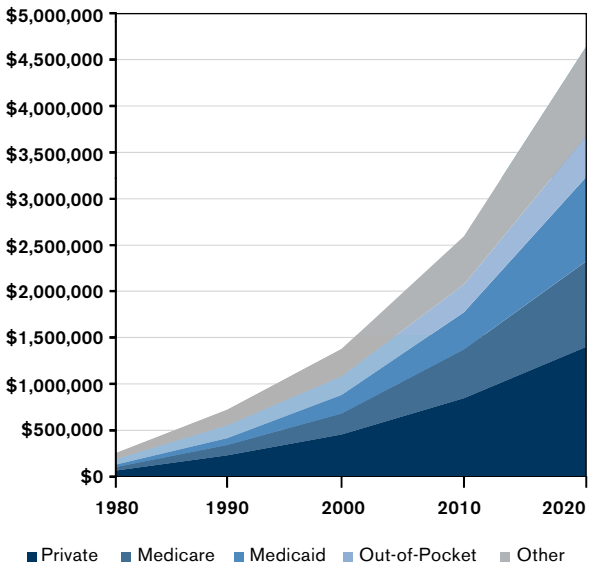
Source: Avalere Health Analysis of American Hospital Association Annual Survey Data for Community Hospitals. Avalere Health. 2008

Safety net hospital funding will likely be affected by Federal and state financial constraints

U.S. healthcare spending will continue to increase. National health expenditures have been forecasted to reach $4.5 trillion in 2020, an increase of $2.0 trillion in 10 years.[70] Spending as a percentage of GDP will rise from 17.7% to 19.8%. Moderate spending growth during 2010-13 is expected to be followed by a significant

expenditure rise of 8.3% in 2014 due to higher service utilization and prescription drug usage resulting from changes in Medicaid and health exchange coverage provided for in the PPACA. The healthcare reform legislation expands access without materially affecting cost constraints.

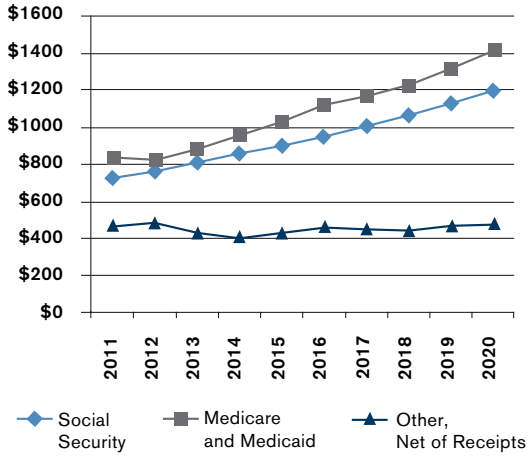
FIGURE 50: NATIONAL HEALTH EXPENDITURES ($ MILLIONS)



Source: Centers for Medicare and Medicaid Services, Office of the Actuary

Total Federal outlays are forecasted to increase from $3.6 trillion in 2011 to $5.0 trillion in 2020. Revenues range from $2.3 trillion to $4.7 trillion in 2011 and 2020, respectively. Mandatory outlays during this period, primarily Social Security, Medicare and Medicaid, account for the entire increase in expenditures; discretionary government spending actually declines from $1,346 billion to $1,313 billion during the decade. Medicare and Medicaid spending already exceed that of Social Security.[71] The increase in projected Medicare and Medicaid spending will fail to meet the healthcare needs of an increasingly insured and aging population.

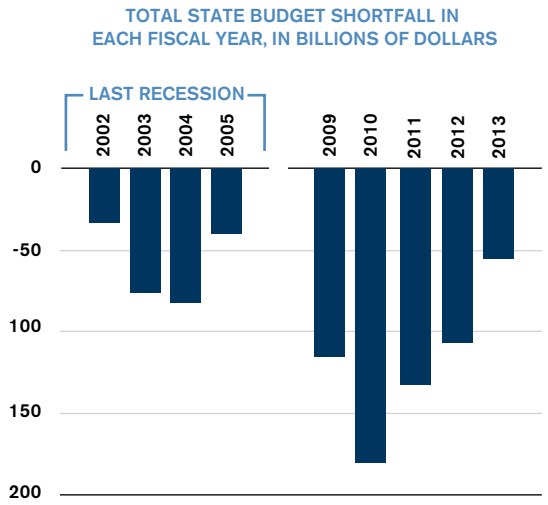
FIGURE 51: PROJECTED MANDATORY FEDERAL OUTLAYS, 2011-2020



Source: CBO. The Budget and Economic Outlook: FY2012-22

The "Great Recession" ravaged state tax collections, with revenues persisting below pre-recession levels.[72] Enactment of the American Recovery and Reinvestment Act (ARRA) in February 2009 provided states with $775 billion.[73] Medicaid grants and Medicare (HITECH) electronic medical record incentive payments were among the largest allocations at $94 billion. A higher Federal Matching Allocation Percentage (FMAP) than historical rates allowed states to temporarily reduce their Medicaid contribution. Expiration of the ARRA in fiscal 2011 required states to either make up the difference or cut Medicaid spending.

FIGURE 52: LARGEST STATE BUDGET SHORTFALLS



Source: Phil Oliff, Chris Mai, Vincent Palacios. "States Continue To Feel Recession's Impact", Center For Budget And Policy Priorities. 6/27/2012

Every state except Vermont mandates a balanced budget. Spending cuts, combined with "withdrawals from reserves, revenue increases, and the use of federal stimulus dollars" closed the respective state shortfalls.[72]

FIGURE 53: BUDGET SHORTFALL BY STATE, FY10-13

	FY10 (begin July 2009)		FY11	
	Shortfall	% Budget	Shortfall	% Budget
	($ Billions)		($ Billions)	
California	$45.5	52.8%	$17.9	20.7%
Florida	6.0	28.5%	4.7	19.5%
Illinois	14.3	43.7%	13.5	40.2%
Louisiana	2.5	27.8%	1.1	14.3%
New Jersey	11.0	40.0%	10.7	38.2%
New York	21.0	38.8%	8.5	15.9%
Pennsylvania	5.9	23.6%	4.1	16.2%
Texas	3.5	10.7%	8.9	20.9%
U.S.	$190.8	29.0%	$130.0	19.9%

	FY12		FY13	
	Shortfall	% Budget	Shortfall	% Budget
	($ Billions)		($ Billions)	
California	$23.9	27.8%	$15.0	16.2%
Florida	3.7	15.8%	1.0	4.1%
Illinois	6.4	18.5%	2.0	5.5%
Louisiana	2.1	25.1%	1.2	14.3%
New Jersey	11.0	37.5%	0.5	1.6%
New York	10.4	18.2%	2.0	3.4%
Pennsylvania	3.7	13.5%	0.5	2.0%
Texas	9.0	20.4%	9.0	24.2%
U.S.	$107.3	15.5%	$55.0	9.5%

Source: Phil Oliff, Chris Mai, Vincent Palacios. "States Continue To Feel Recession's Impact", Center For Budget And Policy Priorities. 6/27/2012

According to the Center on Budget and Policy Priorities, state tax intake grew 8.3% during FY2011 (ending June 2011), offering "a glimmer of hope that states are beginning to climb out of the fiscal hole caused by the recession. Unfortunately, that hole was so deep that even if revenues continue to grow at last year's rate — which is highly unlikely — it would take seven years to get them back on a normal track."[72] The high unemployment rate, a weak housing market, declining real estate values and the impending fiscal cliff represent additional challenges to the economic vitality of the nation.

Safety net hospitals are likely negatively affected by the Medicare Value-based Purchasing Program

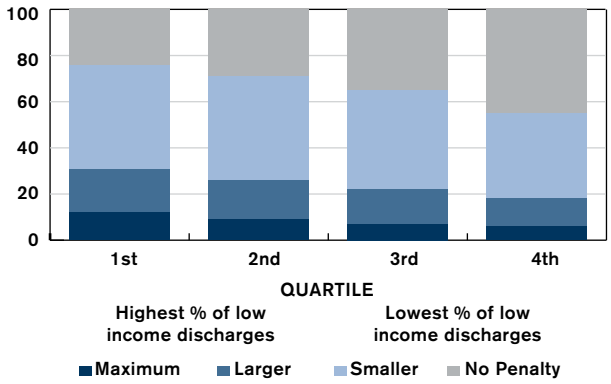
Medicare has adopted a value-based purchasing approach to care delivery in an attempt to reduce hospital re-admissions and hospital-acquired conditions, enhance compliance with evidence-based care guidelines and increase patient satisfaction. The value-based purchasing approach has several elements that could impact safety net hospitals. These elements are discussed, in brief, below.

HOSPITAL RE-ADMISSIONS

A recent Kaiser Health News analysis divided Medicare Disproportionate Share Hospitals (DSH) into quartiles based on the size of penalties applied by Medicare to reduce hospital re-admissions.[60] Each year, nearly 20% of Medicare patients are re-admitted to hospitals within 30 days. CMS has estimated the cost of preventable re-admissions at $12 billion per year.[74] Beginning in FY2013 (October 2012), a 1% hospital penalty will be applied to the total Medicare billing for "excessive" re-admissions during the three-year period from July 2008 to June 2011; penalties reach 3% in 2015.

A two-year analysis of 3,329 Medicare DSH recipients suggests that safety net hospitals are at particular risk for re-admission penalties. The suggestion assumes that safety net hospitals are in the 1st quarter of Medicare DSH recipients or those with the higher percentage of low income discharges. Assuming this proxy, nearly one-third of safety net hospitals would receive large or maximal penalties, whereas only 25% would not receive any penalty. This compares unfavorably with higher income Medicare DSH hospitals.

FIGURE 54: MEDICARE RE-ADMISSIONS BY QUARTILE



Source: Rau Jordan, "Hospitals Treating The Poor Hardest Hit By Readmission Penalties" Kaiser Health News. 10/12/2012

The reduction in Medicare revenues imposed by the penalty is likely to have a disproportionate negative effect on safety net hospital operating margins.

HOSPITAL ACQUIRED CONDITIONS

Beginning in FY2015 (October 2014), Medicare will also impose a 1% reduction in total payments to hospitals that are in the lowest performance quartile in the rate of risk-adjusted Hospital Acquired Conditions (HACs). These conditions include inadvertent falls, infections (e.g., bloodstream, ventilator, surgical site, urinary tract), blood incompatibility, poor glucose control and blood clots. Hospital acquired infections alone account for 99,000 deaths per year.[75]

FIGURE 55: HOSPITAL ACQUIRED INFECTIONS

	Attribute cost per infection, adjusted to 2007 $ ([1,2])	Number of cases
Surgical site infection (SSIs)	$11,874 - 34,670	290,485
Central line associated bloodstream infections (CLABSIs)	$7,288 - 29,156	92,011
Ventilator-associated pneumonias (VAPs)	$19,633 - 28,508	52,543
Catheter-associated urinary tract infections (CAUTIs)	$862 - 1,007	449,334
Gastro-intestinal (Clostridium difficile) associated disease	$6,408 - 9,124	178,000
Total	**$20,549 - $25,903([3])**	**1,737,125**

Sources: (1) Stone PW, Braccia D, Larson E. Systematic review of economic analyses of healthcare-associated infections. Am J Infect Control 2005;33:501-509. (2) Anderson DJ, Kirkland KB, et al. Under-resourced hospital infection control and prevention programs: penny wise, pound foolish? Infect Control Hospital Epidemiology 2007;28:767-773. (3) R. Douglas Scott. The Direct Medical Costs of Healthcare Associated Infections in U.S. Hospitals and the Benefits of Prevention. CDC, 3/2009

PATIENT SATISFACTION

Medicare is also utilizing random survey data from discharged patients to assess the quality of the user experience while in the hospital. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey topics include communication with nurses and doctors, responsiveness of the hospital staff, discharge information, pain management, cleanliness and quiet of the hospital environment, overall rating and willingness to recommend.[76]

A recent study from the Archives of Internal Medicine reported that patients at safety net hospitals had lower measures than non-safety net hospitals on nearly all parameters of patient experience. Importantly, patients were less likely to rate a safety net hospital a 9 or 10 on a 10-point scale (63.9%) than patients at other institutions (69.5%).[77] Another study published by the Archives in March 2012 assessed the association between patient satisfaction in Year 1 with healthcare utilization and expenditures in Year 2.[78] Hospital HCAHPS surveys were used to assess the patient healthcare experience. The results were surprising: "Adjusting for socio-demographics, insurance status, availability of a usual source of care, chronic disease burden, health status, and year 1 utilization and expenditures, respondents in the highest patient satisfaction quartile (relative to the lowest patient satisfaction quartile) had lower odds of any emergency department visit; [and] higher odds of any inpatient admission, greater total expenditures, greater prescription drug expenditures and higher mortality."[78] Implications of the latter findings to Medicare are unclear.

EVIDENCE-BASED PRACTICE

Studies have shown a correlation between compliance with evidence-based practices (e.g., treatment guidelines), and clinical and economic outcomes.[79] As a result, Medicare is tracking compliance with specific practices such as:

a. % heart attacks patients given medication to avert blood clots within 30 minutes of hospital arrival
b. % heart attacks patients given percutaneous coronary interventions within 90 minutes of arrival
c. % heart failure patients given self-management instructions upon discharge
d. % pneumonia patients who had a blood culture prior to antibiotics
e. % pneumonia patients who received the correct antibiotics
f. % surgical patients receiving antibiotics within one hour of surgery
g. % surgical patients receiving the correct antibiotic and had their antibiotics halted within 24 hours post-surgery
h. % surgical patients receiving treatment to prevent blood clots + / - 24 hours pre- and post-surgery

According to a study published in the New England Journal of Medicine, only 55% of patients receive recommended care. Quality varies significantly among medical conditions from 11% for alcohol dependence to 79% for senile cataracts.[80] The data is not surprising given difficulty in deploying standardized clinical practices in most healthcare institutions and the fact it takes 17 years, on average, for new effective medical findings to become standard medical practice.[81]

Under-performing hospitals, whether or not a safety net provider, are at-risk for not only losing reimbursement by not meeting quality benchmarks, but also for medical complications, liability and excessive utilization.

PPACA to Paradoxically Increase Financial Challenges for Safety Net Hospitals

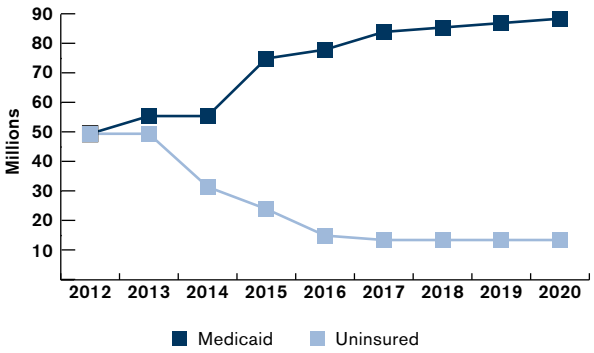
Greater access to insurance benefits places safety net hospitals in the position of having to compete for the patient population that they traditionally served.

The Patient Protection and Affordable Care Act (PPACA) expands insurance coverage through several mechanisms, including: raising the Medicaid income threshold for adults to 133% of the Federal Poverty Limit (FPL), eliminating the use of pre-existing condition coverage restrictions and mandating individual coverage for all Americans. State participation in Medicaid expansion is voluntary, supported by the Supreme Court ruling of June 28. Despite efforts by provider and patient advocate organizations to overturn their decisions, several states have rejected Medicaid expansion, including: Alabama, Georgia, Louisiana, Maine, Mississippi, Oklahoma, South Carolina and Texas. Iowa, Missouri and Nevada are still leaning against expansion.

According to the Census Bureau, 48.6 million Americans were uninsured in 2011, a decline of 1.3 million from 2010 due to the impact of the PPACA provision allowing parents to keep their children under 26 years on their health plans.[82] The number of uninsured Americans has been forecasted to decline further to 28.9 million in 2020 – 3.0 million higher than the estimate prior to the Supreme Court decision allowing states to opt-out of Medicaid expansion without the risk of a penalty.

The impact of the PPACA on the number of uninsured will be primarily determined by state participation in Medicaid expansion to 133% of the Federal Poverty Limit. In participating states, a 40-45% reduction in the number of uninsured has been forecasted; New York will be modestly affected due to already liberal (adult) Medicaid coverage criteria. Louisiana (17.8%) and Texas (23.7%) will continue to have a high level of uninsured residents if their decision to reject Medicare expansion is not overturned. Under the current healthcare reform design premise, there will still be a persistent number of uninsured individuals that will continue to require urgent and chronic disease care.

FIGURE 56: INSURANCE COVERAGE IMPACT OF THE PPACA



Source: CBO. Estimates for the Insurance Coverage Provision of the ACA Updated for the Supreme Court Decision. 7/2012

FIGURE 57: POTENTIAL IMPACT OF PPACA VARIES BY STATE

		2019 Medicaid Coverage Expansion		
	New Medicaid	Previously uninsured adults	Other	% Reduction uninsured adults
Governors accepting expansion:				
California	2,008,796	1,406,101	602,695	41.5%
Illinois	631,024	429,258	201,766	42.5
New Jersey	390,490	292,489	98,001	45.3
New York	305,945	223,175	82,770	14.8
Pennsylvania	482,366	282,014	200,352	41.4
Florida	951,622	683,477	268,145	44.4
Governors rejecting expansion:				
Louisiana	366,318	277,746	88,572	50.7
Texas	1,798,314	1,379,713	418,601	49.4

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Projection based on NHE released January 2011 and includes impact of PPACA

Medicaid coverage gives patients additional provider options. Increased insurance coverage will allow previously uninsured and newly covered Medicaid recipients to obtain healthcare from any institution with a Medicaid arrangement, many non-safety net institutions. In addition, non-traditional providers of services to Medicaid recipients are increasingly attracted to the potential for Medicaid market growth and contracting with Medicaid Managed Care organizations to cover their overhead by increasing patient throughput.[83]

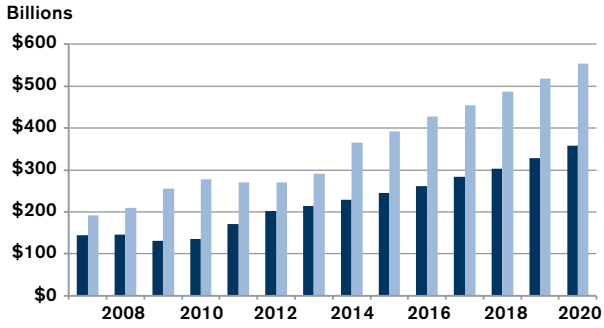
The PPACA will pay for newly insured Medicaid lives at an already under-funded hospital base rate structure

The Patient Protection and Affordable Care Act (PPACA) requires the Federal Government to pay for 100% of new Medicaid enrollees from 2014-2016, and then decline to 95% in 2017, 94% in 2018, 93% in 2019 and 90% thereafter.[84] The federal government will pay hospitals based on the pre-existing below-cost rate structure. The financial implications of increased Medicaid coverage is mixed unless the additional Medicaid covered lives, even at proposed payment levels, become incremental to direct costs. The opportunity for cost shifting at safety net hospitals is limited given a relatively low rate of commercially insured patients. Even with commercial contracts in place, safety net hospitals are typically unable to negotiate third party rates adequate to overcome the entirety of the cost-shift differential.[85]

Despite the PPACA, state Medicaid spending will continue to increase due to a growing dual-eligible population; fiscal pressure on safety net hospitals will continue

The PPACA does not alter the financing formula for the aged and disabled Medicaid dual-eligible population, cohorts accounting for 55-65% of the annual increase in Medicaid spending.[86] It also does not cover previously eligible Medicaid recipients. In 2009, Medicaid spending per capita for children ($2,313) and non-disabled adults ($2,926) was far lower than that of the dual eligible elderly ($13,186) and disabled ($15,453).[87] State outlays for Medicaid have been forecasted by CMS to increase from $158 billion in 2011 to $357 billion in 2020.[70]

FIGURE 58: FEDERAL AND STATE MEDICAID PROJECTIONS



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Projection based on NHE released January 2011 and includes impact of PPACA

In 2011, the total Medicaid spending growth rate of 2.0% was far below the 9.7% spike reported in 2010 (that followed the termination of the enhanced Federal funded included in the American Recovery and Reinvestment Act).[88] Actual Medicaid spending was also below the 7.0% forecast by CMS in January 2011. The decline reflected program eliminations, provider rate restrictions, lower enrollment growth, expanded use of managed care and increasing use of care coordination strategies, including the health home and patient-centered medical home. The elimination by Louisiana of $152 million in safety net hospital funding for FY12 is a particularly impactful example of the longer-term need to reduce state spending.

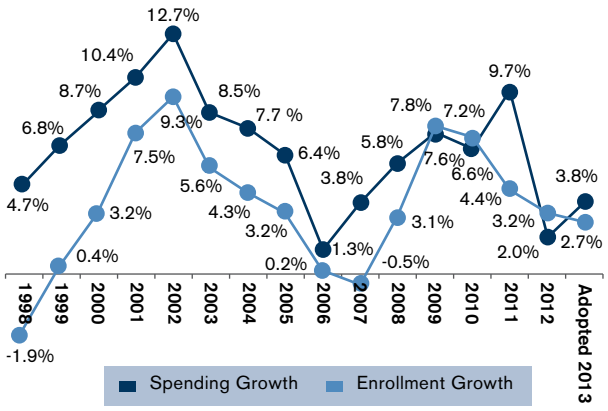
FIGURE 59: SIGNIFICANT CUTS IN STATE MEDICAID PROGRAMS

Florida (1)	In its 2011-2012 budget proposal, the State Senate would cut $720 million to 15 safety net hospitals (a) Medicaid reimbursement rates reduced by 10% (b) eliminate all hospital services under the Medically Needy program (providing hospital services to 177,000 working poor, uninsured Floridians who have had a catastrophic illness –cancer, heart diseases, debilitating injury, or an organ transplant) (c) eliminate the Medicaid for the Aged and Disabled program for 42,000 people.
Illinois (2)	Legislation cuts $1.6 billion from Medicaid including (a) elimination of Illinois Cares Rx affecting 180,000 people (b) limits participation in the Family Care program to 133% FPL (c) adults will no longer be able to receive chiropractic and podiatric services
Louisiana (3)	State financing to the seven hospitals was reduced by $85 million, combined with a loss of federal funding, the reductions totaled to $152 million. The cuts represent a 19% hit out of the system's $802 million budget. 1,487 jobs out of the 6,140 positions in the system's budget will be cut.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Projection based on NHE released January 2011 and includes impact of PPACA

Despite the short-term slowdown in spending, we expect Medicaid expenditures to accelerate with PPACA-related coverage expansion to begin in 2014.[84] History reveals a cyclical nature to Medicare spending and enrollment.

FIGURE 60: ANNUAL PERCENT CHANGE IN TOTAL MEDICAID SPENDING AND ENROLLMENT



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

Source: Laura Snyder et al. Medicaid Enrollment June: 2011 Data Snap Shot. KMCU, Kaiser Family Foundation. 6/2012. PDF File

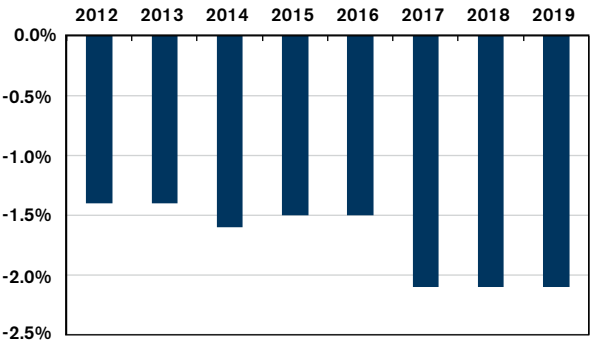
Strategies typically deployed by states to reduce spending have focused on cuts in provider payments, eligibility restrictions and benefit reductions. The PPACA raises Medicaid eligibility for adults to 133% of the Federal Poverty Limit and establishes a set of comprehensive "essential health benefits" for participating states to include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health, substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and pediatric services (oral, vision care).[89] Required essential health benefits reduce the ability of states to contain outpatient costs.

Reduction in annual Medicare market basket update to affect safety net hospital margins

The PPACA includes reductions to the Medicare basket update, the annual increase per sector (e.g., hospitals, skilled nursing facilities, etc.) that "answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period." [90] Reductions have been forecasted by the CBO to save $196.3 billion over 10 years.[91] It's important to recognize that update reductions do not imply negative growth; they reflect a downward adjustment to the expected rate of positive growth.

Historically, the hospital market basket index ranged from 2.0% to 3.0% annually. The PPACA includes an annual productivity adjustment of (-1.3%) to the update, as well as an update factor reduction of (-0.10%) to (-0.75%) through 2019. The net impact of these changes will be Market Basket index increases that lag the historical rate of Medicare reimbursement growth.[92] Among NAPH members, Medicare accounts for 21% of net hospital revenues, a consequential through smaller than average contribution as compared to non-safety net hospitals at 39%.[67 93]

FIGURE 61: REDUCTION IN MEDICARE MARKET BASKET UPDATE. HISTORICAL BASELINE: +2.0-3.0%



Source: Implementing Healthcare Medicare Cost Savings. CMS, Office of the actuary. PDF File.

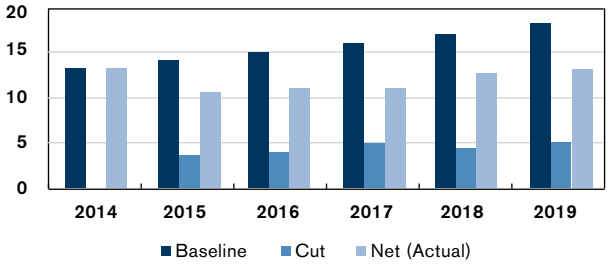
Planned reduction in Medicare disproportionate share hospital (DSH) payments in the PPACA (Section 3133)

The Medicare Advisory Payment Commission (MedPAC) recently determined that only 25% of Medicare DSH payments are justifiable by the cost of providing care to low-income patients.[94] As a result, Medicare hospitals face DSH payment reductions of 75% beginning FY2014; the reductions total an estimated $22.1 billion. Note, however, longer-term net reductions are minimal as the 2019 Medicare DSH baseline spending of $13.2 billion is only $100 million less than actual 2013 levels.

More than 3,300 hospitals currently receive Medicare DSH payments, a percentage far higher than the 2,100 hospitals (43%) providing uncompensated care costs exceeding 5% of their total operating expenses. The

PPACA will re-allocate a portion of Medicare DSH payments to hospitals with the greatest uncompensated care costs.[95]

FIGURE 62: NET CHANGES IN MEDICARE DSH PAYMENTS



Source: (1) CBO. Medicaid and Medicare Baseline and analysis of reconciliation bill 3/20/2010
(2) Williams, David. "Let the Payment Reductions Begin." Horne LLP.

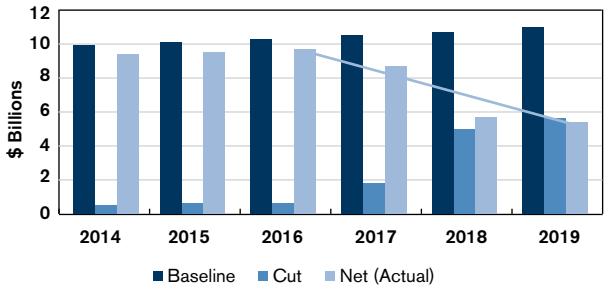
Planned reduction in Medicaid disproportionate share hospital (DSH) payments in the PPACA (Section 2551)

Reductions in Medicaid DSH payments reflect the limited political clout of Medicaid recipients, the uninsured, safety net hospitals and supporting organizations. Baseline spending has been forecasted to decrease from $9.9 billion in 2014 to $5.4 billion in 2019, a decline of 45%. The rationale for the decrease is the reduction of uninsured individuals based on the planned increase in Medicaid eligibility to 133% of the FPL. Note, however not all states will expand Medicaid eligibility and thus, could suffer a reduction in Medicaid DSH payments absent an offset in Medicaid insurance coverage growth. In addition, in states with expanding Medicaid eligibility, it will be difficult to predict the timing of Medicaid enrollment with Medicaid DSH reductions on a hospital-by-hospital basis. Safety net hospitals will remain disproportionately affected by uncompensated care provided to illegal / undocumented immigrants, as well as legal residents ineligible for Medicaid during their first five years of residence.

Future reductions in Medicaid DSH payments may eventually be steeper than those projected in the PPACA, as evidenced by the fact that the recent fiscal cliff bill targeted these payments as a means to fund the Medicare sustainable growth rate, i.e. doctor fee fix.

Temporary increase in payments for primary care physicians not expected to materially affect already limited access

FIGURE 63: DECLINING MEDICAID DSH PAYMENTS

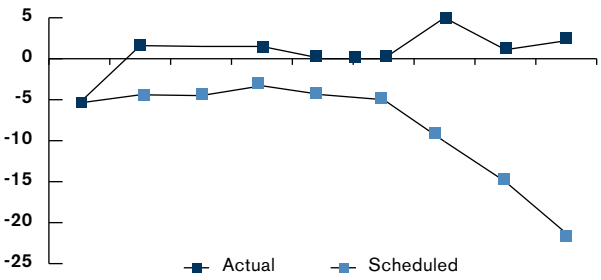


Source: (1) CBO. Medicaid And Medicare Baseline And Analysis Of Reconciliation Bill 3/20/2010
(2) Williams, David. "Let The Payment Reductions Begin." Horne LLP

In a pre-emptive attempt to increase the willingness of primary care physicians to accept new Medicaid patients, the PPACA temporarily matches Medicaid payment rates with Medicaid rates in 2013 and 2014.[96] The current Medicaid-to-Medicare ratio is 0.66 for primary care physicians, with a range of 0.36 to 0.90 among the states.[33] Approximately 14 million previously uninsured people have been forecasted to gain Medicaid insurance coverage in 2014.

Higher Medicaid primary care reimbursement for 2013-14 does not address a potential reduction in Medicare physician payments. The PPACA failed to address the Sustainable Growth Rate (SGR) mechanism, Medicare's codified payment formula for physician services. Until 1992, Medicare paid physicians on usual, customary and reasonable charges. The Center for Medicare and Medicaid Services subsequently used the Resource Based Relative Value Scale (RBRVS) fee schedule to assign prices to 7,000 specific physician tasks and services. The RBRVS assigns value to the time, skill and intensity of a physician's work, practice expenses and malpractice costs.[97] Scheduled reductions in Medicare physician payments have been deferred by Congressional action for the past several years.

FIGURE 64: LACK OF SUSTAINABLE GROWTH RATE INTERVENTION BY CONGRESS

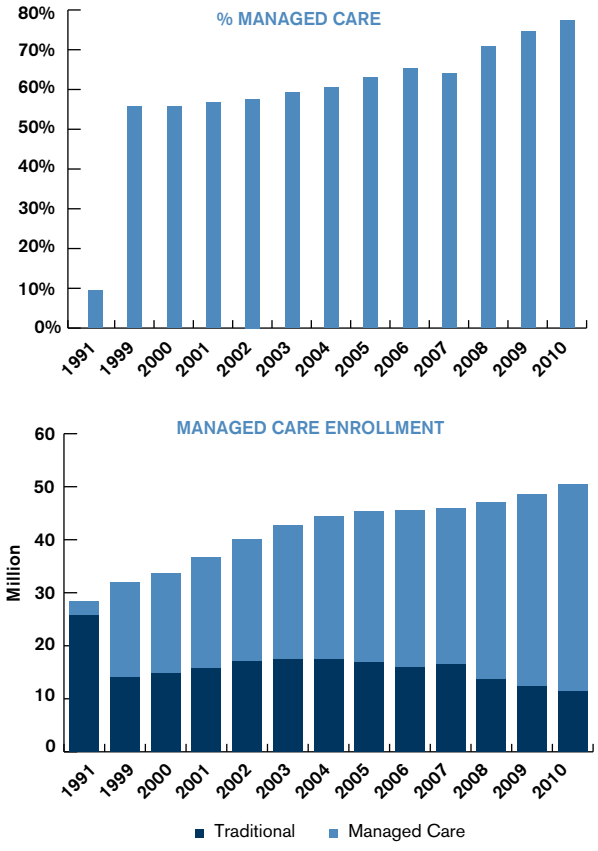


Source: American Medical Association. Health System Reform. 10/15/2009

Medicaid Managed Care Does Not Fundamentally Restructure Care Delivery (With Exception)

During the past 20 years, Medicaid managed care enrollment has increased from nearly 3 million (9.5% of beneficiaries) in 1991 to 39 million (77.4%) in 2010.[5] [98] Medicaid managed care enrollment has been driven by "an emphasis on prevention and quality, as well as greater budget predictability by transferring a large measure of risk from the state to private insurers." [99]

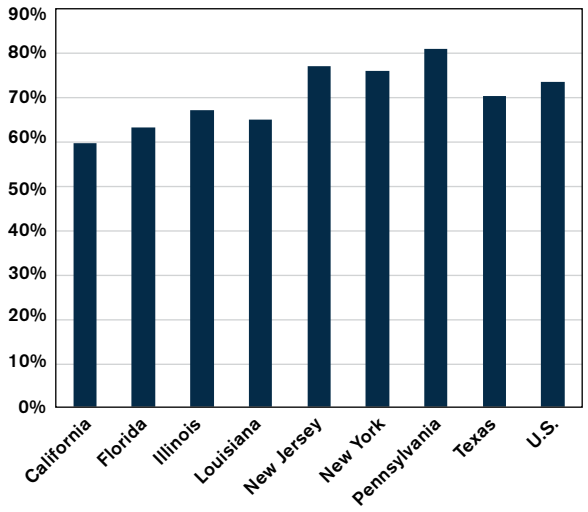
FIGURE 65: MEDICAID MANAGED CARE ENROLLMENT TRENDS



Source: Kaiser Family Foundation "Medicaid Managed Care and Traditional Enrollment" Microsoft PowerPoint File

Medicaid managed care penetration varies by state. Idaho, South Carolina, Tennessee and Utah lead the nation with 100% enrollment. Conversely, Alaska, New Hampshire and Wyoming have the nation's lowest enrollment at 0%. Most of the large states range from 60-80% market penetration.[100]

FIGURE 66: MEDICAID MANAGED CARE ENROLLEES AS A PERCENT OF STATE MEDICAID ENROLLEES, FY09



Source: 2009 Medicaid Managed Care Enrollment Report, Centers for Medicare and Medicaid Services 6/30/2009 PDF File

The most common types of Medicaid managed care plans include HMOs providing a comprehensive set of services on a prepaid capitated risk basis, prepaid ambulatory and / or inpatient health plans and fee-for-service. Primary Care Case Management (PCCM) groups which are contracted to locate, coordinate, and monitor covered primary care. PCCMs may receive incentive payments if Medicaid spending is below baseline expectations; on the contrary, higher than baseline spending may result in financial penalties. Carve-outs of specific services such as mental health and substance abuse, as well as payment adjustments for high risk situations (e.g., low birth weight) are common.

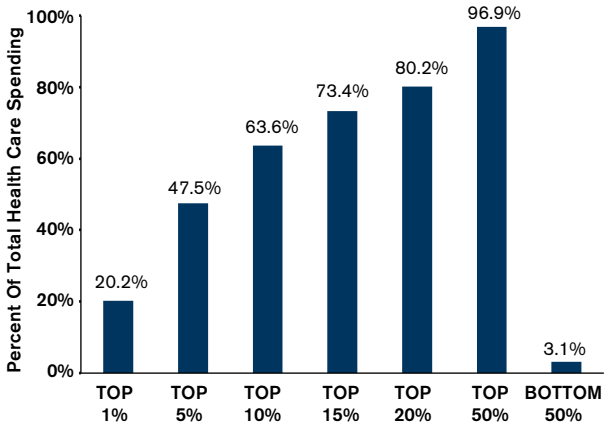
FIGURE 67: TYPES OF MEDICAID MANAGED CARE PLANS

Type of Plan	% Enrollment	Description
Medicaid-only HMO	27%	Provides comprehensive services to only Medicaid beneficiaries
Commercial HMO	20%	Provides comprehensive services to both Medicaid and commercial and/or Medicare.
Prepaid Ambulatory Health Plan (PAHP)	20%	Provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. For example, a Dental PAHP is a managed care entity that provides only dental services.
Prepaid Inpatient Health Plan (PIHP)	16%	Provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. For example, a Mental Health (MH) PIHP is a managed care entity that provides only mental health services.
Primary Care Management Provider (PCCM)	14%	A physician, physician group practice, or an entity employing physicians, nurse practitioners, nurse midwives, or physician assistants who contracts directly with the State to locate, coordinate, and monitor covered primary care (and sometimes additional services).

Source: Medicaid Enrollment in Managed Care by Plan Type, July 1, 2010. Kaiser Family Foundation. 12/20/2012. <http://www.statehealthfacts.org/comparetable.jsp?ind=218&cat=4>

Healthcare spending is highly concentrated with 5% of the population accounting for nearly one-half of total expenditures; conversely, 50% of the population account for only 3% of spending.[101] Children account for 58% of Medicaid enrollees. Ambulatory care sensitive re-admissions for asthma, pneumonia, seizures and complex chronic conditions are important drivers of child healthcare costs.[102] Expenditures for premature births, certain types of cancers (e.g., leukemia), mental disorders (excluding dementia) and trauma are other important contributors to Medicaid costs. Chronic diseases such as congestive heart failure, coronary artery disease, osteoarthritis, chronic obstructive lung disease and diabetes are more common in the dual-eligible population, largely uncovered by Medicaid Managed Care.

FIGURE 68: CONCENTRATION OF HEALTHCARE SPENDING



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any healthcare spending. Healthcare spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.
Source: Healthcare Costs a Primer. Kaiser Family Foundation. 3/2009.

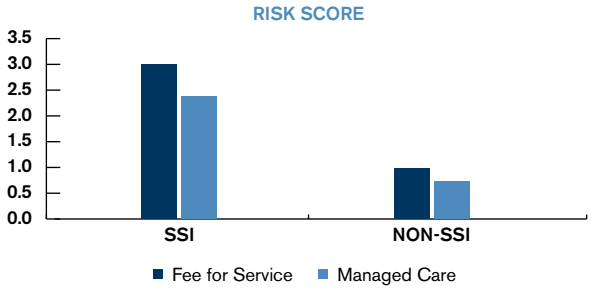
The importance of selection bias, contract exclusions and statistical methodology in the determination of Medicaid Managed Care cost-effectiveness cannot be understated. For example, the South Carolina Department of Health & Human Services signed contacts with managed care organizations (MCOs) that carved out mental health, substance abuse and sickle services; and provided "kicker" payments for newborn, low birth weight and very low birth weight infants.[103]

The South Carolina analysis suggested a healthier, lower risk non-SSI (dual eligible) population in the Medicaid Managed Care Organization cohort (n=290,318) as compared to the fee-for-service (FFS) population (n=114,923). The risk score of the MCO group, a measure of health risk relative to a benchmark population, was 24.4% lower than the comparable FFS risk score suggesting a lower consumption of health resources.[103]

A similar analysis for the covered SSI (dual-eligible) population suggests additional selection bias. The risk score for the MCO SSI group was 21.2% lower than the comparable FFS risk score. The total Medicaid risk adjusted cost was 11.3 -25.3% higher in the MCO group.[103]

The use of exclusion (carve out) criteria by MCOs for mental health patients and substance abusers eliminates high healthcare resource utilization cohorts. In addition, "kicker" payments for newborn, low birth weight and very low birth weight reduce actuarial risk and the financial incentive for prevention.

FIGURE 69: MANAGED CARE SELECTION BIAS



Source: Madalena M, Tester R. Report To South Carolina Department Of Health And Human Service. Proviso 21.33 – Medicaid Cost And Quality Effectiveness. 10/1/2010

Managed care pricing often "shadows" that of fee-for-service plans. Milliman used a different methodology than the South Carolina Department of Health & Human Services to estimate MCO savings of 4.5% relative to fee-for-service plans or $12.2 million for the entire state.[103] The identical 4.5% savings was applied to SSI (dual-eligible), adults and children without an adequate explanation of the differences among these populations.

Actuarial calculations, as well as comparative financial analysis, are subject to assumptions that often differ among organizations. For example, in 2009, for the same level of risk-adjusted per patient services, CMS determined that capitated Medicare Advantage (MA) plans outspent Medicare fee-for-service plans by $14 billion, a "violation" of the budget neutrality requirement. As a result, the Medicare Payment Commission (MedPAC) instituted a multi-year reduction in the MA plan reimbursement rate.[104]

Thomas L. Johnson, President & CEO of Medicaid Health Plans of America, stated in testimony to the House Ways and Means Committee: "We believe that Medicaid managed care has proven to be a highly successful model for coordinating care for low-income and culturally diverse populations and our plans are eager to expand this model to include dual eligible beneficiaries, whom CMS now refers to as Medicare-Medicaid enrollees.[105] The evidence does not wholly substantiate effective care coordination and quality outcomes for the Medicaid population enrolled in managed care.

Successful integrated, non-profit provider-owned Medicaid HMO models of care delivery have been established by many states and providers. Examples of these care delivery models include: Hennepin County (Minnesota), Denver Health and the NYC Health & Hospitals Corporation. Hennepin County established its Metropolitan Health Plan (MHP) in 1983, and subsequently expanded its offerings to dual-eligible and Medicare Advantage recipients. In 2010, revenues were $142 million and the net underwriting gain was $2.0M.[106] MHP required a one-time emergency cash infusion of $6.0M in May 2008 due to billing issues and the need to upgrade its IT infrastructure.

The Denver Health Medical Plan was initially created in 1997 to provide affordable healthcare coverage to the thousands of Denver Health & Hospital Authority employees. Subsequent offerings include Medicaid Choice plans which provide: no cost eye exams and eyewear, no-cost 90-day prescriptions and OTCs, prenatal programs including strollers, car seats and diapers, and rides to and from medical appointments. Benefits are described as better than those available with fee-for-service Medicaid plans.[107]

The Health and Hospitals Corporation in NYC is a $6.7 billion integrated delivery system with 420,000 members in its Metroplus Health Plans (e.g., Medicaid Managed Care, Medicaid HIV Special Needs, Medicare Advantage).[108] HHC provides services "through its 11 acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers and more than 70 community-based clinics." In 2011, Metroplus was ranked as the best Medicaid managed care plan in New York State by its Department of Health (for the fifth time in the last six years) based on preventive care, prenatal, pediatric, chronic disease and behavioral health indicators.[109]

A Review of Benchmark Performers

The California Healthcare Foundation analyzed the financial reports of hospitals with a challenging payor mix; i.e., those in the highest quartile of "Medi-Cal patients, high uncompensated care as a percentage of expenses, and a high percentage of uninsured patients in relation to other hospitals."[110] The analysis suggested a significant variation in hospital financial performance, and identified a minority of profitable and high performing hospitals.

As depicted in the graphic below, the California Healthcare Foundation also identified the critical success factors driving successful management execution:

FIGURE 70: KEY FACTORS CONTRIBUTING TO HOSPITALS' SUCCESS

Source: California Healthcare Foundation. "Success Under Duress: How Five Hospitals Thrive Despite Challenging Payor Mix". 9/2010

- **Quality:** High-quality care is critical to payor negotiations and reputation to attract patients. The Joint Commission has identified specific core measures, as well as performance initiatives, created a Leading Practices library, and offers a Strategic Surveillance System, a diagnostic tool to identify and prioritize areas for quality improvement, and to develop comparative action plans. A Six Sigma approach is often used.[111] [112] [113]
- **Strategic growth:** Patient volume growth is essential to longer-term profitability, along with the expansion of outpatient services and specific service lines.
- **Management discipline:** Frequent and intense budget reviews, combined with a "rapid response to deviations from budget." Throughput, supply costs, new product oversight, flexible nurse staffing and accounts receivable management was supported by significant IT investment.
- **Culture:** Effective leadership, an organizational vision, and shared responsibility for patient quality, efficiency and expense control. Collaborative employee and physician relationships, combined with "celebratory" communications, were critical.

DENVER HEALTH: INTEGRATED CARE, CRITICAL MASS AND LEAN PRODUCTION PHILOSOPHY

Denver Health is an "integrated, efficient, high-quality healthcare system serving as a model for other safety net institutions across the nation." It is comprised of a 477-bed hospital, Level 1 trauma center, eight primary care family health centers and 13 school-based health centers. It manages 355,000 outpatient visits and operates Denver's 911 medical emergency response systems. Denver Health provides care to one-third of Denver's population.[114]

Denver Health's mission is focused on providing access to high-quality prevention, acute intervention and chronic disease management services irrespective of an ability to pay. Teamwork, open communications, continuous performance improvement, efficiency, the elimination of waste and problem-solving are integral components of its culture. Denver Health provided $450 million in uncompensated care in 2012.[115]

Denver Health has been committed to Toyota's LEAN production philosophy since 2005, and was awarded the Shingo Bronze Medallion for Operational Excellence in March 2011. Standard LEAN tools such as "process mapping, waste walks, communication / hand-off circle and standardized work" were utilized.[116] Specific value streams were identified; over 1,300 employees were

involved in 300 LEAN management improvement events.[117] Denver Health generated $88 million in aggregate savings in 2005-2010 and increased clinical productivity 20% despite patient volume increasing 5% per year. Quality metrics such as childhood immunization and preventive screening rates, as well as hypertension and diabetes control showed improvement.[118]

HENNEPIN COUNTY MEDICAL CENTER: GOVERNANCE, CLINICAL EXCELLENCE, PATIENT-CENTERED CARE AND CONNECTIVITY

Hennepin County Medical Center (HCMC), located in St. Paul, Minnesota is comprised of a hospital with 462 operating beds and an average daily census of 324 (70.1% occupancy), Level 1 adult and pediatric trauma centers, 10 neighborhood clinics, 9 downtown primary care clinics, including a 24-hour urgent care clinic and a senior care clinic staffed by geriatricians, and a broad range of downtown specialty clinics.[119] HCMC serves as a teaching hospital and manages 353,872 outpatient visits.

HCMC established a nurse mid-wife service in 1971. Its C-section rate of 12.7% is far below the national average of 30%. About 50% of its patients speak Spanish, Hmong and Somali.[120]

The HCMC has received recognition for workplace practices, including: worksite wellness programs, clinical excellence, electronic medical record implementation (Level 7), and Quality Oncology Practice certification and ACS National Quality Improvement Program participation.[121] [122]

Hennepin County, with a population of nearly 1.2 million represents 22% of the state population. It is a relatively affluent county with a median income of $62,966; only 12.3% of the population lives below the poverty line.[123] Hennepin County assumed ownership of its healthcare safety net in 1964. The Hennepin County Board provides oversights of its mission, operating budget and capital expenditures.

SELECTING THE "RIGHT" BENCHMARKS REMAINS A CHALLENGE

The financial performance metrics identified by the California Healthcare Foundation would not have been met by Denver Health and the Hennepin County Medical Center (HCMC).The fact that these well-respected hospitals do not meet California's benchmarks may relate to the difficulty in defining the appropriate financial metrics for safety net hospitals. Our analysis of Denver Health and HCMC suggests difficulty in "isolating" municipal, county, state and federal subsidies from the financial statements to ascertain operating cash flow, an important measure of fiscal health.

FIGURE 71: CALIFORNIA HEALTH FOUNDATION BENCHMARK CRITERIA

Attribute	Definition	California Bench-marks	Denver Health	Hennepin County Medical Center
Operating Margin	(tot oper rev - tot oper exp) / tot oper rev * 100	>1.8%	N/A	0.0%
Total Margin	(net income) / (tot oper rev + non-oper rev) * 100	>3.3%	1.1%	1.1%
Operating Cashflow (EBITDA) Margin*	(net income + interest + deprec and amort + lease cost) / (tot oper rev) *100	>8.7%	16.0%	18.0%
Days cash on hand	(cash on hand + market securities) / (tot oper expdeprec) / 365	>139.6	40.9	62.1
Cash to debt	(cash on hand) / (tot liabilities)	>97.3%	20.7%	57.8%
Days in Accounts Receivable	(accounts receivable - allowances for uncollectible) / (total operating revenue / 365)	<49.3	55.7	52.4
Current Ratio	(total current assets) / (total current liabilities)	>2.1	1.9	2.0
LTD to capitalization	(tot lt liabilities) / (tot assets - tot liabilities)	<40.7%	64.0%	17.0%
Debt Service to Coverage	(tot oper rev) / (tot liabilities)	>3.3	1.0	3.6
Ratio Average age of Plant	(accum deprec) / (deprec exp)	<10 years	5.8	9.2
Number of Criteria Achieved			2/10	4/10

Source: (1) California Healthcare Foundation. "Success Under Duress: How Five Hospitals Thrive Despite Challenging Payor Mix". 9/2010
(2) Financial Indicators. 2/12/2013. <AHD.COM>

Proposed Solutions

TRANSFORMATIONAL OPPORTUNITIES

Care delivery transformation is required to address the ineffectiveness and inefficiency of our current safety net care delivery system. System complexity, combined with dwindling financial resources and health inequities require more than just incremental solutions. Opportunities exist to create integrated delivery systems and "Super-urban" FQHCs. A coordinated approach among policy makers and providers is essential for implementation.

Create integrated delivery systems

An organized delivery system has been defined as a "network of organization that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served." [124] Care coordination addresses a fundamental flaw in our fragmented, acute care oriented care delivery system. Transition management and team-based case management are essential for the 5-10% of patients accounting for the majority of healthcare costs. Fiscal and clinical accountability requires organizational leadership, financial alignment and infrastructure investment.

An integrated delivery system is more tightly bound and reflects either direct ownership of all clinical and key support functions (e.g., HR, IT, QI, finance) or a contractual relationship in specific areas (e.g., alliance, joint venture, partnership). The benefits of integration are well known and include the potential for comprehensive care irrespective of site, the sharing of common information among all members of the clinical team, more rapid incorporation of evidence-based guidelines and the standardization of care, expanded primary care access via the use of nurse practitioners and physician assistants, scale economies associated with infrastructure leverage and access to capital.

Denver Health, Hennepin County Medical Center and other "best-in-class" safety net hospital systems have fully-integrated their acute care hospital with primary care clinics, and incorporated concepts embedded in the patient-centered medical home (PCMH). According to AHRQ, key elements of the PCMH include a relationship orientation, comprehensive care, coordinated care, accessible services, and quality and safety. Pilot PCMH private insurance and Medicaid initiatives have enrolled over 5 million people, whereas FQHC-Advanced Primary Care Practice initiatives have enrolled another 200,000 persons.[125]

FIGURE 72: PATIENT CENTERED MEDICAL HOME

Attribute	Details	Requirements
Patient-centered	Relationship-based with orientation toward the whole person; requires understanding and respecting each patient's unique needs, culture, values, and preferences	Patients and families as member of care team
Comprehensive Care	Accountable for majority of physical and mental healthcare needs (prevention, wellness, acute care, chronic care)	Team-based approach
Coordinated Care	Hospitals, specialty care, home health and community services and supports	Critical to transitions between sites of care
Accessible Services	Delivers services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team	Technology platforms: e-mail, tele-health, etc.
System-Based Approach to Quality and Safety	Using evidence-based medicine and clinical decision-support tools to guide shared decision making, engage in performance measurement and improvement, measure and respond to patient experiences and patient satisfaction, and practicing population health management	Data, analytics

Source: Agency for Healthcare Research and Quality. Defining the PCMH. U.S. Department of Health and Human Services. 2/13/2013. <http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Defining%20the%20PCMH_v2>

The full integration of primary care with acute care services is preferable to the use of third party intermediaries such as insurance companies to coordinate care. Alternatively, academic and community hospitals could potentially collaborate with FQHC's for their acute care and specialty service capabilities. Strategic leadership, change management, effective execution and the alignment of incentives are essential for success.

Create "Super Urban" FQHCs

Federally Qualified Health Systems (FQHCs) were first organized during the "War on Poverty" in the 1960's and 1970's; and developed in response to limited primary care access and the lack of community control over health services. Primary guiding principles focus on access irrespective of an ability to pay and patient /community governance. FQHC benefits include federal funding via PHS Section 330, enhanced reimbursement, free malpractice coverage through the Federal Tort Claim Act and enhanced access to prescription and non-prescription drugs at reduced costs through the 340(b) program.[126] Increasing primary care access remains essential to improving population health, enhancing patient outcomes, reducing costs and ameliorating Emergency Department over-crowding.

In 2010, 1,124 Federally Qualified Health Centers served 19.5 million patients at 8,139 locations.[127] The average FQHC sees 17,322 patients per year or 70 patients per day distributed among seven sites; each site sees only 10 patients per day.[127] Funding components include Medicaid (37.7%), Federal grants (23.2%), state / local grants and contracts (8.0%), private insurance (6.8%), self-pay (5.9%), Medicare (5.8%) and all other sources (12.7%).[127]

The PPACA created the Health Center Trust Fund and committed funding of $11 billion over five years to expand operational capacity for 20 million new patients.[128] Opportunities exist to utilize FQHC's as a linchpin of community care integrated with academic medical centers and community hospitals for specialist and inpatient care. FQHC's use of nurse practitioners and physician assistants to supplement primary care physicians could be replicated elsewhere.

Only a handful of FQHCs have 90,000 to 235,000 patients per year including Altamed (California), Community Care (Texas), Access Community Health Network (Illinois), Community Care of North Carolina (CCNC) and Primary Health Network (Pennsylvania). CCNC received the Annie E. Casey Innovations Award in Children and Family System Reform from the Harvard Kennedy School of Government in 2007, and has "saved nearly $1.0 billion in the four years between 2007 through 2010." [129]

The concept for a "Super Urban" FQHC was first proposed by Alvarez & Marsal in January 2010 as a key component of North General Hospital's East Harlem community revitalization strategy. East Harlem and similar communities have the sufficient urban density and healthcare needs to support such an entity.

The creation of a "Super Urban" FQHC would require regulatory approval, funding flexibility, capital for infrastructure and facilities, working capital and a broad range of outpatient services focused on prevention, early detection and chronic disease management. Expanded primary care and urgent care services would be offered to relieve Emergency Department overcrowding. Specialty care services such as cardiology and nephrology target local population health needs. Scale would allow for the necessary information technology, quality improvement and personnel investments. Governance flexibility is also needed to support FQHC to FQHC mergers and support a large and regionally concentrated multi-site governance model.

Safety net hospitals, if unable to become part of an integrated healthcare delivery system should consider an alignment with "Super Urban" FQHCs better able to service the primary care and urgent care needs of the local population. Emergency Department overuse would be alleviated. In addition, opportunities for care coordination, site transition management and case management would more likely be implemented and successful with a single entity rather than a large number of providers. Interoperable IT systems would also facilitate care delivery.

INCREMENTAL SOLUTIONS

Policy makers: Federal, state and municipal

- **Permanently increase primary care physician reimbursement** – The U.S. average for the Medicaid-to-Medicare fee index is 0.66 for primary care physicians; wide variation exists among states. The PPACA will temporarily increase the fee index to 1.0 for 2013 and 2014. We believe the increase should be permanent. A Sustainable Growth Rate "fix" should also be made.
- **Alter Medicaid Managed Care contracting process** – Patient selection bias must be reduced, carve-out of behavioral health and other conditions re-integrated

into primary care and condition exclusions minimized to truly manage risk in a cost-effective manner. Care coordination, remote monitoring / telehealth and self-care are essential to reduce costs.

- **Use cost-effective case management approaches to dual-eligible patients, with the objective of (supportive) independent living** - Recipients account for nearly $261 billion in Medicare and Medicaid spending or $28,000-30,000 per person. Complex co-morbidities, often combined with limited social support require intensive case management and home care. Adjunctive wireless health technologies, combined with technology supported self-care increasingly offer cost-effective means for "aging in place." The principles behind successful demonstration projects should be emulated elsewhere.
- **Increase funding transparency** – It remains exceedingly difficult to assess the amount of municipal, county, state and national subsidies allocated to safety net hospitals. The rationale for allocation to specific hospitals is also often unclear. Return on investment cannot be calculated, and alternatives considered without a thorough understanding of financial performance.
- **Alter DSH payment financing** – Medicare DSH payments are allocated to more than 3,300 hospitals, far more than the number of safety net hospitals. Payments could be better targeted to institutions needing financial support. Medicaid DSH payments are being reduced by 50%, an excessive figure given the uncertainty associated with the impact of the PPACA on a hospital-by-hospital basis.
- **Increase funding for Accountable Care Organizations (ACOs) as potentially, an intermediate step to integration** – ACOs represent an extension of the successful Physician Group Practice demonstration and may include primary care physicians, specialists, and care extenders (nurse practitioners, physician assistants) in not only a group practice setting, but also networks of practices and partnerships or joint ventures among providers, hospitals, insurers and others. Requirements include a legal structure for payment distribution, a program commitment of at least three years and adequate primary care capacity to treat at least 5,000 patients. Seven states (Maine, Massachusetts, Minnesota, New Jersey, Oregon, Texas and Vermont) are collaborating with the Center for Health Care Strategies in a 14 month program to design, build and implement an ACO approach.[129] A clinically integrated, capitated approach to care delivery is essential to reduce costs and enhance outcomes.
- **Expand health literacy initiatives** – According to Howard Koh, assistant Secretary of Health of HHS and his co-authors, opportunities exist to "simplify and make written materials easier to understand, and improve provider communication skills and patients' self-management skills." [130]

Providers

- **Enhance governance.** Five critical tasks are essential for Board members: strategic orientation, public accountability, financial oversight, quality assurance, advocacy, and Board development. Board leadership and quality are essential for safety net hospital navigation and survival.[131]
- **Increase clinical effectiveness,** with a particular focus on Medicare value-purchasing parameters (readmissions, hospital acquired conditions, patient satisfaction) – clinical process redesign, evidence-based care, case management
- **Enhance operational effectiveness:** Patient access, throughput and level of care; human resources and labor management, performance benchmarking, process work flow analysis and redesign (LEAN, Six Sigma), outsourcing, use of interoperable and user-friendly IT systems, telehealth
- **Reduce ED overuse:** Establish urgent care centers, implement interoperable EDIS (tracking board, documentation, order management, operations monitor, charge capture, etc.), reduce boarding
- **Improve financial performance:** Revenue cycle, business office efficiency, budgeting/financial planning, supply chain (physician-preference items, supplies, drugs), capital appropriations, labor productivity
- **Obtain economies of scale**
- **Increase consumer engagement:** Cultural relevance, health literacy initiatives, caregiver and social networks, use of technology supported self-care (mobile apps, Web-based)[132]

APPENDIX

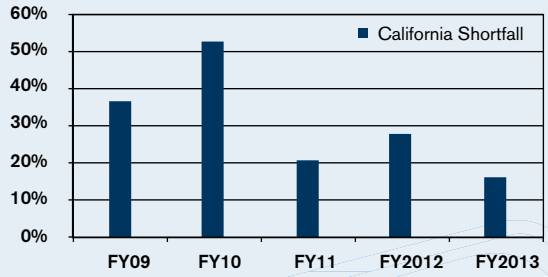
This report highlights national and when appropriate, comparative state data. Additional insights can be extrapolated from a more detailed analysis of state data. Demographics, socioeconomics, population health status, insurance coverage, care delivery (hospitals, physicians, Federally Qualified Health Centers) and financing methodology vary by state. Note, however, even a macro-analysis at the state level requires further refinement as all healthcare delivery is local, at the Metropolitan Statistical Area (MSA), and more specifically, at the primary and secondary service areas.

California

California, with a total population of 37.4 million, has a large resident percentage of Medicaid recipients (18.9%) and the uninsured (19.6%). The median age is 35.2 years and 12% of the population is over 65 years old. Nearly 40% of the population is Hispanic, with 34% having incomes below the Federal Poverty Rate ($23,050 for a family of four). The health status of residents based on the percentage of residents who are overweight, diabetic, smokers or on disability is somewhat better than that of the U.S. average. California has a comparable number of primary care physicians per 100,000 population and more patient encounters per FQHC delivery site (+26.2%). Its Medicaid-to-Medicare fee index for primary care is 0.47. There are 353 hospitals with 73,626 staffed beds, 209 beds / hospital and 190 hospital beds / 100,000 or 26.9% less than the U.S. average. The average length of stay was 4.6 days and the hospital occupancy rate is 54.2%.

California's budget shortfall as a percentage of the general fund has ranged from 13-52% in the past four years. In FY13, its shortfall is $15.0 billion or 16.2% of the budget. Medicaid spending totaled $42.1 billion or 16% of the State budget. Medicaid spending per recipient of $3,821 was significantly below the U.S. average of $6,216. Dual-eligible recipients represent 11% Medicaid recipients and account for 36% of total spending.

FIGURE 1: BUDGET SHORTFALL AS A PERCENTAGE OF GENERAL FUND



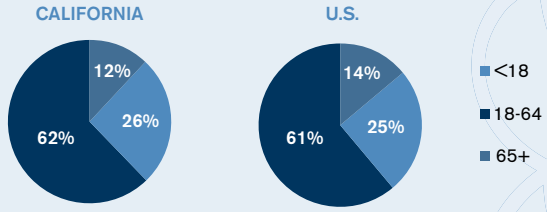
Source: State Budget Shortfalls, Kaiser Family Foundation. <http://statehealthfacts.org/comparereport.jsp?rep=91&cat=1>

FIGURE 2: CALIFORNIA RACE AND ETHNICITY (MILLIONS, %), 2011

Race	California Population	U.S. Population	California Poverty Rate (<100% FPL)	U.S. Poverty Rate (<100% FPL)
White	15.0 (40%)	194.5 (63%)	2.1 (14%)	25.9 (13%)
Black	2.1 (6%)	37.0 (12%)	0.7 (35%)	5.4 (23%)
Hispanic	14.6 (39%)	52.2 (17%)	5.0 (34%)	12.9 (35%)
Other	5.8 (15%)	24.1 (8%)	1.2 (19%)	17.1 (33%)
Total	**37.4**	**307.9**	**8.9 (24%)**	**61.3 (20%)**

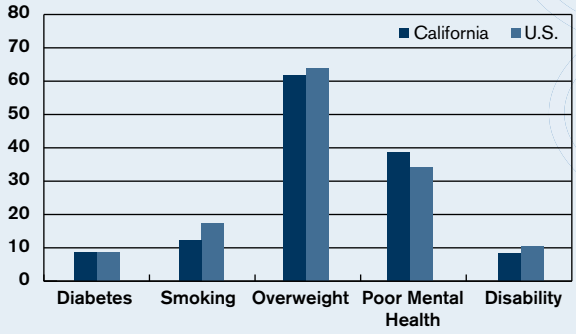
Source: Poverty Rate by Race and Ethnicity (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=14&cat=1>

FIGURE 3: AGE DISTRIBUTION, 2011



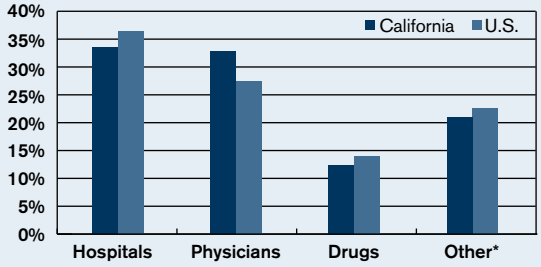
Source: Population Distribution by Age, (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=2&cat=1>

FIGURE 4: CALIFORNIA HEALTH STATUS COMPARISON, 2010



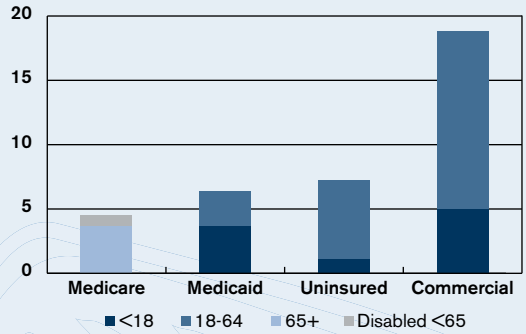
Source: Health Status, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=2&rgn=6&rgn=1>

FIGURE 5: HEALTH EXPENDITURES FY09



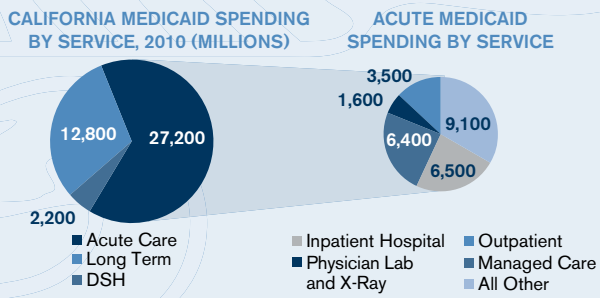
Source: Health Spending by Service 2009, Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=262&cat=5>

FIGURE 6: CALIFORNIA INSURANCE BY STAGE 2011 (MILLIONS)



Source: Health Coverage & Uninsured, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1>

FIGURE 7: MEDICAID SPENDING BY SERVICE



Source: Distribution of Medicaid Spending by Service, Kaiser Family Foundation. <http://statehealthfacts.org/comparetable.jsp?ind=178&cat=4>

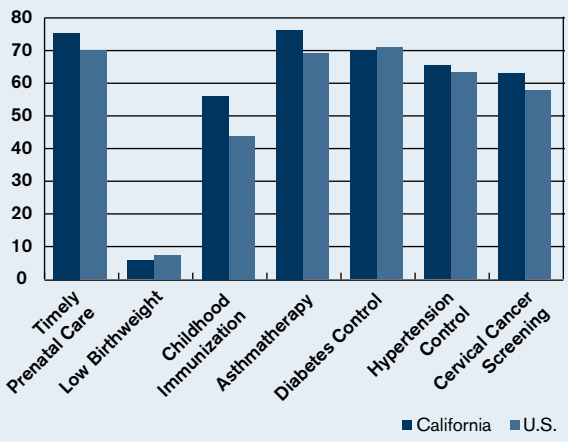
FIGURE 8: PROVIDER, PHYSICIAN AND PROFESSIONAL OVERVIEW 2011

Provider Overview 2011				
	Provider Overview 2011	Nursing Facility Beds / 100,000 Medicare Pop	Patient Encounters per FQHC Delivery Site	Average FQHC Encounters per Patient
CA	190	3,107	11,957	4.23
U.S.	260	4,446	9,469	3.96

Physician and Professional Overview 2011							
	Physicians /100K	PCP /100K	Specialists Physicians /100K	Dentists /100K	RNs /100K	PAs /100K	NPs /100K
CA	254	122	132	76	664	18	45
U.S.	269	128	141	60	874	27	58

Source: Providers & Services Use, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=8&rgn=6&rgn=1>

FIGURE 9: COMMUNITY HEALTH CENTERS QUALITY SCORES



Source: "State Averages: Quality of Care At Community Home Health Centers." Kaiser Health News. 10/31/2012

A&M ANALYSIS

Nearly 40% of California residents are either Medicaid recipients or uninsured. Given the large Hispanic population, "not understanding the 'cultural context' of each patient can lead to inappropriate diagnoses and treatment and contribute to health disparities." [133]

Low Medicaid spending per recipient reflects an increased role of primary care and the efforts made by many safety net hospitals to increase access, and improve quality and safety. However, between 2010-2020, the population of residents >65 years old is expected to grow from 4.2 to 6.2M, +46%. This increase, compared to the total population growth of 13% will exacerbate the demand for primary care services.[134] An increase in the Medicaid-to-Medicare fee index for primary care physicians, combined with greater utilization of nurse practitioners and physician assistants, may be required to ensure adequate primary care access.

The PPACA has been forecasted to add 2.0M Medicaid recipients by 2019, of which 70% were previously uninsured adults.[135] The Federal government will fund 90-100% of the costs for those previously ineligible for Medicaid coverage. The impact of an impending reduction of Medicaid DSH payments (2011: $1.1 billion) on individual safety net hospitals remains unknown. Additional funding may be "lost" via ongoing implementation of the Medicare value-purchasing initiative.

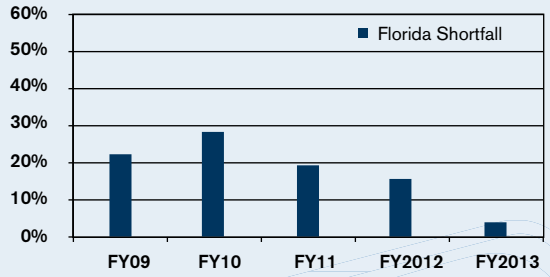
California's Delivery System Reform Incentive Program (DSRIP), initiated in May 2010 has allocated a maximum of $3.3B in matching funds to 21 safety net hospitals over the next five years to "Improve population health, enhance the patient experience, and reduce / control the cost of care."[136] Primary and secondary prevention, hospital acquired conditions (infections), re-admissions and medical homes are emphasized. If hospitals fail to meet pre-defined milestones, they do not receive their incentive payments. Other states are closely monitoring the DSRIP program.

Florida

Florida, with a total population of 18.8 million, has a large resident percentage of Medicaid recipients (14.3%) and the uninsured (20.3%). The median age is 40.7 years and 18% of the population is over 65 years old. 22% of the population is Hispanic and 15% is black, with 32% of the combined Hispanic and black population having incomes below the Federal Poverty Rate ($23,050 for a family of four). The health status of residents based on the percentage of residents who are overweight, diabetic, smokers or on disability approximates the U.S. average. Florida has a slightly lower number of primary care physicians per 100,000 population (-6.5%) and more patient encounters per FQHC delivery site (+15.3%). Its Medicaid-to-Medicare fee index for primary care is 0.55. There are 213 hospitals with 53,147 staffed beds, 250 beds / hospital and 280 hospital beds / 100,000 or 7.7% more than the U.S. average. The average length of stay was 4.7 days and the hospital occupancy rate is 57.5%.

Its budget shortfall as a percentage of the general fund has ranged from 15-29% in the past four years. In FY13, its shortfall is $1.0 billion or 4.1% of the budget. Medicaid spending totaled $17.4 billion or 21% of the State budget. Medicaid spending per recipient of $5,083 was significantly below the U.S. average of $6,216. Dual-eligible recipients represent 14% Medicaid recipients and account for 39% of total spending.

FIGURE 1: BUDGET SHORTFALL AS A PERCENTAGE OF GENERAL FUND



Source: State Budget Shortfalls, Kaiser Family Foundation. <http://statehealthfacts.org/comparereport.jsp?rep=91&cat=1>

FIGURE 2: CALIFORNIA RACE AND ETHNICITY (MILLIONS, %), 2011

Race	Florida Population	U.S. Population	Florida Poverty Rate (<100% FPL)	U.S. Poverty Rate (<100% FPL)
White	11.2 (59%)	194.5 (63%)	1.4 (13%)	25.9 (13%)
Black	2.8 (15%)	37.0 (12%)	1.0 (36%)	5.4 (23%)
Hispanic	4.1 (22%)	52.2 (17%)	1.2 (29%)	12.9 (35%)
Other	0.7 (4%)	24.1 (8%)	0.1 (19%)	17.1 (33%)
Total	**18.8**	**307.9**	**3.7 (20%)**	**61.3 (20%)**

Source: Poverty Rate by Race and Ethnicity (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=14&cat=1>

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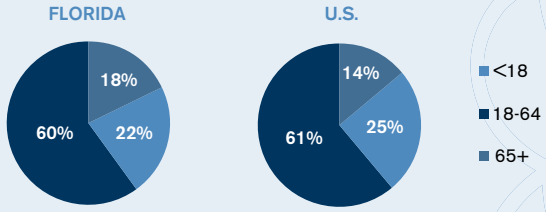

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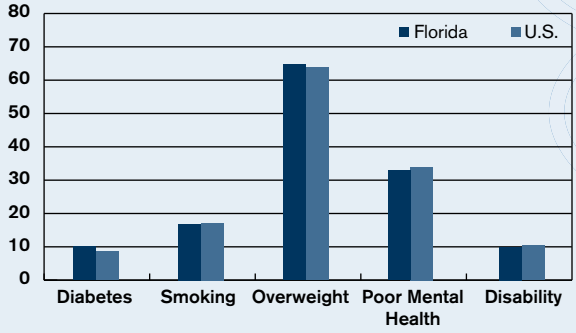

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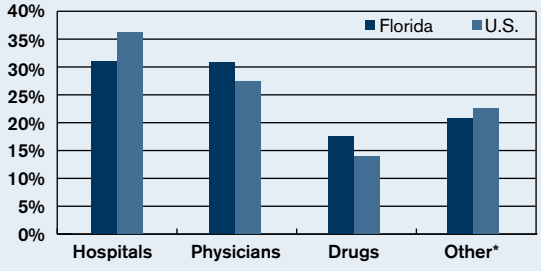

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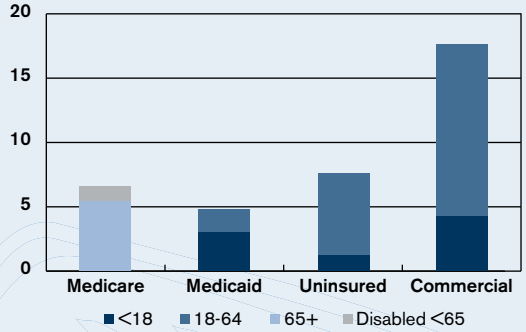

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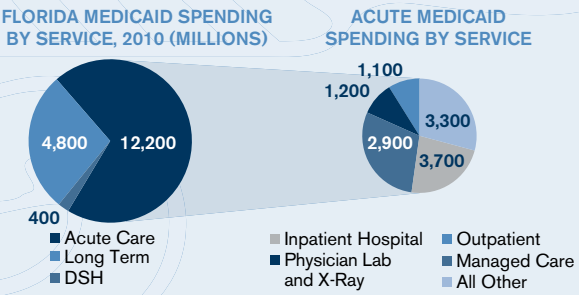

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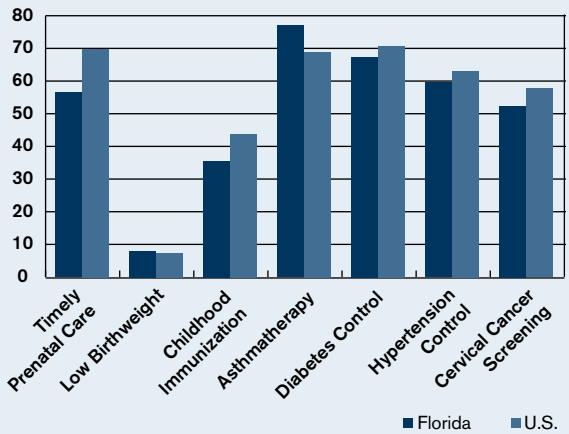
Provider Overview 2011				
	Provider Overview 2011	Nursing Facility Beds / 100,000 Medicare Pop	Patient Encounters per FQHC Delivery Site	Average FQHC Encounters per Patient
FL	280	2,998	10,915	3.76
U.S.	260	4,446	9,469	3.96

Physician and Professional Overview 2011							
	Physicians /100K	PCP /100K	Specialists Physicians /100K	Dentists /100K	RNs /100K	PAs /100K	NPs /100K
FL	248	120	128	53	865	23	67
U.S.	269	128	141	60	874	27	58

Source: Providers & Services Use, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=8&rgn=6&rgn=1>

FIGURE 9: COMMUNITY HEALTH CENTERS QUALITY SCORES



Source: "State Averages: Quality of Care At Community Home Health Centers." Kaiser Health News. 10/31/2012

A&M ANALYSIS

Nearly 35% of Florida residents are either Medicaid recipients or uninsured. In 2010 - 2020, the population of residents >65 years old is expected to grow from 3.3 to 5.1M, +57%. This increase, compared to the total population growth of 25% will exacerbate the demand for primary care services.[134] Governor Scott recently decided not to forego the expansion of the Medicaid program from 100% to 133% of the FPL (as proposed by the PPACA) potentially affecting 1.0M uninsured residents.[135] On March 4, the Florida House Select Committee rejected Governor Scott's proposal to expand Medicaid. Federal Medicaid DSH payments of $200M will be reduced.

The threat of Medicaid budget reductions is ever-present in Florida:

- In April 2011, the Florida House and Senate proposed a 7-10% reduction in Medicaid reimbursement, along with the elimination of the Medically Needy and Medicaid for the Aged and Disabled for a total reduction of $541-671M in spending. [137]
- In June 2011, the state Agency for Health Administration announced a retroactive reduction in Medicaid payments covering January-June if $45M in Medicaid hospital cost savings were not generated; the total impact of the reduction would be $123M including the loss of Federal matching funds. [138] The Governor's budget proposal for FY12-13 included a reduction in hospital Medicaid reimbursement totaling $384M and other cuts of $63M [139]
- In 2012, Florida cut funding to hospitals that treat Medicaid patients by 5.6 percent – following a 12.5 percent cut a year ago. The state is also seeking permission to limit non-pregnant adults to two primary care visits a month, and cap emergency room coverage to six visits a year. [140]

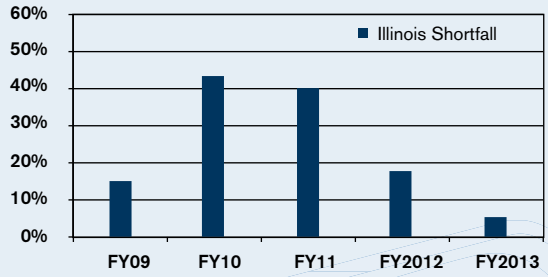
The "overhang" of budget cuts suggests the need for a fundamental restructuring of care delivery. An expansion of Medicaid managed care programs is not the solution despite the Broward County pilot study suggesting the potential for substantial cost savings.[141] The cited study was missing critical encounter data measuring the services and prescriptions administered and / or denied.[142] In addition, 48% of the Medicaid pilot recipients were not enrolled in HMOs but in Provider Services Networks, inclusive of emergency room diversion programs. [143] PSNs often incorporated innovative risk sharing and contracting methodologies. Opportunities also exist to reduce the significant amount of Medicaid & Medicare fraud within Florida. [144]

Illinois

Illinois, with a total population of 12.8 million, has a large resident percentage of Medicaid recipients (16.9%) and the uninsured (14.8%). The median age is 36.6 years and 13% of the population is over 65 years old. 15% of the population is Hispanic and 14% is black, with 35% of the combined Hispanic and black population having incomes below the Federal Poverty Rate ($23,050 for a family of four). The health status of residents based on the percentage of residents who are overweight, diabetic, smokers or in poor mental health is somewhat higher than that of the U.S. average. Illinois also has more primary care physicians per 100,000 population (+8.6%) and fewer patients encounters per FQHC delivery site (-16.1%). Its Medicaid-to-Medicare fee index for primary care is 0.57. There are 142 hospitals with 31,491 staffed beds, 222 beds / hospital and 260 hospital beds / 100,000, in-line with the U.S. average. The average length of stay was 4.5 days and the hospital occupancy rate is 54.4%.

Its budget shortfall as a percentage of the general fund has ranged from 6-44% in the past four years. In FY13, its shortfall is $2.0 billion or 5.5% of the budget. Medicaid spending totaled $15.3 billion or 20% of the State budget. Medicaid spending per recipient of $5,683 was somewhat below the U.S. average of $6,216. Dual-eligible recipients represent 12% Medicaid recipients and account for 22% of total spending.

FIGURE 1: BUDGET SHORTFALL AS A PERCENTAGE OF GENERAL FUND



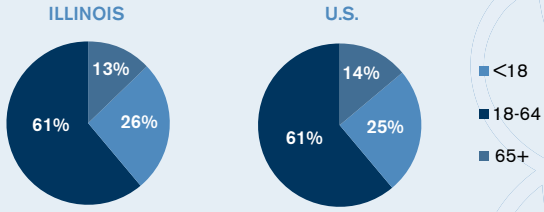
Source: State Budget Shortfalls, Kaiser Family Foundation. <http://statehealthfacts.org/comparereport.jsp?rep=91&cat=1>

FIGURE 2: ILLINOIS RACE AND ETHNICITY (MILLIONS, %), 2011

Race	Illinois Population	U.S. Population	Illinois Poverty Rate (<100% FPL)	U.S. Poverty Rate (<100% FPL)
White	8.2 (64%)	194.5 (63%)	1.0 (12%)	25.9 (13%)
Black	1.8 (14%)	37.0 (12%)	0.7 (36%)	5.4 (23%)
Hispanic	1.9 (15%)	52.2 (17%)	0.6 (33%)	12.9 (35%)
Other	0.8 (6%)	24.1 (8%)	0.2 (19%)	17.1 (33%)
Total	**12.7**	**307.9**	**2.5 (19%)**	**61.3 (20%)**

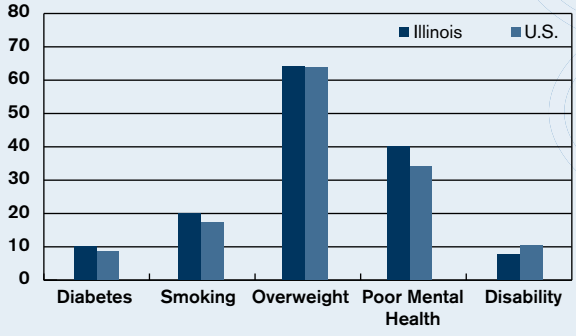
Source: Poverty Rate by Race and Ethnicity (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=14&cat=1>

FIGURE 3: AGE DISTRIBUTION, 2011



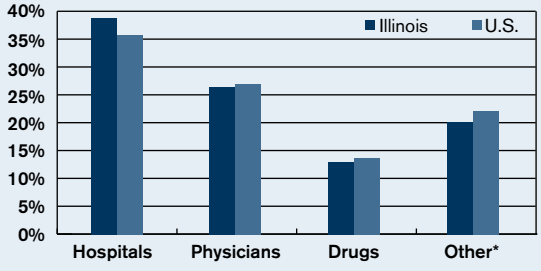
Source: Population Distribution by Age, (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=2&cat=1>

FIGURE 4: ILLINOIS HEALTH STATUS COMPARISON, 2010



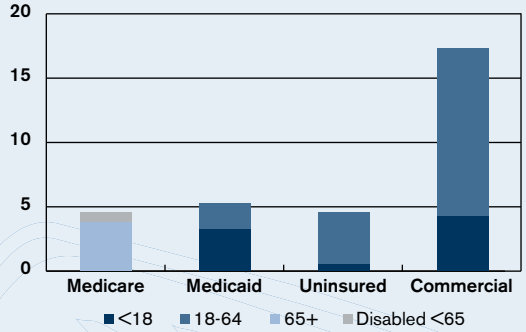
Source: Health Status, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=2&rgn=6&rgn=1>

FIGURE 5: HEALTH EXPENDITURES FY09



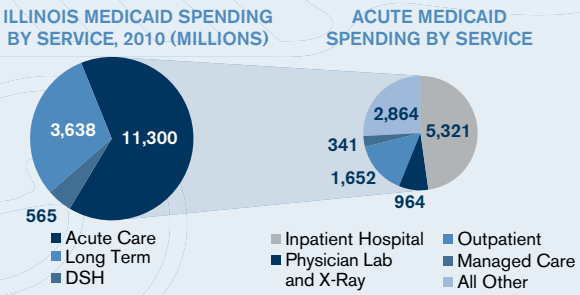
Source: Health Spending by Service 2009, Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=262&cat=5>

FIGURE 6: ILLINOIS INSURANCE BY STAGE 2011 (MILLIONS)



Source: Health Coverage & Uninsured, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1>

FIGURE 7: MEDICAID SPENDING BY SERVICE



Source: Distribution of Medicaid Spending by Service, Kaiser Family Foundation. <http://statehealthfacts.org/comparetable.jsp?ind=178&cat=4>

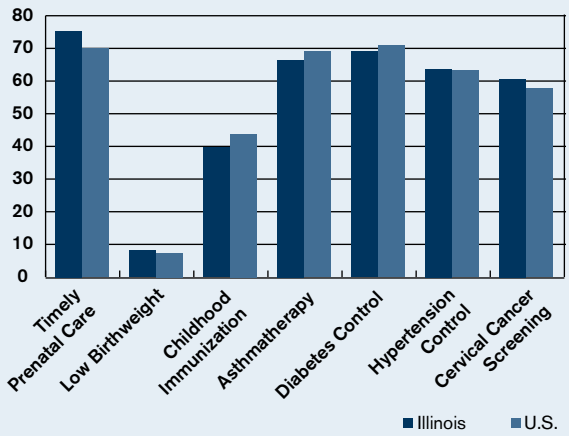
FIGURE 8: PROVIDER, PHYSICIAN AND PROFESSIONAL OVERVIEW 2011

Provider Overview 2011				
	Provider Overview 2011	Nursing Facility Beds / 100,000 Medicare Pop	Patient Encounters per FQHC Delivery Site	Average FQHC Encounters per Patient
IL	260	6,461	7,947	3.79
U.S.	260	4,446	9,469	3.96

Physician and Professional Overview 2011							
	Physicians /100K	PCP /100K	Specialists Physicians /100K	Dentists /100K	RNs /100K	PAs /100K	NPs /100K
IL	278	139	139	64	962	20	35
U.S.	269	128	141	60	874	27	58

Source: Providers & Services Use, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=8&rgn=6&rgn=1>

FIGURE 9: COMMUNITY HEALTH CENTERS QUALITY SCORES



Source: "State Averages: Quality of Care At Community Home Health Centers." Kaiser Health News. 10/31/2012

A&M ANALYSIS

The number of Medicaid recipients and uninsured, as a percentage of the population is around the national average. Illinois plans on expanding Medicaid coverage to 133% of the FPL, thereby adding 631,000 benefit recipients and reducing the number of uninsured by 43% by 2019.[135] Illinois receives $215M in Medicaid DSH payments.

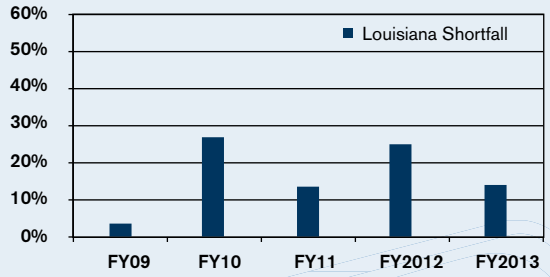
In June, Governor Pat Quinn signed a bill that reduces Medicaid spending by $1.6 billion, effective July 1. Eligibility criteria have been tightened: adult chiropractic and dental benefits (except emergencies such as tooth extractions) have been eliminated, podiatry use has been restricted to diabetics and limited drug co-payments and an eyeglasses replacement cycle has been instituted. Provider reimbursement has also been reduced. An additional cigarette tax of $1.00/pack will generate $350M in revenue and will be matched by the Federal government for total revenue of $700M.[145] The magnitude of the Medicaid reduction highlights the need for a strategic re-evaluation and perhaps, restructuring of the safety net care delivery system.

Louisiana

Louisiana, with a total population of 4.5 million, has a large resident percentage of Medicaid recipients (20.2%) and the uninsured (20.4%). The median age is 35.8 years and 13% of the population is over 65 years old. Nearly one-third of the population is black, with 45% having incomes below the Federal Poverty Rate ($23,050 for a family of four). The health status of residents based on the percentage of residents who are overweight, diabetic, smokers or on disability is somewhat lower than that of the U.S. average. Louisiana also has fewer primary care physicians per 100,000 population (-12.5%) and patients encounters per FQHC delivery site (-32.1%). Its Medicaid-to-Medicare fee index for primary care is 0.90. There are 114 hospitals with 15,505 staffed beds, 136 beds / hospital and 340 hospital beds / 100,000 or 30.7% more than the U.S. average. The average length of stay was 4.7 days and the hospital occupancy rate is 47.6%.

Its budget shortfall as a percentage of the general fund has ranged from 14-28% in the past four years. In FY13, its shortfall is $1.2 billion or 14.3% of the budget. Medicaid spending totaled $7.0 billion or 21% of the State budget. Medicaid spending per recipient of $6,061 approximated the U.S. average of $6,216. Dual-eligible recipients represent 16% Medicaid recipients and account for 26% of total spending.

FIGURE 1: BUDGET SHORTFALL AS A PERCENTAGE OF GENERAL FUND



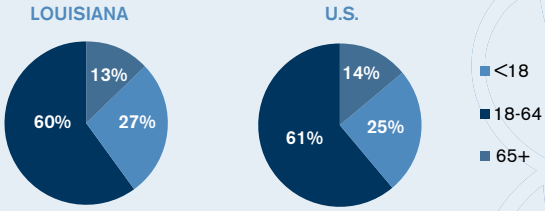
Source: State Budget Shortfalls, Kaiser Family Foundation. <http://statehealthfacts.org/comparereport.jsp?rep=91&cat=1>

FIGURE 2: LOUISIANA RACE AND ETHNICITY (MILLIONS, %), 2011

Race	Louisiana Population	U.S. Population	Louisiana Poverty Rate (<100% FPL)	U.S. Poverty Rate (<100% FPL)
White	2.8 (62%)	194.5 (63%)	0.5 (17%)	25.9 (13%)
Black	1.4 (32%)	37.0 (12%)	0.6 (45%)	5.4 (23%)
Hispanic	0.2 (4%)	52.2 (17%)	0.1 (40%)	12.9 (35%)
Other	0.1 (2%)	24.1 (8%)	- (-)	17.1 (33%)
Total	**4.5**	**307.9**	**1.2 (26%)**	**61.3 (20%)**

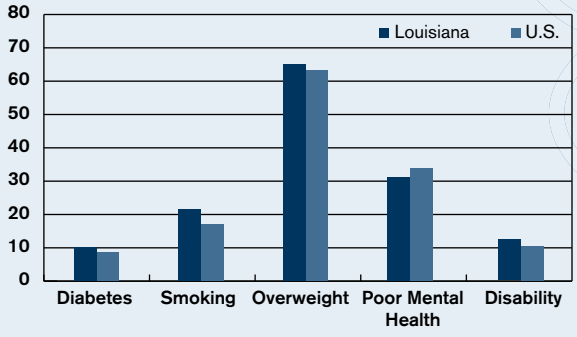
Source: Poverty Rate by Race and Ethnicity (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=14&cat=1>

FIGURE 3: AGE DISTRIBUTION, 2011



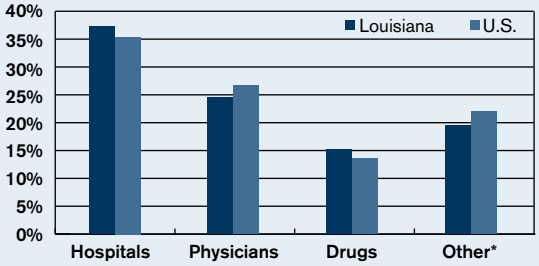
Source: Population Distribution by Age, (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=2&cat=1>

FIGURE 4: LOUISIANA HEALTH STATUS COMPARISON, 2010



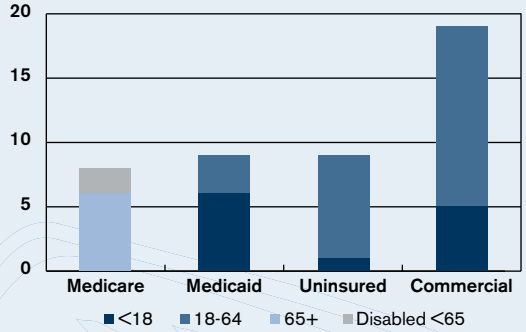
Source: Health Status, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=2&rgn=6&rgn=1>

FIGURE 5: HEALTH EXPENDITURES FY09



Source: Health Spending by Service 2009, Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=262&cat=5>

FIGURE 6: LOUISIANA INSURANCE BY STAGE 2011 (MILLIONS)

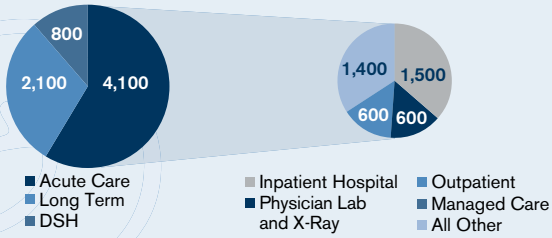


Source: Health Coverage & Uninsured, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1>

FIGURE 7: MEDICAID SPENDING BY SERVICE

LOUISIANA MEDICAID SPENDING BY SERVICE, 2010 (MILLIONS)

ACUTE MEDICAID SPENDING BY SERVICE



Source: Distribution of Medicaid Spending by Service, Kaiser Family Foundation. <http://statehealthfacts.org/comparetable.jsp?ind=178&cat=4>

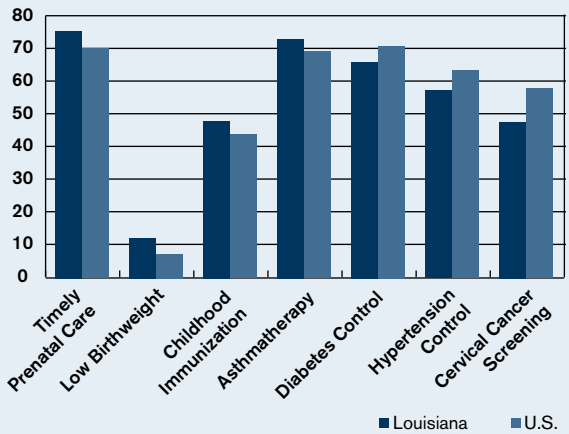
FIGURE 8: PROVIDER, PHYSICIAN AND PROFESSIONAL OVERVIEW 2011

Provider Overview 2011				
	Provider Overview 2011	Nursing Facility Beds / 100,000 Medicare Pop	Patient Encounters per FQHC Delivery Site	Average FQHC Encounters per Patient
LA	340	5,156	6,426	3.32
U.S.	260	4,446	9,469	3.96

Physician and Professional Overview 2011							
	Physicians /100K	PCP /100K	Specialists Physicians /100K	Dentists /100K	RNs /100K	PAs /100K	NPs /100K
LA	246	112	134	49	893	16	52
U.S.	269	128	141	60	874	27	58

Source: Providers & Services Use, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=8&rgn=6&rgn=1>

FIGURE 9: COMMUNITY HEALTH CENTERS QUALITY SCORES



Source: "State Averages: Quality of Care At Community Home Health Centers." Kaiser Health News. 10/31/2012

A&M ANALYSIS

About 40% of Louisiana residents are receiving Medicaid or are uninsured, creating a significant financial burden on the state. The elimination of incremental Medicaid subsidies provided by the American Recovery and Reinvestment Act (ARRA) has exacerbated the funding crises. Governor Jindal does not intend to expand Medicaid coverage to 133% of the Federal Poverty Limit (FPL) as outlined in the PPACA.

In July, Governor Jindal announced an $859M reduction in Medicaid spending, a figure including Federal matching grants. Significant reductions in provider reimbursement were made. In October, the LSU Board of Supervisors approved a plan to reduce state funding to seven Southern Louisiana hospitals by $85M. This reduction will cause an additional $67M loss in matching Federal grants. 19% of the $802M LSU system budget has been eliminated. Reduced access and care is inevitable. [146] Public-private hospital partnerships are being explored to fill the service gap.

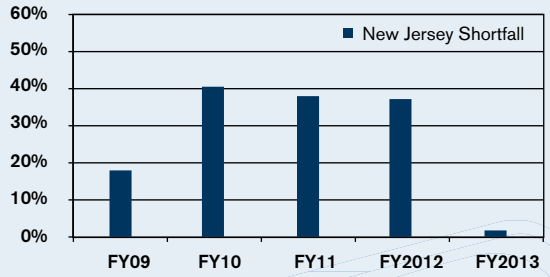
Many Louisiana hospitals are small, with low occupancy rates and minimal, if any, profitability. Consolidation and closures are likely. An opportunity exists to re-create the Louisiana safety net healthcare delivery system on an integrated and scalable basis that potentially incorporates the practices of "best-in-class" performers from elsewhere.

NEW JERSEY

New Jersey, with a total population of 8.8 million, has a significant resident percentage of Medicaid recipients (12.4%) and the uninsured (15.5%). The median age is 39.0 years and 14% of the population is over 65 years old. 21% of the population is Hispanic and 13% is black, with 31% of having incomes below the Federal Poverty Rate ($23,050 for a family of four). The health status of residents based on the percentage of residents who are overweight, smokers, in poor mental health or on disability is better than the U.S. average. New Jersey has slightly more primary care physicians per 100,000 population (5.6%) and more patient encounters per FQHC delivery site (+34.7%). Its Medicaid-to-Medicare fee index for primary care is 0.41. There are 75 hospitals with 21,403 staffed beds, 285 beds / hospital and 240 hospital beds / 100,000 or -7.7% below the U.S. average. The average length of stay was 4.6 days and the hospital occupancy rate is 62.8%.

Its budget shortfall as a percentage of the general fund has ranged from 2-40% in the past four years. In FY13, its shortfall is $0.5 billion or 1.6% of the budget. Medicaid spending totaled $10.2 billion or 15% of the State budget. Medicaid spending per recipient of $10,122 far exceeds the U.S. average of $6,216. Dual-eligible recipients represent 20% Medicaid recipients and account for 39% of total spending.

FIGURE 1: BUDGET SHORTFALL AS A PERCENTAGE OF GENERAL FUND



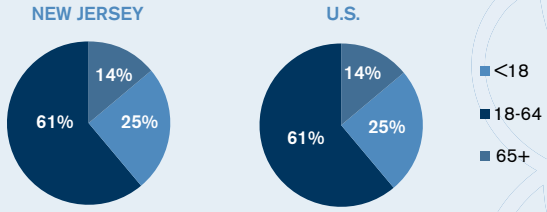
Source: State Budget Shortfalls, Kaiser Family Foundation. <http://statehealthfacts.org/comparereport.jsp?rep=91&cat=1>

FIGURE 2: NEW JERSEY RACE AND ETHNICITY (MILLIONS, %), 2011

Race	New Jersey Population	U.S. Population	New Jersey Poverty Rate (<100% FPL)	U.S. Poverty Rate (<100% FPL)
White	5.0 (58%)	194.5 (63%)	0.5 (9%)	25.9 (13%)
Black	1.1 (13%)	37.0 (12%)	0.4 (33%)	5.4 (23%)
Hispanic	1.8 (21%)	52.2 (17%)	0.5 (29%)	12.9 (35%)
Other	0.8 (9%)	24.1 (8%)	0.1 (13%)	17.1 (33%)
Total	**8.7**	**307.9**	**1.4 (16%)**	**61.3 (20%)**

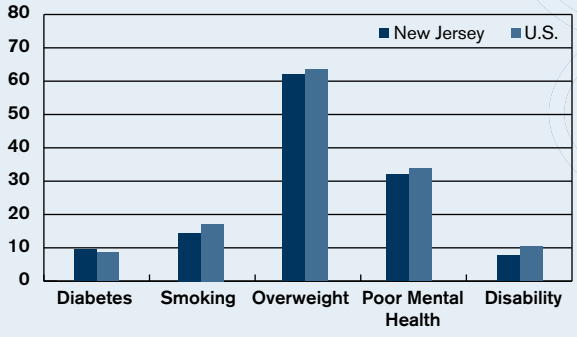
Source: Poverty Rate by Race and Ethnicity (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=14&cat=1>

FIGURE 3: AGE DISTRIBUTION, 2011



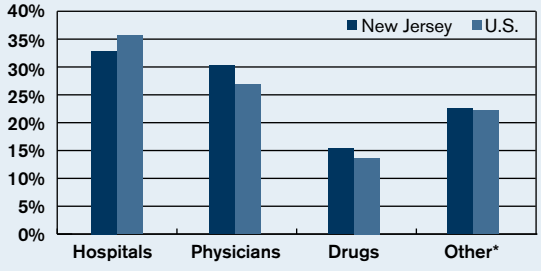
Source: Population Distribution by Age, (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=2&cat=1>

FIGURE 4: NEW JERSEY HEALTH STATUS COMPARISON, 2010



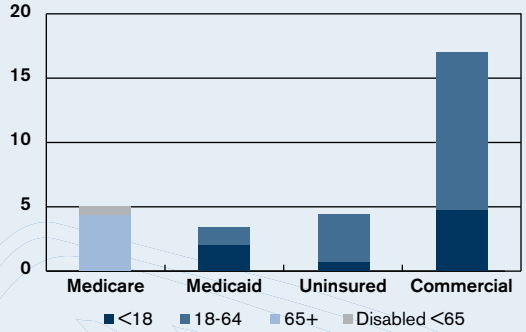
Source: Health Status, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=2&rgn=6&rgn=1>

FIGURE 5: HEALTH EXPENDITURES FY09



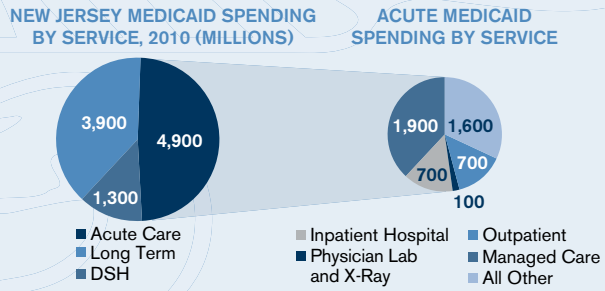
Source: Health Spending by Service 2009, Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=262&cat=5>

FIGURE 6: NEW JERSEY INSURANCE BY STAGE 2011 (MILLIONS)



Source: Health Coverage & Uninsured, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1>

FIGURE 7: MEDICAID SPENDING BY SERVICE



Source: Distribution of Medicaid Spending by Service, Kaiser Family Foundation. <http://statehealthfacts.org/comparetable.jsp?ind=178&cat=4>

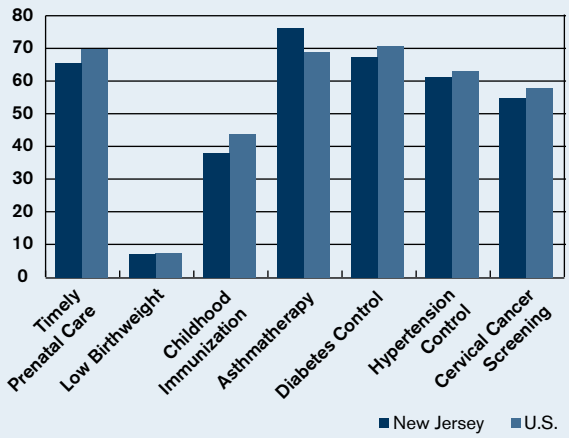
FIGURE 8: PROVIDER, PHYSICIAN AND PROFESSIONAL OVERVIEW 2011

Provider Overview 2011				
	Provider Overview 2011	Nursing Facility Beds / 100,000 Medicare Pop	Patient Encounters per FQHC Delivery Site	Average FQHC Encounters per Patient
NJ	240	4,721	12,754	3.51
U.S.	260	4,446	9,469	3.96

Physician and Professional Overview 2011							
	Physicians /100K	PCP /100K	Specialists Physicians /100K	Dentists /100K	RNs /100K	PAs /100K	NPs /100K
NJ	284	135	149	81	886	15	62
U.S.	269	128	141	60	874	27	58

Source: Providers & Services Use, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=8&rgn=6&rgn=1>

FIGURE 9: COMMUNITY HEALTH CENTERS QUALITY SCORES



Source: "State Averages: Quality of Care At Community Home Health Centers." Kaiser Health News. 10/31/2012

A&M ANALYSIS

New Jersey has a relatively low percentage of Medicaid recipients and uninsured; however, its spending per recipient is exceeded only by Alaska. The percentage of Medicaid recipients who are dual-eligible, 20%, is higher than that of Florida (18%) and Arizona (9%) despite a far younger population. Spending per aged dual eligible at $21,378 is 28.2% higher than the U.S. average; comparable figures for the disabled dual eligible are $24,579 and 55.6% higher. [147] The NJ population of those >65 years old has been forecasted to increase from 1.2M in 2010 to 1.6M, +30.9% in 2020.

New Jersey plans on expanding Medicaid coverage to 133% of the FPL, thereby adding 390,000 benefit recipients and reducing the number of uninsured by 45% by 2019.[135] New Jersey receives $644M in Medicaid DSH payments, a disproportionate amount of aid given the size of its Medicaid and uninsured population; i.e., nearly 6% of total payments for 2% of the target population.

Opportunities clearly exist to better manage the dual-eligible population; i.e., aged patients with complex co-morbid medical conditions and the disabled, many with mental health issues. The high level of Medicaid managed care interest in dual-eligible populations reflects the exceedingly high spending level associated with existing inefficiencies.

NEW YORK

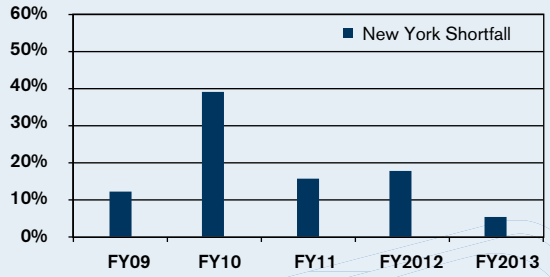
New York, with a total population of 19.4 million, has a significant resident percentage of Medicaid recipients (21.6%) and the uninsured (13.6%). The median age is 38.0 years and 13% of the population is over 65 years old. 18% of the population is black and 14% is Hispanic, with 34% of the combined black and Hispanic population having incomes below the Federal Poverty Rate ($23,050 for a family of four). The health status of residents based on the percentage of residents who are overweight, smokers, in poor mental health or on disability approximates the U.S. average. New York has significantly more primary care physicians per 100,000 population (20.3%) and more patient encounters per FQHC delivery site (+28.5%). Its Medicaid-to-Medicare fee index for primary care is 0.36. There are 204 hospitals with 59,301 staffed beds, 291 beds / hospital and 310 hospital beds / 100,000 or -19.2% above the U.S. average. The average length of stay was 5.6 days and the hospital occupancy rate is 57.6%.

Its budget shortfall as a percentage of the general fund has ranged from 3-39% in the past four years. In FY13, its shortfall is $2.0 billion or 3.4% of the budget. Medicaid spending totaled $52.1 billion or 30% of the State budget. Medicaid spending per recipient of $10,008 far exceeds the U.S. average of $6,216. Dual-eligible recipients represent 14% Medicaid recipients and account for 39% of total spending.

A&M ANALYSIS

New York is tied for third for the highest percentage of its population on Medicaid at 22%. It's exceeded only Vermont (24%), Washington D.C. (24%) and tied with Maine and New Mexico. Spending levels per recipient are exceeded by only Alaska and New Jersey. The percentage of Medicaid recipients who are dual-eligible at 14%, is consistent with national levels. However, spending per aged dual eligible at $28,384 is 70.2% higher than the U.S. average; comparable figures for the disabled dual eligible are $37,312 and 136.2% higher.[147] The NY population of those >65 years old has been forecasted to increase from 2.6M in 2010 to 3.3M, +24.1% in 2020.

FIGURE 1: BUDGET SHORTFALL AS A PERCENTAGE OF GENERAL FUND



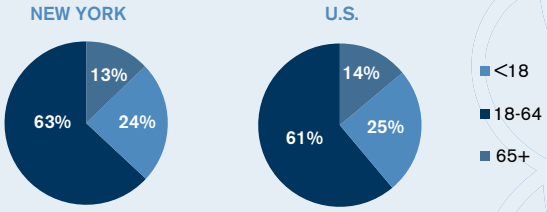
Source: State Budget Shortfalls, Kaiser Family Foundation. <http://statehealthfacts.org/comparereport.jsp?rep=91&cat=1>

FIGURE 2: NEW YORK RACE AND ETHNICITY (MILLIONS, %), 2011

Race	New York Population	U.S. Population	New York Poverty Rate (<100% FPL)	US.. Poverty Rate (<100% FPL)
White	11.0 (57%)	194.5 (63%)	1.5 (14%)	25.9 (13%)
Black	2.7 (18%)	37.0 (12%)	0.9 (21%)	5.4 (23%)
Hispanic	3.5 (14%)	52.2 (17%)	1.2 (29%)	12.9 (35%)
Other	1.9 (10%)	24.1 (8%)	0.5 (26%)	17.1 (33%)
Total	**19.2**	**307.9**	**1.4 (16%)**	**61.3 (20%)**

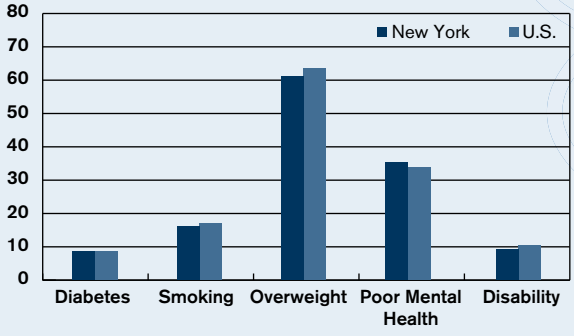
Source: Poverty Rate by Race and Ethnicity (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=14&cat=1>

FIGURE 3: AGE DISTRIBUTION, 2011



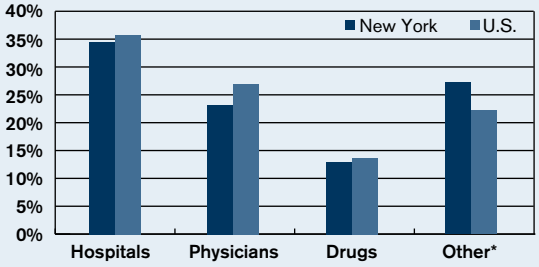
Source: Population Distribution by Age, (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=2&cat=1>

FIGURE 4: NEW YORK HEALTH STATUS COMPARISON, 2010



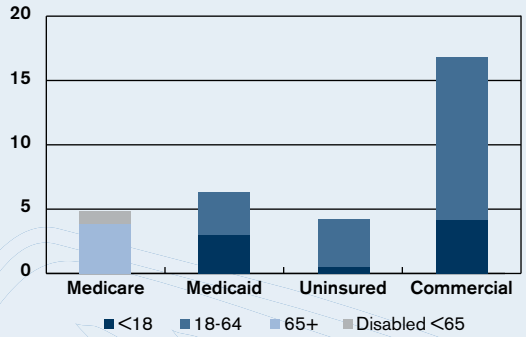
Source: Health Status, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=2&rgn=6&rgn=1>

FIGURE 5: HEALTH EXPENDITURES FY09



Source: Health Spending by Service 2009, Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=262&cat=5>

FIGURE 6: NEW YORK INSURANCE BY STAGE 2011 (MILLIONS)

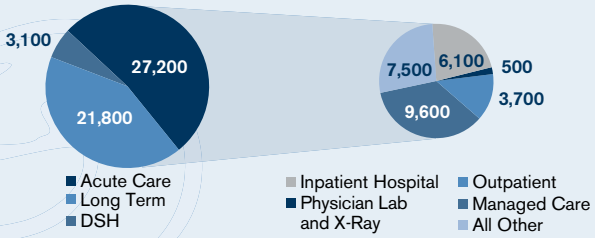


Source: Health Coverage & Uninsured, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1>

FIGURE 7: MEDICAID SPENDING BY SERVICE

NEW YORK MEDICAID SPENDING BY SERVICE, 2010 (MILLIONS)

ACUTE MEDICAID SPENDING BY SERVICE



Source: Distribution of Medicaid Spending by Service, Kaiser Family Foundation. <http://statehealthfacts.org/comparetable.jsp?ind=178&cat=4>

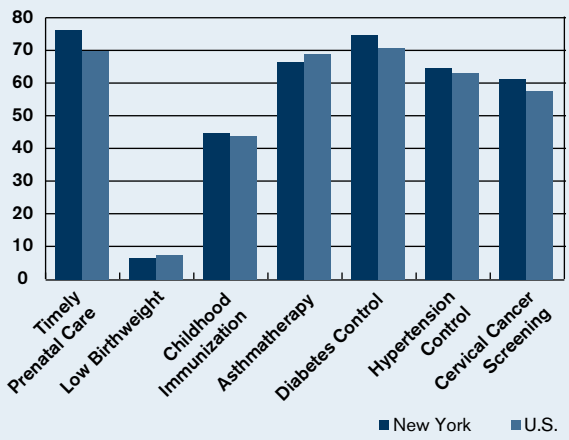
FIGURE 8: PROVIDER, PHYSICIAN AND PROFESSIONAL OVERVIEW 2011

Provider Overview 2011				
	Provider Overview 2011	Nursing Facility Beds / 100,000 Medicare Pop	Patient Encounters per FQHC Delivery Site	Average FQHC Encounters per Patient
NY	310	4,985	12,165	4.63
U.S.	260	4,446	9,469	3.96

Physician and Professional Overview 2011							
	Physicians /100K	PCP /100K	Specialists Physicians /100K	Dentists /100K	RNs /100K	PAs /100K	NPs /100K
NY	351	154	197	79	905	36	82
U.S.	269	128	141	60	874	27	58

Source: Providers & Services Use, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=8&rgn=6&rgn=1>

FIGURE 9: COMMUNITY HEALTH CENTERS QUALITY SCORES



Source: "State Averages: Quality of Care At Community Home Health Centers." Kaiser Health News. 10/31/2012

New York plans on expanding Medicaid coverage to 133% of the FPL, thereby adding 306,000 benefit recipients and reducing the number of uninsured by 15% by 2019. The relatively small number reflects non-restrictive eligibility criteria for Medicaid already in place. New York receives $1.6 billion in Medicaid DSH payments, a figure far exceeding California and Texas, and a disproportionate amount of aid given the size of its Medicaid and uninsured population; i.e., 14% of total payments for nearly 7% of the target population.

In 2006, the Commission on Healthcare Facilities in the 21st Century, also known as the Berger Commission, generated a series of recommendations to "reform New York's healthcare system to improve quality and affordability, and make it more responsive to current healthcare needs." It focused on falling hospital occupancy rates and the excess capacity of beds. The Berger Commission recommended closure of nine hospitals and the reconfiguration of 48 others, inclusive of merger or hospital bed conversion to other uses. They also recommended a few policy changes; fundamental changes in care delivery were not part of its charter.

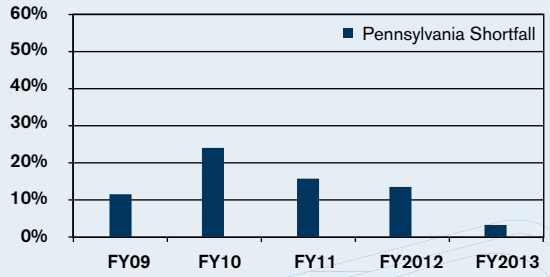
In January 2011, Governor Cuomo established a Medicaid Redesign Team to reduce healthcare costs. Phase I, completed a month later in February 2011, generated 79 recommendations and identified opportunities to reduce spending by $2.2 billion in FY2011-12. Phase II established 10 working groups with 175 members to address complex issues, and establish a multi-year action plan. In August 2012, a 1115 Medicaid waiver application was submitted to the federal government to allow the re-investment of up to $10 billion in savings generated by the reforms. Areas of transformative reinvestment includes: "primary care expansion, health home development, new care models, expansion of the Vital Access Provider Program and Safety Net Provider program, public hospital innovation: New models of care for the uninsured, Medicaid supportive housing expansion, Managed Long-Term Care Preparation program, capital stabilization for safety net hospitals, hospital transition, workforce training, public health innovation, regional health planning, and the MRT Waiver and Evaluation program."

PENNSYLVANIA

Pennsylvania, with a total population of 12.7 million, has a significant resident percentage of Medicaid recipients (14.5%) and the uninsured (10.9%). The median age is 40.1 years and 16% of the population is over 65 years old. 80% of the population is white, with blacks (10%) and Hispanics (6%) accounting for the majority of the remainder; 26% have incomes below the Federal Poverty Rate ($23,050 for a family of four). The health status of residents based on the percentage of residents who are overweight, diabetic, smokers or on disability is slightly worse than the U.S. average. Pennsylvania has a significantly higher number of primary care physicians per 100,000 persons (18.8%) and fewer patient encounters per FQHC delivery site (-2.5%). Its Medicaid-to-Medicare fee index for primary care is 0.62. There are 177 hospitals with 36,108 staffed beds, 204 beds / hospital and 310 hospital beds / 100,000 or 19.2% above the U.S. average. The average length of stay was 4.7 days and the hospital occupancy rate is 57.1%.

Its budget shortfall as a percentage of the general fund has ranged from 2-24% in the past four years. In FY13, its shortfall is $0.5 billion or 2.0% of the budget. Medicaid spending totaled $18.8 billion or 21% of the State budget. Medicaid spending per recipient of $8,532 was significantly above the U.S. average of $6,216. Dual-eligible recipients represent 18% Medicaid recipients and account for 36% of total spending.

FIGURE 1: BUDGET SHORTFALL AS A PERCENTAGE OF GENERAL FUND



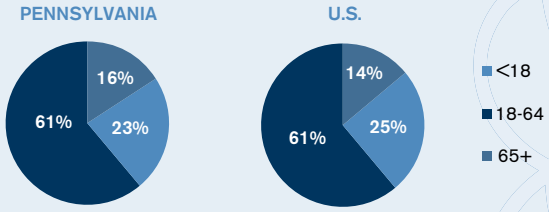
Source: State Budget Shortfalls, Kaiser Family Foundation. <http://statehealthfacts.org/comparereport.jsp?rep=91&cat=1>

FIGURE 2: PENNSYLVANIA RACE AND ETHNICITY (MILLIONS, %), 2011

Race	Pennsylvania Population	U.S. Population	Pennsylvania Poverty Rate (<100% FPL)	U.S. Poverty Rate (<100% FPL)
White	10.1 (80%)	194.5 (63%)	1.3 (13%)	25.9 (13%)
Black	1.3 (10%)	37.0 (12%)	0.5 (21%)	5.4 (23%)
Hispanic	0.7 (6%)	52.2 (17%)	0.3 (12%)	12.9 (35%)
Other	0.5 (4%)	24.1 (8%)	0.2 (7%)	17.1 (33%)
Total	**12.6**	**307.9**	**3.3 (26%)**	**61.3 (20%)**

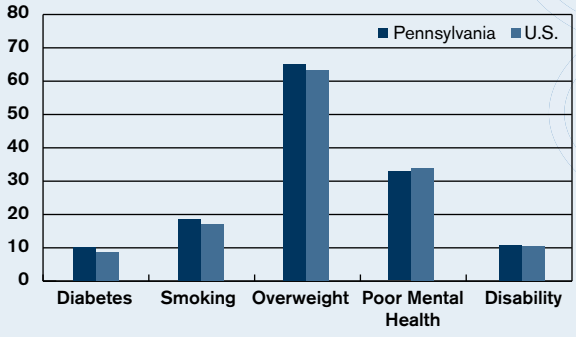
Source: Poverty Rate by Race and Ethnicity (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=14&cat=1>

FIGURE 3: AGE DISTRIBUTION, 2011



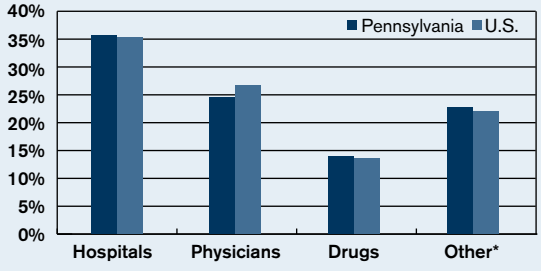
Source: Population Distribution by Age, (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=2&cat=1>

FIGURE 4: PENNSYLVANIA HEALTH STATUS COMPARISON, 2010



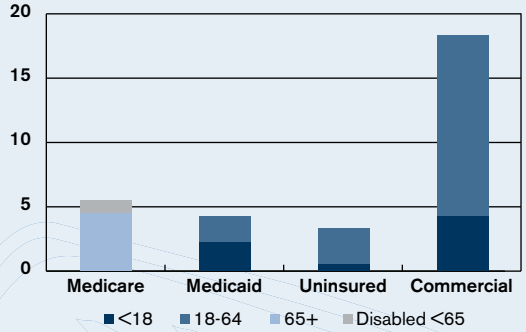
Source: Health Status, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=2&rgn=6&rgn=1>

FIGURE 5: HEALTH EXPENDITURES FY09



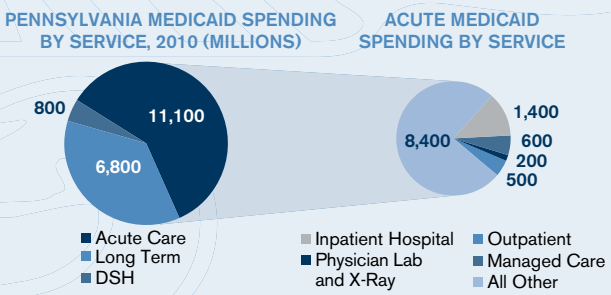
Source: Health Spending by Service 2009, Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=262&cat=5>

FIGURE 6: PENNSYLVANIA INSURANCE BY STAGE 2011 (MILLIONS)



Source: Health Coverage & Uninsured, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1>

FIGURE 7: MEDICAID SPENDING BY SERVICE



Source: Distribution of Medicaid Spending by Service, Kaiser Family Foundation. <http://statehealthfacts.org/comparetable.jsp?ind=178&cat=4>

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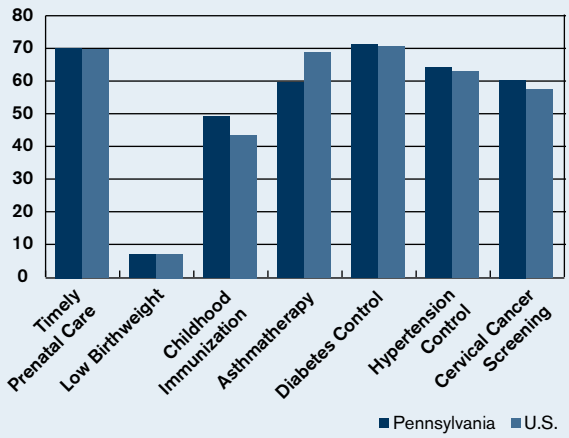
Provider Overview 2011				
	Provider Overview 2011	Nursing Facility Beds / 100,000 Medicare Pop	Patient Encounters per FQHC Delivery Site	Average FQHC Encounters per Patient
PA	310	4,903	9,237	3.45
U.S.	260	4,446	9,469	3.96

Physician and Professional Overview 2011							
	Physicians /100K	PCP /100K	Specialists Physicians /100K	Dentists /100K	RNs /100K	PAs /100K	NPs /100K
PA	324	152	172	62	1,026	36	59
U.S.	269	128	141	60	874	27	58

Source: Providers & Services Use, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=8&rgn=6&rgn=1>

FIGURE 9: COMMUNITY HEALTH CENTERS QUALITY SCORES



Source: "State Averages: Quality of Care At Community Home Health Centers." Kaiser Health News. 10/31/2012

A&M ANALYSIS:

Compared to many other states, Pennsylvania has one of the lowest rates of Medicaid recipient and uninsured at 25%; the U.S. average is 32%. Primary care physicians are available, and hospital capacity is greater than the U.S. average. The decision to expand Medicaid coverage, as per the PPACA forecasts, adds 0.5M to Medicaid by 2019, and reduces the number of uninsured by 41%.[135] Medicaid DSH payments total $562 billion.

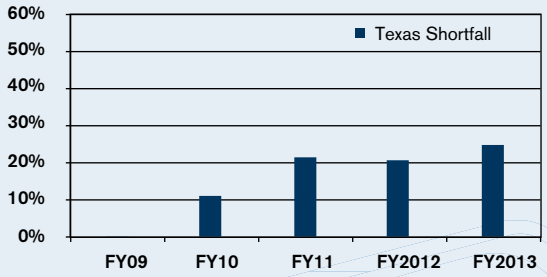
Pennsylvania's population of residents >65 has been forecasted to increase by 443,000 in 2010-2020, potentially increasing the funding requirements for the aged and poor. Dual-eligible recipients already account for 36% of Medicaid spending, while long-term care accounts for 84% of dual-eligible spending. In Pennsylvania, a wide dispersion in spending exists between the aged dual-eligible ($26,767) and the disabled dual-eligible ($11,986), compared to the U.S. average where spending is only slightly different ($16,672 vs. $15,799).[147]

TEXAS

Texas, with a total population of 25.3 million, has a significant resident percentage of Medicaid recipients (15.6%) and the uninsured (24.2%). The median age is 33.6 years and 10% of the population is over 65 years old. 40% of the population is Hispanic, with 34% of the Hispanic population having incomes below the Federal Poverty Rate ($23,050 for a family of four). The health status of residents based on the percentage of residents who have diabetes, are overweight, in poor mental health or on disability is slightly worse than the U.S. average. Texas has significantly fewer primary care physicians per 100,000 population (-20.3%) and more patient encounters per FQHC delivery site (+14.6%). Its Medicaid-to-Medicare fee index for primary care is 0.68. There are 372 hospitals with 56,751 staffed beds, 153 beds / hospital and 240 hospital beds / 100,000 or -7.7% below the U.S. average. The average length of stay was 4.7 days and the hospital occupancy rate is 56.2%.

Its budget shortfall as a percentage of the general fund has ranged from 11-24% in the past four years. In FY13, its shortfall is $9.0 billion or 24.2% of the budget. Medicaid spending totaled $27.2 billion or 33% of the State budget. Medicaid spending per recipient of $6,060 approximates the U.S. average of $6,216. Dual-eligible recipients represent 14% Medicaid recipients and account for 23% of total spending.

FIGURE 1: BUDGET SHORTFALL AS A PERCENTAGE OF GENERAL FUND



Source: State Budget Shortfalls, Kaiser Family Foundation. <http://statehealthfacts.org/comparereport.jsp?rep=91&cat=1>

FIGURE 2: TEXAS RACE AND ETHNICITY (MILLIONS, %), 2011

Race	Texas Population	U.S. Population	Texas Poverty Rate (<100% FPL)	U.S. Poverty Rate (<100% FPL)
White	10.6 (42%)	194.5 (63%)	1.3 (12%)	25.9 (13%)
Black	2.9 (12%)	37.0 (12%)	0.9 (31%)	5.4 (23%)
Hispanic	10.1 (40%)	52.2 (17%)	3.4 (34%)	12.9 (35%)
Other	1.7 (7%)	24.1 (8%)	0.3 (18%)	17.1 (33%)
Total	**25.3**	**307.9**	**5.9 (18%)**	**61.3 (20%)**

Source: Poverty Rate by Race and Ethnicity (2010-2011), Kaiser Family Foundation. <http://statehealthfacts.org/comparebar.jsp?ind=14&cat=1>

FIGURE 3: AGE DISTRIBUTION, 2011

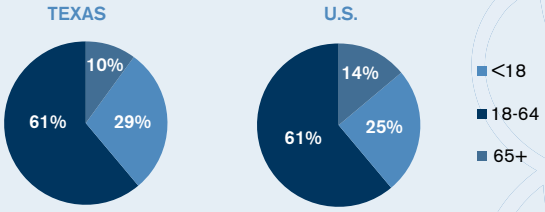


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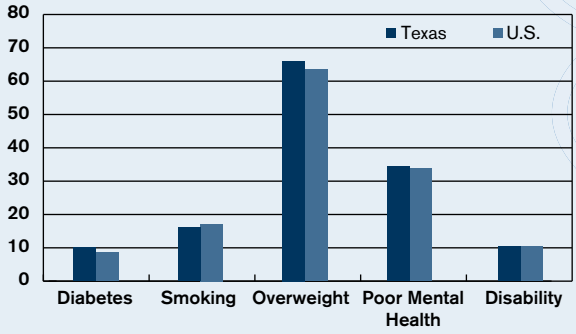
FIGURE 4: TEXAS HEALTH STATUS COMPARISON, 2010



Source: Health Status, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=2&rgn=6&rgn=1>

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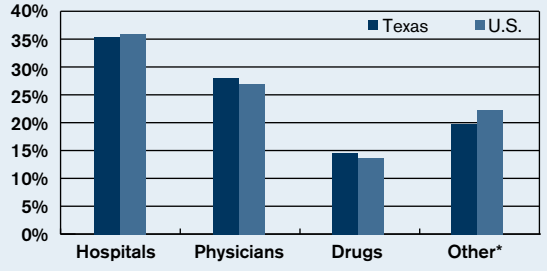

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FIGURE 6: TEXAS INSURANCE BY STAGE 2011 (MILLIONS)

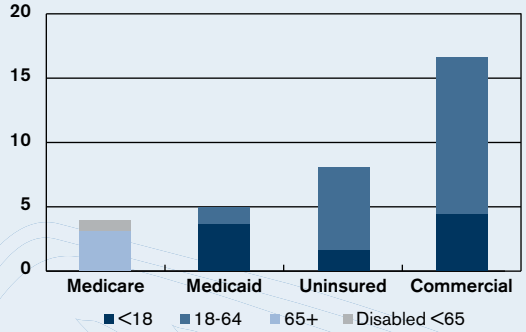

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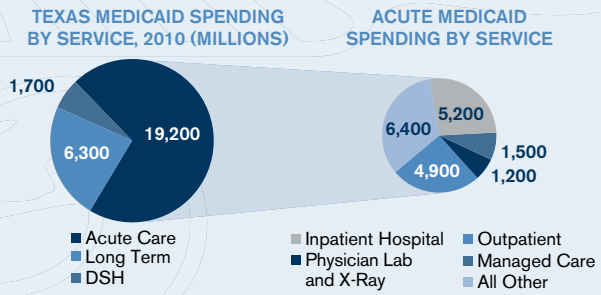
FIGURE 7: MEDICAID SPENDING BY SERVICE



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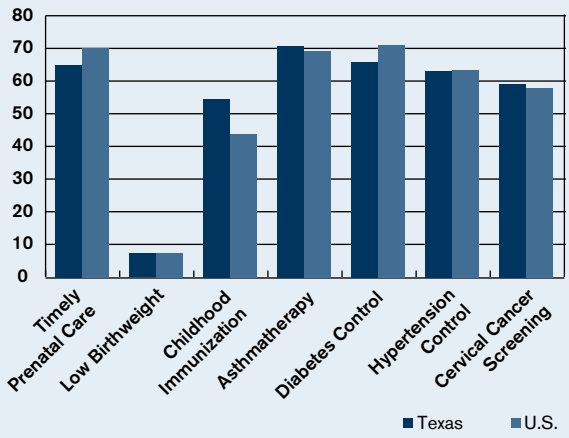
Provider Overview 2011				
	Provider Overview 2011	Nursing Facility Beds / 100,000 Medicare Pop	Patient Encounters per FQHC Delivery Site	Average FQHC Encounters per Patient
TX	240	5,491	10,846	3.85
U.S.	260	4,446	9,469	3.96

Physician and Professional Overview 2011							
	Physicians /100K	PCP /100K	Specialists Physicians /100K	Dentists /100K	RNs /100K	PAs /100K	NPs /100K
TX	214	102	112	46	720	22	28
U.S.	269	128	141	60	874	27	58

Source: Providers & Services Use, Kaiser Family Foundation. <http://statehealthfacts.org/comparecat.jsp?cat=8&rgn=6&rgn=1>

FIGURE 9: COMMUNITY HEALTH CENTERS QUALITY SCORES



Source: "State Averages: Quality of Care At Community Home Health Centers." Kaiser Health News. 10/31/2012

A&M ANALYSIS

Nearly one-fourth of the Texas population is uninsured. Hospitals reported $11.6 billion in uncompensated care charges for 2006, an inflated figure that does not reflect the actual costs of providing care and may vary significantly by institution. [148] Fragmented approaches to the reimbursement of uncompensated care exist, though with a heavy dependence upon the collection of hospital district (county) taxes.

In December 2011, Texas obtained approval for a Section 1115 Medicaid Waiver, Healthcare Transformation and Quality Improvement Program, to expand the use of managed care, and provide the Texas Health and Human Services Commission the authority to make "payments for uncompensated care to Medicaid eligible patients and uninsured patients and incentive payments for healthcare delivery system reforms." The latter incentive payments require participation in a Regional Healthcare Partnership to improve local access to quality, affordable care - always a challenge given multiple stakeholders and a lack of centralized authority. Public hospital providers must also agree to provide the intergovernmental transfer (IGT) of public funds (i.e., hospital district taxes) as the state share for Medicaid payments.

Despite the large number of uninsured residents, Governor Perry has decided not to expand Medicaid coverage from 100% to 133% of the FPL; 1.8M fewer uninsured were forecasted for 2019.[135] Texas will also not create a health exchange. Federal Medicaid DSH payments total $957M. The shortage of primary care physicians will be exacerbated by a rapidly aging population of those >65 years old, from 2.6M in 2010 to 3.8M, +44% in 2020. An integrated or semi-integrated safety net care delivery network, with aligned management incentives is far more likely to be more efficient and effective than voluntary or insurance-mandated regional activities. The small size of many Texas hospitals facilitates consolidation, the attainment of scale economies and the use of wireless technologies, including telehealth.

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AUTHOR'S BIOGRAPHY

David Gruber M.D., M.B.A., is Director of Research with Alvarez & Marsal (A&M) Healthcare Industry Group. A&M is a leading global professional services firm specializing in turnaround and interim management, performance improvement and business advisory services.

Dr. Gruber brings nearly 30 years of healthcare experience as a corporate executive, Wall Street analyst and physician focused on strategy, technology, innovation and new ventures. Until 2011, as an independent consultant, Dr. Gruber completed a wide variety of client assignments while supporting three different IT start-ups focused on consumer engagement, behavioral health and telemedicine. Until December 2008, he was VP, Corporate Development and New Ventures with the Johnson & Johnson Consumer Group of Companies.

Between 1995-2004, Dr. Gruber worked on Wall Street as a top-ten rated medical supplies and devices analyst at Lehman Brothers, Piper Jaffray and Sanford Bernstein. He was the lead analyst for the initial public offering of Intuitive Surgical and Given Imaging, as well as a merchant banking investment in Therasense. Prior to entering Wall Street, Dr. Gruber was Vice President, Planning & Business Development, for the $1.6 billion Healthcare Group at Bristol-Myers Squibb.

Dr. Gruber is a magna cum laude graduate of a six-year B.S.-M.D. program, having received his bachelor's degree from CCNY and his medical degree from the Mt. Sinai School of Medicine. He also has an M.B.A. from Columbia University, and was a Kellogg Foundation National Fellow. Dr. Gruber is currently a Senior Fellow, Healthcare Innovation and Technology Lab (HITLAB) at Columbia Presbyterian and a Trustee on the Teaneck, New Jersey Board of Education.

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