HealthLeaders Media

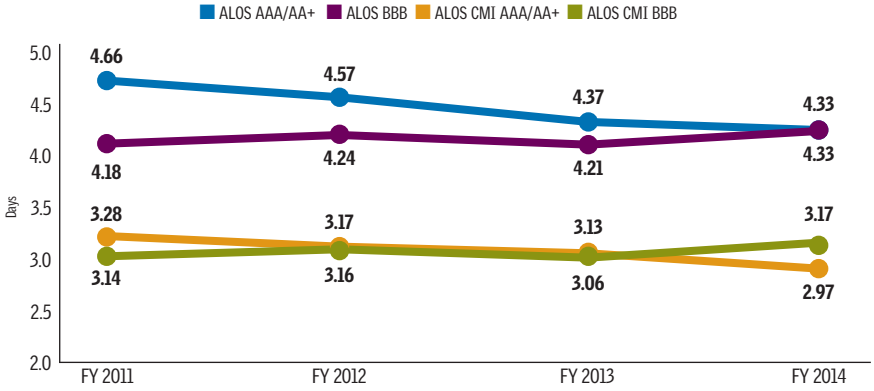
FACTFILE

High and Low Bond Ratings

Healthcare organizations with strong bond ratings are regarded favorably from a financial perspective, of course. In addition, research by the Truven Health Analytics™ ActionOI® program shows that such organizations tend to excel in other categories, such as average length of stay and results of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys.

AVERAGE LENGTH OF STAY

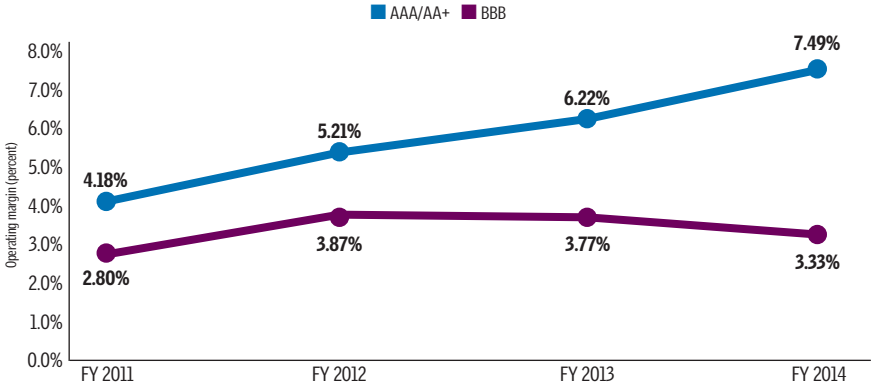
Higher-rated facilities have continued to reduce the average length of stay, both on a raw and on a case mix index–adjusted basis, improving by 7.1% and 9.5%, respectively, from 2011 to 2014. Lower-rated organizations have seen no significant changes in length of stay.



SOURCE: Truven Health Analytics ActionOI.

OPERATING MARGIN

Healthcare organizations with high bond ratings have improved operating margin by 3.31 percentage points between 2011 and 2014. Lower-rated organizations had some modest ups and downs, ending up just 0.53 percentage points over that period.



SOURCE: Truven Health Analytics ActionOI.

ABOUT THE DATA: Among the survey responses from hospitals participating in the Truven Health Analytics ActionOI® program is self-reported information categorizing their most recent bond agency rating. Those results were initially aggregated into four comparative groups (high, mid-high, mid-low, and low ratings). Outliers were trimmed* and medians for two groups** (high and low) are displayed in this report. Average sample sizes were 95 hospitals for the highest rated and 50 hospitals for the lowest rated. The data reflect bond ratings of U.S. hospitals for calendar years 2011–2014. Data are from the Truven Health ActionOI database. With operational and financial data from more than 750 healthcare organizations across the country, ActionOI has the largest comparative database in the industry. For more information email *info@truvenhealth.com*, call 1-800-525-9083, option 4, or visit *www.truvenhealth.com*

* Outliers for operating margin were trimmed at 1.5 interquartile ranges and outliers for other statistics at 2.58 standard deviations on a lognormal scale.

** High-rating group: Moody's, Aaa through Aa3; S&P, AAA through AA+; Fitch, AAA through AA+; low-rating group: Moody's, Baa1 through Baa3; S&P, BBB+ through BBB; Fitch, BBB+ through BBB-.

SPONSORED SUPPLEMENT

JUNE 2015

Healthcare Utilization and Expenditures

National health expenditures were $2,793.4 billion in 2012, comprising 17.2% of the gross domestic product. Comparably, NHE amounted to $724.3 billion, or 12.1% of the GDP in 1990. NHE per person were $147 in 1960 and grew steadily to reach $8,915 by 2012. Here are some additional statistics from the Centers for Medicare & Medicaid Services.

- **In 2013**, total net federal outlays for CMS programs were $747.7 billion, 21.6% of the federal budget.
- **Medicare Part A** benefit payments are projected to increase to $264.4 billion for fiscal year 2014, up from $261.8 billion for fiscal year 2013, and Medicare Part B benefit payments are projected to increase to $256.2 billion for fiscal year 2014, up from $243.1 billion for fiscal year 2013.
- **Medicare hospice** benefit payments are projected to increase to $16.8 billion for fiscal year 2014, up from $15.6 billion in 2013.
- Between 1985 and 2012, the number of **short-stay hospital discharges increased** from 10.5 million to 11.2 million, an increase of 6.7%.
- **The Prospective Payment System** short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.0 days in 2012, a decrease of 44%.
- **About 33.3 million** people received a reimbursed service under Medicare fee-for-service during 2012. Comparably, almost 64.2 million people used Medicaid services or had a premium paid on their behalf in 2011.
- The ratio of **Medicare aged users** of any type of covered service has grown from 528 per 1,000 enrolled in 1975 to 892 per 1,000 enrolled in 2012.
- **6.7 million people** received reimbursable fee-for-service **inpatient hospital services** under Medicare in 2012.
- **32.3 million people** received reimbursable fee-for-service **physician services** under Medicare during 2012, and 22.3 million people received reimbursable physician services under Medicaid during 2011.
- **24.7 million people** received reimbursable fee-for-service **outpatient hospital services** under Medicare during 2012, and during 2011, 15.2 million people received Medicaid reimbursable outpatient hospital services.
- More than **28 million people received prescribed drugs** under Medicaid during 2011.

SOURCE: *2014 CMS Statistics*, U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services; *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf#table1*.

Upcoming Topic:
> Health System Performance

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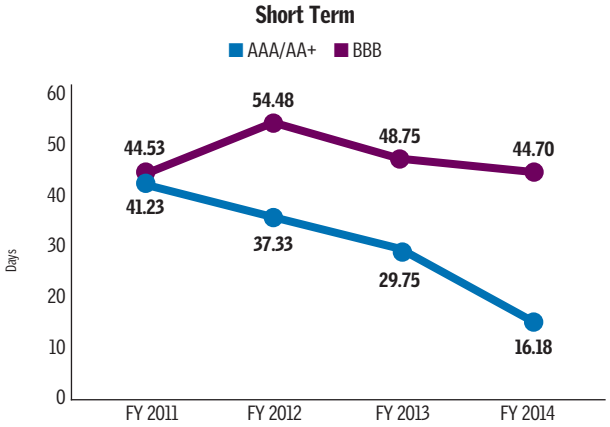
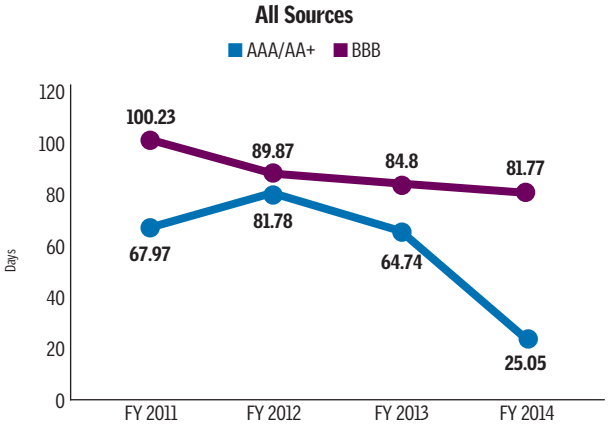
DAYS CASH ON HAND

Financially stronger hospitals have reduced their holdings of cash and liquid investments over the past few years, for both short-term cash and all sources. Weaker hospitals have maintained a stronger cash position. While liquidity is viewed favorably by creditors, excess amounts of cash or short-term investments generally provide a lower return than long-term investments.



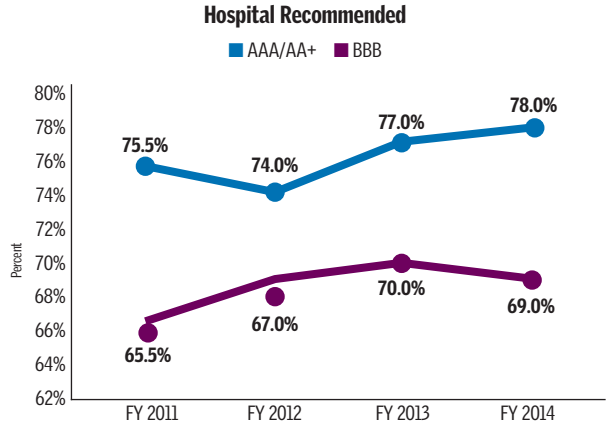
SOURCE: Truven Health Analytics ActionOI.



SOURCE: Truven Health Analytics ActionOI.

HCAHPS RATINGS

Organizations that are rated higher financially also are rated higher by patients. In FY 2014, hospitals with better bond ratings outperform those with lower ratings by 9 percentage points on whether patients would recommend the hospital to others, and by 6 percentage points on the overall HCAHPS rating.



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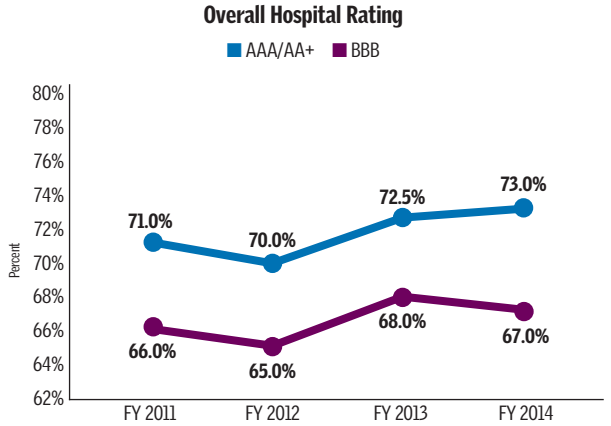
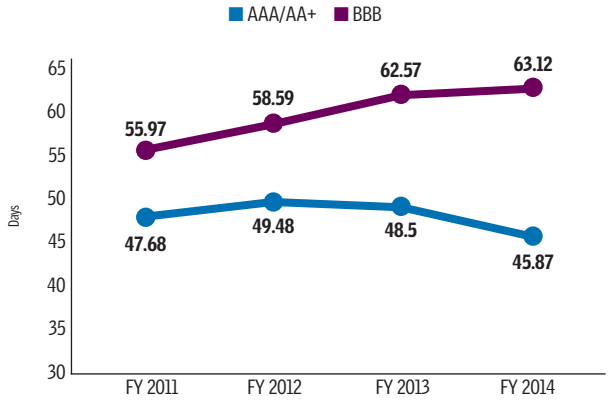


SOURCE: Truven Health Analytics ActionOI.

AVERAGE PAYMENT PERIOD

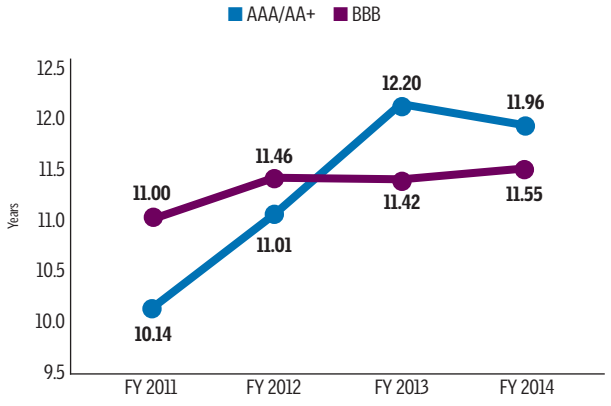
The primary purpose of ratings is to provide an objective assessment of creditworthiness. The average payment period formula documents how quickly an organization meets current obligations. Higher-rated facilities pay bills more than two weeks sooner than weaker organizations.



SOURCE: Truven Health Analytics ActionOI.

AVERAGE AGE OF FACILITIES

In FY 2011, stronger organizations had newer facilities but have not been reinvesting in buildings and equipment. Indeed, in FY 2014 the age of higher-rated facilities exceeded that of lower-rated facilities by 0.41 years.



SOURCE: Truven Health Analytics ActionOI.