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SPECIAL COMMENT

Risk of Payment Cuts Looms for U.S. Healthcare Providers

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Analyst Contacts:

NEW YORK 1.212.553.1653

Jessica Gladstone 1.212.553.2988
Vice President- Senior Analyst
Jessica.Gladstone@moodys.com

Dean Diaz 1.212.553.4332
Vice President-Senior Credit Officer
Dean.Diaz@moodys.com

Tiina Siilaberg 1.212.553.4068
Analyst
Tiina.Siilaberg@moodys.com

Karim Rahimtoola 1.212.553.0196
Associate Analyst
Karim.Rahimtoot@moodys.com

John Diaz 1.212.553.1977
Managing Director-Corporate Finance
John.Diaz@moodys.com

» The potential for reduced payments from government-sponsored insurance programs, namely Medicare and Medicaid, is one of the biggest credit risks facing many healthcare companies today.

» Medicare pays more than $300 billion to U.S. healthcare providers each year. While healthcare reform legislation mandated numerous payments cuts to providers, we believe additional reimbursement reductions are likely as regulators try to stem escalating healthcare costs.

» Not all sectors will be targeted equally for payment reductions. Sectors with low barriers to entry, high Medicare margins and high growth rates will likely come under the most scrutiny.

» Home health and oxygen/durable medical equipment companies are slated for some of the largest reimbursement cuts – nearly $70 billion over the next decade. We believe hospice, nursing homes and specialty hospitals, which together receive more than $40 billion in annual Medicare payments, could also face longer-term reimbursement reductions.

» About 70% of rated U.S corporate healthcare providers rely on Medicare and Medicaid for more than one-third of their total revenues.

» The healthcare industry's increased focus on efficiency, accountability and cost management will likely spur consolidation among providers. Medicare and Medicaid pressures may also drive companies to make acquisitions in order to diversify their revenue sources.

» Healthcare companies, particularly those in the highest risk sectors, must maintain financial policies and capital structures that will allow them to withstand the revenue declines that would accompany payment cuts, and avoid financial distress.

Overview

Eight months after the enactment of the Patient Protection and Affordable Care Act of 2010 (PPACA), controversy continues to swirl around the sweeping healthcare legislation. State attorneys general have brought legal challenges. And with midterm elections giving Republicans control of the House of Representatives, uncertainty around the implementation of certain aspects of the law has increased.

Regardless of the outcome, we believe that, amid steadily rising healthcare costs, state and federal agencies will look more closely at providers and reduce payments to those that appear to be earning excessive profits or failing to deliver the most cost-efficient care. Medicare pays more than $300 billion to U.S. healthcare providers each year, including those with rated debt. About 70% of rated U.S corporate healthcare providers rely on Medicare and Medicaid for more than one-third of their total revenues, so payment reductions could severely impair their financial performance and credit ratings.

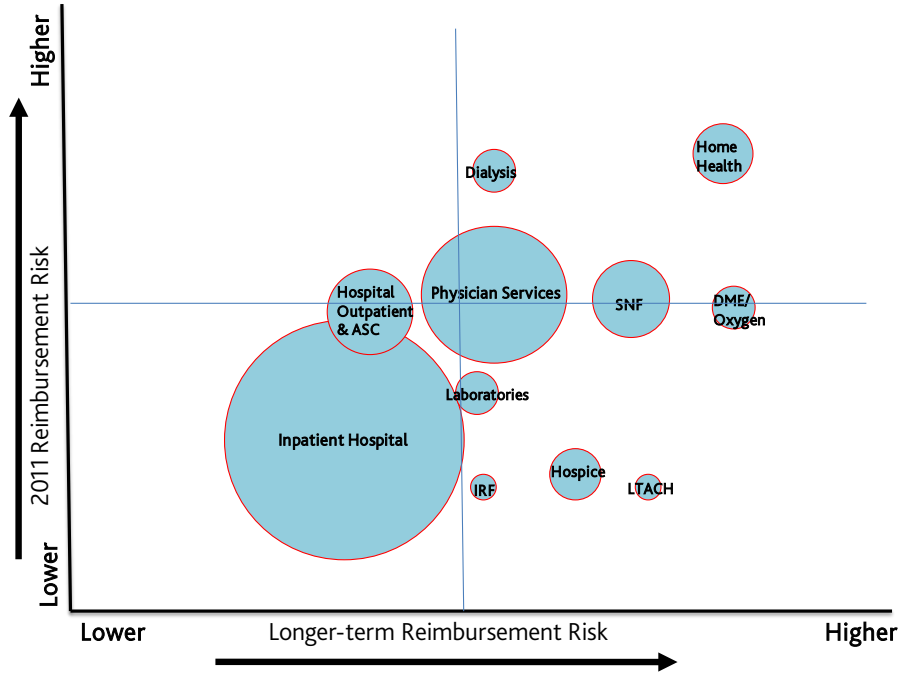
We believe, however, that not all industries will be targeted equally for reimbursement cuts and that certain characteristics put some sectors more at risk. Industries with historically low barriers to entry, which are therefore more vulnerable to fraud and abuse, will likely face some of the biggest payment cuts over the next several years. Sectors that experience rapid growth in aggregate Medicare payments, earn relatively large profit margins from Medicare patients, or receive larger payments than other provider types for similar services could also face increased scrutiny. Healthcare sectors that we view as possessing one or more of these attributes include hospice, home health, nursing homes, long-term acute-care hospitals and home oxygen/durable medical equipment providers.

Changes stemming from healthcare legislation and general reimbursement pressures could also spur industry consolidation as providers seek scale, efficiency and negotiating power with insurance companies. Additionally, providers may pursue acquisitions to diversify away from a single Medicare payment fee schedule or concentration in a single state Medicaid program. Still, despite the temptation to make acquisitions, companies - particularly those in the highest risk sectors - must maintain financial policies and capital structures that will allow them to withstand the revenue declines that would accompany reimbursement reductions. Otherwise, they could face financial distress.

This Special Comment analyzes the trends and attributes of healthcare subsectors with the largest direct exposure to Medicare and Medicaid and attempts to identify the providers most at risk for reimbursement cuts, and subsequent financial pressure.

FIGURE 1

Relative Risk of Reimbursement Reductions By Sector



Source: Moody's

Note: The size of each circle reflects the relative amount of Medicare payments each sector receives.

Medicare & Medicaid – A Primer

Medicare is a program administered by the federal government, which provides health insurance to people who are at least 65 years old, and others who meet certain criteria. Medicare is partially financed by payroll taxes.

In 2008, Medicare provided healthcare coverage for more than 40 million Americans, making it the largest single healthcare payor in the nation. Enrollment is expected to nearly double by 2030, when the baby boomer generation is fully eligible. Total Medicare spending was just under $500 billion in 2009, including about $300 billion paid directly to healthcare providers.

Medicaid provides healthcare coverage and other services for low-income individuals and families. It's jointly funded by the state and federal governments. Each state administers its own Medicaid program. Medicaid expenditures were about $350 billion in 2009.

The Centers for Medicare & Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS), administers these two programs. It also monitors the state-run Medicaid programs and establishes the standards, such as quality and eligibility, that states must meet.

Congressional committees oversee Medicare and Medicaid. Together, the programs provide healthcare insurance for one in four Americans.

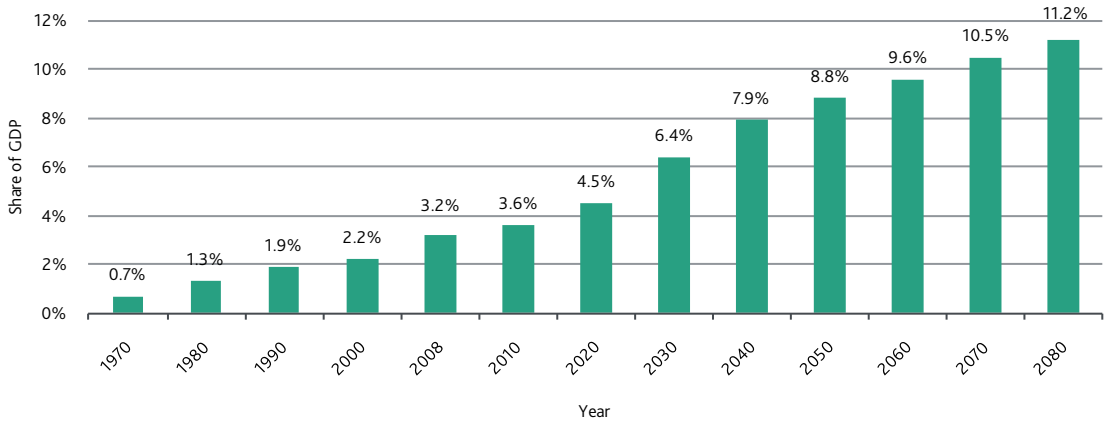
Cost Concerns to Trigger Increased Scrutiny

The PPACA mandated dramatic change in the long-term delivery and oversight of healthcare. One of the law's primary goals is to increase the quality and efficiency of the U.S. healthcare system, while reducing the costs of medical care. The legislation doesn't specify how to implement many aspects of change, however, leaving lawmakers and regulators to determine those details in coming years.

In the meantime, steadily rising healthcare costs are threatening the solvency of government insurance programs. The Social Security Administration, in its August 2010 report, estimated that the Medicare Trust Fund will be exhausted in 2029. Yet, many industry participants, including the Office of the Actuary for the Centers for Medicare & Medicaid Services (CMS)[1], view this as an overly optimistic projection due to the underlying assumptions used in the calculations. Aging baby boomers, increased life expectancy and technological innovation are all expected to contribute to an acceleration of Medicare spending.

[1] Memo, dated August 5, 2010, from the Office of the Actuary entitled: "Projected Medicare Expenditures Under an Illustrative Scenario With Alternative Payment Updates to Medicare Providers."

FIGURE 2
Medicare Spending as a % of GDP



Source: 2009 Medicare Payment Advisory Commission (MedPAC) website: "A Data Book: Healthcare Spending and the Medicare Program (June 2010)"

Note: These figures do not include the estimated impact of the PPACA.

Medicaid also faces funding challenges. The financial burden on states, many of which are experiencing unprecedented budget deficits, will only increase with the implementation of PPACA provisions extending coverage to uninsured individuals. This pressure will be particularly acute in 2014, when Medicaid enrollment expands significantly.[2] The 2009 economic stimulus package increased federal Medicaid matching rates (FMAP) to help under-funded states, and a separate act President Obama signed in August 2010 extended those increases through June 30, 2011. It's unclear whether cash-strapped states will be able to continue adequately funding Medicaid, particularly if and when the elevated federal matching funds expire.

Amid these budgetary concerns, CMS will likely reduce payments to healthcare providers, particularly in certain sectors. Such reductions could dramatically weaken a company's financial profile and lead to credit rating downgrades since many healthcare providers rely on government funding for a significant portion of revenue and cash flow.

Government Reimbursement Cuts Can Stun a Sector

Government reimbursement risk can come in many forms, and our universe of rated issuers has exposure to it all. That makes analysis of regulatory and reimbursement risk particularly complex and essential for understanding a company's longer-term credit quality. Certain healthcare providers, including hospitals and nursing homes, are paid directly by Medicare and Medicaid (direct reimbursement risk). For medical device manufacturers or distributors, government programs reimburse their customers for use of the product or device (indirect reimbursement risk). In addition to government reimbursement risk, private insurance companies, facing higher costs and government restrictions of their own, could also reduce payments to medical providers.

Because the government is the country's largest payor and can cut payments unilaterally (private insurance payments, by contrast, are typically negotiated with providers), this report focuses solely on issuers with direct reimbursement risk from Medicare and Medicaid.

Sudden changes to government reimbursement systems have triggered bankruptcies in the past, including nursing homes and home health companies in the late 1990s and early 2000s, and diagnostic imaging providers following the Balanced Budget Act of 2005. While many other healthcare sectors and companies have weathered government reimbursement reductions with little

[2] Medicaid eligibility in 2014 will be expanded to 133% of the poverty level.

impact on credit quality, historical examples can illustrate the potentially disruptive nature of reimbursement cuts.

Case Study: Nursing homes in the late 1990s

Through the late 1980s and early 1990s, nursing homes were reimbursed by Medicare under a cost-based system. While there were limits for payments on routine services (room and board), there were no limits for payments on ancillary services, such as physical therapy. Medicare expenditures were increasing 20% to 30% a year, with most of the growth coming from ancillary services. The U.S. Government Accountability Office (GAO) reported fraud and abuse in the industry, including unnecessary or excessive services to nursing home residents, as well as sub-par care. In addition to nursing home quality initiatives implemented by the Clinton Administration, the Balanced Budget Act of 1997 addressed the unsustainable growth in nursing homes.

Beginning in 1998, nursing homes were paid a fixed amount based on the patient's condition, or acuity. This is known as a prospective payment system (PPS). All rehabilitation therapy, medical supplies and other ancillary services were paid through separate, set-fee schedules, with an annual per-beneficiary cap of $1,500 for certain therapy services. Before implementation of the PPS, industry estimates projected the Balanced Budget Act of 1997 would reduce Medicare payments to nursing homes by $13 billion from 1998 through 2002. This savings estimate was later revised to over $22 billion - a significant figure considering annual Medicare payments to nursing homes were about $10 billion at the time. According to public filings by nursing home company Sun Healthcare, its average Medicare Part A revenue per patient day dropped more than 30% from 1998 to 1999.

The payment cuts sent shock waves through the industry, particularly the large companies that had increased their debt levels in prior years. By mid-2000, five of the seven biggest publicly traded nursing home companies (Sun Healthcare, Vencor (now Kindred), Mariner, HIS and Genesis) had filed for Chapter 11 bankruptcy protection. Skilled Healthcare filed in 2001. While there were a number of reasons for the wave of bankruptcies, including higher insurance and professional liability costs, and a significant debt-funded acquisition spree by many companies, the reimbursement cuts pushed many companies into insolvency.

The Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 were meant to mitigate some of the negative effects of the Balanced Budget Act of 1997. They implemented temporary payment increases, in particular for the patients who were most ill, and placed a moratorium (which continues today) on the $1,500 therapy cap.

Payor Concentration Is a Key Rating Driver

Payor concentration is one the most important factors in our credit risk analysis. We consider diversification by private payor and Medicare fee schedule and, for those companies with heavy reliance on Medicaid, diversity by state. Lastly, we look at the relative risk of reimbursement cuts in the company's sectors based on the factors discussed below. As illustrated in the following table, many rated issuers have direct government exposure and many providers receive payment from both Medicare and Medicaid. While we view Medicare and Medicaid as separate reimbursement systems and therefore somewhat diversified from each other, they both face similar budgetary constraints.

FIGURE 3

Rated Issuers with Direct Medicare and Medicaid Exposure, and Revenue Composition by Payor

IPPS = Inpatient Prospective Payment System
HOPPS = Hospital Outpatient Prospective Payment System
SNF PPS = Skilled Nursing Facility Prospective Payment System
MPFS = Medicare Physician Fee Schedule
ESRD = End-Stage Renal Disease
DMEPOS = Durable Medical Equipment Prosthetics Orthotics and Supplies

				FY 2009 Reimbursement Exposure (% of total revenue)[9]		
Company	Rating	Outlook	Primary Medicare Fee Schedule	Medicare	Medicaid[5]	Other[6]
Inpatient (general) hospitals						
Universal Health Services, Inc. [1]	Ba2	Stable	IPPS/Inpatient Psychiatric Facility PPS	24%	14%	62%
LifePoint Hospitals, Inc.	Ba3	Stable	IPPS/HOPPS	30%	10%	60%
CHS/Community Health Systems, Inc.	B1	Stable	IPPS/HOPPS	27%	10%	63%
Health Management Associates, Inc.	B1	Stable	IPPS/HOPPS	32%	9%	59%
Psychiatric Solutions, Inc.[1]	B1	Stable	Inpatient Psychiatric Facility PPS	14%	44%	42%
HCA, Inc.	B2	Positive	IPPS/HOPPS	23%	6%	71%
Tenet Healthcare Corporation	B2	Stable	IPPS/HOPPS	25%	8%	67%
Vanguard Health Holding Company II, LLC	B2	Stable	IPPS/HOPPS	26%	7%	67%
IASIS Healthcare Corporation	B2	Stable	IPPS/HOPPS	23%	7%	71%
Ardent Medical Services, Inc.	B2	Stable	Inpatient PPS/Hospital Outpatient PPS	NA	NA	NA
Prime Healthcare Services, Inc.	B2	Stable	Inpatient PPS/Hospital Outpatient PPS	>60%*		<40%
Capella Healthcare, Inc.	B2	Stable	IPPS/HOPPS	39%	10%	51%
Skilled nursing facilities						
Sun Healthcare Services	B1	Stable	SNF PPS/MPFS	30%	40%	31%
HCR Healthcare LLC[2]	B2	Stable	SNF PPS/MPFS	44%	24%	32%
GGNSC Holdings, LLC	B2	Stable	SNF PPS/MPFS	NA	NA	NA
Genoa Healthcare Group, LLC	B2	Stable	SNF PPS/MPFS	35%	48%	17%
Skilled Healthcare Group, Inc.	B2	RUR-Down	SNF PPS/MPFS	35%	32%	33%
Home health						
Gentiva Health Services, Inc.[3]	Ba3	Stable	Home Health PPS/ Hospice PPS	82%	5%	13%
Advanced HomeCare	B2	Stable	Home Health PPS	~90%	<10%	<10%
Long-term acute care/specialty hospitals						
RehabCare Group	Ba3	Stable	LTCH PPS/MPFS	34%	1%	65%
HealthSouth	B1	Stable	Inpatient Rehabilitation Facility PPS	68%	2%	30%
Select Medical Holdings Corporation	B2	Stable	LTCH PPS/Inpatient Rehabilitation Facility PPS	47%	2%	51%
LifeCare Holdings, Inc.	Caa1	Negative	LTCH PPS	57%	0%	43%
Ambulatory surgical centers (ASCs)						
Surgical Care Affiliates[4]	B2	Stable	HOPPS/MPFS	22%*		78%
United Surgical Partners International	B2	Stable	HOPPS/MPFS	9%*		91%
Symbion, Inc.	B3	Negative	HOPPS/MPFS	24%*		76%
Dialysis						
DaVita, Inc.	Ba3	Stable	Medicare ESRD Program	57%	8%	35%
Renal Advantage	B3	Stable	Medicare ESRD Program	N/A	N/A	N/A
American Renal Holdings, Inc.	B2	Stable	Medicare ESRD Program	57%*		43%
U.S. Renal Care, Inc.	B2	Stable	Medicare ESRD Program	56%*		44%
Oxygen						

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Rated Issuers with Direct Medicare and Medicaid Exposure, and Revenue Composition by Payor

IPPS = Inpatient Prospective Payment System
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				FY 2009 Reimbursement Exposure (% of total revenue)[9]		
Company	Rating	Outlook	Primary Medicare Fee Schedule	Medicare	Medicaid[5]	Other[6]
Apria Healthcare Group Inc.	Ba3	Negative	DMEPOS Fee Schedules & Competitive Bidding	22%	6%	72%
Rotech Healthcare, Inc.	Caa1	Stable	DMEPOS Fee Schedules & Competitive Bidding	42%	7%	51%
Specialty medical supply distributors						
Hanger Orthopedic Group	B1	Stable	DMEPOS Fee Schedules[7]	30%	10%	60%
Harrington Holdings[8]	B2	Stable	DMEPOS Fee Schedules & Competitive Bidding	<10%	NA	NA
CCS Medical	B3	Stable	DMEPOS Fee Schedules & Competitive Bidding	47%	NA	NA
Diagnostic imaging						
Alliance Healthcare Services, Inc.	B1	Stable	HOPPS/MPFS	4%	<5%	>90%
RadNet Management, Inc.	B2	Stable	HOPPS/MPFS	20%	3%	77%
Diagnostic Imaging Group, LLC	B3	Stable	HOPPS/MPFS	10%	NA	NA
Radiation therapy						
Radiation Therapy Services, Inc.	B2	Stable	MPFS	42%	NA	NA
OnCure Holdings, Inc.	B2	Stable	MPFS	39%	5%	56%
US Oncology Holdings, Inc.[10]	B2	RUR-Up	HOPPS/MPFS	32%	4%	64%
Clinical laboratories						
Quest Diagnostics	Baa2	Stable	Clinical Laboratory Fee Schedule/MPFS	15%	3%	82%
Laboratory Corporation of America	Baa2	Stable	Clinical Laboratory Fee Schedule/MPFS	17%	2%	81%
Aurora Diagnostics	B1	Stable	Clinical Laboratory Fee Schedule/MPFS	25%*		75%
Caris Diagnostics	B2	Stable	Clinical Laboratory Fee Schedule/MPFS	NA	NA	NA
Ambulance/emergency						
AMR Holdco, Inc. & EmCare Holdco, Inc.	Ba1	Stable	Ambulance Fee Schedule/MPFS	23%	5%	72%
Team Health	B1	Positive	MPFS	26%*		74%
Rural/Metro Corporation	B1	Stable	Ambulance Fee Schedule	43%	16%	42%
Sheridan	B2	Stable	Ambulance Fee Schedule/MPFS	N/A	N/A	N/A
Air Medical	B2	Stable	Ambulance Fee Schedule	~40%*		60%
Behavioral health						
ResCare, Inc.	Ba3	RUR-Down	Medicaid	0%	64%	36%
Providence Service Corporation	B2	Positive	Medicaid	0%	100%	0%
Youth & Family Centered Services	B2	Negative	Medicaid	NA	NA	NA
NMH Holdings, Inc.	B3	Stable	Medicaid	0%	90%	10%
CRC Health Corporation	B3	Stable	Medicaid	0%	20%	80%

1 Universal Hospitals Services has signed a definitive agreement to acquire Psychiatric Solutions.
2 Data is for 2008, as cited in Moody's August 2009 Credit Opinion.
3 Gentiva acquired Odyssey Healthcare on August 17, 2010. These figures represent a pro forma estimate, based on the first half of 2010 results.
4 Reimbursement data is for 2008, as cited in Moody's December 2009 Credit Opinion.
5 Includes other local government sources as well as Medicaid.
6 Includes Managed Medicare and Managed Medicaid programs.
7 Prosthetics & orthotics have been excluded from competitive bidding.
8 Data is for 2008, as cited in Moody's May 2009 Credit Opinion.
9 Fiscal 2009, or most recently reported fiscal year.
10 On November 1, 2010 McKesson Corporation announced its intention to acquire US Oncology.
* Represents a combined Medicare and Medicaid figure.

Source: Company reports and public filings; Moody's credit opinions; Moody's estimates. Figures for private companies have been previously published in Moody's credit opinions.

Certain Attributes Put Sectors Most at Risk

In analyzing historical healthcare trends, as well as the recommendations of the Medicare Payment Advisory Commission (MedPAC)[3], we believe certain attributes make healthcare providers vulnerable to government scrutiny and reimbursement cuts.

FIGURE 4

Risk And Mitigating Factors For Reimbursement Cuts By Sector

	Risk Factors				Mitigating Factors	
	Low barriers to entry	High relative payment rates	High relative Medicare margins	Rapid growth in expenditures	High % of not-for profits	High % of Medicaid/indigent
Ambulatory surgical centers			NA			
Clinical laboratories	X		NA			
Dialysis				X		
Durable medical equipment [1]	X		X	X		
Home health	X		X	X		
Hospice	X		X	X	X	
Inpatient (general) hospitals		X			X	X
Inpatient rehabilitation facilities		X	X			
Long-term acute-care hospitals		X		X		
Hospital outpatient					X	X
Skilled nursing facilities			X	X		X

NA = Not available. Ambulatory surgical centers and clinical labs have not been required to submit cost data to CMS, so Medicare margins are unknown.
1 Includes home oxygen equipment and supplies.
Source: Moody's; MedPAC; CMS

Low barriers to entry

We believe that healthcare services with low capital costs and other low barriers to entry have a higher long-term reimbursement risk. These industries can have a rapid influx of new entrants, heightening the potential for fraud and abuse, and spurring government regulators and watchdogs to recommend payment cuts.

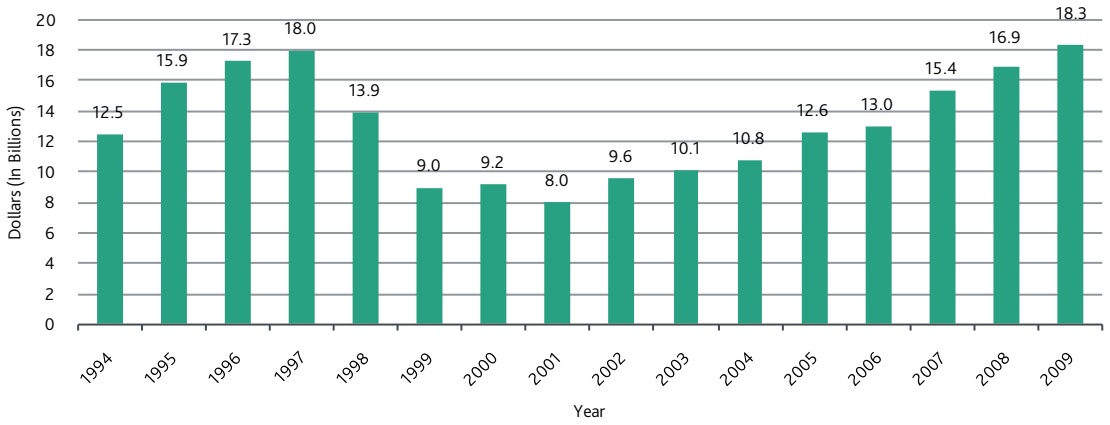
Home healthcare, through which nurses and aides care for patients at home, is an example. Home health providers are governed by Certificate of Need (CON)[4] requirements in some, but not all, states. The relatively easy access has contributed to a rapidly growing and highly fragmented industry, in which the revenues of the top four providers account for less than 6% of the total $70 billion home health industry (this total includes Medicaid, private insurance and other payment sources). There have been widespread reports of Medicare fraud in certain parts of the country, namely Florida, where there are no CON requirements and few barriers to entry. Even small pockets of abuse can trigger investigations and the potential for across-the-board payment cuts. The home health industry, which experienced a dramatic reimbursement system change in the late 1990s (which led to a significant decrease in the number of providers), faces another round of payment cuts over the next several years. While some of these cuts are being phased in over time, we believe they will put meaningful downward revenue and margin pressure on the sector.

[3] MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. Their recommendations are often, but not always, implemented by Congress and/or CMS.
[4] A CON is a legal permit granted by state agencies that allows new healthcare providers to operate.

The PPACA mandated home health industry reductions totaling $40 billion over the next 10 years. The reductions will be phased in over four years, beginning in 2014. With total Medicare payments to home health agencies of about $18 billion per year, that equates to more than a 20% haircut to the industry over the next decade. On top of that, CMS announced in November 2010 the final payment rates for the home health industry in 2011, which were meaningfully lower than the industry expected earlier in the year. There will be a nearly 5% cut, or $960 million reduction, in Medicare payments to home health agencies beginning in January 2011.

Home Health Payments

FIGURE 5
Spending For Home Healthcare, 1994 - 2009



Source: MedPAC website: "A Data Book: Healthcare Spending and the Medicare Program (June 2010)"

High payment rates relative to other sectors

Also subject to heightened regulatory scrutiny are sectors that receive high payments relative to other types of providers, particularly when similar patients can be treated by multiple provider types. High payments made to certain specialty hospitals, including long-term acute-care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), have led regulators to investigate potential abuse.

In fiscal year 2010, the base LTCH payment rate approached $40,000 per patient, compared with the standard rate of roughly $5,000 per patient for a general hospital. Patients in LTCHs are supposed to be much sicker than other patients and require extended periods of intensive care, often on ventilators. There are no clear guidelines for which patients should be in an LTCH and which should be in the intensive care unit (ICU) of a general hospital, except that LTCH patients generally need to be admitted for a minimum of 25 days.

CMS believed it was overpaying for certain patients to be in LTCHs when those patients could have received treatments from a less expensive general hospital. This was particularly true when the LTCH was located in a wing of a general hospital (an arrangement known as a "hospital within a hospital," or HIH).

CMS, as a result, passed rules meant to ensure legitimate LTCH use that significantly reduced Medicare reimbursement to those hospitals. One of the main provisions is known as a 25% rule: no HIH can have more than 25% of patients admitted from its host hospital. The rule was later expanded to nearly all LTCHs, even freestanding ones. It limited to 25% the patients admitted from a single feeder hospital, otherwise payments would be reduced to the lower general hospital rates. Other laws

would significantly reduce extra payments for patients that have unusually high costs and would also impose a one-time, across-the-board reduction of payment rates. Many of these negative provisions have been delayed in exchange for a moratorium on new LTCH beds, leaving the industry in a state of limbo.

Inpatient rehabilitation facilities (IRF) have had a similar history. Rehabilitation for a patient in an IRF costs significantly more than in a skilled nursing facility (SNF). In 2004, CMS required 75% of patients in an IRF to have one of 13 specific and serious diagnoses, including stroke or spinal cord injury. IRFs, as a result, were forced to redirect many patients to nursing homes.

High profit margins relative to other sectors

One of the key factors MedPAC analyzes in its annual reports to Congress is a sector's margins and how much payments from Medicare exceed the providers' costs for delivering patient care. Very high patient access to a healthcare service, a large influx of new providers and high profit margins are often viewed by MedPAC as signs that a payment system may be poorly designed and provides the wrong incentives for providers. We don't believe CMS wants to slash reimbursements to such low levels that providers no longer want to provide services, but we don't thinks CMS wants providers earning excess returns on the back of the Medicare Trust Fund either.

These concerns may have led to a series of Medicare cuts for home medical equipment providers, particularly home oxygen providers, over the past five years. Based on public information from the four largest U.S. home oxygen companies, we estimate the median adjusted EBITDAR[5] margin in 2003 and 2004 (prior to the effect of the reimbursement reductions) to be 32%. The mean margins for LTCHs, home health agencies, general hospitals and skilled nursing facilities were closer to 15% at the time.

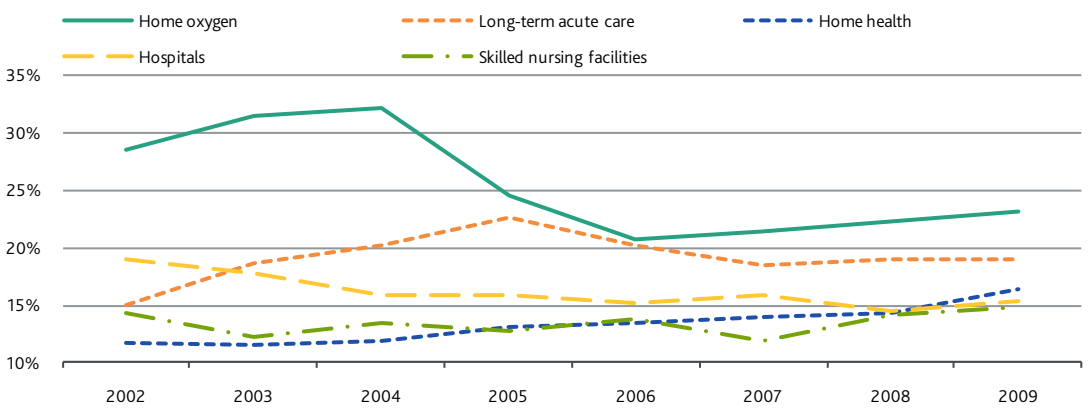
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Deficit Reduction Act of 2005 (DRA), the State Children's Health Insurance Program (SCHIP) Extension Act of 2007 and the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) all included measures that have significantly eroded home oxygen providers' revenues and margins over the past several years. Profits for inhalation medication (nebulizer) providers have also declined significantly due to generic entrants and new regulations. While home oxygen industry margins have declined meaningfully, they remain significantly higher than the margins of other providers.

Still to come, however, is the implementation of competitive bidding for home oxygen and medical equipment. Based on bids received for the first round (which takes effect January 1, 2011), average payments for equipment included in the program will be reduced by 32%. While the bidding program will be phased in relatively slowly over the next six years, we expect meaningful margin erosion in the industry over time.

CMS estimates the competitive bidding program will reduce payments to durable medical equipment and oxygen providers by about $28 billion over the next 10 years. That will yield $17 billion of savings to Medicare and $11 billion to Medicare beneficiaries in the form of lower co-payments. This is a significant amount, considering Medicare spends about $8 billion per year on these items. The reductions represent a 35% haircut to the industry over the next decade.

[5] Earnings before interest, taxes, depreciation, amortization and rent expense.

FIGURE 6
Adjusted EBITDAR Margins of Selected Sectors[6]



Source: Moody's MFM; company reports and filings; Moody's estimates
Note: Data is for rated issuers and major unrated, public companies.

In the chart above, we analyze some of the largest companies in these healthcare sectors, which enjoy significant scale and operating efficiencies. It is important to note that, in many cases, the overall sector margins, including the not-for-profits and mom-and-pop operators, are likely significantly lower than those depicted in the chart. For example, the Medicare margin for all IRFs in 2008 was 9.5%, according to MedPAC, but 16.8% for the for-profit IRF companies.

Further, private insurance companies typically pay more than Medicare and help boost providers' profit margins. Because our EBITDAR margin calculations don't correspond with CMS calculations, we have included, for illustrative purposes, the Medicare-only margins for selected sectors as reported by MedPAC. For sectors paid almost entirely by Medicare, such as home health, the margins are very similar between the Figures 6 and 7. For sectors, such as general hospitals, that receive a high percentage of revenue from non-Medicare sources, the margins diverge significantly.

FIGURE 7
Medicare-Only Margins of Selected Sectors

Medicare Margin	2008
Home health	17.4%
Skilled nursing facilities	16.5%
Inpatient rehabilitation	9.5%
Hospice[1]	5.9%
Long-term acute-care hospitals	3.4%
Dialysis	3.2%
Inpatient (general) hospitals	-4.7%
Hospital outpatient	-13.0%
Average	**4.8%**

1 Hospice data is for 2007.

Source: MedPAC website: "A Data Book: Healthcare Spending and the Medicare Program (June 2010)"

[6] The margins in Figure 5 are calculated before depreciation, amortization, interest expense and rent costs. The margins in Figure 6, calculated by MedPAC, are after these expense items.

Rapid growth in Medicare expenditures

Even if a sector's expenditures are a small piece of the overall Medicare pie, we believe any segment that grows rapidly over a number of years may attract increased scrutiny. We have rarely seen drastic cuts to sectors with flat expenditures.

Hospice, home health, nursing homes and LTCHs have experienced the fastest growth rates in Medicare expenditures over the past six to eight years. It is worth noting, however, that the rates have not necessarily been equal over that time frame. For example, the compound annual growth rate in Medicare expenditures on LTCHs was 22% from 2001 to 2005. The rate plunged below 3% between 2005 and 2009, when CMS adjusted reimbursements policies. Similarly, Medicare payment amounts to IRFs increased 11% annually from 2001 to 2005. Payment amounts then declined 3% per year from 2005 to 2009, after the implementation of the rule requiring 75% of patients in those rehabilitation facilities to have certain serious diagnoses (the requirement is now 60%).

For dialysis, growth in payments for anemia drugs (which are more profitable than the dialysis treatments themselves) grew at a compounded rate of nearly 14% between 1996 and 2004, making it one of the largest components of prescription drug costs for Medicare. Medicare's outlays for the drugs then shrank by 3% per year between 2004 and 2008 following regulatory changes made by CMS in 2005, as well as FDA warnings about the safety of the drugs' use.

To be sure, legitimate reasons for growth exist. Nursing homes drew more patients following tougher admission criteria for IRFs. Hospice use has expanded as more patients become familiar with the home-based service and choose it over treatment for terminal illnesses.

Still, MedPAC has found that longer patient stays accounted for a portion of the rapid hospice growth, raising concerns that hospices are selectively accepting patients they believe will live longer and will therefore be more profitable. The longer a patient receives hospice care, the more profitable she is because hospice agencies are paid a daily rate for a patient's care, even on days when no services are provided. MedPAC has proposed overhauling the reimbursement system to increase payments at the beginning and end of a patient's hospice stay (where the most costs are incurred) and reduce payments for the time in between.

FIGURE 8

Medicare Spending Growth and Share of Medicare Spending

Medicare Spending ($ billions)	CAGR of Medicare Expenditures	CAGR Timeframe	Medicare Spending ($ billions)	% Total Medicare Spend
Hospice	18.4%	2000-2008	11	2%
Long-term acute-care hospitals	11.9%	2001-2009	5	1%
Home health	10.9%	2001-2009	18	4%
Skilled nursing facilities	9.8%	2001-2009	26	5%
Durable medical equipment[1]	8.6%	2000-2008	8	2%
Hospital outpatient	7.9%	2002-2008	28	6%
Clinical laboratories	7.9%	2001-2009	8	2%
Ambulatory surgical centers	7.7%	2002-2009	3	1%
Physician services	5.7%	2001-2009	64	13%
Dialysis	3.4%	2004-2009	8	2%
Inpatient (general) hospitals	3.2%	2002-2008	109	22%
Inpatient psychiatric	3.1%	2001-2009	4	1%
Inpatient rehabilitation	3.0%	2001-2009	6	1%

Source: MedPAC; Medicare spend data is for 2009 except for hospice and inpatient acute care, which are for 2008.

Services included in this chart represent roughly 60% of Medicare expenditures. Other major categories not included in the chart include Medicare managed care and prescription drugs under Medicare Part D.

1 Durable medical equipment (DME) includes oxygen and supplies, which represent approximately one-quarter of DME expenditures.

Sectors with the risk factors described above won't necessarily see large-scale payment cuts. A number of mitigating factors buffer healthcare sectors, including a high proportion of not-for-profits in a sector, which operate with relatively low margins. Nonprofits are prevalent in the hospice and general hospital sectors. Broad Medicare cuts that put legitimate providers out of business would severely limit patients' access to care, and that's not something we believe Medicare wants to do.

FIGURE 9

Share of Not-for-Profits Within Sectors

Industry	% For Profit	% Not-for Profit/Government
Inpatient (general) hospitals	20%	80%
Hospice	50%	50%
Skilled nursing facilities	68%	32%
Long-term acute care	81%	19%
Dialysis	81%	19%
Home health	86%	14%
Ambulatory surgical centers	96%	3%

Source: MedPAC and American Hospital Association. LTCH data represents % share of discharges.

Other, less quantifiable mitigating factors include a sector's lobbying power and its importance to local economies. General hospitals, for example, can be the largest employer in many towns and have significant influence in Washington to shape legislation.

One last factor mitigates some of the risk to rated issuers. If Medicare significantly reduced its payments to a sector, many of the larger companies we rate could benefit from volume or share increases as smaller competitors, facing severe margin pressure, exit the market.

Reimbursement Concerns Could Spur Industry Consolidation and Increased Debt Leverage

We believe longer-term pressures on Medicare and Medicaid payment rates may spur consolidation among healthcare companies for a number of reasons. Companies may seek greater scale to gain operating efficiencies and increased negotiating power with private payors and suppliers. We have already seen significant acquisition activity by for-profits within the hospital sector. Companies might also want to diversify their revenue streams across Medicare payment fee schedules. This was the case with Gentiva Health Services, a home health company that recently acquired hospice provider Odyssey Healthcare, in part to reduce its reliance on Medicare home health reimbursement.

We could also see more alliances and acquisitions between different provider types. The pilot programs mandated by the PPACA to test payment bundling, in which Medicare and Medicaid make a single payment for a patient's acute- and post-acute-care services, could push different types of providers together.

The downside of consolidation is higher debt leverage. Companies that merge could find themselves in trouble if reimbursement cuts come more quickly or more steeply than expected, as nursing homes experienced a decade ago. Companies must maintain financial discipline over the coming years and capital structures that will be sustainable even after meaningful reimbursement reductions from the government.

Our healthcare company ratings are often constrained by ongoing uncertainty regarding the regulatory environment and future funding. A company's credit metrics alone could justify a higher rating, but our ratings incorporate providers' higher fundamental business risk due to reimbursement exposure. While our ratings reflect our best view on the impact of known legislation and published payment rates, we believe there is a less quantifiable risk of unexpected reimbursement cuts that investors should consider. Below we calculate the impact to revenue and leverage of a theoretical 10% reduction in Medicare reimbursement for the companies we rate with direct Medicare exposure.

FIGURE 10

Company Exposure to Hypothetical 10% Medicare Reimbursement Cut

			Hypothetical 10% Medicare Cut	
Company	Rating	Outlook	Est Δ in Sales	Est Δ in Leverage
Inpatient (general) hospitals				
Universal Health Services, Inc. [1]	Ba2	Stable	-2.4%	2.5%
LifePoint Hospitals, Inc.	Ba3	Stable	-3.0%	3.1%
CHS/Community Health Systems, Inc.	B1	Stable	-2.7%	2.8%
Health Management Associates, Inc.	B1	Stable	-3.2%	3.3%
Psychiatric Solutions, Inc.[1]	B1	Stable	-1.4%	1.4%
HCA, Inc.	B2	Positive	-2.3%	2.4%
Tenet Healthcare Corporation	B2	Stable	-2.5%	2.6%
Vanguard Health Holding Company II, LLC[2]	B2	Stable	-2.6%	2.6%

FIGURE 10

Company Exposure to Hypothetical 10% Medicare Reimbursement Cut

			Hypothetical 10% Medicare Cut	
Company	Rating	Outlook	Est Δ in Sales	Est Δ in Leverage
IASIS Healthcare Corporation	B2	Stable	-2.3%	2.3%
Ardent Medical Services, Inc.	B2	Stable	NA	NA
Prime Healthcare Services, Inc.	B2	Stable	-4.8%	5.0%
Capella Healthcare, Inc.	B2	Stable	-4.0%	4.2%
Skilled nursing facilities				
Sun Healthcare Services	B1	Stable	-3.0%	3.0%
HCR Healthcare LLC	B2	Stable	-4.4%	4.6%
GGNSC Holdings, LLC	B2	Stable	NA	NA
Genoa Healthcare Group, LLC	B2	Stable	-3.5%	3.7%
Skilled Healthcare Group, Inc.	B2	RUR-Down	-3.5%	3.6%
Home health				
Gentiva Health Services, Inc.[3]	Ba3	Stable	-8.2%	8.9%
Advanced HomeCare	B2	Stable	-9.0%	9.9%
Long-term acute care/specialty hospitals				
RehabCare Group	Ba3	Stable	-3.4%	3.6%
HealthSouth	B1	Stable	-6.8%	7.3%
Select Medical Holdings Corporation	B2	Stable	-4.7%	4.9%
LifeCare Holdings, Inc.	Caa1	Negative	-5.7%	6.1%
Ambulatory surgical centers (ASCs)				
Surgical Care Affiliates	B2	Stable	-2.0%	2.0%
United Surgical Partners International	B2	Stable	-0.8%	0.8%
Symbion, Inc.	B3	Negative	-2.2%	2.2%
Dialysis				
DaVita, Inc.[4]	Ba3	Stable	-5.7%	6.0%
Renal Advantage	B3	Stable	NA	NA
American Renal Holdings, Inc.	B2	Stable	-5.1%	5.4%
U.S. Renal Care, Inc.	B2	Stable	-5.0%	5.3%
Oxygen				
Apria Healthcare Group Inc.	Ba3	Negative	-2.2%	2.2%
Rotech Healthcare, Inc.	Caa1	Stable	-4.2%	4.4%
Specialty medical supply distributors				
Hanger Orthopedic Group	B1	Stable	-3.0%	3.1%
Harrington Holdings	B2	Stable	-0.9%	0.9%
CCS Medical	B3	Stable	-4.7%	4.9%
Diagnostic imaging				
Alliance Healthcare Services, Inc.	B1	Stable	-0.4%	0.4%
RadNet Management, Inc.	B2	Stable	-2.0%	2.0%
Diagnostic Imaging Group, LLC	B3	Stable	-1.0%	1.0%
Radiation therapy				

FIGURE 10

Company Exposure to Hypothetical 10% Medicare Reimbursement Cut

			Hypothetical 10% Medicare Cut	
Company	Rating	Outlook	Est Δ in Sales	Est Δ in Leverage
Radiation Therapy Services, Inc.	B2	Stable	-4.2%	4.4%
OnCure Holdings, Inc.	B2	Stable	-4.0%	4.2%
US Oncology Holdings, Inc.	B2	RUR-Up	-3.2%	3.3%
Clinical laboratories				
Quest Diagnostics	Baa2	Stable	-1.5%	1.5%
Laboratory Corporation of America	Baa2	Stable	-1.7%	1.7%
Aurora Diagnostics	B1	Stable	-2.3%	2.3%
Caris Diagnostics	B2	Stable	NA	NA
Ambulance/emergency				
AMR Holdco, Inc. & EmCare Holdco, Inc.	Ba1	Stable	-2.3%	2.4%
Team Health	B1	Positive	-2.3%	2.4%
Rural/Metro Corporation	B1	Stable	-4.3%	-4.5%
Sheridan	B2	Stable	NA	NA
Air Medical	B2	Stable	-3.6%	3.7%
Behavioral health				
ResCare, Inc.	Ba3	RUR-Down	0.0%	0.0%
Providence Service Corporation	B2	Positive	0.0%	0.0%
Youth & Family Centered Services	B2	Negative	0.0%	0.0%
NMH Holdings, Inc.	B3	Stable	NA	NA
CRC Health Corporation	B3	Stable	0.0%	0.0%

Source: Company reports and public filings; Moody's credit opinions; Moody's estimates. Figures for private companies are based on Moody's estimates.

Note: For companies whose exposure to Medicare and Medicaid is combined in Exhibit 2, we have assumed 90% Medicare and 10% Medicaid in our revenue and leverage impact estimate.

1 Universal Hospitals Services has signed a definitive agreement to acquire Psychiatric Solutions.

2 Leverage calculation reflects the issuance of the $225 million add-on to the 8.0% senior unsecured notes and Moody's assumptions on earnings related to the expected acquisition of Detroit Medical Center.

3 Gentiva acquired Odyssey Healthcare on August 17, 2010. Figures are pro forma as per Moody's estimates.

4 Leverage calculations are pro forma for the recent refinancing transaction.

Conclusion

The massive and controversial Patient Protection and Affordable Care Act of 2010 (PPACA) is meant to increase healthcare quality and access, while reducing costs and inefficiencies in the delivery of medical services. While there is uncertainty about whether, when and how some of these provisions will be implemented, it is clear that steadily rising healthcare costs continue to threaten the solvency of government-sponsored insurance programs, such as Medicare and Medicaid. We believe the organizations that administer these two programs will increasingly scrutinize healthcare providers, with the goal of reigning in unnecessary or excessive costs. We also believe the risk of payment reductions is one of the biggest credit risks facing many medical providers today.

Sectors that have low barriers to entry and are therefore vulnerable to waste and abuse, those that receive high payments relative to other provider types, and sectors that have been growing rapidly will likely be the focus of reimbursement cuts by the government. Hospice, specialty hospitals, home health and oxygen/durable medical equipment are among the sectors we believe could be at risk for increased scrutiny and reimbursement reductions. Reimbursement pressures could also trigger accelerated industry consolidation as companies seek scale, operating efficiency and diversification. Providers, particularly those in the higher-risk sectors, must maintain capital structures that will allow them to withstand what could be significant cuts to their revenue streams.

Appendix

Sector-by-Sector Comparison of Reimbursement Outlooks

Inpatient (General) Hospitals

Short-term: Medicare payments to general hospitals will decline by 0.4%, or $440 million, in fiscal year 2011 compared with 2010, according to CMS estimates. We expect CMS to publish its proposed 2012 reimbursement rates in May 2011. (The Medicare/Medicaid fiscal year begins in October.) We expect payments for hospitals to be flat to slightly negative again in 2012 since another case-mix-creep adjustment is slated to take effect. The adjustment is meant to offset the tendency of healthcare providers to diagnose an increasingly large percentage of patients with relatively serious, and expensive-to-treat, illnesses. This gradual shift toward more serious diagnoses is known as case-mix creep.

Long-term: Increased private or Medicaid insurance coverage for Americans should benefit the hospital industry by reducing the bad-debt expense that hospitals incur when they treat uninsured patients. Expanded insurance coverage won't take effect until 2014 though. Longer term, however, payment pressures mandated by the PPACA, including the compounded effects of productivity adjustments (payment reductions intended to offset productivity increases, which are expected to reduce payments by about 1% per year) and market basket decreases (which will trim annual inflation increases by 0.25%), could pressure margins if hospitals can't drive a commensurate efficiency improvement. A report from the CMS Office of the Actuary predicts that healthcare providers will not be able to achieve long-term productivity gains and that, by 2019, the mandated annual reductions would result in negative total facility margins for about 15% of hospitals, skilled nursing facilities and home health agencies. The population of facilities with negative margins would rise to 40% by 2050.

Long-Term Acute-Care Hospitals

Short-term: Aggregate payments to LTCHs will increase by about 0.5 percent, or $22 million, in fiscal year 2011, according to CMS estimates. Although healthcare legislation reduced the market basket increases to LTCHs, we viewed the law as a short-term positive because it extended the moratorium on new LTCHs and significant Medicare reimbursement reductions another two years, until 2012.

Long-term: We believe CMS may publish specific guidelines about which patients should be admitted to an LTCH versus a general hospital. This would likely result in some operational disruption to the industry as companies readjust their admissions processes. Still, we view this outcome as more favorable to the longer-term health of the industry than the alternative, which would involve the expiration of the moratorium and CMS making significant across-the-board payment cuts to LTCHs.

Inpatient Rehabilitation

Short-term: Payment rates for IRFs will increase 2% in fiscal year 2011 - a net increase of $135 million, according to CMS estimates.

Long-term: The 75% patient criteria rule has been permanently reduced to 60%. While healthcare legislation included some longer-term initiatives for IRF, including new quality reporting requirements, productivity adjustments and a bundling pilot program (these were included for most sectors), the legislation doesn't include anything specific to IRFs that we view as particularly disruptive.

Skilled Nursing Facilities (Nursing Homes)

Short-Term: Medicare payment rates for fiscal year 2011 will increase 1.7%, or $542 million, according to CMS estimates.

CMS is now adjusting the system by which Medicare reimburses healthcare providers according to patient diagnoses. Medicare expanded in 2006 the number of payment categories and added nine new categories with higher payment rates for medically complex patients. Since then, the distribution of payments has shifted toward the higher acuity patients. Indeed, most nursing homes have publicly stated their intention to attract these patients, who often require therapy.

Medicare's expanded model was intended to maintain overall spending levels, but it instead caused expenditures to jump because actual use of the diagnostic codes differed significantly from Medicare's projections. We believe the adjustments CMS is making, which are currently in process, pose a risk to companies that focus on attracting the most complicated patients.

Medicare will be reducing payments to nursing homes that provide physical therapy to multiple people at the same time (called group therapy). Medicare will also reduce reimbursement rates for different therapies provided to one patient in a single day, beginning in January 2011.

Long-term: We remain concerned that Medicare could reduce its payment rates for certain patients, specifically those requiring rehabilitative therapy. This sector's Medicare margins are relatively high and Medicare payment to these providers have increased rapidly in recent years. Payments are expected to continue rising rapidly as the baby boomer generation ages and requires more nursing care.

Home Health

Short-term: CMS has finalized a larger-than-expected 4.89% cut in Medicare payments to home health agencies beginning January 1, 2011, which will reduce payments about $960 million, according to CMS estimates. Home health agencies are now also permanently subject to a 10% agency-level cap on high-cost outlier payments.

Long-term: CMS had proposed an additional 3.79% reduction to home health rates in 2012 due to case-mix creep, but has postponed that cut pending further analysis. PPACA also mandated home health industry reductions totaling $40 billion over the next 10 years. The reductions will be phased in over four years, beginning in 2014. We don't yet know the specifics of the reductions, but the PPACA specified that aggregate payments won't be reduced more than 3.5% per year.

Hospice

Short -term: Hospice will receive an estimated 1.8% increase in Medicare payments for fiscal year 2011.

Long-term: The PPACA didn't legislate significant reimbursement cuts for the hospice industry, but inflationary rate increases to hospice providers are slated to be reduced (in the form of a market basket reduction) every year through 2019. CMS will also begin collecting hospice data for a budget neutral payment reform no earlier than fiscal year 2013. As noted above, MedPAC has recommended increasing payments at the beginning and end of a patient's hospice benefit (where the most costs are incurred) and reduced payments for the interim period. This approach, if implemented, could reduce aggregate payments to for-profit hospice providers by 3% to 5%.

Dialysis

Short-term: CMS is implementing a new bundled payment for dialysis services at the start of 2011. Currently, Medicare reimburses dialysis services separately for the administration of the associated pharmaceuticals and lab costs. The new rule includes an option to phase the new system in over a four-year period and is designed to be budget neutral, less 2%. Additionally, the new methodology will include a market basket increase to account for the inflationary impact on the costs of providing services. The final rule also calls for an additional 3.1% cut in 2011 to establish budget neutrality, based on assumptions about the number of dialysis providers likely to phase in the new payment system. We believe the industry could face some disruptions as the new system is implemented.

Long-term: For 2012 and beyond, dialysis providers are expected to receive an annual update of the market basket minus a productivity improvement factor. Dialysis companies generally rely on providing services to patients with commercial insurance coverage to offset the losses associated with serving Medicare patients. Additional downward pressure on commercial pricing or a decline in the number of privately insured patients, due to high unemployment rates, could further strain industry profitability.

Hospital Outpatient/Physician Fee Schedule

Short-term: Many different types of companies are affected by changes in the hospital outpatient perspective payment system (HOPPS) and physician fee schedule, including general hospitals (for outpatient services), ambulatory surgical centers, diagnostic imaging companies and radiation therapy companies. Pathology services performed by laboratory companies are also paid through the physician fee schedule. Different services can receive different payment changes, so it is more difficult to analyze the broad impact of change on companies.

The 2011 market basket increase is 2.35% for hospital outpatient departments. Payments to ambulatory surgical centers (ASCs) are generally based on a percentage of the rates paid to a hospital outpatient department (it was 62% in 2010). ASC payment rates will increase by 0.2%, after factoring in a productivity adjustment mandated by the PPACA. For certain procedures, which are often performed in a physician's office, ASCs are paid the lower of the ASC rate or the rate a physician would be paid to perform the procedure in her office.

Payments to doctors under the physician fee schedule are governed by a formula, called the Sustainable Growth Rate formula (SGR), which was enacted in the Balanced Budget Act of 1997 to limit growth in spending on physician services. Yet, because actual physician spending has exceeded targeted amounts, the current SGR mandates a 30% cut to physician payments over the next year. Congress has, however, stepped in every year for the last seven years to prevent payment reductions. The cuts required by the SGR formula have again been delayed until late 2010, with a 2.2% increase to physician payments in place until December 1, 2010.

For diagnostic imaging providers, which are paid based on the physician fee schedule, healthcare legislation calls for raising the equipment use factor assumption to 75% from 50% in 2011. This change would significantly reduce reimbursement payments. Diagnostic imaging has been one of the fastest growing subsectors paid by Medicare over the past decade and has faced a number of reimbursement cuts and regulatory changes to discourage unnecessary imaging procedures performed by physicians.

Long-term: Given the PPACA's focus on improving access to preventative care, we believe general and preventative types of procedures will benefit over time from increased volumes and, at a minimum, a stable reimbursement environment. Stability in these relatively simple, low-cost procedures may

continue to come at the expense of more expensive therapeutic procedures, such as oncology and radiation procedures, which have already faced cuts. We also expect insurance payors, including Medicare, to continue driving patients to the least expensive provider, such as an ASC.

It's unclear how Congress will handle the SGR formula. A permanent fix to the formula may entail a one-time, across-the-board payment cut.

Oxygen/Durable Medical Equipment

Short-term: The first round of competitive bidding is slated to begin in 2011, with the new rates effective January 1, 2011. In competitive bidding, suppliers compete against each other, based on price, to serve Medicare patients in a designated geographic area. The near-term impact on national companies is likely to be limited as the program is being piloted in only nine U.S. cities. Based on bids received for the first round, average payments for equipment included in the program will be reduced by 32%.

Long-term: Longer term, however, the impact on issuers could be dramatic. The competitive bidding program is scheduled to expand to roughly 100 markets beginning January 2013 and could expand further in later years. The ultimate impact will vary by company and by market, based on who is chosen as a winning bidder and subsequent changes in market share. CMS estimates the competitive bidding program will save Medicare more than $17 billion over 10 years (in addition, beneficiaries will save another $11 billion). This is a significant amount, considering the U.S. Government Accountability Office estimates that Medicare spent a total of $8.3 billion for durable medical equipment and related supplies in 2007.

Laboratory Companies

Short-term: Lab companies will be subject to an approximately 1% reduction in 2011 in the clinical laboratory fee schedule.

Long-term: The PPACA legislated annual reductions in the clinical laboratory fee schedule of 1.75% per year for five years beginning in 2011. This will be offset by a consumer price index (CPI) inflation adjustment, but the CPI adjustment will be reduced by 0.5% each year.

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Author
Jessica Gladstone

Senior Production Associate
Wendy Kroeker

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