



healthcare financial management association www.hfma.org

FEATURE STORY

Daniel M. Grauman
John M. Harris
Christine Martin

access to capital implications for hospital consolidation

The financial difficulties of the past two years are forcing increasing numbers of not-for-profit hospitals to consider forgoing their independence.

AT A GLANCE

- > Recent economic challenges have left many independent hospitals and their boards concerned about long-term viability of their organizations as stand-alone facilities.
- > The CFO's role should be to facilitate a candid, objective assessment of the organization's ability to continue to go it alone.
- > Key indicators that should be considered in such an assessment include patient volume, degree of physician alignment, profitability, current debt burden, cash, available capital versus capital requirements, and credit rating changes.

Hospital CFOs have become adept at managing the familiar trends of declining revenue, shrinking reimbursement, and cost pressures. Yet recent market conditions, exacerbated largely by the recent economic downturn, have added new challenges to the mix. A growing number of CFOs are facing the question, "Can my organization remain independent?"

To answer this question, the CFO must thoroughly understand the broader market and financial context for the decision, be capable of leading the analysis and discussion with the board, and know how to monitor the organization's position and to assess consolidation options.

Market and Financial Context

In 2006, the median growth in hospital expenses outpaced revenue growth, and according to a recent report issued by Moody's Investors Service, this trend continued through 2008 (*Not-for-Profit Healthcare Hospital Medians for Fiscal Year 2008 Show Weakening Across All Major Ratios and All Rating Categories*, August 2009).

The recession created an explosion of bad debt for many hospitals as people lost their jobs, with patients migrating to state Medicaid rolls or being unable to pay at all. As a result, about one-third of hospitals experienced negative operating margins in 2008, as noted in the American Hospital Association's online *Trendwatch Chartbook 2009*. At a time when many hospitals were reliant on cash from investments and philanthropy to offset operational shortfalls, the 20 to 25 percent average decline in portfolio values during the recent recession was unsustainable.

Hospitals are now dealing with both reduced profitability and simultaneous investment losses, leading to lower reserves—and lower credit ratings. Downgrades have outpaced upgrades almost every year for the last decade.

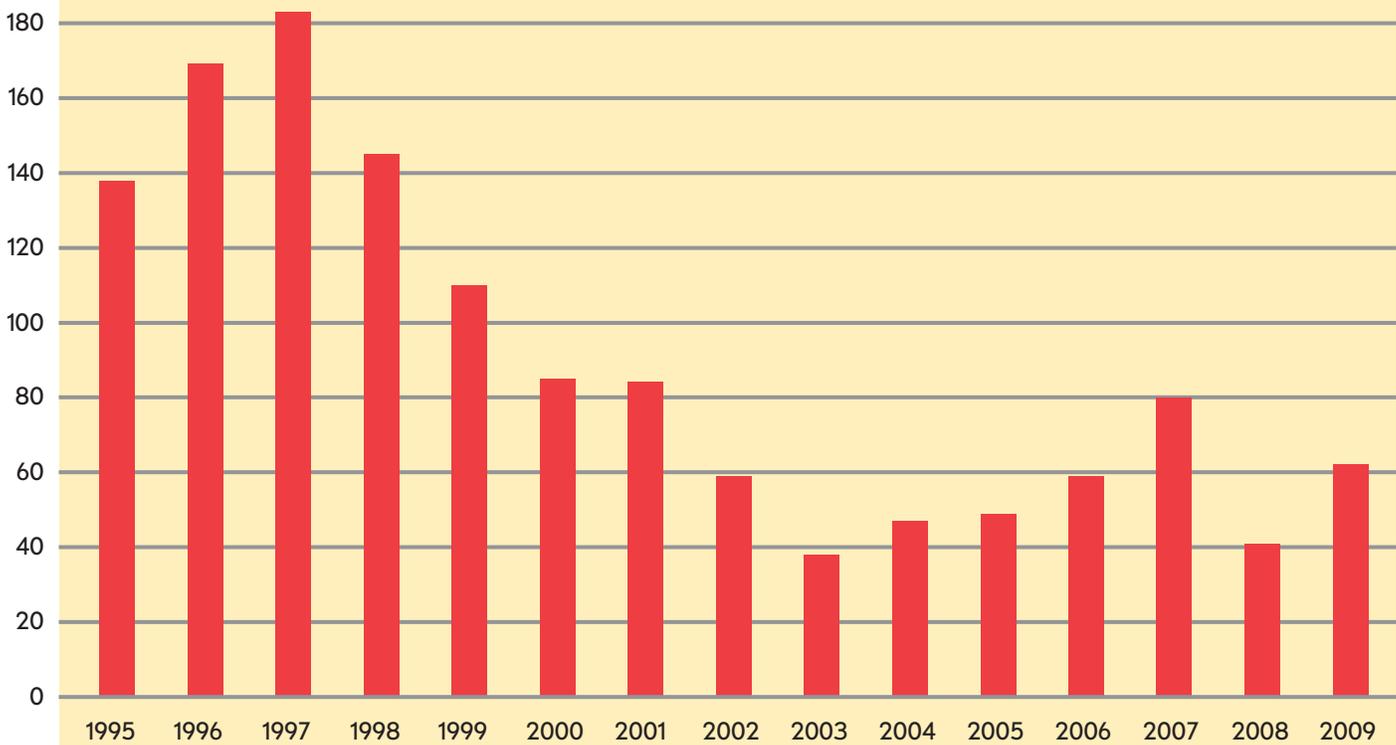
And after relative stability in the middle of the decade, 2008 and 2009 saw an extremely high ratio of downgrades to upgrades, as was noted by Standard and Poor's in its Feb. 18, 2009, report *U.S. Not-for-Profit Health Care Sector Moves Toward Stability, but Its Long-Term Outlook Is Uncertain*.

For years, low-cost capital fueled facility expansions and growth strategies. The availability of capital helped organizations maintain competitive advantage, attract physicians, and fund compliance with new regulatory mandates. Now, in a financial perfect storm rising from the recent economic downturn, hospitals have been buffeted by the combined effects of declining patient volume, a rising uninsured population, expected tightening of Medicare payments, and an inability to access capital at low rates, which has left many hospitals and boards concerned about the long-term viability of their institutions and forced them to reevaluate their ability to weather the storm alone.

As fixed-rate debt became virtually unobtainable for healthcare borrowers with weaker credit, and as variable rate debt came packaged with significantly more restrictions, hospitals quickly scaled back their capital projects. A recent McGraw Hill Construction survey reported a 43 percent decline in new square footage hospital construction over the first nine months of 2009 (McGraw Hill Construction, *The 2010 Construction Outlook*, Oct. 16, 2009). Similarly, the American Society for Healthcare Engineering reported recently that 42 percent of hospital projects in 2009 were cancelled or delayed due to the higher cost of capital (Carpenter, D., "Boom Going Bust? Credit and Financial Crisis Make for Uncertain Hospital Construction Outlook," *Healthcare Facilities Management*, February 2009).

There will continue to be a handful of stand-alone hospitals with strong credit ratings that can access capital markets at reasonable rates. Those with weaker ratings will be greatly constrained in

ANNOUNCED HOSPITALS AND SYSTEM TRANSACTIONS



Source: Shattuck Hammond Partners analysis including Irving Levin Associates historical data. Transactions include sales of for-profit hospitals; individual transactions may include multiple hospitals.

obtaining the capital they need for facility improvements, product line development, IT improvements, or physician alignment strategies. This pressure may push them over the edge to seek a merger partner or acquisition.

Indeed, given the ever-growing pressures cited above, it is imperative that each hospital be willing to perform a candid, objective assessment of its ability to continue to go it alone.

Many hospitals already have chosen to forgo independence and merge because of several very real benefits of consolidation:

- > Access to capital
- > Negotiating leverage with payers
- > Access to management expertise
- > Shared services

Access to capital, in particular, almost certainly will improve as a result of consolidation because a system with the same financial performance as a hospital (e.g., as reflected in margins, liquidity, and leverage) typically will receive a better credit rating than the hospital due to the dispersion of risk—as has been noted in a report issued by Standard & Poor’s (*U.S. Not-For-Profit Health Care Stand-Alone Fiscal 2008 Median Ratios Weaken Across the Board*, July 7, 2009).

The CFO’s Unique Role

A hospital’s senior financial executive has a unique role to play in helping his or her organization decide whether to maintain its independence or to merge or be acquired. Because the question of viability as an independent hospital is, at its core, a question of creditworthiness, the CFO is in an unmatched position to guide these discussions. Unfortunately, these are often emotionally charged discussions for the board and senior management.

Not-for-profit hospital boards have a bias toward independence. Often, boards would rather “control our own future” than become part of a system that they believe won’t care about the communities they serve. Board members invest a great deal of their wealth and wisdom into their hospitals, creating a sense of pride in the independence of

It is incumbent on hospital leaders to keep an ongoing watch on the hospital’s ability to remain independent.

their institutions. They usually resist being the ones in charge when a decades-long legacy of independence is abandoned, even if the communities they serve would be better served through consolidation, or even if a hospital’s very survival depends on it. As a result, hospitals often delay considering merging until they are desperate and the terms are less than optimal.

Hospital CEOs also often exhibit a bias toward remaining independent. The CEO may be concerned that allowing the organization to lose its independence may reflect badly on his or her ability as a leader to steer the organization to success as a stand-alone entity.

For the CFO, it’s one thing to consider the impact of capital access on hospital mergers as a market phenomenon. It’s quite another thing to face the difficult decisions about your own hospital’s financial position and independence.

Ultimately, it is the CFO who is in the best position to help ensure the objectivity of the decision-making process, and to help inform the dialogue with financial metrics and an understanding of their long-term implications for capital access.

The CFO’s Imperative

To help hospital leadership, including the board, make well-informed decisions regarding the hospital’s ability to maintain its independence, the CFO should:

- > Provide an accurate assessment of the hospital’s current financial position, including its credit rating

- > Educate management, physicians, and the board about the relationship of credit ratings and access to capital, and why access to capital is critical to survival and success
- > Develop long-range financial projections based on the strategic plans of the organization
- > Clarify what can and cannot be done with likely available capital
- > Engage the finance committee in discussions about the assumptions that drive the models, and about various scenarios
- > Estimate the impact of potential improvements or reductions in the hospital's credit rating and possible paths to either outcome
- > Acknowledge that the loss of independence would also carry financial risks (e.g., a new partner may develop its own financial troubles)

Regarding development of long-range financial projections (the third point), the CFO should ensure that projections include estimated capital requirements, as well as the expected cost and availability of this capital. The estimates should also include thoughtful sensitivity analyses, so that leadership can grasp the relative potential impact of key drivers and assumptions.

When clarifying what can and cannot be done with available capital (the fourth point), the CFO should be specific about needs/opportunities that would help serve the community so the board understands the trade-offs.

The importance of discussions with the finance committee (the fifth point) is in helping the committee make sure it has considered all options, recognizing that the broader board will depend on the committee's analysis and objectivity.

Finally, acknowledging the risks associated with the loss of independence (the last point) is crucial to maintaining board confidence. These risks carry both financial and organizational implications, some of which are listed below:

- > Centralized decision making not necessarily tailored to the needs of the community
- > Loss of philanthropic support as hospital may be perceived as part of a "corporation"

- > Loss of senior executives with well-established ties to the community
- > Change in level of services provided as parent seeks out optimal "system" delivery location
- > Turmoil in the medical staff
- > Diminished level of board involvement and influence
- > Change in culture due to affiliated hospital's integration into new system

Additionally, the merger or sale of a not-for-profit hospital to a for-profit system prompts another layer of considerations that should be understood and examined. Most notably, the charitable requirements for tax exemption are no longer relevant, which may have a significant effect on the financial policies of the institution, impacting the community at large, as well as other hospitals in the service area. And a sale to a for-profit may be complicated by the need for court approvals. On the positive side, a community foundation is often established, with the mission of continuing to improve the health of the community. (For additional discussion of the challenges involved in the sale of a not-for-profit hospital to a for-profit system, go to www.hfm.org/hfm.)

Current Financial Position

To assess a hospital's current financial position, it is helpful to compare the hospital's performance with rating agency median benchmarks, looking at either the overall median or the median for an appropriate target credit rating. Either way, the hospital will have an objective standard for comparison that can allow it to identify areas of concern.

Consider, for example, the areas of concern apparent in the exhibit on page 66, which depicts trends in a hospital's financial ratios and a comparison with median hospital experience. Although the hospital's cash position is strong and debt levels are relatively low, bad debt expense has grown at an alarming rate over the past two years, well in excess of rating agency growth benchmarks, and potentially unsustainable over the longer term. In addition, facility and equipment

replacement have lagged, resulting in an average age of plant that is higher than desirable. If this is expected to be a long-term trend, the need for sizeable capital outlays may be growing, becoming a ticking time bomb for the facility. Finally, operating margins have been declining, and investment income has played a more significant role in generating cash for the hospital than in other facilities. This may be a good time to take a candid look at the long-term financial forecast and the hospital's ability to fund needed capital replacement without a serious deterioration in its cash balances.

Monitor Leading Indicators

Hospital leaders, including board members and senior management, have a fiduciary responsibility to ensure the viability of the hospital as a community asset, and to ensure that high-quality

acute care remains available. That means that in addition to performing specific financial analyses when the question of independence is raised, it is incumbent on hospital leaders to keep an ongoing watch on the hospital's ability to remain independent, and on whether independence continues to be in the hospital's best interest.

A weakening in key financial metrics, a softening market share, or an inability to keep pace with facility and technology upgrades may point to the need for affiliation or merger. The starting point is an understanding of your current position, as well as a realistic forecast of what the numbers look like for the institution over the foreseeable future. Watching "leading indicators" can provide warning of impending problems, thereby ensuring that the hospital retains the leverage to

SAMPLE COMPARISON OF A HOSPITAL'S PERFORMANCE WITH RATINGS AGENCY BENCHMARKS

Financial Ratios	Key Indicators	Median Benchmarks			Hospital		
		Standard & Poor's	Fitch†	Moody's‡	Year 1	Year 2	Year 3
Profitability	Operating Margin	1.8	2.2	2.1	3.2	2.2	1.3
	Excess Margin	1.2	2.9	4.6	4.8	0.0	7.7
	Operating Cash Flow Margin	8.8	8.9	9.3	10.5	9.3	8.0
	Investment Income as a Percentage of Excess Income	N/A	29	N/A	33	N/A	75
	Bad Debt Expense as a Percentage of Revenue	5.8	5.7	5.8	3.0	4.0	5.0
Leverage	Maximum Annual Debt Service as a Percentage of Revenue	2.5	3.1	3.8	2.3	2.2	2.2
	Debt to Capitalization (Percentage)	44	42	40	27	25	23
	Average Age of Plant (Years)	9.8	9.9	9.7	9.8	10.5	11.3
	Capital Expenditures as a Percentage of Depreciation	158	154	N/A	105	78	95
Liquidity	Days Cash on Hand	134	152	147	214	202	227
	Days in Accounts Receivable	48	48	52	37	34	29
	Cash to Debt (Percentage)	89	101	102	187	207	235

* Standard & Poor's, *U.S. Not-For-Profit Health Care Stand-Alone Fiscal 2008 Median Ratios Weaken Across the Board*, July 7, 2009, using 2008 data.
 † Fitch Ratings, *Public Finance, 2009 Medians for Nonprofit Hospitals and Health Care Systems*, Issued Aug. 7, 2009, using 2008 data.
 ‡ Moody's Investors Service, *U.S. Public Finance, Not-for-Profit Healthcare Hospital Medians for Fiscal Year 2008 Show Weakening Across All Major Ratios and All Rating Categories*, August 2009, using 2008 data.

A weakening in key financial metrics, a softening market share, or an inability to keep pace with facility and technology upgrades may point to the need for affiliation or merger.

achieve a positive outcome if it becomes necessary to explore options for collaboration.

To monitor the hospital's financial health on an ongoing basis, it is necessary to look not only at financial ratios, but also at leading market and financial indicators that offer forewarning of serious financial distress. If these indicators point to serious trouble on the horizon, it's time to evaluate collaboration options. The following indicators are useful for this purpose.

Patient volume. This indicator is a measure of average daily census, emergency department visits, and outpatient visits. Because so much of a hospital's cost is fixed, drops in volume are a powerful early indicator of future financial difficulty. Irreversible volume dips are of particular concern.

Physician alignment. In the long term, hospitals need strong positive relationships with their medical staff. Increasingly, those relationships are achieved by moving along the continuum toward greater alignment and integration with physicians. If a hospital's current strategies are not getting traction, it is important that the hospital takes steps to remedy the situation, as results will be needed soon to support long-term viability.

Profitability. Profitability is, of course, central to long-term financial strength. Any decrease in profitability, therefore, is a critical leading indicator of future financial difficulties, particularly if it cannot be quickly reversed.

Current debt burden. If a hospital has the profitability to support additional debt, it also needs to assess whether current debt levels will allow it.

Cash. A drop in cash can accelerate a crisis like no other factor. It is critical that the board consider options before cash is a crisis, because at that point, the hospital will find itself looking for any willing partner on poor terms.

Available capital versus capital requirements. This consideration is critical, and not just when the question of continued independence has been raised; it's also essential for a hospital to routinely compare its "gotta have" and its "ideally would want" capital needs with its expected available capital, and to make sure it has considered reasonable capital investment requirements for facilities, service lines, IT, and physician alignment.

Credit rating changes. Because a hospital's credit rating summarizes all of the factors affecting its long-term viability, this indicator is a critical one to monitor. Because the credit rating also directly affects the hospital's access to and cost of capital, it can drive the organization's decision about long-term viability.

These indicators should be computed and reviewed quickly on a quarterly basis and in more detail annually. Unfavorable changes should be evaluated. If the degree of change exceeds the organization's tolerance threshold, then it may be time to act.

It is always best to make this determination and then be proactive in evaluating the "independence versus collaboration" question. The board and senior management should develop a clear and shared understanding about the choice: What do we think the hospital will look like if we go it alone, and how might the picture change if we collaborate or join a system?

Consolidation and Collaboration Options

Many collaboration options exist, from a shared service arrangement through an outright sale. Among not-for-profit hospitals, the corporate

PLANNING SERVICES

- > Strategic Planning
- > Business Planning
- > Financial Planning & Modeling
- > Facility Master Planning
- > Mergers and Acquisitions

PHYSICIAN-HOSPITAL ALIGNMENT

- > Medical Staff Planning & Development
- > Joint Venture Development
- > Physician Compensation Design
- > Physician Community Need Assessment
- > Academic Department Assessment

BUSINESS INTELLIGENCE & OPERATIONS

- > Healthcare Business Intelligence
- > Business & Functional Requirements for IT
- > Payer Contracting
- > Managed Care Operations
- > PACE Services

VALUATION SERVICES

- > Medical Practice Valuation
- > Business Valuation
- > Physician Compensation Fair Market Value
- > Litigation Support

Philadelphia

New York

Washington, DC

www.dgapartners.com
800 241-5268