Financing the Future II

Report 6: The Outlook for Capital Access and Spending

In partnership with

GE Healthcare Financial Services and KaufmanHall
Introduction

The first Financing the Future series, published from November 2003 through September 2004, brought together key stakeholders to share knowledge about and produce solid empirical evidence of healthcare capital needs, availability, and factors associated with access. Led by HFMA in partnership with GE Healthcare Financial Services and with research conducted by HFMA and PricewaterhouseCoopers, the series continues to be cited and used extensively in the healthcare industry.

The first three reports in Financing the Future II illustrate how actual hospitals and healthcare systems have applied the seven principles of best practice financial management to achieve successful performance and capital access. The fourth report focuses on how healthcare leaders can pursue joint venture opportunities within a corporate finance-based framework that aligns the joint venture with the organization’s long-range strategic, financial, and operating plans. The fifth report addresses strategies for financially distressed hospitals.

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The bedrock tenet of the information provided in six reports in the first Financing the Future series was that solid financial performance is a prerequisite for capital market access. The series thus began the process of highlighting strategies hospitals and other healthcare providers could use to improve access to capital.

Financing the Future II, developed by HFMA in partnership with GE Healthcare Financial Services and Kaufman, Hall & Associates, Inc., and published from May 2005 through August 2006, continues this process. Its cornerstone principle, carried through in each of its six reports, is this: Adherence to a rigorous corporate finance process is critical to a hospital’s ability to increase access to capital, make wise investments in the organization’s future, and improve financial performance.

The second Financing the Future series seeks to help healthcare organizations of all sizes “raise the bar” on financial performance.

To obtain capital at an affordable cost, hospitals must show rating agencies, bond insurers, investors, and other capital market constituents a track record of solid financial results. Organizations arrive at such outcomes through implementation of consistent, high-quality planning processes and thorough monitoring and revision of plans, as appropriate. By providing practical how-to information in the form of concrete strategies, tools, timelines, and other materials, the second Financing the Future series seeks to help healthcare organizations of all sizes “raise the bar” on financial performance.

We asked these leaders such questions as: What are the trends hospitals should be most attentive to in their strategic, financial, and capital planning? How should hospitals determine where to focus their capital spending? How is access to capital likely to change in the next five to 10 years? Their responses, which appear with updated industry statistics, frame this report.
What Big-Picture Trends Should Hospitals Be Most Attentive To in Their Strategic, Financial, and Capital Planning?

Strategic, financial, and capital planning by hospitals begins with an assessment of the environment in which they operate. Described fully in Report 3 of the second Financing the Future series, this industry evaluation identifies trends affecting or likely to affect the organization now and into the future. As mentioned by Martin Arrick, one of our panelists, “Leaders assessing their environment must think globally about their business and about the forces that could impact the organization at multiple levels.”

Change has been and will likely continue to be ever-present in the healthcare industry. Although the “jury was out” with our panelists on whether such current trends as consumer-directed health care and pay for performance will persist into the future, the opinion was unanimous that three big-picture issues warrant ongoing focus from hospital leaders: competition, payment, and technology.

Competition

The competitive landscape for not-for-profit hospitals and healthcare systems has altered dramatically in the past decade. Although the intensity of competition varies by location, many organizations are facing significant threats—particularly in relation to highly profitable services, such as orthopedics and cardiology—from physicians, regional healthcare providers, and for-profit companies. Demographic growth occurring in some local or regional markets may support new nontraditional providers, but more often than not, general hospitals are feeling intense competitive heat in key service areas.

Paul Ginsburg: “The most important trend for hospitals, and one that probably creates more planning uncertainty than any other factor, is hospitals’ changing relationship with their physicians. An increasing portion of lucrative outpatient services offered by hospitals is subject to competition from physician-owned facilities, including physician practices. Some hospitals are much more vulnerable to competitive challenges from physicians than others.

“Research indicates that population aging is not as large a factor as many in the hospital industry have imagined, but local population trends can also be extremely important to hospital planning efforts. For example, consider how fast hospitals in the Phoenix area need to expand just to keep up with population growth.”

Payment

Payment constraints are hardly new news, having been a major environmental factor for hospitals and healthcare systems since Medicare’s prospective payment system in 1983 and the Balanced Budget Act of 1997. The mounting federal budget deficit since 2002, however, has greatly exacerbated an already tough situation and makes government-based payment a particularly hot-button issue.

Lisa Goldstein: “Medicare payment will be the first and foremost issue that drives hospital financial and capital planning. Medicare accounts on average for 50 percent of a hospital’s revenue base. Although rates are favorable and the outlook stable for 2006, the rate of Medicare payment is likely to slow in the next couple of years.”

Martin Arrick: “Key issues on the horizon and likely to emerge within a couple of years include whether the federal government can continue to fund Medicare at the current levels plus an increased percentage each year, and whether states can afford Medicaid healthcare expenditures that exceed growth in overall state revenues each year.”

Dick Clarke: “Healthcare financial managers should take into account the federal budget deficit as they develop their longer-term financial plans. The obvious method by which the government deals with funding shortfalls is to limit payment, so, as part of their
projections, managers need to consider likely reductions in the rate of payment increases, and potentially even a rate of overall payment reduction. Operating plans must reflect the imperative to drive down costs and/or strategic plans must reflect consideration of different scenarios for diversification into new markets with new revenue and payer streams.

“Price inflexibility will present hospitals with a significant challenge. In addition to Medicare constraints on pricing, consumer price sensitivity is expected to be a key issue in the next decade. Consumers and payers will require price transparency. As consumers become more responsible for making their healthcare purchasing decisions, they will shop for prices that are ‘in line’ with market rates.”

**Technology**

During the past 20 years, advances in technology related to patient diagnosis and treatment have made possible increasingly complex inpatient procedures and shifted the provision of many less complex services from acute care settings to outpatient facilities. Healthcare IT is helping hospitals improve clinical quality, patient safety, and physician recruitment.

*Randy Fuller:* “During the next decade, hospitals will continue to struggle in defining and selecting the ‘right’ portfolio of high-tech equipment. New technologies are evolving very quickly and increasingly enabling new services, and thus are generating top-line growth. These technologies can support the growth goals of hospitals and help to enhance a hospital’s position in increasingly competitive markets. Hospitals should be attentive in their future planning to how they will support technology-related capital expenditures.”

*Lisa Goldstein:* “Hospitals need to be attentive to developments in technology. Electronic health records, quality/outcomes tracking, clinical decision support, revenue/cost management systems, and other IT applications will be ‘the enabler’ for managing hospital issues coming down the pike. IT will help decide to what degree an organization is able to address current trends, whether managing or tracking pay for performance, consumer-directed health care, or demographic changes.”

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**How Is Access to Capital Likely to Change in the Next Five to 10 Years?**

The first *Financing the Future* series addressed such questions as: What is the profile of a hospital with broad access to capital and a hospital with limited access to capital? Do they share certain performance characteristics? Are the percentages of such hospitals increasing or decreasing? Are such hospitals found in specific areas of the country?

**Access Categories**

Hospitals defined in the first series as having broad (or “wide”) access to capital met certain criteria related to profitability, liquidity, and debt burden. These hospitals would be able to fund their own capital needs or would be considered excellent credit risks to the capital markets.

Hospitals defined as having limited (or “constrained”) access to capital met a second set of criteria, which was representative of organizations under significant financial strain—not profitable, not liquid, and with significant debt burden. Access to capital may be possible for these hospitals, but it would come from a more limited number of sources and at a higher cost than hospitals with stronger financial performance.

The first *Financing the Future* series described a gap that exists between U.S. hospitals that have capital to invest strategically and those that no longer produce operating margins sufficient to access capital and support their capital needs. With constrained capital access, these “have-not” hospitals are falling behind in the market.

The first series noted that the gap separating “have” from “have-not” hospitals was widening. Between 1997 and 2001, the percentage of hospitals with wide access to capital declined from 42 percent to 36 percent, and the percentage of hospitals with constrained access to
capital rose even more sharply, nearly doubling from 11 percent to 19 percent.

Exhibit 1 defines the criteria used to classify hospitals with wide and constrained access to capital. Exhibit 2 provides most recent data related to the capital access gap, reflecting years 2002 through 2004. The following observations can be made:

- More than half of U.S. hospitals (60 percent) currently have moderate access to capital. This proportion has remained relatively constant during the past three years.
- The gap between hospitals with wide access (19.6 percent) and those with constrained access (20.4 percent) appears to be narrowing modestly. (This is most likely due to the more stable payment environment experienced by hospitals in the past few years which is expected to turn unfavorably in the near future.)

When looking at this information, it is important to note that an apples-to-apples comparison with earlier data is not possible because criteria for and weighting of access categories have changed.

Data also indicate that constrained access was a higher 25.1 percent for hospitals not affiliated with a system over a three-year period, so it would appear that being part of a system positively influences capital access for some hospitals. Researchers also noted that more rural hospitals are included in the constrained access category (22.3 percent) than hospitals as a whole (20.9 percent).

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### Exhibit 1

**Thresholds for Categorizing Hospitals by Ability to Access Capital**

<table>
<thead>
<tr>
<th></th>
<th>Wide Access</th>
<th>Constrained Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating margin</td>
<td>more than 2.0%</td>
<td>less than 0.0%</td>
</tr>
<tr>
<td>Debt service coverage ratio</td>
<td>more than 3.50</td>
<td>less than 1.25</td>
</tr>
<tr>
<td>Days cash on hand</td>
<td>more than 150</td>
<td>less than 15</td>
</tr>
<tr>
<td>Current ratio</td>
<td>more than 2.0</td>
<td>less than 1.0</td>
</tr>
<tr>
<td>Debt to capitalization ratio</td>
<td>0% to 35%</td>
<td>less than 0% or more than 70%</td>
</tr>
</tbody>
</table>

Notes: Data reflect updates to those presented in *Financing the Future I, Report 1: Access to Capital in Health Care Today*. PricewaterhouseCoopers defined the original methodology and conducted analysis related to identifying hospitals by capital-access category.

The updated scoring allocates a +.5 for each wide access criterion and a –.5 for each constrained access criterion met. Operating margin is weighted as 1 point and each remaining criterion is weighted as 1 point (to allow equal weighting for profitability, liquidity, and capital structure). A hospital score greater than 1 is considered wide access and less than –1 is considered constrained access. Scores between 1 and –1 are moderate access.


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### Exhibit 2

**Access to Capital: 2002-04**

Source: *Financing the Future I, Report 1* (Exhibit 4) based on Solucient data. Updated.

Given the critical nature of reinvestment and the relative needs of most hospitals, Fitch expects the financial gaps between credits at both ends of the rating scale to continue to widen in 2006.

Access by Geography

Exhibits 3–5 indicate that geography continues to be a key differentiator between wide and constrained capital access for hospitals. This finding likely relates to state-specific issues, such as certificate-of-need laws and Medicaid payment. Exhibit 3 shows the top 10 states in percentage of hospitals falling within wide-access and constrained-access categories.

Key findings include:
● None of the top 10 states in terms of percentage of wide-access hospitals is in the top 10 for percentage of constrained-access hospitals.
● New York ranks first in the percentage of hospitals designated as having constrained access to capital.
● Indiana, Wisconsin, and Nebraska have the highest proportion of hospitals with wide capital access.

Exhibit 4 shows the proportion of hospitals within each state defined as having constrained capital access; Exhibit 5 shows the proportion of hospitals defined as having wide access.

Financial Performance

The performance gap between high-performing and low-performing hospitals, as measured by total margin, widened significantly in the 2002–04 period (Exhibit 6). Although median total margin increased modestly, total margins for high-performing hospitals spiked to more than 8 percent, while total margins for low-performing hospitals dipped into the red, dropping below -2 percent.

Creditworthiness based on financial performance and credit ratings are inextricably linked. Exhibit 7 illustrates a parallel widening disparity of credit quality. In 1990, 5 percent of the credits rated by Moody’s Investors Service were Aa rated, 65 percent were A rated, and 27 percent were Baa rated. In 2005, the curve has flattened with 16 percent Aa rated, 44 percent A rated, and a larger 30 percent Baa rated.
Bond insurance is on the rise, due in part to the re-entry of additional bond insurers into the healthcare space and improved overall industry performance in recent years. In 2005, slightly more than 50 percent of total healthcare debt was insured, up from approximately 40 percent in 2004.

The Performance-Access Link

The first Financing the Future series concluded that the cost of capital will be higher for the have-not hospitals, pushing them further and further behind. This conclusion remains valid today and in all likelihood into the future. Hospitals and healthcare systems with lower credit ratings will pay higher interest rates for capital.

than hospitals with better credit ratings. Our panel of experts offered the following comments about future capital access and cost:

**Ken Kaufman:** “Access to capital is entirely dependent on whether a hospital achieves the financial performance required to meet its long-term financial goals. As described at the beginning of this series, every hospital or health system has a defined level of profitability and financial success necessary to meet its strategic financial requirements. A hospital is or is not meeting those requirements and as a result, will either have or not have access to low-cost capital.

“Large organizations, growing larger, have capital access and are borrowing more through much larger debt offerings. Use of bond insurance, available to strong credits, with just a few exceptions, is increasing and lowering the cost of capital for hospitals that can access insurance.

“For hospitals and health systems with declining creditworthiness, as reflected in declining financial performance, access to the capital markets is increasingly limited and will continue to be so. A single notch drop in a bond rating can mean a significant difference in the price of capital. A slightly higher interest rate can amount to significant dollars over the lifetime of the typical 30-year bond issue. The implications for certain healthcare borrowers could be serious and significant.

“Healthcare industry credit ratings have been heading downward for almost a decade. Between 1998 and 2004, bond downgrades significantly outpaced upgrades. 2005 represents the first time in many years that the proportion of upgrades exceeded downgrades by two of the three rating agencies.”

**Lisa Goldstein:** “If you subscribe to the notion of the strong getting stronger and the weak getting weaker, hospitals whose financial performance or credit profile is weakening are likely in the next decade to incur a higher cost of capital and may not have access to bond insurance; hospitals with strong financial performance and a solid credit profile are likely to have good access both to low-cost capital and bond insurance.

“Will the gap widen between stronger and weaker credits? The healthcare industry has changed rapidly in some ways and at a glacially slow pace in other ways. Depending upon local market conditions, the bifurcation between the strong and the weak has mostly been a slow one, but may be accelerated by quality as a differentiation strategy. The gap between hospitals that don’t have or don’t choose to invest capital in the IT and personnel required for quality initiatives, such as achieving Magnet status and high ratings in metrics-based scoring systems, and those that do invest in quality initiatives may widen the performance gap between hospitals in the next decade. Higher-rated hospitals with more resources to dedicate to quality initiatives may achieve growth in volumes and market share, improved payer arrangements, and cost reductions. Hospitals that cannot differentiate themselves in fragmented markets may fall further behind.”

**Randy Fuller:** “Liquidity, bond market access, and hospital credit quality are currently quite healthy, so overall capital access is likely to be robust for the next few years. This situation could change rapidly with modification of federal or local payment. Hospitals that currently do not have a healthy financial picture are likely to continue struggling over the next few years. Without access to affordable capital, turning around a distressed facility is very difficult and calls for a clear view of market position and trends and a crystal clear strategic plan. This is very difficult to achieve while dealing with problematic day-to-day issues.”

**Martin Arrick:** “The past two or three years have been good years for many hospitals, and in some sense, a rising tide lifts all boats. In the future, hospitals ‘at the top’ with exceptional performance will continue to have unlimited and unfettered access to capital. Hospitals in the middle tier will continue to have good access even if their margins drop a bit. However, the hospitals in the bottom tier are going to have a tougher time as their margins drop to a negative level.”

**Dick Clarke:** “A hospital’s continuing access to capital will reflect its ability to respond to market and environmental changes. Organizations that are relatively nimble and, which in fact, can seize emerging opportunities, will continue to have fairly broad access to capital. Organizations at the other end of the spectrum, which have had difficulties responding to marketplace and industry challenges, are not going to have capital access. Organizations in the middle of the spectrum, with moderate capital access, will need to identify their areas of distinctive competence and focus their capital spending on these areas.”
How Should Hospitals Determine Where to Focus Their Capital Spending?

The three capital spending priorities most frequently cited in the first Financing the Future series—digital radiology systems, computerized physician order entry systems, and other major IT—were all technology-centered. Spending on facility construction was increasing during the 1997-2001 period as a total dollar amount industrywide, but decreasing as a percentage of total healthcare spending.

A number of trends are accelerating capital spending and necessitate sound planning practices, including:

- Continued aging of facilities, which although leveling off, was at a historic high point of 9.8 in 2004, up from 7.9 in 1990
- Continued rapid development of new equipment and technology
- National focus on safety and the benefits that can be achieved with electronic health records, CPOE, and other IT systems
- Industry trends, such as consumer-driven health care, pay for performance, pricing transparency, and clinical decision support—all of which are driving increased IT expenditures

Technologies represent a significant portion of hospitals’ planned capital spending, which is estimated to be approximately $12 billion to $15 billion in 2006.1 Electronic medical records, bar coded medication management, and CPOE currently are the three IT applications most frequently cited as priorities by healthcare leaders.2

Our panel of experts addressed the process hospitals should use to allocate capital, the required tools, and the areas requiring significant future capital spending.

The Process

Randy Fuller: “Decisions about where to focus capital spending should be based on a sound strategic plan, which is itself based on sound data and information about what customers need and want, where the market is going, and a full understanding of the payment environment. The capital allocation decision-making process should be multidisciplinary, involving medical directors, CFOs and finance staff, and strategy/business development leaders.”

Dick Clarke: “The organization’s overall strategic plan, which is linked to a financial and capital plan, should guide capital allocation. The strategic plan reflects an internal and external assessment of market conditions—it essentially is a SWOT (strengths, weaknesses, opportunities, and threats) analysis, which identifies the organization’s strategic priorities. The capital plan defines the investments needed to support those priorities within the organization’s financial abilities and how the required capital will be obtained.”

Ken Kaufman: “Healthcare executives should be making capital spending decisions based on strategic-financial analyses of what they need to do to keep their organizations strong and competitive into the future. This is determined through the development of strategic, financial, and capital plans that identify strategic and financial goals and the debt, cash, capital, and profitability required to meet those goals. Through implementation of the integrated planning process described in earlier Financing the Future reports, hospitals invest in a portfolio of initiatives that provides a positive contribution to the strategic financial position of the organization.”

The Tools

Dick Clarke: “Hospitals must have comprehensive and cohesive strategic plans that make sense for the organizations and their markets, and which position the organizations to meet their missions. Textbooks, educational programs, consultants, and other sources described in this series provide guidance in developing high-quality strategic plans. Capital planning and allocation tools must have capabilities that include sensitivity analyses so that hospitals can test a variety of assumptions about strategies pursued, payers, volume by payer, underlying cost structures, and other factors.”

Randy Fuller: “Hospitals should ensure that they have sound decision-support systems that allow them to fully understand their markets, customers, costs, and
revenues. Also important are capital support or asset tracking systems that allow hospitals to identify age and life cycle issues related to equipment and other assets.”

Ken Kaufman: “Hospitals should use rigorous calendar management to guide an integrated strategic, financial, and capital planning process; best practice capital management to achieve the right capital structure and a solid balance sheet; consistent processes and templates to evaluate capital investment opportunities; and monitoring and controls to track strategic and financial performance.”

Lisa Goldstein: “Hospitals that perform the best, whether measured strategically, financially, operationally, or through quality measures, are characterized by a key enabling tool. This tool is the unflagging commitment by governance to support the hospital’s strategic financial planning process, embrace its strategies as long-term ones, and provide the expertise and approve the resources needed to carry out the strategies.”

Capital Spending Priorities

Martin Arrick: “Hospitals need to focus on IT spending, but this will continue to be tricky. Spending on IT doesn’t ensure that a hospital will get what it expects or wants in terms of capabilities. These IT ‘black holes’ may be one of the reasons why some organizations, especially smaller hospitals, are still reluctant to make the needed IT investment.

“Consumerism and service-line profitability will also drive capital spending. Plush specialty centers and convenient outpatient facilities with plenty of parking are being designed to meet consumer expectations. Intent on sustaining the organization over time, hospitals are investing money in service lines that make money. They are not building new psychiatric facilities, for example, but instead, are investing in new cardiac and oncology centers.”

Lisa Goldstein: “Hospitals need to focus spending on their facilities, as evidenced by climbing national age-of-plant averages. Years of thin or deferred capital spending can place hospitals at a significant competitive disadvantage with patients, payers, physicians, and employees. IT requires sustained capital spending to meet strategic, clinical, operational, quality, and financial goals. Hospitals must embrace IT as a long-term strategy because IT touches every aspect of an organization’s operations.”

Paul Ginsburg: “Hospitals should devote planning efforts to identifying major new technology-based procedures and services and to developing the capacity to deliver such services. In recent years, many hospitals have paid particular attention to expanding services that are most profitable. CMS recently proposed a rule to address the inadvertent differences in profitability of inpatient services that come from the reimbursement structure—an approach likely to be broadened to outpatient services in the future—so incentives are about to change dramatically. Hospitals should be tracking this closely.”

Are Hospitals Spending Enough to Meet Competitive and Consumer Needs?

The first Financing the Future series reported that despite a double-digit increase in utilization, hospitals’ aggregate capital spending increased only about 1 percent between 1997 and 2001, in large measure attributable to the financial effects of the Balanced Budget Act of 1997. However, 72 percent of CFOs surveyed in 2001 expected their hospitals’ capital spending to increase at a rate of 14 percent per year during the 2001 to 2006 period.

Spending Levels

In general, capital spending levels don’t appear to be keeping up and needs for capital are expected to continue to accelerate. That said, it should be noted that data related to aggregate capital spending levels are difficult to obtain and sometimes paint different pictures.

Total capital spending as a percentage of total operating expense has declined steadily during the 1997 to
2004 period, and fell to an average of below 7 percent for all hospitals in 2004, according to healthcare information source Solucient.3 (Exhibit 8)

Moody’s Investors Service indicates that capital spending levels since 2001 have been increasing both in the aggregate and as a percentage of depreciation—the ratio most commonly used to assess capital spending levels.4

The capital spending ratio, defined as capital expenditures as a percentage of depreciation expense,5 is used extensively in addition to average age of plant, the traditional measure of the level of organizational investment.

Median capital spending ratios by rating category are similar by rating agency, but there is a wide discrepancy in spending between hospitals with high credit ratings (“have” hospitals) and those with lower credit ratings (“have-not” hospitals).

Exhibit 9 provides 2005 median capital spending ratios by rating category. Higher-rated credits tend to spend more capital in relation to depreciation expense than lower-rated credits. The higher cash flow generation and/or stronger liquidity in organizations with higher ratings provide increased resources and debt capacity that enable these organizations to spend more.6

The effect of spending levels by rating category on the age of physical facilities is significant. Although average age of plant is levelling off after its decade-long ascent, wide discrepancy exists in median plant age by rating category, ranging from 9 years for Aa-rated hospitals to 14.5 years for hospitals rated below Baa (Exhibit 10).

This trend provides further evidence that hospitals with the financial performance needed to achieve higher ratings can access and are spending capital to replace and refurbish facilities; hospitals without sufficient capital access are falling further and further behind in their ability keep their facilities up to date. In a short three-year period, median age of plant increased from 11 percent to 14.5 percent for hospitals with below-investment-grade ratings.
Industry sources of healthcare bond issuance data show a strong recent increase in “new money” projects—likely to be primarily major construction—and in the overall volume of healthcare bonds, which has nearly doubled over the past five years.

**Spending Adequacy**

Our panel offered the following comments about whether capital spending is adequate now and will be adequate into the next decade:

**Martin Arrick:** “Ten or 15 years ago, A-rated hospitals typically spent 100 percent of depreciation. Now the weak BBB credits are spending 100 percent of depreciation and the AA-rated credits are spending almost two times depreciation year in and year out. Spending equal to depreciation has become a kind of floor, not a target. This is related to consumer expectations and the need for hospitals to remain competitive in their marketplaces.”

**Dick Clarke:** “Hospitals with wide access to capital will be able to spend at the level needed to meet their strategic goals. They may not be able to do everything they want to do, but they will have enough capital to support their strategic direction. Hospitals in the middle, moderate-access category will need to be very careful about how much they spend and the initiatives they choose to invest in.”

**Lisa Goldstein:** “Spending is likely to be adequate according to the measures we use to assess spending levels, but whether or not spending will be enough to meet consumer and competitive needs remains to be seen. Hospitals with strong performance that operate in states with certificate-of-need regulation and/or with strong population growth are more likely able to maintain a competitive position, while those hospitals without adequate performance and reserves in states without certificate-of-need regulation and in highly competitive local markets may fall further behind. Future capital spending adequacy will be very market specific.”

**Exhibit 10**

<table>
<thead>
<tr>
<th>Rating Category</th>
<th>2001</th>
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<tr>
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<td>A</td>
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<tr>
<td>Below Baa</td>
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</table>

What Should Hospitals Do to Close the Gap Between Capital Need and Spending?

What are the likely scenarios for struggling and/or ultimately unsuccessful hospitals? As noted by Jason Sussman of Kaufman Hall in the third report of *Financing the Future II*: “Few healthcare organizations have sufficient capital capacity to meet their comprehensive strategic capital requirements. The organization must set priorities among, and allocate resources to, the most important strategies with the highest potential return as a portfolio of opportunities.” Continued borrowing for and spending on projects that do not generate acceptable financial returns can have devastating and potentially fatal long-term consequences.

Two key gap-closing strategies are improvement of financial performance and pursuit of alternative funding sources. Our panel comments about these strategies and the likely scenarios unsuccessful hospitals may experience in the years to come.

**The Performance Improvement Mandate**

*Martin Arrick:* “The answer is really very simple: hospitals must improve cash flow and overall operating performance by doing a better job, day in and day out.”

*Lisa Goldstein:* “Although our audits indicate that 2005 was a record year of strong financial performance by the credits we rate, all organizations should focus on improving financial performance. Now is the time for hospitals to build reserves, in essence, to stockpile for the rainy days when they need to enter into a heavy capital spending mode.”

*Randy Fuller:* “Hospitals should shore up their financial position. This may involve taking a hard look at their mission and their portfolio of services. If some services are marginal in terms of financial performance and in helping them meet their mission, they should think critically about whether they can continue these services and adjust their portfolio accordingly.”

*Paul Ginsburg:* “Capital need is not an objective or measurable concept. A number of hospitals have shown that they can make very useful adjustments when access to capital is limited. For example, some hospitals have been revamping their operations to increase efficiency, which in turn enables them to serve more patients with their existing facilities. The pressure to use capital more efficiently is healthy for the healthcare system.”

**Alternative Funding Sources**

Philanthropy and leasing represent two options for capital access.

**Philanthropy.** Forty-five percent of CFOs surveyed for the first *Financing the Future* series indicated that they were going to rely more on philanthropy in the future. During recent years, however, philanthropy in U.S. hospitals has increased only modestly. After experiencing a significant drop from $8.01 billion in 2001 to $5.53 billion in 2002, attributed largely to the economy, fundraising increased to $6.1 billion in 2004.

Forecasting the possibility of unprecedented challenges to community hospital philanthropy for decades 2010 through 2030, the Association for Healthcare Philanthropy reports record numbers of professional hospital fundraisers and the growing involvement of CEOs in fundraising. Yet, the proportion of philanthropic income to total hospital income remains a minimal amount, largely an unchanged percentage for decades,” notes the AHP.

In a recent article, *Unleashing the Untapped Potential of Hospital Philanthropy*, one fundraising executive notes that fundraising is becoming a strategic imperative, particularly for not-for-profit community hospitals: “More institutions are incorporating explicit expectations of fundraising into their financial planning and now consider fundraising a ‘must’ for survival.”

Another strategist comments that trends, such as growing commercialization of not-for-profit hospitals, continuing civic disengagement, increasing demographic diversity, and challenges to tax-exempt status, could diminish returns on hospital fundraising and result in a much less robust future than predicted for hospital philanthropy, especially for community hospitals.
The future impact of philanthropy as an alternative capital source is unclear.  

Lisa Goldstein: “During the past 10 years, there’s been a lot of interest in different types of debt vehicles, such as subordinate debt and various forms of off balance sheet debt. However, beyond operating leases, we haven’t seen the healthcare industry actually adopt new vehicles or structures to any material degree. Traditional tax-exempt bonds continue to be the primary vehicle for capital. Capital vehicles and sources may change during the next five to 10 years. Hospitals are just now awakening to fundraising as an untapped source of capital. Philanthropy is likely to increase nationwide. Certain hospitals, particularly children’s hospitals and some academic medical centers, have been extremely successful in their philanthropic efforts, which are ingrained in their culture.”

Leasing. The U.S. healthcare equipment leasing market, which continues to grow at an average annual rate of 7 percent, is projected to reach $7.5 billion in new volume in 2006 and $8 billion by 2007. Although leasing dollars have increased, lease financing penetration is low (Exhibit 11 on page 13).

Randy Fuller: “Leasing as an alternative financing solution can enable hospitals to expand their capital expenditure capacity. Financing companies can help hospitals obtain needed equipment and match up equipment payments with payment streams flowing from the equipment.”

Scenarios for Struggling or Unsuccessful Hospitals

Report 5: Strategies for Financially Distressed Hospitals in Financing the Future II described hospitals that are experiencing severe financial stress. Performance at this level may leave such hospitals in need of a turnaround to ensure survival as an ongoing independent entity or to position the organization for purchase or merger with another entity. For the hospitals highlighted in the report, development and successful execution and monitoring of an improvement plan that addressed strategic, clinical, operational, and financial performance was key to turnaround success.

Industry data provide evidence of what currently is occurring with financially distressed hospitals. According to Irving Levin Associates, Inc., hospital mergers and acquisitions are continuing at a pace greater than that experienced at the 10-year low in 2003: “Fifty domestic transactions were announced in 2005, involving 88 acute care hospitals with a combined 11,294 beds. This represents a drop from 2004 when, due to several portfolio sales, 59 deals were announced involving 236 hospitals and 25,300 beds.” The number of transactions is expected to slow in 2006 due to concerns about rising energy prices and mid-term congressional elections.

Exhibit 12 on page 13 provides an eight-year look at hospital mergers and acquisitions. Data related to the number of hospitals affiliated with systems show that hospitals increasingly are joining, merging, or being acquired by healthcare systems. In 1999, approximately 2,525 community hospitals were affiliated with systems; by 2003, more than 2,600 hospitals were affiliated.

Our panel offered the following comments about merger, acquisition, and closure scenarios for struggling or unsuccessful hospitals.

Dick Clarke: “Hospitals that cannot respond to market and environmental challenges and cannot improve access to capital will have to merge with a stronger credit, transform themselves into a different kind of provider, or close.”

Lisa Goldstein: “Hospitals that do not have critical mass in terms of bed size or admission size, or hospitals that are truly essential in their local market (with no other hospital around for miles) may look for capital partners either from other hospitals or larger systems. Or they may be acquired or merge.

“We’re also seeing an increased number of financial loans from larger hospitals or systems or other arrangements to help smaller hospitals meet their capital needs. These ‘capital partnerships’ or 80/20 joint ventures with for-profit companies that allow the smaller not-for-profit hospital to retain 20 percent interest are not called outright acquisitions, but at the end of the day, pretty much function like an acquisition as the tax-exempt bonded debt is redeemed. The for-profit partner is essentially in control.”
Exhibit 11

**Healthcare Equipment Leasing**

![Graph showing healthcare equipment leasing trends](image)


Exhibit 12

**Hospital Mergers and Acquisitions**

![Graph showing hospital mergers and acquisitions](image)

Martin Arrick: “Struggling hospitals often experience a very slow downward spiral. As they lose the ability to access and deploy capital, their age of plant creeps up. They begin to be unable to meet consumer and competitive needs, and eventually, if they are not acquired, they wind down and close. But, in small rural areas where there is no competition, such hospitals can hang on for quite a long time.”

Randy Fuller: “Many for-profit entities are looking to acquire hospitals with a reasonable patient and service mix in attractive markets. Hospitals without these would not be acquisition candidates; closure may be their only option. This is likely to become an important public policy issue in both federal and state governments. We’ve already seen New York State convene a panel to ‘rightsize’ its provider capacity. With the increasing focus on hospitals’ roles in emergency care and providing surge capacity, will struggling hospitals be allowed to close or will some vehicle be developed to provide additional support to those hospitals with a critical role in providing emergency capacity?”

Paul Ginsburg: “I would hope that closure or being acquired would be the response for hospitals that cannot improve financial performance and access needed capital. However, we know that many will continue to stay open, despite being unable to provide state-of-the-art care. There is substantial opportunity for for-profit chains to acquire nonprofit hospitals well regarded in their communities but without sufficient capital to remain competitive.”

Closing Comment

Since publication of the first Financing the Future series, most healthcare organizations have continued to experience financial pressures related to increased competition, constrained payment, and growing capital needs. Development and methodical execution of corporate finance-based strategies to improve financial position, using the processes described in this series, are critical to ongoing capital market access and continued hospital operations.

“Financial performance must be sufficient to meet the cash flow requirements of the strategic plan and, at the same time, maintain or improve the financial integrity of the organization within an appropriate credit and risk context,” comments Ken Kaufman of Kaufman Hall. “Corporate finance holds that if you’re earning an adequate return, you’re going to have access to capital. If you’re not earning an adequate return, you’re not going to have adequate access to capital. End of story.”

We end the story here, too, with a restatement of the series’ cornerstone principle: Adherence to a rigorous corporate finance process is critical to a hospital’s ability to increase access to capital, make wise investments in the organization’s future, and improve financial performance.

HFMA wishes to acknowledge the significant contributions of writer Nancy Gorham Haiman for reports one through six in the Financing the Future II series.
References

1 2006 HIMSS analytics; AHA at www.aha.org/aha/press_room-info/content/CostCaring.pdf.
5 Standard & Poor’s and Fitch Ratings add to the definition the words “plus amortization expense.”
HFMA’s Financing the Future series began the process of highlighting strategies hospitals and other healthcare providers could use to improve access to capital through successful financial planning and execution. Financing the Future II continues this process. By providing practical how-to information in the form of concrete strategies, tools, timelines, and other materials, the second Financing the Future series seeks to help healthcare organizations of all sizes “raise the bar” on financial performance. Financing the Future II is being developed in partnership with GE Healthcare Financial Services and Kaufman, Hall and Associates, Inc., and will include six reports for healthcare financial leaders, their staffs, and healthcare executives and board members.
For more information about Financing the Future II, visit www.financingthefuture.org.

HFMA is the nation’s leading membership organization for more than 34,000 healthcare financial management professionals employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members’ positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant. HFMA offers educational and professional development opportunities; information on key issues affecting healthcare financial managers; resources, such as technical data, checklists, and research reports; and networking opportunities—all of which provide our members with the practical tools and ideas they need to ensure career and organizational successes. For more information, visit HFMA’s web site at www.hfma.org.

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