HEALTHCARE • MANAGEMENT
THE RINER GROUP INC. CONSULTING

Mediscene Newsletter

The Riner Group
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Volume 32 Issue 2

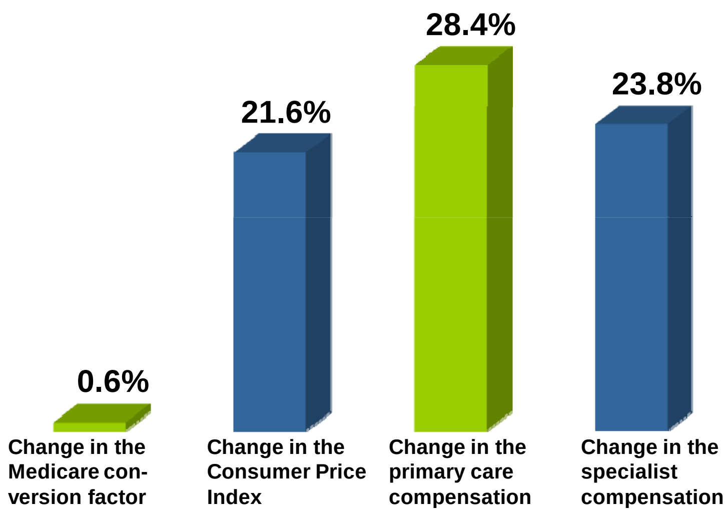
August 2011

KEEPING UP WITH INFLATION AND MEETING EXPECTATIONS

While passage of the Patient Protection and Affordability Care Act has been touted as the most important healthcare legislation of the recent past, most practice administrators are focusing their attention not on the long term implications of this act but whether Congress will take on the Sustainable Growth Rate (SGR) formula.

MGMA survey data illustrate that increases in physician compensation from 2001-2009 were not related to a growth in the conversion factor but more likely related to increased productivity, improved efficiency, and enhanced utilization of in-house ancillary services.

Percent Changes 2001-2009



Source: Medical Group Management Association, MGMA Connexion, 1/2010

Compensation Changes 2001-2009

	Change in Compensation					
	Physician-owned groups			Hospital-owned groups		
	2001	2009	% change	2001	2009	% change
Family Practice (without OB)	$153,000	$189,691	24.0%	$150,000	$183,152	22.1%
Internal Medicine: General	$156,880	$200,452	27.8%	$154,840	$197,756	27.7%
Obstetrics and Gynecology	$232,456	$274,998	18.3%	$230,055	$288,922	25.6%
Surgery: General	$250,695	$334,995	3.36%	$258,380	$339,700	31.5%
	Change in Production					
	Physician-owned groups			Hospital-owned groups		
	2001	2009	% change	2001	2009	% change
Family Practice (without OB)	$315,722	$417,556	32.3%	$292,100	$377,269	29.2%
Internal Medicine: General	$315,945	$393,377	34.5%	$287,927	$340,351	18.2%
Obstetrics and Gynecology	$553,654	$639,939	15.6%	$467,051	$596,464	27.7%
Surgery: General	$530,602	$612,157	15.4%	$476,663	$480,911	0.9%

Source: MGMA Physician Compensation & Production Survey 2002 report based on 2001 data & 2010 report based on 2009 data, MGMA Connexion, 1/2010

Data show that medical groups are more efficient today than they were 8 years ago, but the degree of change is too great to attribute to improved efficiency alone. According to the chart the increase in physician compensation is almost certainly due to increased productivity and additional services. In physician-owned medical groups the equation for compensation is relatively simple. The income for practice owners is what remains for total revenue after operating expenses are paid and non-physician providers are compensated.

However, while most physicians are in private practice, an increasing percentage have traded their autonomy for the security of employment contracts with hospitals and health systems, especially since reimbursement for ancillary services has been drastically reduced. Additionally, many physicians in medical groups are reaching ages of retirement and newly graduated physicians are not interested in assuming the burdens of private practice.

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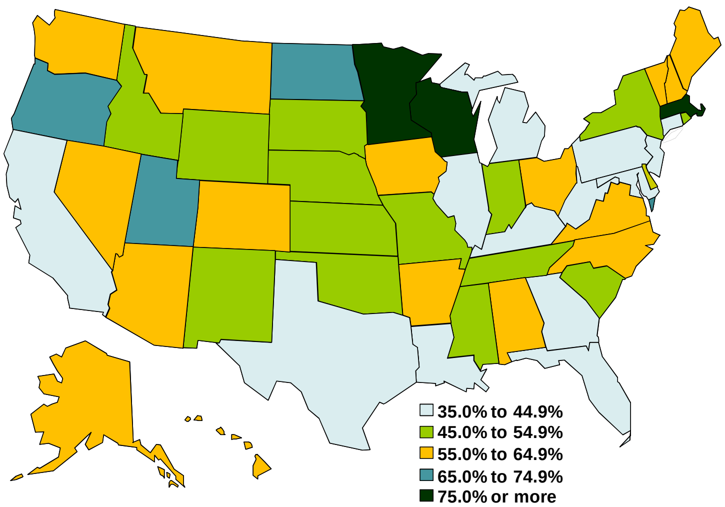
EHR USAGE INCREASES

According to preliminary estimates from a CDC survey, 2010 was the first year that about half of office-based physicians had any kind of electronic medical records system. Minnesota led the nation with more than 80% of the physicians; EHR use was at its lowest in Kentucky with just over 38%.



Source: "Electronic Record/Electronic Health Record Systems of Office-based physicians: U.S., 2009 and Preliminary 2010 state estimates." National Center for Health Statistics, CDC, 1/28/10; American Medical News, 1/17/11

THE EHR EFFECT ON PRODUCTIVITY AND PROFITS

Performance Indicator	Paper records/ charts	EHR	Hybrid
Total support staff FTE	4.17	3.98	4.10
Total RVUs	13,504	11,854	9,649
Patients	2,331	2,844	2,800
Total operating cost (% of medical revenue)	67.69%	67.62%	66.25%
Total medical revenue after operating and non-physician provider cost	$155,854	$161,447	$152,537
Days gross fee-for-service charges in accounts receivable	44.54	28.48	44.47

Source: "Electronic Records' Impacts on Revenue, Costs and Staffing, MGMA 2010 Report; Medical Economics, 3/10/11

Considerable discussion revolves around how EHRs, especially at their initiation, alter and reduce productivity. Is it the EHR system or operational improvement that drives eventual profitability? In reality, it's both. Operational improvement usually is required before the transition to EHRs, but once in place, EHRs allow for greater efficiency, especially after the physicians learn how to use them. A recent Medical Group Management Association (MGMA) survey demonstrated that total medical revenue per Full Time Equivalent (FTE) position after operating costs was consistently greater across single specialty and multi-specialty groups using EHRs than for their peers not using EHRs. The table provides key performance indicators for 2009 data on primary care practices (median per FTE physician) using paper records, EHRs, or a hybrid of paper and EHRs.

Higher levels of productivity, supported by fewer staff per FTE physician, resulting in higher levels of revenue, collected faster. Only by combining operational changes with EHR implementation can a practice achieve significant improvement – although one would never deny that the process is extremely painful.

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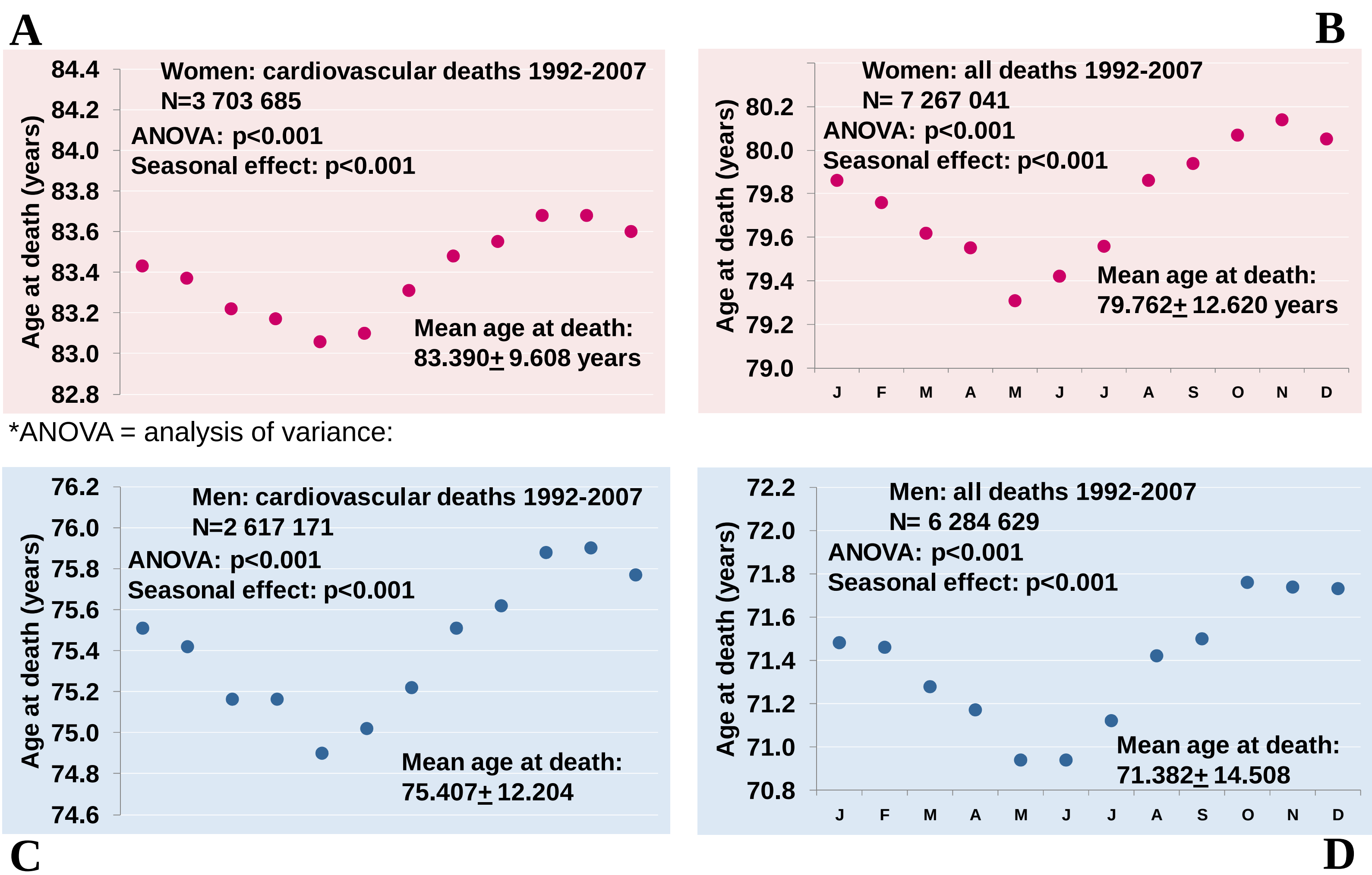
CARDIOVASCULAR MORTALITY – IS IT RELATED TO SEASON OF BIRTH?

There is an increasing evidence that environmental factors in early pre- and post-natal life have significant impact on the development of various diseases later in adulthood. Season of birth presents a well defined variable associated with various environmental factors in early life, which are most likely not directly related to the genetic background. Not only meteorological factors, daily sunlight exposure and alterations in air pollution and food supply, but many other behavioral changes including dietary habits and physical activity levels throughout the year, are being discussed as potential influence associated with season of birth. The graphs show a highly significant seasonal effect demonstrated for both cardiovascular deaths and all-cause deaths ($p < 0.001$).

AGE/MONTH RELATIONSHIPS TO DEATH



*ANOVA = analysis of variance:

(A) Age at death was lowest in subjects dying from CV cause born around May and highest in subjects born around November. On average, the difference between age at death in subjects born in May and those born in November was 11.7 months for men and 7.3 months for women for CV deaths. **(B)** Similar patterns were observed for all-cause death. Standard deviation was 9.47 to 9.76 yeas for A (women), 12.13 to 12.25 years fro B (men), 12.48 to 12.76 years for C (women), and 14.42 to 14.59 years for D (men).

Source: Journal of American College of Cardiology, Vol, 57, No 7, 2011

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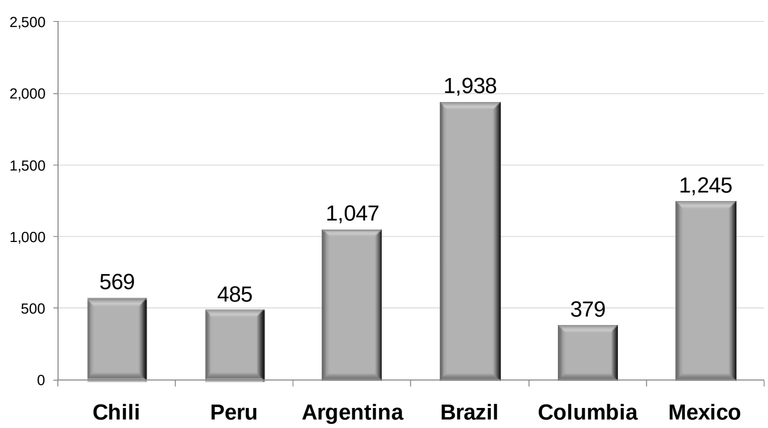
CLINICAL TRIALS BUSINESS – SMALL LATIN AMERICAN COUNTRIES THINK BIG

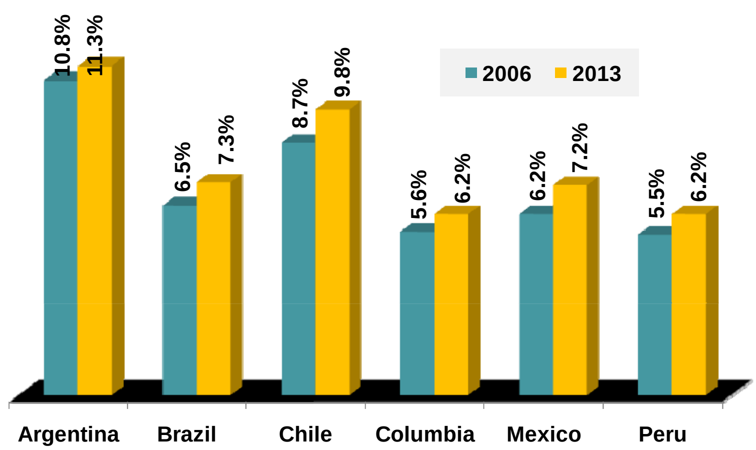
Due to the increasing costs of running clinical trials in the U.S., many pharmaceutical companies are looking to Latin America to run their clinical trials. The figure below shows the distribution of clinical trials among countries in Latin America. Although obstacles abound, there are many opportunities. To the extent that new regulations, stronger intellectual property rights enforcement and other government efforts continue to take place, the attractiveness of the pharmaceutical market in Latin America, in general, will continue to grow. In the current state of the pharmaceutical industry, foreign pharmaceutical companies will continue to be drawn to this region.

CLINICAL TRIALS IN LATIN AMERICA



Source: clinical trials.gov; Genetic Engineering & Biotechnology News, 12/2010

PERCENTAGE OF POPULATION AGED 65+



Source: clinical trials.gov; *Genetic Engineering & Biotechnology News*, 12/2010

INSURERS DOING ALRIGHT DESPITE REFORM

Health system reform measures that plans said could hurt their bottom lines became law in 2010, but so far many continue to post gains. Profits at the nation's seven largest publicly traded insurers went up in 2010. Plans spent less on care and used income to buy back their stock to boost per share earnings. Net earnings rose in 2010 compared with 2009 for six of the seven largest shareholder owned plans.

Company	Revenue		Net Income		Earning Per Share	
	2009	2010 (change)	2009	2010 (change)	2009	2010 (change)
Aetna	$34,764	$34,246 (-1%)	$1,277	$1,767 (38%)	$2.84	$4.18 (47%)
Cigna	$18,414	$21,253 (15%)	$1,302	$1,345 (3%)	$4.73	$4.89 (3%)
Coventry	$13,904	$11,588 (-16%)	$ 242	$ 439 (45%	$1.64	$2.97 (45%)
Health Net	$15,713	$13,620 (-13%)	-$ 49	$ 204 (516%)	-$0.47	$2.06 (538%)
Humana	$30,960	$33,868 (9%)	$1,040	$1,099 (6%)	$6.15	$6.47 (5%)
UnitedHealth Group	$87,138	$94,155 (8%)	$3,822	$4,634 (21%)	$3.24	$4.10 (27%)
WellPoint	$65,028	$58,802 (-10%)	$4,746	$2,887 (-39%)	$9.88	$6.94 (-30%)

*Coventry revenue figures are operating results only and therefore exclude investment and other income.

Source: Company filings with the Securities and Exchange Commission American Medical News, 2/28/11

In general insurers spent less on medical care for members so they were able to profit despite the drop in incoming premiums. Medical-loss ratios (the percentage of each premium dollar spent on medical care) dropped for six of the seven biggest health insurers in the fourth quarter of 2010 compared to the fourth quarter of 2009 because of a continuing slowdown in the rate of growth in medical spending. Insurers have said they expect utilization to return to normal in 2011

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ORGAN TRANSPLANTS – THE NEED CONTINUES TO GROW

Every year, thousands of transplant success stories emerge from hospital operating rooms. The field of transplant medicine offers proven treatments for serious and often fatal diseases and conditions. Organ availability, however, falls short of meeting the needs the growing number of people - more than 86,000 – on the national organ transplant waiting list.

One year survival rates after transplant speak to the advances made in surgical techniques and drug regiments to prevent organ rejections. According to most recent available data, those with the highest one year survival rates – which range from 95% to 98% are kidney transplant recipients and pancreas transplant recipients. One year survival rates for those receiving a liver, intestine, lung or heart transplant are approximately 81% to 90%. Organ transplants aren't just for the young. Among organ transplant recipients, about 15% are adults age 65 and older.

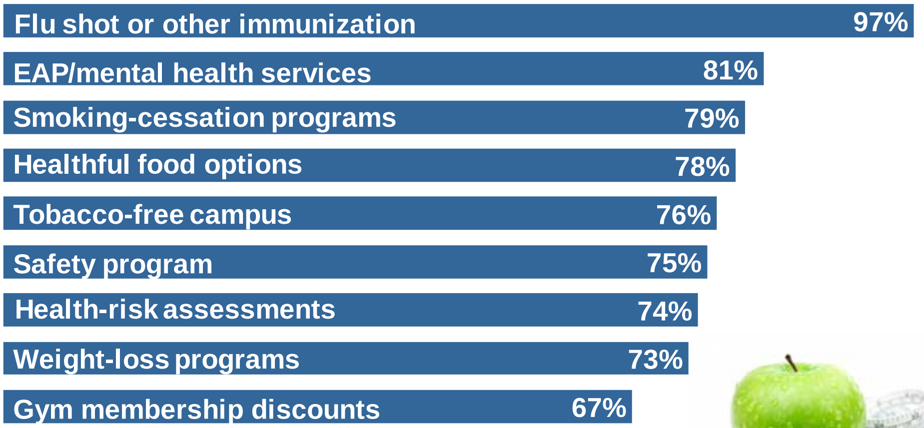
U.S. organ transplant numbers and recipient survival rates

Organ transplants 2009	Kidney	Liver	Heart	Lung	Pancreas	Intestine
Number of procedures in the U.S.	16,829	6,320	2,211	1,660	379	180
Number of living donor transplants	6,387	219	Not applicable	1	0	2
Current approximate number on waiting list	86,254	16,001	3,144	77	1,434	255
Number performed on ages 50 to 64	6,555	3,607	964	812	81	38
Percent survival at 5yr (2001 to 2006)	81%	72%	75%	53%	79%	41%
Number performed on age 65 and older	2,659	697	287	368	1	1
Percent survival at 5yr (2001 to 2006)	68%	64%	67%	44%	Not known	60%

Source: The Organ Procurement and Transplantation Network and Scientific Registry of Transplant Recipients; www.HealthLetter.Mayoclinic.com, 1/2011

EMPLOYEE WELLNESS – IT'S WORTH THE EFFORT

MOST COMMON WELLNESS PROGRAMS OFFERED



Source: "A Call to Action: Creating a Culture of Health," AHA, January 2011; HHN, 3/2011

There has always been skepticism about wellness programs given that their first wave in the 1990s didn't produce good data on return on investment (ROI). Just 20% of healthcare employers offering wellness programs believe they reduce healthcare costs, according to a 2010 survey by the Kaiser Family Foundation and HRET.

Measuring ROI is challenging. A recent American Hospital Association (AHA) survey indicates just a third of hospitals have attempted it. 7% have succeeded, and those tend to be urban hospitals with more than 200 beds or part of a health system. The good news: 82% of hospitals that measure ROI report their ratio is equal to or better than expectations

There is also good news about ROI coming from business researchers looking at wellness programs as a whole. A report in the Harvard Business Review that reviewed wellness programs at 10 large employers including M D Anderson Cancer Center in Houston, concluded that the programs can be effective ways for employers to chip away at their enormous healthcare costs, which are only rising with an aging workforce.

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A 2008 LAW PROMPTS MANY PLANS TO CUT MENTAL HEALTH BENEFITS

Most Frequently Billed Medicare DRGs Ranked by 2009 Medicare patient discharges.	DRG Code	Discharges	Charges (Average)[1]	Reimbursement (average)
1 Psychosis	885	429,305	$22,576	$ 7,239
2 Major joint replacement or reattachment of lower extremity[2]	470	414,243	45,020	11,017
3 Septicemia or severe sepsis w/o mechanical ventilation 96-plus hours[3]	871	293,128	44,737	11,603
4 Rehabilitation[3,4]	945	278,580	34,654	16,382
5 Esophagitis, gastroenteritis & miscellaneous digestive disorders[2]	392	253,577	16,841	3,478
6 Heart failure and shock[3]	291	241,629	32,789	8,823
7 Heart failure and shock[4]	292	205,105	21,083	5,682
8 Kidney & urinary tract infections[2]	690	204,562	16,825	4,114
9 Simple pneumonia & pleurisy[4]	194	203,860	21,770	5,621
10 Nutritional & miscellaneous metabolic disorders[2]	641	173,657	14,946	3,693
11 Chest pain	313	178,798	14,396	2,597
12 Syncope & collapse	312	171,992	17,555	3,794
13 Chronic obstructive pulmonary disease[3]	190	160,399	27,705	7,551
14 Chronic obstructive pulmonary disease[2,5]	192	152,250	15,824	3,779
15 Chronic obstructive pulmonary disease[4]	191	145,597	21,783	5,413
16 Simple pneumonia & pleurisy[3]	193	140,787	32,914	8,477
17 Percutaneous cardiovascular procedure with drug-eluting stent[2]	247	140,251	54,092	11,107
18 Cellulitis[2]	603	139,034	17,450	4,464
19 Cardiac arrhythmia & conduction disorders[2,5]	310	136,890	13,314	2,818
20 Heart failure and shock[2,5]	293	131,830	15,044	3,915

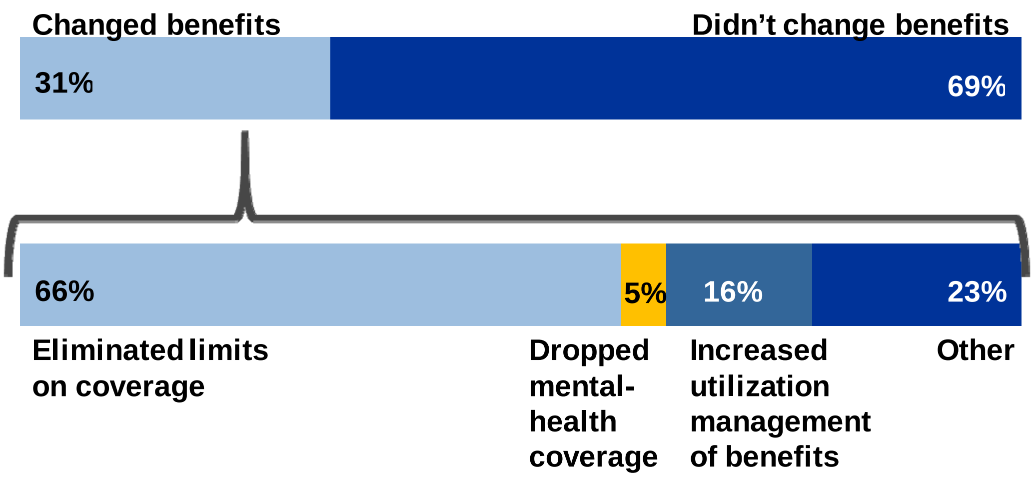
[1]The figures reflect an estimate of what hospitals charge before contractual discounts. [2]Without complication or comorbidity
[3]With major complication or comorbidity [4]With complication or comorbidity [5]Without complication or comorbidity
Note: Data based on CMS Medicare data, Medicare Provider Analysis & Review for federal fiscal 2009. DRG codes are CMS-assigned. Data reflect MedPAR discharges identified as part of the fee-for-service Medicare hospital insurance program.

Source: Thompson Reuters, Modern Healthcare, 1/17/11

HOW FIRMS WITH MORE THAN 50 WORKERS RESPONDED TO THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The 2008 law that requires that mental health and substance abuse benefits, *if offered*, be as robust as medical or surgical benefits. Many are beginning to alter their benefit structure by dropping such coverage to circumvent the requirements.

According to the Kaiser Family Foundation 2010 Employer Health Benefits survey, about one-third of firms with more than 50 workers said they made changes in the benefits they offer in response to the law, and 5% of those said they dropped mental health coverage all together.



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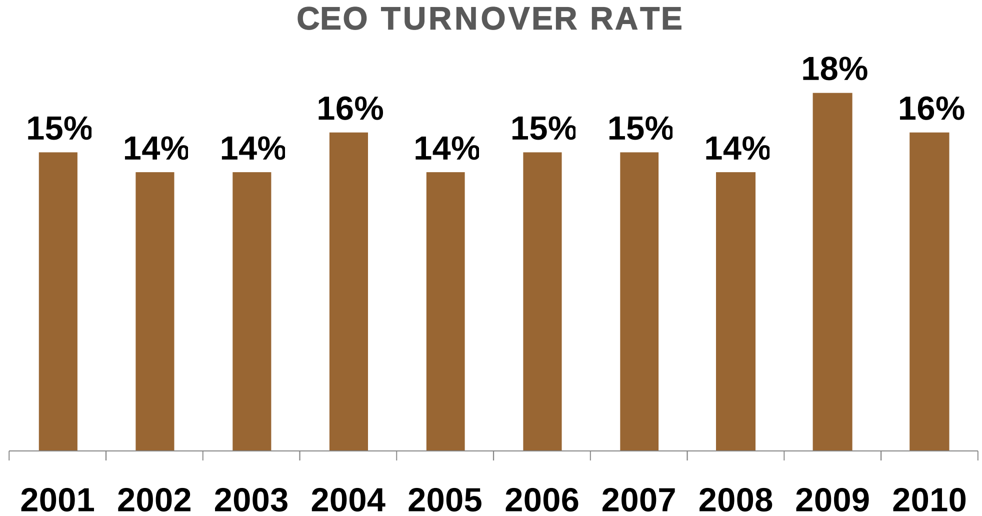
DID YOU KNOW?

- **Focus on Reducing Readmissions to the Hospital** – There is considerable focus on reducing readmissions to the hospital. 1/3 of patients who go home from the hospital are readmitted within 30 days. According to Healthcare Intelligence Network's 2nd Annual May 2010 Managing Care Transitions Across Sites e-survey the following healthcare professionals conducted home visits – home visits are a critical piece to maintain patients on the medications that were prescribed at time of discharge and assisting the patients in maintaining stable medical care.
  - ✓ Certified home health agency nurse: 37.1%
  - ✓ Nurse practitioner: 37.1%
  - ✓ Other 34.3%
  - ✓ Case manager: 25.7%
  - ✓ Physical therapist: 5.7%
  - ✓ Physician: 5.7 %

- **Speed of Stroke Treatment –** Barely more than a quarter of acute stroke patients eligible for treatment with intravenous tissue plasminogen activator (tPA) received the drug within an hour after arriving in a hospital, according to a registry of more than 1,000 U.S. hospitals dedicated to evidence based stroke care during 2003-2009. Among the 641 hospitals in the registry that treated at least 10 stroke patients with intravenous tPA within 3 hours of symptom onset, only 7% of the hospitals achieved a door-to-needle time of 60 minutes or less in a majority of their patients. Many hospitals across the country are focused on improving their care of patients with stroke symptomatology.

- **CEO Turnover** – CEO turnover peaked at 18% in 2009 according to data from the American College of Healthcare Executives. Average turnover has been historically high at 14% and greater.



Source: American College of Healthcare Executives; Modern Healthcare, 3/14/11

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DID YOU KNOW?

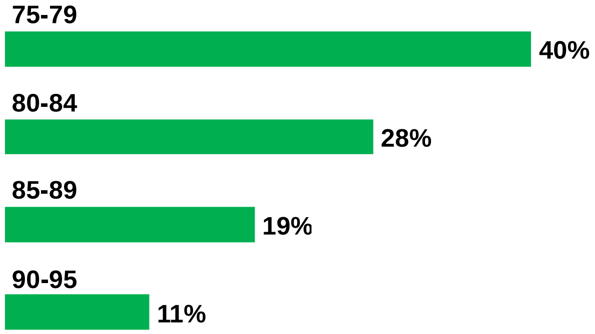
- **Dementia Research** – Almost 13% of those 65 and older are reported to already have Alzheimer's disease. This is only one of many forms of dementia. As the Baby Boomers age the number will increase astronomically. In 2011 the medical costs of American dementia patients will come to be $183 billion. The care provided for them by family and other unpaid care givers was valued at $202 billion for a total annual cost of $385 billion, according to the Alzehimer's Association. Unless effective treatment and prevention can be found, by 2050 the number of American's with dementia will triple to nearly 16 million while the medical cost of caring for them will balloon to $1.1 trillion per year.

- **Pay for Performance –** Records for some 470,00 patients with hypertension treated in Great Britain's National Health Service from 2001 to 2007 showed no change in patterns of treatment that could be attributed to a pay-for-performance program started in 2004, according to researchers at Harvard Pilgrim Health Care Institute in Boston and colleagues in Britain and Canada. This and other reports are beginning to look at whether pay-for-performance is actually a panacea for improvement within the healthcare arena.

- **Radiation Exposure in CT Scans** – The number of x-ray procedures conducted in the U.K. increased by 10% between 1997 and 2008, bringing the average Brit's annual exposure to radiation up from 0.33 mSV in 1997 to 0.4 mSv in 2008, a report published by the U.K. Health Protection Agency found. While the volume of x-rays rose by 10% between 1997 and 2008, the number of CT scans performed spiked 140% over the same period from 1.4 million to 3.4 million. In the U.S. a similar increase in imaging occurred. The fact remains that healthcare today is imaging dependent. The number of annual emergency room visits that included CT scans increased by 500% in the U.S. – from 2.7 million to 16.2 million – between 1995 and 2007, according to a study appearing in the November 29, 2010 issue of the journal *Radiology*. In addition to finding a substantial increase in the number of CT scans performed annually, the researchers also noted that imaging procedures necessitating higher doses of radiation exposure increased at a faster rate than those requiring less radiation. Imaging manufacturers as well as hospitals, health systems and medical providers using these technologies are looking at ways of reducing the amount of radiation that patients are exposed to.

- **Sex – It's Still All Good** – A study of men's attitudes towards sex in their golden years confirms what some have long suspected – it's not over till it's over. One in three men ages 75 to 95 remain sexually active, defined as having had sex at least once in the past year, according to a long running study of 2,783 Australian men in the *Annals of Internal Medicine*.

PERCENTAGE OF MEN HAVING SEX BY AGE GROUP



Source: Annals of Internal Medicine; USA Today, 12/7/10

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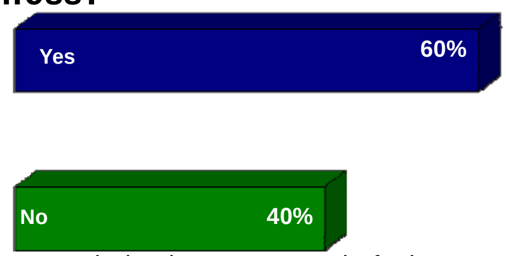
OUR QUICK POLL RESULTS

The following question was posted on the Riner Group Website for the months May – July 2011.

" Do you feel money can buy happiness?"



Perspective: The notion that money can't buy happiness is popular, especially among Europeans who believe that growth-oriented, free-market economies may have it all wrong. They drew comfort from a work of a Professor of Economics at the University of Southern California, by the name of Richard Easterlin, who reviewed data in the 1970s and observed only a loose correlation between money and happiness. Although income and well being were closely correlated within countries, there seemed to be little relationship between the two when measured over time and between countries. This was frequently, then referred to as the "Easterlin Paradox." He suggested that well being depended not on an absolute, but on relative income: people feel miserable not because they are poor but because they are poor among their own group.

However, more recent work, especially by Betsey Stevenson and Justin Wolfers of the University of Pennsylvania, suggest that while the evidence for a correlation between income and happiness over time remains weak, that for a correlation between countries is strong. According to Mr. Wolfers, the correlation was unclear in the past because of a paucity of data.

There are now data on the effective income and on well being almost everywhere in the world. In some countries (South Africa and Russia) the correlation is closer than in others (like Britain and Japan), but it is visible everywhere.

The variation in life satisfaction between countries is huge. (See chart) Countries at the top of the league (all of them developed) score up to 8 out of 10; countries at the bottom (mostly African, but with Haiti and Iraq putting in a sad, but not surprising appearance) score as low as 3.

All the richer countries are clearly happier; the correlation is not perfect, which suggests that other, presumably cultural factors, are at work. Western Europeans and North Americans bunch pretty close together; there are some anomalies such as the surprisingly gloomy Portuguese. Asians tend to be somewhat less happy than their income would suggest, and the Scandinavians a little bit more so. Hong Kong and Denmark, for instance have similar incomes at purchasing power parity; but Hong Kong's average life satisfaction is 5.5 on a 10 point scale and Denmark's is 8. Latin Americans are cheerful, the ex Soviet Union particular miserable, and the saddest place in the world relative to its income per person is Bulgaria.

Additionally, according to a new study from Princeton University, about $75,000 a year will buy you happiness. The further a person's household income falls below that level, the unhappier he or she is. But no matter how much more than $75,000 people make, it doesn't bring them any more joy. According to the Princeton study there are actually two types of happiness. There is your changeable, day-to-day mood; whether you're stressed or exuberant. Then there's the satisfaction you feel about the path your life is taking – ruminative road. Self evaluation is heavily influenced by income. The more money people earn above $75,000 the more they believe their life is working, but money doesn't make them any more jovial in the morning.

The Princeton study draws these data from more than 250,000 Americans polled by Gallup and Healthways in 2008 and 2009. Participants were asked how they felt the previous day and how they would rate their life from being the worse possible to the best. It would appear that it isn't low income that saddens people; it's that less money makes them feel more ground down by other issues like health and relationship troubles.

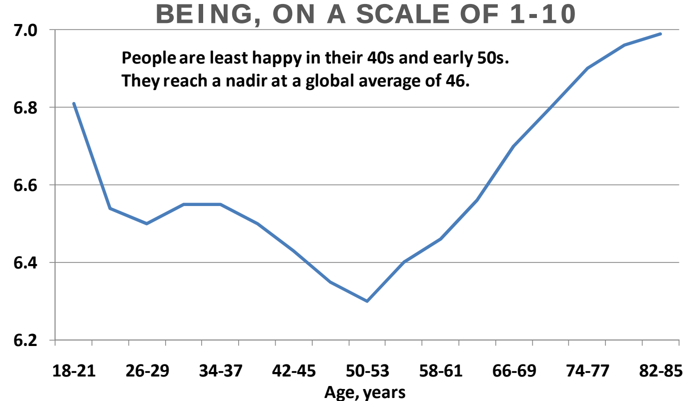
Among divorced people, about 51% who made less than a $1,000 a month reported feeling sad or stressed by the previous day, while only 20% of those earning more than $3,000 a month did. Among people with asthma, 41% of low earners reported feeling unhappy, compared with about 22% of the wealthier group.

At $75,000, however, that effect disappears. From there on up, individual temperament and life circumstances like age and education level have much more sway on how a person feels on any given day than money does.

We wish everyone happiness!

Sources: The Economist, 12/18/2010; Time Magazine, 9/27/2010

THE U-BEND - SELF REPORTING WELL BEING, ON A SCALE OF 1-10



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SPEAKING ENGAGEMENTS

Dr. Riner and his colleagues frequently speak at events across the U. S. The topics offer interesting perspectives on healthcare issues for you to share with your colleagues or to strategize for the future of your practice or healthcare organization. Some examples of recent presentations which coincide with our work include, but are not limited to:

- So You're Going to Start an Accountable Care Organization (ACO) – Really? Let's Talk
- A House is Not a Home – The Concept of Medical Home In Evolution
- Strategic Positioning of the Single Specialty Practice in Reference to Your Hospital and the Community
- The Infrastructure Needed for Shared Value Payment Mechanisms
- "Meaningful Use" Perspectives from an IT Vantage Point and from a Clinical Vantage Point
- The Persistent Necessity for Growth Strategies in Our Current Healthcare Environment
- Teamwork – Lessons from the Trenches. How to Form Effective Healthcare Teams
- Referral Science in 2011 – The Critical Role of Hospitalists
- A Board Approach to Growth and Alignment Strategies in Healthcare

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With over 30 years of business experience in healthcare, we have worked with physician practices, hospitals, health systems, academic medical centers and healthcare businesses throughout the United States with a focus on strategy, new business development and performance improvement. We specialize in integrating the business and clinical aspects of healthcare.

Our PRIORITY … excellence in the business and the science of medicine.
Our SPIRIT … superb patient care.