SECOND EDITION

Focus on Finance

10 CRITICAL ISSUES FOR HEALTHCARE LEADERSHIP

A Governance Institute Signature Publication

BY KENNETH KAUFMAN

KaufmanHall

THE GOVERNANCE INSTITUTE

A service of NATIONAL RESEARCH Corporation

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Skokie, IL

A service of NATIONAL RESEARCH *Corporation*

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About the Author

Kenneth Kaufman is Chair of Kaufman, Hall & Associates, LLC, a management consulting firm that provides advisory services and software to hospitals and health systems nationwide. Since 1976, Mr. Kaufman has provided healthcare organizations with expert counsel and guidance in areas including strategy, finance, financial and capital planning, and mergers, acquisitions, and partnerships. Clients include organizations of all types and sizes—community hospitals and health systems, academic medical centers, and regional or national health systems.

Recognized as a leading authority and committed to industry education, Mr. Kaufman has given more than 400 presentations at meetings such as those organized by the American College of Healthcare Executives (ACHE), American Hospital Association, Healthcare Financial Management Association, The Governance Institute, and others.

Mr. Kaufman has authored or co-authored seven books, including *Fast and Furious: Observations on Healthcare's Transformation* and *Best Practice Financial Management, 3rd Edition,* published by ACHE. In addition, he's often quoted and his articles regularly appear in major healthcare publications.

Mr. Kaufman has an M.B.A. with a concentration in Hospital Administration from the University of Chicago Graduate School of Business.

About Kaufman, Hall & Associates, LLC

Kaufman Hall provides management consulting services, benchmark data and analytics, and enterprise performance management software that help clients to sustain success in a changing environment. Since 1985, Kaufman Hall has been a trusted advisor to boards and executive management teams, enabling them on a self-sufficient basis to incorporate proven methods into their strategic planning and financial management processes and quantify the financial impact of their plans to consistently achieve their goals.

Kaufman Hall helps clients identify and execute initiatives that drive strategic and financial performance; provides financial advisory services to clients seeking capital; prepares and implements integrated strategic, financial, and capital plans; designs comprehensive capital allocation processes; and assists in the evaluation, structuring, and negotiation of partnership and divestiture opportunities.

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Kaufman Hall's extensive industry expertise and tailored solutions for healthcare, financial institutions, higher education, and other key industries enable clients to take advantage of proven best practices and realize faster time to value.

The Governance Institute

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

The Governance Institute is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.

Member Editorial Board

The Governance Institute's member editorial board provides expertise and opinion to our research and publications. We consider this a "working editorial board," and members are asked to comment on our annual education and research agendas, provide input on specific research questions and member surveys, and offer commentaries for publications.

The composition of the member editorial board reflects Governance Institute membership overall: hospitals and health systems, varying sizes of organizations, private and public boards, children's hospitals, academic medical centers, secular and religious affiliation/sponsorship, geographic representation, physician CEOs, outstanding reputation, and a passion about governance.

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Preface

Disruptive forces are reshaping healthcare nationwide and affecting all stakeholders, including provider organizations, employers, payers, and consumers. Hospitals and health systems are experiencing the effects of change in ways such as declining use of inpatient and certain outpatient services, decreasing payments, and mounting pressures to provide access to high quality, lower cost, consumer-oriented care at the right time and the right place.

THE TRANSITION TOWARD A VALUE-BASED SYSTEM FOCUSED on managing a population's health will require organizations to offer services through a mix of strategically located brick-and-mortar sites *and* virtual/telehealth services provided wherever consumers want.

Healthcare is a highly competitive industry, and no organization is immune to healthcare's transformation. While the pace of change varies from market to market, even high-performing hospitals and health systems in slow-moving markets must develop strategies to move to a value-based care delivery and payment system. Organizations must be willing to proactively pursue new delivery and payment models.

Hospital and health system executives and directors should closely track trends and issues associated with the industry's changing business model, assess the financial implications to their organizations, and devise and implement effective plans to address the challenges. Deliberate thinking and controlled contingency planning will help organizations secure a solid market position and continued financial stability.

Fortunately, directors of The Governance Institute's member hospitals and health systems consistently rank their boards' financial oversight as the best-performed of their fiduciary duties and core responsibilities.[1] This is, at least in part, due to educational initiatives by The Governance Institute, which has focused on best practices in financial leadership.

Healthcare finance can be a daunting topic, but the need for continued accessible and thorough education is ever-present and urgent. This signature publication focuses on 10 critical issues, providing the framework directors and executives can use to ensure high-quality financial decisions. The publication reflects three decades of consulting, presentations, articles, and books provided in client and professional forums by the undersigned and partners and staff of Kaufman, Hall & Associates, LLC.

A special thanks to The Governance Institute for its leadership role in healthcare finance and its expert management of educational initiatives. The Governance Institute's commitment to providing the essential knowledge and solutions necessary for hospitals and health systems to achieve excellence in governance is appreciated.

Kenneth Kaufman, Chair
Kaufman, Hall & Associates, LLC
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Executive Summary and Discussion Guide

As the transition from a volume- to value-based business model accelerates in healthcare, hospitals and health systems are facing disruptive forces: declining utilization, a shift of care to ambulatory, virtual, and other non-acute settings, increasing consumerism and price sensitivity, emergence of non-traditional competitors, and a focus on managing population health. These forces are creating critical strategic, operating, and financial challenges.

THE LONG-RUN ECONOMIC HEALTH OF THE NATION DEPENDS on having a less costly and more efficient and effective healthcare delivery system. Hospital and health system directors and executives charged with guiding their organizations through the transition must focus on disciplined planning toward these goals. Addressing the challenges ahead requires deep understanding of the key factors driving the new value-based payment and delivery model.

The following summary provides a high-level picture of the financial concepts and integrated strategic/financial planning processes described in depth in this publication. It includes points of discussion and questions for boards, senior leaders, the CFO and finance team, and the board finance committee to consider. It is important to refer to the full publication for complete definitions and depth of information necessary to determine the appropriate next steps for your organization.

Board and Senior Leader Discussion:

First, and perhaps foremost, directors and senior executives are tasked with the critical job of determining how best to right-size their care delivery systems for an ambulatory- and virtual-centric delivery system. This includes determining:

- The right mix of services and facilities
- The appropriate number and locations for specific types of facilities
- The organization's role as a community, regional, or national provider

Disciplined Planning: The Groundwork for Success

Three characteristics of the most successful hospitals and health systems, defined as those able to sustain strong financial performance over long periods of time, are:

1. Disciplined planning that integrates strategy and finance
2. Recognition of growth as a process involving innovation and reinvention
3. Use of a data-driven approach to assess and select the portfolio of opportunities worthy of their investment

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. This requires organizations to use a continuous and integrated strategic, financial, and capital planning process that includes five interrelated functions:

1. A continuous *strategic financial planning process* that balances an organization's mission-based and market strategies with its financial capabilities
2. *Capital structure management* that is appropriate to the organization's current financial and credit position
3. A *capital allocation process* that enables the organization to prioritize capital spending decisions related to *all* organizational investments
4. An *annual budget* that reflects the strategic, financial, and capital plans
5. *Ongoing monitoring and control* functions that accurately assess whether strategic, financial, and capital targets are being met

Board and Senior Leader Discussion:

- What are the critical facts about existing and potential geographic market areas?
- Which markets present the strongest development opportunities for our organization?
- What strategies should we pursue to build position and market essentiality in the priority markets?

Why Credit Ratings Matter

A healthcare organization's long-term competitive position today depends substantially on its ability to raise affordable capital in the debt markets. This, in turn, is highly dependent on the organization's credit rating and overall creditworthiness. Boards and executive teams must ensure that their organizations attain and maintain a credit rating that allows for effective competition in a challenging business environment.

Rating agencies assess an organization within the context of the local, regional, and national service area, as appropriate. They analyze how an organization has positioned itself in the past and is positioning itself for the future. Factors considered include:

- Effectiveness of governance and management
- Market and strategic position
- Financial performance and debt position

Finding the Right Balance of Cash and Debt

Spending capital, incurring debt, and maintaining adequate cash are critically important leadership functions. Key issues include:

- Respect for the capital markets
- Ability to incur debt into the future
- Understanding that with credit ratings, what goes down doesn't necessarily go up
- Business risk and community trust
- Investment performance and the primacy of cash
- Sustainability

Board and Senior Leader Discussion:

- How much liquidity does our organization need to compete long term?
- If we deliberately reduce the required liquidity level to support current strategic investment, what is the plan to replace lost liquidity, and is this plan a realistic one?
- If we spend down cash, and increase debt and the level of strategic capital investment, what is the probable outcome of that financial strategy?
- Will the clinical and strategic investments produce sufficient cash flow over time to allow our organization to improve its credit position and capital capacity and repair its balance sheet?

How Much Can the Hospital Afford to Spend?

Developing the competencies and infrastructure for a value-based/population health management care delivery and payment system requires a high level of spending—much of which may lower financial performance for a period of time, but would lead to projected benefits long term. With numerous investment demands occurring simultaneously, it is especially important that board and management teams carefully prioritize and monitor spending.

Capital allocation is the process for deploying scarce capital resources (cash and debt capacity). *Capital management* is the ongoing monitoring and control function that ensures the integrity of the allocation decision process and appropriate application of allocated funds. How much capital to spend, and the projects on which dollars will be spent, are critical decisions with long-term strategic and financial implications. The organization's long-range strategic financial plan, including operating, financial, and capital projections based on defined strategies, should guide spending decisions.

Strategic Market and Position Assessment

The integration of strategic planning and financial planning involves analysis of the current market, forecasting of changes related to payment arrangements, demographics, and many other factors, as well as defining the role the organization will play in its community based on these factors. Effective plans are based on strategic and market realities. Thorough analyses of comprehensive data enable hospitals and health systems to identify financially viable competitive strategies.

Board and Senior Leader Discussion:

Key questions asked and answered during an ongoing strategic market and position assessment process include:

- Which areas/regions does our organization currently serve? What is our market share? How has this changed over time and how might it change as networks form to manage population health?
- What are the current and projected future characteristics of the population and the local economy?
- What changes are anticipated in demand for healthcare services within the market? How will changes in the payer/employer environment, demographics, and emerging technologies affect future demand for the inpatient and ambulatory services we provide?
- What is our current service-delivery configuration, and what is the condition of our physical assets? How might this change to meet new needs for services in ambulatory and home settings?
- Who are our principal competitors? How are these competitors positioned and what strategies are they pursuing? How will these strategies affect our organization's position?
- What important trends are occurring related to value-based contracting, and inpatient and ambulatory service utilization?
- What is the organization's desired role in population health management? What are its program/service strengths, weaknesses, and development opportunities relative to that desired role?
- What is the structure of the physician market and the organization's physician staff? How might the organization need to develop its physician enterprise for the provision of clinically integrated services in new networks that are forming?

To meet and sustain population health management goals of coordinated and managed care across the continuum, hospitals and health systems must have strong capabilities in nine areas. These areas are particularly important to establishing the organization's value to consumers, payers, clinicians, employers, and other stakeholders:

- Network strength (development, configuration, and relevance)
- Clinical integration
- Operational efficiency
- Clinical care management
- Clinical and business intelligence
- Financial strength
- Purchaser relationships (and managed care contracting)
- Customer service and consumer engagement
- Leadership and governance

Board and Senior Leader Discussion:

Analyses built on a thorough fact base enable fully informed decisions about strategic opportunities that will position the organization for success into the future. Directors must be asking the following questions of their organization's leadership:

- Does our organization have high-quality data sources and information-gathering mechanisms to monitor market and strategic trends closely?
- Is the organization converting such information into meaningful strategies and specific actions?

Setting Organizational Direction

The financial plan, or the financial planning portion of an integrated strategic financial plan, assesses the feasibility of identified strategies. The plan has a long time horizon—most commonly five years. It quantitatively identifies the profitability and liquidity requirements of the organization's strategic initiatives and addresses the issues of funding and financing required to meet such objectives.

Identifying the strategies or initiatives that will enable the hospital or health system to achieve market strength, differentiation, and sustainable competitive financial performance involves finding the balance between strategic needs and financial capabilities. The equilibrium lies in a "corridor of control" where the organization balances two opposing goals:

- Compete as effectively as possible, which requires aggressive investment of capital and commitment of operating dollars, but
- Respect the fiduciary role of management and the board to maintain the long-term financial integrity of a community asset.

If an organization over-invests, its financial need or strategic capital appetite exceeds its financial capability. On the other hand, an organization that under-invests might have a fair amount of money, but lacks a strategic plan that outlines how to grow and spend that money.

Organizations must establish and implement criteria for the evaluation and selection of strategic capital investment opportunities. The boards of financially successful organizations govern around explicit financial expectations and metrics and are guided by an attitude that senior management will deliver expected results on a consistent basis. The board's comprehensive view of the organization's overall financial target enables it to manage all events toward reaching that objective.

Financing Organizational Strategy

Once strategic direction has been established, leadership must then secure sufficient capital to support selected strategies while meeting ongoing operating requirements.

Equity capital and debt capital comprise the two broad categories of capital. When considering which debt vehicle is most appropriate for the organization's circumstances and credit position, leaders should start by defining the borrowing goals, and then keep those goals in mind throughout the process. All capital decisions must support the organization's strategic plan, provide as much flexibility as possible given existing and pending laws or restrictions, involve the lowest overall cost for the risk of the asset and liability portfolios, and allow for future financing needs.

Managing Capital Structure and the Balance Sheet

Capital structure is the combination of debt and equity that funds an organization's strategic plan. In not-for-profit healthcare organizations, capital structure includes debt and other sources of capital invested in the organization over time. The effective management of capital structure requires focus on:

- The type of debt incurred
- The cost and terms of debt capital
- Its flexibility and risk
- Its overall ability to support the organization's competitive position and financial performance

Capital structure management involves creating, shaping, and directing the debt and equity portfolio in response to changing market and financial conditions. At any point in time, there *is* an optimal capital structure. Through a strategic approach to balance sheet management, healthcare organizations can achieve the asset and liability mix that yields the best return given the organization's capital flexibility needs and risk tolerance.

Board and Senior Leader Discussion:

Achieving success with any management effort requires laying the appropriate groundwork. Education ensures that the board of directors and senior leaders are on the same page about the benefits and importance of effective capital structure management to the organization's competitive financial performance and future positioning. All board members and senior leaders may not need to be familiar with capital structure intricacies, such as the many available derivative and swap vehicles. However, they do need to know enough to ask questions, such as:

- Will a capital structure decision or vehicle expose the hospital or health system to inappropriately high risk?
- Is the debt portfolio being monitored to achieve the lowest possible interest costs?

Understanding and Managing Risk

In order to navigate the reform agenda and healthcare's new business model, healthcare leaders will need to move quickly to strategically reposition their organizations for a fee-for-value environment. New strategies related to physician alignment, network participation, coordinated care infrastructure, partnerships, and other considerations, will be expensive and pose significant financial risk to many organizations.

Effective risk management is important under any market or economic conditions and for any entity at any stage in its development. Three notable forms of risk should be of concern to every healthcare director and executive: business risk, financing risk, and event risk. An organization's total risk is the sum of all types of risk. Organizations compete most effectively when there is relatively little difference between their financial position and actual level of risk on the total risk/financial strength continuums.

A successful approach to integrated and enterprise-wide risk management requires a solid framework, which:

1. Is complementary to the financial plan and sets realistic expectations
2. Is cohesive and straightforward, enabling communication among all stakeholders, and sustainable over time
3. Clearly differentiates between tools and strategies
4. Recognizes the many roles of cash and investments in support of the broad enterprise

Implementing this approach involves three essential activities:

- Understand and catalog the risk portfolio
- Define available resources to manage risk
- Integrate operating and balance sheet analyses

Discussion Guide

In addition to the questions posed in the sidebars above, healthcare directors and executive teams should be asking and answering three key questions:

- How fast does our organization need to move to effectively reposition for a fee-for-value environment?
- Are we moving fast enough, and if not, what strategies should we be pursuing?
- Do we have the necessary financial resources to compete in the fast changing environment, and if not, what partnerships or relationships might be necessary?

Addressing the 10 issues described in this publication is a prerequisite for hospitals and health systems to maintain competitive financial performance during healthcare's transition to a population health-focused model. Identification and pursuit of best-fit strategic options based on thorough and integrated strategic financial planning should be top priorities. Organizations *must* maintain a minimum cash position with the ongoing shift to value-based care and payment, and take exceptional care of the overall balance sheet to achieve the lowest possible cost of capital, maximize return of cash and investments, create capital capacity, and diligently manage risk.

Chapter 1: Understanding Healthcare's New Business Model and the Implications for Hospitals and Health Systems

Due to unsustainable spending and share of GDP,[2] U.S. healthcare is moving to a value-based business model from a volume-based model that has been in place since the 1960s.

AS THIS TRANSITION OCCURS, HOSPITALS AND HEALTH SYSTEMS are facing disruptive forces that are creating critical strategic, operating, and financial challenges. Forces include declining utilization, a shift of care to ambulatory, virtual, and other non-acute settings, increasing consumerism and price sensitivity, emergence of non-traditional competitors, and a focus on managing population health.

The combined impact of these forces will be significant for all types of providers. Because the transition to the new model is based on economic principles, it will not be possible for any hospital board member or executive to ignore the associated challenges.

Change is already a fact of life for hospitals participating in Medicare. To reduce costs and improve care access, outcomes, and quality, CMS announced in January 2015 a goal of tying 50 percent of traditional fee-for-service Medicare payments to quality or value through alternative payment models by the end of 2018.[3] That same month, a large group of major commercial insurers and healthcare providers announced their commitment to move 75 percent of their business to value-based payments by 2020.[4]

The long-run economic health of the nation depends on having a less costly and more efficient and effective healthcare delivery system. Hospital and health system directors and executives charged with guiding their organizations through the transition must focus on disciplined planning toward these goals.

Addressing the challenges ahead requires deep understanding of the key factors driving the new value-based payment and delivery model.

Employer and Insurance Market Transformation Is Increasing Consumerism

Patients historically have been shielded from the true costs of care through employee-sponsored health plans with low copayments and deductibles. But, unwilling to shoulder rapidly rising healthcare spending, employers increasingly are shifting costs to employees by moving them from defined benefit to defined contribution, high-deductible health plans (HDHPs). Twenty-four percent of workers with employer-sponsored insurance were enrolled in a HDHP with a savings option in 2015, up from 4 percent in 2006.[5] The percentage is expected to be higher, perhaps much higher, in the future.

Public health insurance exchanges, as mandated by the 2010 Affordable Care Act, and expanding private health insurance exchanges are accelerating the spread of HDHP-like plans. Forty-five percent of the plans participating in the public health exchanges in 2015 were tiered or narrow-network plans that offer individuals a lower premium price in exchange for a more limited number of providers in the insurer's network.[6] Forty percent of individuals in the individual (non-group) market are enrolled in lower-cost plans with high deductibles, defined as $1,500 or more for an individual or $3,000 or more for a family.[7]

By making enrollees responsible for a significant share of their healthcare expenses, HDHPs prompt individuals to become healthcare "consumers" and to comparison shop for health coverage as they would other purchases.

With purchase decisions firmly in the consumers' court, healthcare is rapidly changing from a wholesale transaction to a retail transaction. This transformation is fundamentally altering the traditional provider–patient relationship. Patients no longer are relying primarily on their physicians to direct their care. Many consumers are taking an active and engaged role, seeking information to compare their provider and treatment options, and avoiding expensive office visits or tests.

Employers, payers, and consumers all are increasingly price sensitive and looking for improved healthcare value. Greater transparency is required to identify the value of services, so

insurers and other companies have launched transparency tools to provide patients and families with information about the cost and quality of care. Fifty-six percent of Americans have accessed information about healthcare prices before getting care.[8]

Start-up firms have entered this space. For example, one firm is using cloud-based technology as a platform for consumers to compare prices for common medical procedures among more than 40,000 providers in 44 markets. Additionally, the company offers price information to employers, payers, and health networks seeking to reduce expenditures.[9]

Well-Funded Competitors Are Emerging

Consumerism is creating fertile ground for new entrants to the healthcare industry. These new entrants can gain market share by offering innovative care models, greater convenience, and lower costs. Non-traditional competitors, such as retail giants, digital health start-ups, and insurers, are capitalizing on this new consumerism, offering an array of care options and access points, including store-based clinics, online consultations, and mobile health applications.

The nation's largest drug store chains, for example, are positioning themselves as primary care providers. They offer services such as physical exams, treatment of minor illnesses and injuries, management of chronic conditions, follow-up calls to patients starting new medications, and online and mobile prescription management. Some retail chains also are partnering with telehealth providers to offer customers 24/7 access to board-certified physicians via mobile, desktop, and tablet devices.

Another telehealth company is now offering patients round-the-clock access to affordable, high-quality non-emergency medical services via secure online video, mobile applications, and the Web.

Boards of directors and executive teams should not look for a "tipping point" in the transition to the value-based population health model. The drumbeat for value has been ongoing and is growing considerably faster and louder. Healthcare leadership must heed its call in order to meet fiduciary responsibilities.

Innovative Technology Is Changing Care Delivery

Technology, such as telehealth and mobile health, is reshaping the delivery of care and its costs, and redefining access from inpatient and outpatient facilities to in-home "anywhere care and anywhere health."

Technological advances also are allowing individuals to use mobile applications and wearable devices for a variety of monitoring and diagnostic functions that previously required expensive equipment and in-person visits. In fact, every major company from Apple to Google to Samsung is developing biometric devices that soon may be able to measure individuals' blood chemistries, vitamin levels, blood pressure, heart rate, and more.[10]

These companies make no qualms about their goals of disrupting traditional delivery structures and legacy healthcare providers. "We're changing the complete paradigm of how healthcare, health services, and health enterprises are delivered," said the cofounder and chief technology officer of one such company. "We want to deliver it in the same way that an Amazon or an eBay or a Priceline is delivered—straight to the consumer."[11]

Defining the Path Forward for Legacy Providers

The myriad disruptive forces affecting the healthcare industry have significant implications for the strategic and financial management of hospitals and health systems. Provider organizations will need to be nimble in order to respond.

First, and perhaps foremost, directors and senior executives are tasked with the critical job of determining how best to right-size their care delivery systems for an ambulatory- and virtual-centric delivery system. This includes determining:

- The organization's role as a community, regional, or national provider
- The right mix of services and facilities
- The appropriate number and locations for specific types of facilities

Defining a strategy on how best to develop and configure virtual health offerings, and balancing physical and virtual assets, also are vital. At this point, rates of telehealth adoption by acute care hospitals vary significantly around the country. Overall, 42 percent offer some form of telehealth, including remote patient monitoring, electronic intensive care units (eICUs), and video visits with physicians or other healthcare providers.[12] Healthcare leaders should routinely revisit such strategies in order to stay abreast of shifting consumer needs and new technology. Regular strategic market assessment is required, as described in later chapters.

Careful and credible planning and decision making are more critical than ever. Planning ensures appropriate analysis, integration, flexibility, and coordination of mission-based strategic initiatives to help providers sustain strong financial performance. It also provides the roadmap to explore new ventures, respond to disruptive forces, and make the very best decisions to position the hospital for success going forward.

History has demonstrated that change in the healthcare delivery system tends to occur in a series of peaks and valleys. Boards of directors and executive teams should not look for a "tipping point" in the transition to the value-based population health model. The drumbeat for value has been ongoing and is growing considerably faster and louder. Healthcare leadership must heed its call in order to meet fiduciary responsibilities.

Chapter 2:
Disciplined Planning: The Groundwork for Success

One of the chief characteristics of the most successful hospitals and health systems, defined as those able to sustain strong financial performance over long periods of time, is disciplined planning that integrates strategy and finance. The rapidly changing healthcare environment makes this process more critical than ever, as organizations work to position themselves for the new healthcare era.

DRIVEN BY THE BOARD OF DIRECTORS AND EXECUTIVE TEAM, disciplined planning ensures appropriate analysis, integration, and coordination of mission-based and strategic endeavors. Ingrained in the culture and occurring 24/7/365 organization-wide, rigorous planning provides the framework to achieve results in all dimensions—strategy, operations, clinical quality, physician engagement, staffing, and financial performance.

Present Reality

Board members responding to The Governance Institute's Biennial Survey of Hospitals and Healthcare Systems[13] have consistently cited financial oversight as the board's top fiduciary duty and core responsibility. Ensuring alignment between an organization's strategic, financial, capital, operational, and quality improvement plans is essential to that oversight, according to the survey, and performance of this practice is nearly universal among responding board members.

However, planning practices in healthcare organizations vary, ranging from disconnected processes with limited analyses to highly integrated processes with sophisticated tools and analytics. Data from the 2015 Biennial Survey support this observation: on a 3-point scale with 3 being full adoption of the practice, represented organizations scored an average of 2.22 in relation to having adopted policies and procedures that define how strategic plans are developed and updated, and other important parameters such as who is to be involved, timeframes, and the role of the board, management, physicians, and staff.

Without appropriate policies and procedures, strategic plans are unlikely to be developed and updated in a timely fashion. The lack of timeliness with strategic plans makes it difficult, if not impossible, to ensure their integration with financial and capital plans. In the absence of integrated planning, strategies cannot be pursued and achieved within the financial context required to sustain competitive financial performance into the future.

Why Plan?

Most healthcare organizations have multiple strategic and financial goals related to meeting healthcare needs in their community and to building new competencies required for value-based, population health-focused care delivery. Current goals typically relate to physician alignment strategies, ambulatory facilities, health information technology to support a care management platform, and new partnership arrangements to provide a defined continuum of services across a defined area.

Few organizations have sufficient capital capacity to meet their comprehensive capital requirements. Their leaders must make choices. An integrated planning process effectively provides the "rules of the road" that guide organizations toward achieving their stated purpose(s) within the constraints of financial capability, while navigating the transition from volume-based to value-based care delivery and payment.

Integrated strategic financial planning is central to the time-honored principles and navigational discipline of corporate finance. Used by Fortune 500 companies and successful hospitals and health systems, integrated planning provides the answers to the two critical questions faced by all entities: What investments

should we make? How should we pay for the investments? How executives answer these questions is critical to an organization's success or lack thereof.

Maintaining strong financial performance and market essentiality enable hospitals and health systems to access the capital markets for the funds required to support growth and continued operations. Capital investors and the agencies that rate healthcare debt issues expect hospitals and health systems to have the same discipline around planning as organizations in other industries. As described in more detail in Chapter 3, these players evaluate the quality and integration of a hospital's planning functions. They investigate mission and direction and assess whether leaders have done the financial analyses needed to confirm that the selected strategies can be implemented within financial capabilities over the near and longer-term, and in an acceptable credit context.

Continuous planning that incorporates financial projections at least five years into the future is strongly preferred by the rating agencies. Unlike in past decades when changes occurred more slowly and each strategic decision was additive and influenced another decision perhaps only slightly, the current nature and speed of change in healthcare brings complexities that can make each strategic decision of major import to other decisions. Through "multiple new inputs, constraints, and interconnections," notes one healthcare writer, "each changing vector influences others in ways that rapidly lead us beyond any simple prediction or trend lines."[14] Current decisions can have significant cumulative effects on subsequent decisions.

Scenario planning is critical in this environment. For many capital market players, the absence of financial projections that demonstrate sound planning completely discredits a hospital or health system's strategy and "red flags" the organization's credit status. As described in Chapter 3, the effect on capital access can be significant and long lasting.

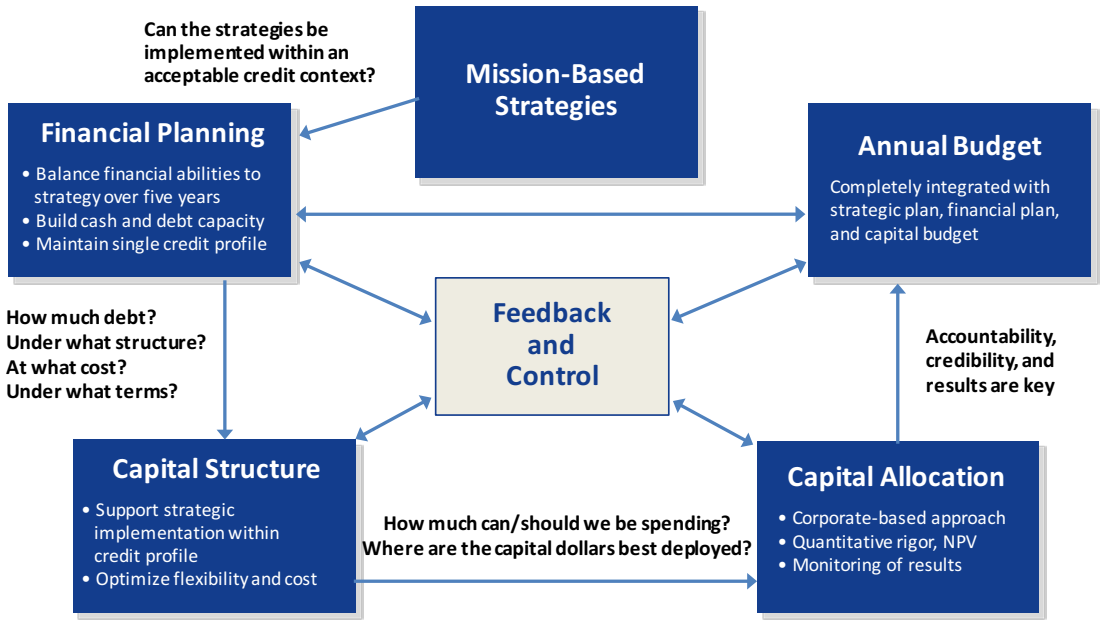
The Planning Process

High-quality responses to the two central questions of corporate finance can be obtained by adhering to the following organizing principle:[15]

> *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.*

This principle requires organizations to use a continuous and integrated strategic, financial, and capital planning process (see **Exhibit 2.1**). The approach involves identifying the strategies best able to achieve the organization's purposes, ensuring the viability of such strategies through solid financial testing and scenario analysis, and then directly and aggressively supporting selected strategies with the needed capital.

Exhibit 2.1: Integrated Planning and Management



Source: Kaufman, Hall & Associates, LLC.

In some organizations, the planning process involves a strategic plan that is linked to a financial plan; in other organizations, the planning process results in one integrated plan. Either approach is appropriate if the planning process includes five interrelated functions:

1. A continuous *strategic financial planning process* that balances an organization's mission-based and market strategies with its financial capabilities
2. *Capital structure management* that is appropriate to the organization's current financial and credit position
3. A *capital allocation process* that enables the organization to prioritize capital spending decisions related to *all* organizational investments
4. An *annual budget* that reflects the strategic, financial, and capital plans
5. *Ongoing monitoring and control* functions that accurately assess whether strategic, financial, and capital targets are being met

The key output of the planning process is a fiscally sound business plan that provides the platform for both long-term and day-to-day decisions, enabling staff at all levels to respond to opportunities and challenges in a flexible, coordinated manner. The plan outlines the organization's strategy and how initiatives are to be pursued, funded, and monitored. It maximizes outcomes while reducing business risk of failure and maintaining a sustainable bottom line.

Learning from Leaders

Through rigorous planning, directors and executives can guide their organizations through the business model transition. Many of the best planning organizations have developed planning processes and capabilities that are modeled on, or share key characteristics of, the disciplined planning used for decades by companies such as General Electric (GE) and Procter & Gamble (P&G), and more recently by the newer Fortune 500 companies, such as Microsoft, Amazon, Apple, and CVS Health.

Disciplined planning likely is *the* key factor supporting strong financial performance over five decades. Of the 30 blue chip companies that were on the Dow Jones Industrial Average in 1976, only four are still on the list—GE, P&G, 3M, and DuPont. These companies and the hospitals and health systems that use a similar approach share a number of core planning attributes, as follows.

A Leadership-Driven and Team-Based Process

"Every study we've ever done underscores the powerful, differentiating role of discipline—disciplined people who engage in disciplined thought and take disciplined action," commented management educator and author Jim Collins. "The sequence is important; there is no disciplined action without first having disciplined people."[16]

Disciplined planning starts with an engaged board of directors and chief executive officer (CEO). They set the tone for the organization, establish management expectations, engender broad participation, and ensure that the organization makes a real commitment to planning.

The subject of considerable study through the decades, GE's planning process is a *top-down* mandate from the board, with management beginning the planning process by setting goals.[17] All business units use the same rigorous planning process, with clearly identified milestone activities and timelines. A *bottom-up process* based on an understanding of competitive position is used to identify growth strategies to achieve strategic and financial targets. Strategic plans roll up from sub-business units to business units, divisions, and then corporate plans.

Healthcare Example. At a major hospital system in Illinois, the solid focus on planning—particularly strategic planning—has been in place for more than a decade. The process used to create the strategic plan and translate that plan into annual implementation plans varied through the years, but a five-year cycle of integrated planning remained constant. That cycle has now been extended to 10 years in order to address longer-term strategic, capacity, facility, and capital needs. Both small-group and large-group planning processes encourage active and open involvement of the board, senior management, medical staff, and academic leaders.

Although each team member brings specific functional expertise to the table, silos in best-practice planning organizations typically are prohibited and regularly sought out and broken down. Finance education is often critical. At GE, such education provides the glue for the integrated planning process and is provided to non-financial professionals company-wide. *Everyone* is expected to have a baseline understanding of financial processes. Vigilance of leadership also is critical. Leaders of successful companies are "hyper vigilant about threats and changes in their environment, developing worst-case scenarios and contingency plans, assuming that conditions will turn against them," commented Jim Collins.[18]

Growth as an Innovation Process

A second attribute of best-practice planning organizations is their recognition of growth as a process involving innovation and reinvention.

Healthcare's transition to a value-based business model is redefining how organizations view growth. Rather than focusing on adding services and capacity as they have for decades, healthcare leaders today must emphasize strategic growth aimed at increasing the overall value of care, offering services in the most appropriate and lowest-cost setting, and building capabilities to best position the organization for population health management. Growth will be measured by indicators related to the number of individuals covered under risk- or value-based contracting arrangements, clinical outcomes, cost efficiency, and patient satisfaction.

Healthcare organizations are reinventing their community-wide mission to offer a new value proposition. For example, seven-hospital Mount Sinai Health System is taking a much broader view of healthcare—one aimed at keeping people out of the hospital—advertising that "If our beds are filled, it means

we've failed." New techniques include mobile acute care teams that provide care in patient homes and post-acute programs that target assistance for patients at high risk of readmission following discharge.

Innovation is growing rapidly, particularly in the low-intensity healthcare delivery space, funded by companies that are going outside traditional channels to offer the choice, convenience, and connectivity that consumers now are expecting in healthcare. For example, CVS Health has extended its role in providing healthcare services beyond the traditional retail pharmacy business model, achieving 25 million visits and expanding to nearly 1,000 locations in 2015 since opening its first retail health clinic in 2000.[19] Uber, which disrupted the taxi industry, is delivering flu shots to consumers' doors. Telemedicine provider Teladoc offers 24/7 access to board-certified doctors via phone and online video consultations.

Organizations need to discover "the new formula." "Any organizational structure you have today is irrelevant because no competition or innovation is going to respect those boundaries," said Satya Nadella, the CEO of Microsoft. "How do we take the intellectual capital of 130,000 people and innovate where none of the category definitions of the past will matter?"[20]

Leading organizations are increasing their efforts to understand, foster, and adopt innovation as part of their growth process. And, "the innovation field has shifted its focus from the generation of ideas to rapid methods of running experiments to test them," noted two experts from the Center for Health Care Innovation at the University of Pennsylvania. "New disciplined techniques are being deployed for testing potentially value-producing ideas faster, less expensively, and more reliably."[21]

Many organizations are partnering with external "accelerators" to quickly and efficiently start innovating. Jim Collins suggests that ability to scale innovation—to go from something small or isolated to something more universal—may be the greatest strength of U.S. enterprises in uncertain and chaotic times.[22]

Growth through reinvention and innovation requires capital. An organization's capital capacity must grow each year to fund its strategies, access to and servicing of debt, and required financial reserves. The ability to incur debt for capital spending positions the organization to be flexible as the industry changes and deliver resources when and where they are needed to achieve strategic objectives, thereby maintaining the organization's competitive performance and overall health.

A Data-Driven Approach

The challenge now for hospitals and health systems is to find ways to achieve growth. The key is to determine, based on solid facts rather than intuition, which opportunities to pursue and, perhaps as important, which *not* to pursue.

Identifying and evaluating opportunities that will enable the organization to grow must occur within an integrated strategic financial planning process. Not all growth is profitable growth, so organizations need to assess and understand the relative risks and rewards of a selected portfolio of opportunities.

A third attribute of best-practice planning organizations is their use of a data-driven approach to assess and select the portfolio of opportunities worthy of their investment. These organizations solidly establish the quantitative fact base required to guide strategic decision making. Their initial big-picture planning questions include:

- What are the critical facts about existing and potential geographic market areas?
- Which markets present the strongest development opportunities for our organization?
- What strategies should we pursue to build position and market essentiality in the priority markets?

Information required to answer these questions includes population demographics (size, growth projections, income, and age/gender distributions), the payer market (industries in the area, payers' relationships with employers, and profitability by payer), hospital and ambulatory competition (market share of competitors by geographic cluster and/or by programs/services), and utilization trends and demand projections.

Data-rich assessments indicate the organization's current position in the market, the competitive arena, and the organization's strengths and weaknesses related to the care delivery role it wishes to assume in priority markets. Careful review and evaluation of collected data enable identification of data that add value and are relevant to decision making. Data and analytics support idea generation and decision making based on solid evidence.

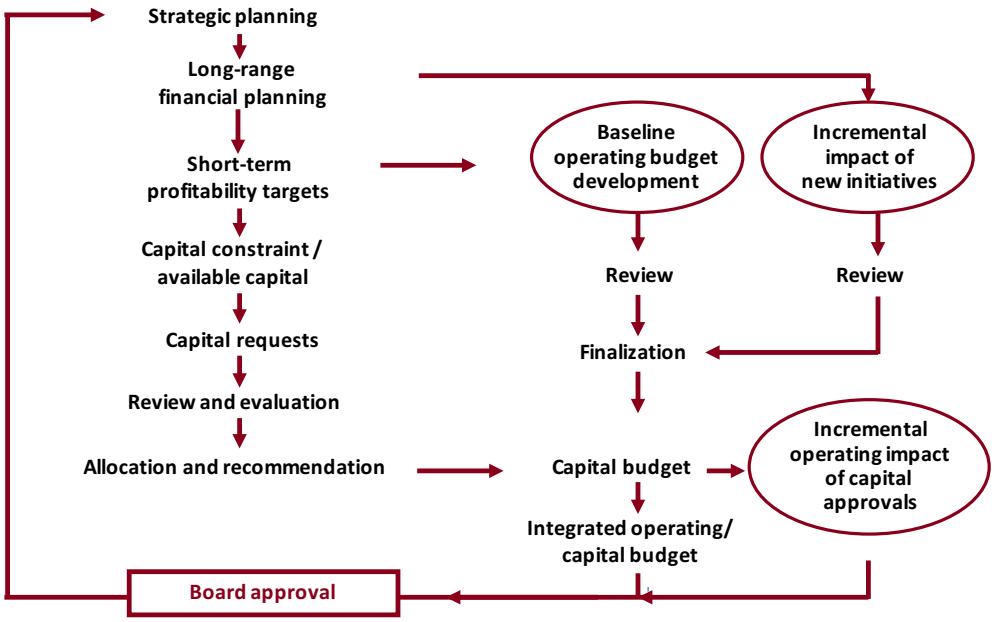
Planning, in effect, is all about increasing organizational self-awareness through systematic, disciplined learning. Planning data and analytics enable organizations to gain a clear view of current reality and the actions needed to shape that reality to a better future.

Structured Decision Making

Decision making at best-practice planning organizations is structured and calendar-driven. Specific planning and review tasks occur in specific months of the year, and culminate with key decisions related to market strategies, financing of the strategies, strategic allocation of capital, and implementation of allocated capital through the budgeting process occurring in each quarter of the year (see **Exhibits 2.2** and **2.3**).

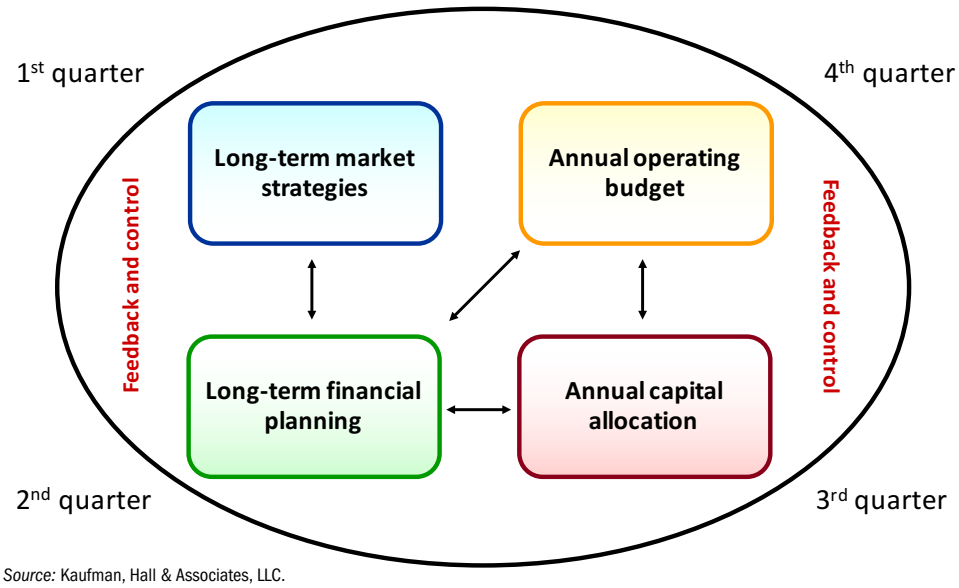
Structured decision making related to strategies that will meet mission, market, and financial goals is key. GE uses Growth Councils comprised of leaders and managers to generate growth ideas, which derive from baseline information about the company's markets, customers, competitors, and capabilities. The top 10 ideas, as identified from a large pool of ideas by the Councils through a grid or matrix-scoring process, receive priority attention. This "less-is-more" philosophy ensures that the organization can focus on those ideas likely to have the best potential.

Exhibit 2.2: The Integrated, Calendar-Driven Planning Process



Source: Kaufman, Hall & Associates, LLC.

Exhibit 2.3: Calendar-Driven Planning Elements



Source: Kaufman, Hall & Associates, LLC.

In the strategic plan of the Illinois hospital system described earlier, the structure for making decisions about investment opportunities involves scoring and ranking the opportunities based on their contribution to the organization's three big-picture goals—to provide the best patient experience; to recruit, develop, and retain the best people; and to develop financial resources needed to achieve its goals through exceptional financial performance. The intent is to select the optimal mix or portfolio of projects that advances best patient experience and best people goals while attaining financial performance targets, as measured by operating income, margin, and cash. Ideas brought forward that are *not* consistent with these objectives are not eligible for funding, no matter how interesting the idea.

Because bad capital allocation decisions can overwhelm an organization's financial resources, the leaders of best-practice planning organizations take extra steps to ensure that they understand the risk, expected return, and exit strategies associated with major capital investment decisions. They incorporate risk analysis into their long-term planning to evaluate upside and downside potential. Sensitivity analysis enables executives to better understand the range of possible outcomes for individual initiatives and the interplay of initiatives.

For example, best-practice decision making requires a health system that is considering major investment in facility reconfiguration, a service line strategy, and a partnership opportunity to take a multi-year look at the financial ramifications. **Table 2.1** indicates the risk over a three-year period under different scenarios assuming the organization achieved only 50 percent of the desired strategies, which also included a cost management initiative.

Goal Setting and Performance Monitoring

The boards of financially successful organizations govern around explicit financial expectations and metrics and are guided by an attitude that senior management will deliver expected results on a consistent basis. Executives set financial goals according to national standards for similarly rated organizations or organizations in the desired rating category. They base financial targets

Table 2.1: Testing the Strategies through Risk Analysis

Sensitivity/Risk Analysis	Target Goal	Minimum Threshold	Year 1	Year 2	Year 3	Variance from Year 3
Strategic Plan						
Operating Margin	5.0%	2.0%	0.9%	1.0%	1.2%	N/A
Operating EBIDA Margin	12.0%	10.0%	8.9%	9.2%	9.6%	N/A
Debt to Capitalization	35.0%	45.0%	21.6%	20.0%	18.4%	N/A
Days Cash on Hand	200.0	175.0	159.7	159.9	147.1	N/A
Cost Management Initiative at 50%						
Operating Margin	5.0%	2.0%	0.7%	0.8%	0.9%	(0.3%)
Operating EBIDA Margin	12.0%	10.0%	8.5%	8.7%	8.9%	(0.7%)
Debt to Capitalization	35.0%	45.0%	21.7%	20.1%	18.5%	0.1%
Days Cash on Hand	200.0	175.0	155.7	155.9	143.1	(4.0)
Facility Reconfiguration at 50%						
Operating Margin	5.0%	2.0%	(1.1%)	(1.0%)	(0.8%)	(2.0%)
Operating EBIDA Margin	12.0%	10.0%	6.4%	6.7%	7.1%	(2.5%)
Debt to Capitalization	35.0%	45.0%	24.6%	23.0%	21.4%	3.0%
Days Cash on Hand	200.0	175.0	139.7	139.9	127.1	(20.0)
Service Line Strategy at 50%						
Operating Margin	5.0%	2.0%	(0.1%)	(0.0%)	0.2%	(0.7%)
Operating EBIDA Margin	12.0%	10.0%	7.4%	7.7%	8.1%	(0.8%)
Debt to Capitalization	35.0%	45.0%	22.1%	20.5%	18.9%	0.5%
Days Cash on Hand	200.0	175.0	149.7	149.9	137.1	(6.0)
Partnership Evaluation at 50%						
Operating Margin	5.0%	2.0%	0.8%	0.9%	1.1%	(0.1%)
Operating EBIDA Margin	12.0%	10.0%	8.9%	9.2%	9.6%	0.0%
Debt to Capitalization	35.0%	45.0%	27.5%	25.9%	24.3%	5.9%
Days Cash on Hand	200.0	175.0	185.4	185.6	172.8	25.7

Source: Kaufman, Hall & Associates, LLC.

on credible projections that reflect a healthy balance between top-down expectations and bottom-up realities, and are built with plausible and defensible assumptions. Assumptions are in line with past actual performance and industry benchmarks.

Each year, GE leadership sets targets that encourage managers to stretch toward breakthrough thinking. Stretch goals are negotiated, but leaders set a high bar. All organizational functions and departments have targets, whether related to customers, employee satisfaction, quality, finances, productivity, or other dimensions. Based on the principle that what gets measured gets done, all targets are monitored with the same rigor. Information on the targets and performance toward meeting them is available and shared widely as an integral part of the planning process.

Broad strategic objectives and goals remain the same from year to year, but actionable initiatives to achieve these goals are revisited annually. Specific individuals are held accountable for each initiative through defined targets and monitoring of success in meeting the targets. Metrics are defined for each target and dashboard scorecards are maintained for both long- and short-term initiatives.

Best-practice planning organizations define strategy success indicators, measure performance against these indicators, and devise and implement plans to respond to less-than-anticipated performance. After new initiatives are fully operational, defined as 24 months for a large start-up or after 12 months for a quick start-up project, leaders assess whether the initiatives are achieving both qualitative and quantitative expectations as defined in the business plan. Modifications or exit strategies are developed as needed.

Concluding Comments

Planning, in effect, is all about increasing organizational self-awareness through systematic, disciplined learning. Planning data and analytics enable organizations to gain a clear view of current reality and the actions needed to shape that reality to a better future. As Jack Welch noted in GE's 1996 annual report, "The desire and the ability of an organization to continuously learn from any source—and to rapidly convert this learning into action—is its ultimate competitive advantage."[23]

Planning provides the roadmap to guide the exploration of new ventures, respond to external changes, and achieve and sustain competitive performance. Rigorous organization-wide planning is a "must have" prerequisite for future success.

So is top-notch leadership. Not-for-profit boards of directors and executives must ensure that the hospitals and health systems they direct increase knowledge-based self-awareness, and the ability to respond to change and shape their future.

Great leaders have the capacity to achieve what Jim Collins calls the "genius of the AND," which is the ability to embrace two opposing ideas at the same time, avoiding the "tyranny of the OR," which pushes people to believe that things must be either A OR B, but not both.[24] So they can embrace:

- Dedication to mission *and* financial stability
- Creativity *and* discipline
- Consistency of values *and* response to change
- Zooming in to implement empirically sound business recipe changes *and* zooming out to assess a change in the environment and to adapt to the unexpected
- Prevention *and* treatment
- Cost *and* quality
- And on and on

Chapter 3:
Why Credit Ratings Matter

A healthcare organization's long-term competitive position today depends substantially on its ability to raise affordable capital in the debt markets. This, in turn, is highly dependent on the organization's credit rating and overall creditworthiness. Boards and executive teams of hospitals and health systems must ensure that the organizations they direct attain and maintain a credit rating that permits the organization to effectively compete in a challenging business environment. Simply stated, credit ratings matter.

Credit Rating Basics

A credit rating reflects a credit rating agency's independent assessment of the borrower's ability to make full and timely payments of principal and interest on a debt security over the course of its amortization period. An agency bases its rating on the organization's (i.e., borrower's) past financial performance and its assessment of the organization's future ability to repay debt obligations based on such factors as its governance and management, and its market and strategic position and plans.

Bond ratings—the key type of credit rating in healthcare—largely determine the interest rate, covenants, and security that investors will require to purchase the bonds and thus the borrower's cost of borrowing money. Each agency uses a slightly different bond rating system. (See sidebar, "What Is a Bond Rating," for a list of rating categories by agency.)

Ratings are reviewed at regular intervals throughout the life of the bonds, typically annually, to reflect internal and external factors that may affect the credit profile and to assure investors of the accuracy of the rating at any given time. Every rating has an "outlook" attached to it, which represents the agency's view of where the rating might be headed in the next one to two years. For example, outlook categories used by Moody's Investors Service include positive, negative, stable, and developing.[25]

What Is a Bond Rating?

A bond rating is a credit agency's assessment of the ability and willingness of an issuer of debt to make full and timely payments of principal and interest on the debt security over the course of its maturity. Each rating agency uses a slightly different rating system, as shown below (from high rating to low rating for investment-grade bonds):

Moody's Investors Service	Aaa, Aa1, Aa2, Aa3, A1, A2, A3, Baa1, Baa2, Baa3
Standard & Poor's Ratings Services	AA+, AA, AA-, A+, A, A-, BBB+, BBB, BBB-
Fitch Ratings	AA, AA-, A+, A, A-, BBB+, BBB, BBB-

Each agency offers non-investment grade ratings as well. Ratings are borrower and issue-specific, meaning that they are assigned by credit agencies based on an evaluation of factors affecting the borrower and its ability to perform in accordance with particular debt obligation requirements.

Sources: Moody's Investors Service, *Rating Symbols and Definitions,* March 2015; Standard & Poor's, *U.S. Not-for-Profit Health Care System Median Ratios Likely to Remain Stable Through 2016 Despite Industry Pressures,* September 2015; and Fitch Ratings, *2015 Median Ratios for Nonprofit Hospitals and Health Care Systems,* August 2015.

The Credit Rating Process

The rating process begins when a healthcare borrower, its financial advisor, or the investment banker contacts a rating agency to request a rating. This generally occurs at least two months

prior to the organization's bond pricing date established for the bond sale. Healthcare organizations are generally required by investors in both the tax-exempt and taxable capital markets to obtain ratings from two of the three rating agencies.

The healthcare organization submits credit information and legal documents to the rating agency. Information reviewed in the rating process often includes basic prospectus information describing the organization; relevant legal documents such as Master Trust Indenture, Trust Indenture, and loan agreements; annual audited and year-to-date financial statements; historical and year-to-date inpatient and outpatient utilization; the current budget; financial projections (especially for new-money issues); sources and uses of funds statements; and the schedule of principal and interest payments for both proposed and outstanding debt.

Rating agencies also examine an organization's capital structure for potential event risks, such as bank credit facility renewals, investor rights to demand immediate repayment for certain types of debt, and the borrower's covenant "headroom,"—i.e., the cushion before triggering an event of default based on financial metrics and the borrowers' underlying bond ratings.

A face-to-face meeting between rating agency and healthcare organization representatives occurs at the agency's offices or at the organization. Rating meetings provide issuers the opportunity to discuss the organization's strategy, vision, and financial profile in the best and most realistic light. The meeting provides the agency the opportunity to assess the management team, board, medical staff, facility(ies), and plans for the near and longer term. Given the changing healthcare environment, the vision and strategic direction discussion is of utmost importance.

Onsite credit presentations typically last two to three hours and sometimes include a site tour. For initial or complex ratings, the organization's CEO, chief financial officer (CFO), chief operating officer (COO), board member(s), physician representative, investment banking underwriter, and financial advisor should be available. A follow-up discussion via conference call is common.

Senior executives must know what numbers they have provided the rating agencies during prior rating evaluations and be able to explain deviations from targets. Both negative and positive deviations from budgets and near-term forecasts are important. Executives should be prepared to explain what they have accomplished since the last review, including where the organization stands relative to any strategic and cost management initiatives. When an organization's numbers are repeatedly below budget or it cannot execute its strategic plan, agencies justly question whether governance and management truly understand the organization's strategic and financial challenges.

Several weeks before pricing, the lead rating agency analyst assigned to the issuance makes a credit presentation to the agency's rating committee. The presentation includes a rating recommendation and rationale. Rating decisions are made by a majority vote of the committee. The lead analyst informs the healthcare organization's representatives of the decision immediately following the vote.

If public (versus private) ratings are desired, which is practically always the case, a formal report is published by the rating agency. The healthcare organization typically has an opportunity to review the report in advance of publication to check for factual inaccuracies. By agreeing to a public rating, the organization is committed to interacting with and providing ongoing information to the rating agency for the life of the bonds.

Effective leadership is critical to strong financial performance, which, in turn, is critical to creditworthiness. Good managers and board members can make things happen; ineffective managers and board members cannot. Finding the right people is particularly critical for healthcare organizations during periods of rapid change.

What the Rating Agencies Look For

Rating agencies assess an organization within the context of the organization's local, regional, and national service area, as appropriate. In individual credit analyses, the agencies analyze how an organization has positioned itself in the past and is positioning itself for the future in such markets.

Agencies thoroughly assess relevant data to evaluate whether the organization understands its marketplace challenges and opportunities and is able to identify financially viable and competitive strategies in order to be successful. Strategies encompass key creditworthiness factors broadly categorized as governance and management, market and strategic position, and financial performance and debt position.

Governance and Management

Effective leadership is critical to strong financial performance, which, in turn, is critical to creditworthiness. Good managers and board members can make things happen; ineffective managers and board members cannot. Finding the right people is particularly critical for healthcare organizations during periods of rapid change.

Rating agencies determine whether management has developed or hired people with the skills and understanding to cope with new business challenges and whether the organization has modified its operations to meet those challenges. They assess board members' ability to balance market and growth opportunities with competitive financial performance. Directors must be capable of high-level strategic thinking. Equally important, they must be able to link strategy to financial projections and analysis. A healthy respect for the capital markets and recognition of the importance of preserving credit quality are essential.

Market and Strategic Position

Market position involves gauging the extent to which the organization operates in the marketplace, looking specifically at the organization's size, geographic dispersion of facilities and services offered, market share, and the presence or potential entry of formidable competitors. Rating agencies assess an organization's market strength and competitive differentiation, both of which are critical to long-term competitive financial performance. Key questions include:

- How prepared is the organization to assume value- and risk-based payment mechanisms?
- How well does the organization perform on quality measures?
- Does the organization have an appropriate IT platform?
- Does the organization provide the appropriate services in the most appropriate settings?
- Who are the key competitors?
- How attractive is the organization to payers?
- Is the organization able to compete as a cost-effective provider?
- How strong is the organization's physician enterprise?
- Does the organization have the right talent to achieve its goals and maintain capital access?
- Does the organization need to partner to achieve its strategic goals?

Data required to answer all of these questions are not "nice-to-know" information, but rather "need-to-know" information for the capital markets.

Many organizations are making substantial investments to restructure their operations and care delivery in preparation for managing population health. Healthcare leaders must consider the potential ramifications of such investments on their organization's credit rating and capital access. Rating agency representatives understand that infrastructure investments for value-based care and population health management reduce revenue and increase costs in the short term—but they stress the importance of communicating plans with them "early and often."[26]

Notes one rating agency official, "Financial performance is a product of the qualitative and strategic factors pursued by the organization. Expectations for future financial performance and, ultimately, the credit rating, are informed by assessment of those factors. As long as a borrower's underlying strategic position remains sound, a certain amount of financial variability should not affect the rating."

Financial Performance and Debt Position

Rating agencies assess financial performance through financial metrics that indicate an organization's ability to repay debt. For system-affiliated hospitals, credit agencies focus on the system entity rather than specific hospital operations. Rating agencies see benefits associated with the scale systems possess and their ability to manage risks. This is an increasingly important issue as hospitals take on financial and clinical risk for managing a specific population's health under value or risk-based arrangements. The larger and more diversified the organization, the greater the flexibility it has in key ratios relative to standalone hospitals, which must meet higher standards because of their smaller size and scope.

Rating agencies review consolidated financial information with a focus on cash flow generated from core operations and on the key ratios that incorporate cash flow. These factors go to the heart of the assessment of credit risk. On the revenue side, rating agencies review the organization's payer mix, contractual arrangements, and ability to negotiate favorable terms in the market.

Multi-year financial planning and financial projections that are linked to the concrete initiatives described in the organization's strategic plan are strongly preferred by the rating agencies. How cash balances are invested is important, as are the organization's dependence on non-operating income to bolster profit margins and ability to duplicate or exceed the current year's financial performance.

Revenue and expense management are increasingly important aspects of creditworthiness. With declining inpatient utilization, pricing pressures, and increasing competition, many organizations must go beyond traditional cost management initiatives and significantly reduce their cost structures. Cost restructuring involves right-sizing the scope of business and service offerings and determining how best to distribute them to meet community needs.

Key Rating Issues Over the Immediate Term

Rating agencies revise a credit rating, either upward or downward, when an event or combination of events have weakened or strengthened an organization's ability to repay its debt obligation. In some cases, unexpected occurrences or developments, such as a hurricane or flood, have been material enough to warrant a rating change. Moody's Investors Service published a list of key rating issues:[27]

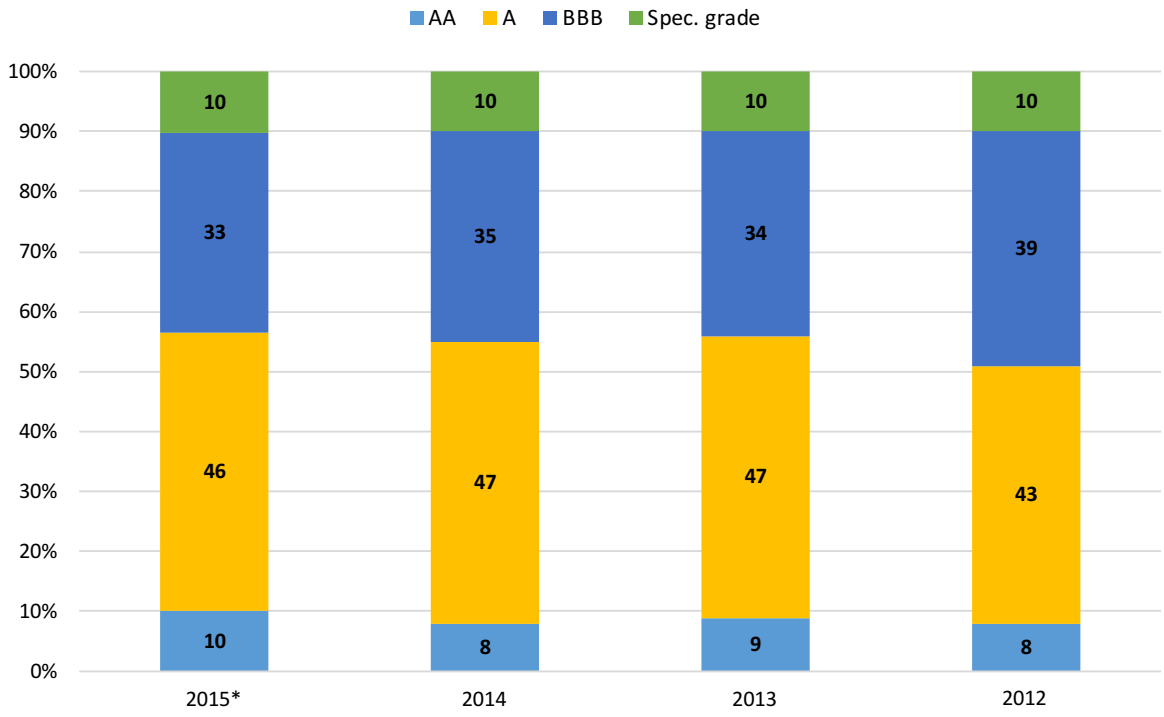
1. *Demand for service:* The aging of the population is expected to continue to drive the need for more healthcare services, but providers are subject to utilization pressures as patients avoid non-emergent procedures and defer physician visits to reduce out-of-pocket costs.
2. *Pricing pressure:* Universal concern about rising healthcare spending has led to increasing pressure on payments for healthcare services.
3. *Regulatory scrutiny:* Increased focus on the cost of healthcare services has amplified the level of regulatory scrutiny.
4. *U.S. healthcare reform:* The Affordable Care Act of 2010 continues to have uneven repercussions for healthcare markets around the country, including the expansion of health insurance coverage to millions of Americans and lowering of bad debt in some communities, reductions in Medicare payments, and continued uncertainty about the long-term implications of many provisions of the law.
5. *Consolidation:* The drive to control healthcare costs and pricing pressure are increasing the need for organizations to operate efficiently and effectively. These pressures are making it harder for standalone operations to remain competitive. Increased administrative burdens associated with ensuring quality of care and tracking clinical outcomes also require significant investment that in turn requires sufficient capital access, which is more readily available to the larger established providers that can leverage these investments across a larger base.

Healthcare industry credit ratings have been relatively stable in recent years following decades of declines. In 1983, more than 70 percent of the credits in Standard & Poor's healthcare rating portfolio (including standalone hospitals and health systems) were in the "A" category. In 2014, this proportion was 47 percent.[28] **Exhibit 3.1** shows the stable healthcare ratings distribution for standalone hospitals since 2012.

Capital Access and Other Rating-Impacted Benefits

Access to capital is entirely dependent on whether a hospital achieves the financial performance required to meet its long-term goals. Every hospital or health system has a defined level of profitability and financial success necessary to meet its strategic financial requirements. Depending on whether a hospital is or is not meeting those requirements, it either will have or not have access to low-cost capital, as chiefly determined by its credit rating. For hospitals and health systems with declining creditworthiness, as reflected in declining financial performance,

Exhibit 3.1: Standalone Hospital Ratings Distribution



*As of July 18, 2015

Source: Standard & Poor's, *U.S. Not-for-Profit Health Care Stand-Alone Ratios Signal Continued Stability Through Next Year Despite Industry Pressures*, September 2015.

access to the capital markets is increasingly limited and will continue to be so.

Benefits enjoyed by organizations with strong credit ratings, defined as "A" or above, are described below.

Improved Capital Market Opportunities

Credit enhancement, such as a letter of credit, enables an organization in the "A" or better category to essentially "buy up" to a higher credit rating on a floating-rate debt obligation. In recent years, private lenders, especially commercial banks, will extend credit to borrowers by directly purchasing their securities through a private placement or by extending a direct loan. A higher rating means lower interest costs on bonds and these debt instruments as well. A small decrease in the interest rate or credit spread, multiplied out over the life of the debt instrument, can mean significant savings and the difference between competitive and non-competitive financial performance. Creditworthy organizations also can access derivative options, such as interest-rate swaps, caps, and other means or mechanisms to reduce risk exposure and overall interest rate costs.

Access to Both Taxable and Tax-Exempt Debt

Taxable debt, not accessible to organizations with lower credit ratings, may be required for certain programs or services that don't qualify for tax-exempt debt. Organizations with strong credit ratings may want to exercise the taxable debt option for investments such as medical office buildings, joint-venture ambulatory facilities, information technology needs, or physician group practice acquisitions.

Less Restrictive Bond Document Covenants

Bond documents include covenants, which are the requirements that the borrower must meet on an annual, and sometimes quarterly, basis. For example, bond covenants frequently define the number of days cash on hand or a specific debt service coverage ratio that the borrowing organization must maintain. Covenants can limit an organization's financial flexibility—for example, its ability to respond quickly to an acquisition opportunity that would reduce liquidity indicators, such as days cash on hand. Lower-rated organizations are held to different standards that limit their flexibility.

Lower Costs Associated with Bond Issuance

Higher-rated organizations enjoy an expanded pool of potential bondholders. Many of the large investor groups, funds, and insurance corporations that normally buy tax-exempt hospital bonds are precluded from buying debt beneath the "A"-rated category. Hence, the pool of potential investors for "BBB" bonds, for example, is much smaller than it is for higher-rated bonds. Because of the lower risk associated with issuing bonds for a creditworthy organization, costs related to letters and lines of credit from banks as well as underwriting and remarketing charges are lower.

Creditworthy Organizations Are Market Consolidators

Because they can offer excess capital capacity and lower capital costs, organizations with the highest credit ratings are the most attractive partners to those with lower ratings. Organizations with capital capacity are consolidating markets through acquisitions, mergers, or a variety of different types of strategic partnerships aimed at building market essentiality and new-era capabilities, while also preserving access to cost-effective capital.

Key Indicators Used in Many Effective Financial Analyses

Profitability Indicators

- *Operating margin* reflects the profitability of an organization from its active patient care and other operations, including health plans.
- *Excess margin* reflects profitability from operations and includes revenue and expense from non-operating activities such as investment earnings and philanthropy.
- *Operating earnings before interest, depreciation, and amortization (EBIDA) margin* provides a good look at an organization's ability to generate enough cash to meet interest and principal payments on debt.

Liquidity Indicators

- *Days cash on hand,* probably the most important credit ratio in use today, reflects the number of days of cash set aside by the organization to support operating expenses if revenue stream were to be reduced or eliminated.
- *Cash-to-debt ratio* measures the availability of an organization's liquidity to pay off existing debt; this assumes greater importance for organizations with demand debt that stipulates that the lender or investors can immediately seek repayment.

Debt Indicators

- *Debt-service coverage ratio* measures the ability of an organization's cash flow to meet its debt-service requirements.
- *Debt-to-capitalization ratio* indicates how highly leveraged, or debt financed, the organization is—the higher the capitalization ratio, the higher the risk.

Other Indicators

- *Average age of plant* provides a relative measure of the age of the physical facilities and provides insight into the organization's future capital needs.
- *Capital spending ratio* assesses capital spending as a percentage of EBIDA.

Source: Kaufman, Hall & Associates, LLC.

Table 3.1: Key Creditworthiness Ratios

Indicator	Financial Ratio
Operating margin	Total operating revenue – Operating expenses / Total operating revenue
Excess margin	Income from operations + Non-operating revenue / Total operating + Non-operating revenue
Operating EBIDA margin	Operating income + Interest + Depreciation + Amortization / Total operating revenue
Days cash on hand	Cash + Marketable securities + Board-designated funds / (Total operating expenses – Depreciation – Amortization) / 365
Cash-to-debt ratio	Cash + Marketable securities + Board-designated funds / Long-term debt + Short-term debt
Debt-service coverage ratio	Excess revenue over expenses + Depreciation + Interest + Amortization / Annual debt service
Debt-to-capitalization ratio	Long-term debt (less current portion) / Long-term debt (less current portion) + Unrestricted net assets
Average age of plant	Accumulated depreciation / Annual depreciation
Capital spending ratio	Capital expenditures (additions to property, plant, and equipment) / Depreciation expense

Source: Kaufman, Hall & Associates, LLC.

Understanding an Organization's Credit Position

Dozens of factors are relevant to financial performance; the challenge for an organization's board and management team is to select those most indicative of financial strengths and weaknesses and closely monitor these on a regular basis. (See sidebar, "Key Indicators Used in Many Effective Financial Analyses," for a list of key measures used in many effective financial analyses, and **Table 3.1**, which defines their associated ratios.)

Boards and executives can better understand a hospital or health system's current credit position by conducting a financial credit analysis. This essentially allows them to compare the organization's recent financial performance to relevant national standards that serve as a benchmark.

Organizational leaders typically construct the necessary data chart by using key median indicators from Moody's, Standard & Poor's, or Fitch Ratings for similarly rated organizations. These indicators include revenue, income, cash, and debt figures as well as profitability, debt, and liquidity ratios (see **Table 3.2** for financial credit analysis highlights for a hypothetical sample health system). An analysis of the data enables the board and management to draw conclusions or make key observations about relative performance. Benchmarking against median data often enables organizations to identify negative trends that must be addressed in order to preserve or enhance the organization's credit rating.

Table 3.2: Financial Credit Analysis Highlights for a Sample Health System *(dollars in millions)*

Ratio/Statistic	Moody's	S&P	Fitch	Fiscal Year Ended December 31,		
	A3	A-	A-	2013	2014	2015
Total Operating Revenue	$494.5	—	$489.3	$456.0	$462.0	$480.0
Net Patient Service Revenue	$460.3	$316.5	—	$445.9	$463.0	$490.0
Operating Income	$14.4	—	—	$7.1	$5.8	$7.8
Operating EBIDA	$47.5	—	—	$41.4	$41.0	$43.0
Net Income	$30.5	—	—	$19.1	$11.5	$19.8
Cash Flow (Net Inc + Depr)	$62.8	—	—	$45.9	$39.5	$48.3
Unrestricted Cash	$232.9	$189.9	—	$240.0	$257.0	$285.0
Long-Term Debt	$206.8	—	—	$170.0	$170.0	$166.0
Capital Expenditures	$37.5	—	—	$22.0	$31.3	$30.8
Profitability						
Operating Margin	3.0%	3.0%	3.9%	1.6%	1.3%	1.6%
Operating EBIDA Margin	9.3%	9.8%	10.3%	9.1%	8.9%	9.0%
Debt Position						
MADS Coverage (x)	4.2	3.8	3.7	4.4	3.8	4.5
Long-Term Debt to Capitalization	38.3%	32.6%	40.3%	41.0%	40.2%	38.1%
Long-Term Debt to Cash Flow (x)	3.5	—	—	3.2	3.6	3.0
Liquidity						
Cash to Long-Term Debt	127.6%	149.9%	119.1%	141.2%	151.2%	171.7%
Days Cash on Hand (days)	197.2	202.6	191.4	230.8	234.4	247.3
Other						
Average Age of Plant	11.1	10.8	10.7	10.3	11.2	11.0
Capital Spending Ratio	104.8%	119.0%	93.8%	82.1%	111.8%	108.1%

Source: Kaufman, Hall & Associates, LLC, using Moody's, S&P, and Fitch 2015 rating medians (2014 data); Sample Health System FY2013 and 2014 audits; FY2015 budget.

Concluding Comments

Debt capital remains available, but the bond and capital markets are increasing the requirements for access by healthcare organizations. Healthcare leaders must heed the financial assessments of rating agencies and the institutional investor community. Markets are expecting not-for-profit healthcare organizations to have the same kind of focus and attitude that publicly traded corporations maintain in dealing with Wall Street. This means real business plans, financial results that measure up to previous forecasts, expert allocation of capital, and vigilant attention to strategic and financial trends.

Credit and creditworthiness are enduring concepts. Healthcare organizations that understand the importance of creditworthiness and maintain a strong credit position will do well in the future. Those that neither understand the factors underlying creditworthiness nor maintain a strong credit position are operating in uncertain circumstances with an unpromising future.

Chapter 4:
Finding the Right Balance of Cash and Debt

One of the most challenging areas in healthcare management today is how hospital boards and management meet the organization's strategic capital requirements now and into what is projected to be a very different future.

FOR MANY ORGANIZATIONS, THE FOCUS OF CAPITAL spending in past years was on bricks-and-mortar inpatient facilities. But this focus continues to shift to strategic investments in areas such as the physician enterprise, ambulatory services, information technology, and health plans. Directing the hospital's capital spending, cash and debt positions, and associated credit rating involves pivotal leadership decisions that can sustain (or impair) an organization's future.

The Crux of the Challenge

Spending capital, incurring debt, and maintaining adequate cash are critically important leadership functions. Key data reflect current national trends in each area:[29]

- Capital spending by non-profit hospitals continues to slow. After years of increases, the median growth rate of capital spending turned negative in 2013 and fell to -3.9 percent in 2014. The median average age of plant rose to 10.8 years in 2014 as a result, up from 10.6 years in 2013 and 10.4 years in 2012.
- Median total direct debt declined nearly 2 percent, to $243.9 million in 2014 from $245.0 million one year earlier.
- Days cash on hand continued its significant upward climb, reaching nearly 205.8 in 2014, up from 164.2 in 2010. Not surprisingly, cash-to-direct debt increased to 151.2 percent in 2014, up from 117 percent in 2010.

A hospital's ability to access the capital markets depends on credit ratings and overall creditworthiness, as described in Chapter 3. Balancing long-term creditworthiness against the need for capital has become an increasingly difficult exercise. On which side do leaders err—more debt and more acquired capital, which may very well lower bond ratings, or less debt and less acquired capital, which will possibly stabilize bond ratings, but may harm strategic and clinical competitiveness?

And how much cash is enough cash for operating and reserve purposes? This question arises in many director and executive forums. The frequently unspoken related question is, "Why shouldn't we dip into cash reserves to meet strategic capital needs?"

The entire credit versus capital debate is frequently argued in overly simplistic terms. In reality, both credit and access to capital are highly complex concepts. Without a keen understanding of that complexity, boards and senior executives might find the organizations they direct exposed to a series of increased risks that were not properly evaluated or understood. A more complete discussion includes the following issues.

Key Issues

Respect for the Capital Markets

Over time, the strategy of spending down cash and borrowing aggressively will likely lower average bond ratings for an organization in the "A" category to the "BBB" category. Deliberately reducing bond ratings to accommodate strategic investment reflects a certain naiveté about the capital markets. Such a strategy assumes that "BBB" credits will always have easy and unfettered access to both capital and market liquidity. This assumption has been disproven as recently as during the subprime mortgage crisis.

Future Ability to Incur Debt

At lower credit-rating levels, capital market requirements for debt service coverage—the revenue available for debt service payments—are not as stringent as they are at higher credit ratings. Organizations willing to let their credit rating slide are able to take on more debt. Deliberately lowering a credit rating, thus, in the short run, increases debt capacity. However, in the long run, debt capacity will suffer if financial performance does not improve over time, presumably at least in part from the strategic investments made from the incremental debt. Deteriorating debt capacity has been a major competitive obstruction

for many hospitals, leading many organizations to seek strategic partners or to become part of a larger organization with greater debt capacity.

What Goes Down Doesn't Necessarily Go Up

Organizations that allow their credit rating to drop are "banking on" financial returns from incremental strategic investments that will allow the organization's rating to bounce back up over some period of time. Past performance does not support this expectation. As the economists say, bond ratings are "sticky down." Once ratings decline, they rarely go back up as quickly as organizations expect, and, when they do go back up, they go back up slowly.

Business Risk and Community Trust

Pursuing a credit strategy of higher debt and lower liquidity exposes an individual hospital to significant business risk. Some questions are appropriate:

- How much liquidity does the organization need to compete long term?
- If the hospital's leaders deliberately reduce the required liquidity level to support current strategic investment, what is the plan to replace lost liquidity, and is this plan a realistic one?

Investment Performance and the Primacy of Cash

How might a deliberate reduction of liquidity affect the hospital's investment portfolio? What if stock market averages dropped 1,000 points at the same time hospital financial leaders were converting cash to facilities and physician practice acquisitions? Would such a combination of events materially weaken the hospital's balance sheet?

Having ample cash reserves and a sound balance sheet management strategy are more important than ever. Increased liquidity gives organizations the ability to weather challenges in the market, payer, credit, and other environments. The financing platform of not-for-profit hospitals is dependent on operating cash flow and debt. Cash buys time. When times get tough, the capital markets require a larger "insurance policy" on the balance sheet. Cash provides such insurance.

Sustainability

The key issue really is sustainability, with the critical questions being these: If an organization spends down cash, and increases debt and the level of strategic capital investment, what is the probable outcome of that financial strategy? Will the clinical and strategic investments produce sufficient cash flow over time to allow the organization to improve its credit position and capital capacity and repair its balance sheet?

The long-term consequences of capital investment that degrades credit position are significant. Healthcare industry history suggests that few organizations will be able to rehabilitate declining liquidity and compromised credit ratings. In fact, a lower credit rating almost always goes hand-in-hand with decreased financial competitiveness.

The consequences of "over-borrowing" to solve a major strategic problem, and then actually failing to solve that problem, are almost always financially problematic. Many organizations are financially paralyzed by such an outcome and often left with exit strategies that are undesirable to both the board and the hospital community at large.

Sustainability in healthcare is achieved through maintaining adequate liquidity, debt positions, and associated credit ratings that are consistent with a hospital's long-term strategic and capital requirements. Thoughtful credit decisions that are made within an appropriate financial context will help to preserve an organization's long-term strategic financial health.

How Much Cash Is Enough Cash?

Cash continues to be king. It is critical for funding operations and providing credit strength. Cash also gives an organization the reserves for new strategic initiatives and/or future partnerships. Unlike public for-profit companies that focus attention on earnings and shareholder returns, not-for-profit organizations concentrate more on days cash on hand and their ability to fund capital initiatives to meet their mission.[30] In successful not-for-profit hospitals and health systems, leadership attention to cash position is rigorous and pervasive.

The days-cash-on-hand ratio, *the* critical measure of liquidity, has been increasing for years. This ratio indicates the numbers of days a hospital or health system could continue paying its cash operating expenses from existing liquidity balances in the absence of any future cash inflows. The median days cash on hand for "A"-rated standalone hospitals in Standard & Poor's portfolio is 273; for "AA"-rated organizations, the median is 402 days.[31] These medians are expected to decline somewhat in coming years as organizations redeploy capital to meet major spending needs, particularly those related to information technology, physician ventures, and health plan investments.

So how much cash should an organization maintain on its balance sheet? Should the medians be the target? There's no simple answer. Liquidity is a critical factor that rating agencies analyze in assigning a credit rating. One rating agency representative

notes: "We understand that the industry is going through fundamental change and that with greater uncertainty comes greater risk. Our goal is to understand what that risk represents to an organization's ability to make timely payments of principal and interest. A strong liquidity position allows greater tolerance for negative variation in expected operating performance."[32]

The "right" amount of cash will vary by organization based on the competitive environment, market dynamics, payer challenges, and many other factors.

The rating agencies and other capital market players look for a balance between capital spending and balance sheet growth. Their goal in evaluating organizational credit is to ascertain whether the organization is spending enough to maintain or improve its competitive position and prepare for the new value-based business model, while preserving enough cash on the balance sheet to weather declining inpatient utilization and payments and other adverse changes. High liquidity coupled with both outdated facilities and information technology signals that the organization may be under-spending and losing ground competitively. Similarly, spending down cash to accommodate strategic investment that doesn't bring balance sheet growth or improve an organization's positioning is a risky proposition, as described earlier.

Without access to the equity markets and typically achieving modest philanthropic support, not-for-profit hospitals are entirely dependent on operating cash flow and debt. They must have sufficient cash to weather a business downturn. The organization's overall strategy for capital replacement and capital investment as it relates to cash levels is critical.

How Much Debt Can We Afford?

Moving from the left to the right side of the balance sheet, access to external capital is an equally essential resource for all competitive healthcare providers. No healthcare organization can fund its long-term strategic initiatives solely from reserves or even a combination of reserves and operating cash flow. Almost all not-for-profit hospitals and health systems must access the capital markets on a regular basis.

Answering the question, "How much debt can the organization afford?" also often poses a significant challenge. Too much debt can lower an organization's credit rating, resulting in higher cost of capital and diminished financial flexibility. So what's the right amount? Again, there's no one simple answer, but a close look at debt capacity by an organization's leadership team provides a place to start.

Debt Capacity

Defined as the amount of debt an organization is capable of supporting within a particular credit rating profile, *debt capacity* establishes the parameters of the right side of the balance sheet. Debt capacity must expand each year if an organization wants to remain strategically and financially competitive. The ability to incur additional debt makes hospitals more responsive to their markets and more resilient to expected and unexpected changes. Access to new debt capacity is a function of an organization's creditworthiness, which is based on factual data, expected performance, and the willingness of the capital markets to support an organization's strategy.

Determination of debt capacity is both art and science. The art involves assessment of perceived risk inherent in the organization's environment (for example, physician relations and competition) and the organization's ability to achieve results given these risks. If results are not achieved, obviously the organization would not be able to support the targeted level of debt. The science involves the objective measurement of capacity using data including the amount of debt outstanding and cost of capital. The rating agencies publish ratios on the level of debt capacity organizations generally assume given bond ratings, which are based on selected operating and financial characteristics.

Finance managers should give careful thought to the selection of debt capacity methodologies, including which ratios to use, relative weightings across ratios, and when to measure (historical or projected). Three credit ratio-based approaches can be used:

1. *Debt Service Coverage* (cash flow approach), which focuses on the relationship between current profitability and maximum annual debt service (MADS, or the maximum amount of cash an organization has available annually to make debt payments), is calculated as follows:

   Excess of revenue over expenses + Interest + Depreciation + Amortization / Maximum annual debt service

2. *Debt to Capitalization* (leverage approach), which focuses on the relationship between debt and total capitalization, is calculated as follows:

   Long-term debt (less current portion) / Long-term debt (less current portion) + Unrestricted net assets

3. *Cash to Debt* (liquidity approach), which focuses on the relationship between liquidity and debt, is calculated as follows:

   Cash and marketable securities + Board-designated funds / Long-term debt + Short-term debt

The calculations result in different debt capacities, so managers will want to apply weightings to reflect the perceived importance of each approach. Best-practice management of debt capacity is based on maintaining appropriate credit profile targets and balance among these methodologies.

Table 4.1 illustrates how a hypothetical organization used three ratios—MADS Coverage, Debt to Capitalization, and Cash to Debt—and weighted each (50 percent, 10 percent, and 40 percent respectively) to calculate its weighted incremental debt capacity at various ratings. The results show how the organization's incremental debt capacity is constrained within the organization's applicable A3/A- rating medians. Any significant future borrowing for this organization is dependent on generating strong operating cash flow *and* improved cash on the balance sheet.

After an organization has determined its debt capacity, it knows how much it can borrow in the debt markets and how much capital will need to come from other sources to fund its strategies.

Concluding Comments

Finding the right level of capital spending and the right balance of cash and debt involves disciplined financial planning, execution, and continued monitoring to ensure the most effective use of capital, cash, and debt resources. Strong leaders are willing to make the tough decisions needed to preserve cash and grow debt capacity for continued organizational investment and competitiveness.

Table 4.1: Calculating Weighted Debt Capacity

($'s in millions)	Key Target	Estimated Incremental Debt Capacity 2013	2014	2015	Weighting
1. **MADS Coverage**					
Moody's - A3	4.2x	$7.1	$0.0	$13.0	50%
S&P - A-	3.8x	$27.7	$0.6	$34.2	
2. **Debt to Capitalization**					
Moody's - A3	38.3%	$0.0	$0.0	$1.6	10%
S&P - A-	32.6%	$0.0	$0.0	$0.0	
3. **Cash to Debt**					
Moody's - A3	127.6%	$18.1	$31.4	$57.4	40%
S&P - A-	149.9%	$0.0	$1.4	$24.1	

Target Metrics	Estimated Incremental Weighted Debt Capacity 2013	2014	2015
Moody's - A3	$10.8	$12.6	$29.6
S&P - A-	$13.9	$0.9	$26.7

Note: Cash flow debt capacity calculated using 30-year amortization at 5 percent interest rate and normalized investment return at 6 percent.
Source: Kaufman, Hall & Associates, LLC.

Chapter 5:
How Much Can the Hospital Afford to Spend?

Changes occurring in healthcare are pushing hospitals and health systems to rethink their traditional delivery networks to ensure a configuration that maximizes quality while minimizing cost.

DEVELOPING THE COMPETENCIES AND INFRASTRUCTURE for a value-based/population health management care delivery and payment system requires a high level of spending—much of which may lower financial performance for a period of time, but would lead to projected benefits long term. Few healthcare organizations have sufficient capital resources to meet all of their strategic capital spending requirements (e.g., physician enterprise, information technology, care delivery infrastructure/partnerships, care coordination models/protocols, network development, etc.). With numerous investment demands occurring simultaneously, it is especially important that board and management teams carefully prioritize and monitor spending.

Capital allocation is the process for deploying scarce capital resources (cash and debt capacity). *Capital management* is the ongoing monitoring and control function that ensures the integrity of the allocation decision process and appropriate application of allocated funds. How much capital to spend—the topic of this chapter—and the projects on which dollars will be spent—the topic of Chapter 7—are critical decisions with long-term strategic and financial implications. The organization's long-range strategic financial plan, including operating, financial, and capital projections based on defined strategies, should guide spending decisions.

High-Level Oversight and Organization

High-level management/control is the linchpin to the consistency, integrity, and ongoing success of a capital allocation and management process. A best-practice process depends on the clear definition of process roles, responsibilities, and accountabilities. Although oversight structures will vary by organization, they must involve high-level corporate and operational management. By definition, managing capital is a process that involves money; through the distribution of dollars, the process also apportions influence and power.

In establishing the oversight structure ("the capital management council"), the board and senior leaders should consider the following questions:

- Should oversight be concentrated in senior or corporate management only?
- What role should be played by constituencies such as medical staff and operating entity managers?
- Who will/will not have voting privileges?
- How often should the capital management oversight group meet?
- Will middle management interact with the oversight group? If so, how?
- What process steps and tasks should the oversight group delegate, and to whom?

With so much at stake, process oversight must be completely supported by the CEO. Even if the CEO names the CFO as head of the capital management council, it should be absolutely clear that the CEO is working in close partnership with the CFO to affect this important decision-making process body. The CEO's unconditional support and leadership help ensure a level playing field among senior executives and the avoidance of process run-arounds, which are more likely to occur without such leadership.

The sidebar entitled "Capital Allocation and Management Oversight Structure" provides a suggested oversight structure. The group should include key members of the C-suite—for example, the CEO, CFO, COO, chief information officer (CIO), chief medical officer (CMO), and newer designations such as chief transformation officer (CTO) and/or chief population health officer (CPHO)—and operational executives. In a multihospital system, the operational executives would typically be CEOs of subsidiary entities or regional executives. In a community hospital, vice president-level executives responsible for major operating components, such as network development and management, and patient engagement, may be included as voting members of the oversight group.

Capital Allocation and Management Oversight Structure

Voting Members

- Chief executive officer
- Chief operating officer
- Chief financial officer
- Chief information officer
- Chief medical officer
- Chief transformation or population health officer
- Operational representatives (two or three)

Non-Voting Staff Support

- Finance staff
- Strategic planning staff
- Network development/contracting staff
- Information systems staff

Source: Kaufman, Hall & Associates, LLC.

Capital Resources Defined

A corporate finance approach to capital allocation and management is based on a contemporary definition of capital, which should include all types of proposed investments (uses of cash) that will be subject to the policies and structure of the capital allocation process. As such, this definition extends beyond traditional capital items, such as property, plant, and equipment, to embrace everything that might appear on the cash flow statement, including such items as working capital for delivery network enhancements or start-ups, joint venture investments, and all other items that take cash *out* of the organization.

The standard definition of capital that focuses only on depreciable assets is far too narrow to support truly strategic capital management. Because of the breadth of sources for the capital deployed through the capital allocation and management process and the variety of uses for capital, a broad definition of capital is needed. The sidebar entitled "Types of Investments Covered by the Capital Allocation Process" provides a broader description of capital that could apply to a typical community hospital as easily as to a sophisticated regional provider or multihospital health system. These types of capital should be covered by the capital allocation process regardless of the accounting treatment or source of financing.

Types of Investments Covered by the Capital Allocation Process

- Facilities, property, and equipment
- Physician enterprise development
- New businesses/partnerships
- Network development
- Managed care investments
- Information technology
- Routine infrastructure

Source: Kaufman, Hall & Associates, LLC.

The Process

A best-practice capital allocation and management process is framed by a clear definition of how much the organization can afford to spend. Calculation of the organization's *capital constraint* identifies the net capital available for spending during a designated period of time, often defined as next year and three to five years into the future.

The complete picture of the capital constraint emerges through a thorough analysis of an organization's capital position. This analysis considers all sources and uses of funds (see **Table 5.1**), including principal payments, working capital changes, and additions to balance sheet cash reserves, which are added to an income statement-based calculation.

Table 5.1: Capital Position Should Reflect Comprehensive Organizational Cash Flows

Sources of Cash	Uses of Cash
Net income plus depreciation	Principal payments
New financing proceeds	External transfers
Bond-related construction funds	Carry-forward capital
Cash reserve spend-down	Contingency set-aside
Working capital release	Balance sheet cash reserve
Philanthropy (donor restricted)	Working capital funding

Source: Kaufman, Hall & Associates, LLC.

Calculating the Capital Constraint

To determine an organization's capital constraint, leaders should start by asking the question: What amount of capital, obtained through both internal operations and external sources, are we reasonably sure can be generated to support the organization's development over a defined period of time?

The answer lies in how much the organization can and should borrow, as well as the level of cash that it can generate and retain from operations in uncertain times. The following are the basic components that make up capital constraint (see sidebar, "A Formula for Capital Constraint").

A Formula for Capital Constraint

The basic components of the capital constraint calculation include the following:

Cash Flow
- \+ Total Sources of Cash:
  - Debt proceeds
  - Philanthropy
  - Other sources of cash
- – Total Uses of Cash:
  - Working capital
  - Principal payments
  - Carry-forward capital
  - Cash reserve requirements
  - Other uses of cash
- = Total Cash Available for Capital
- – Contingency
- = Net Cash Available for Capital Allocation (the Capital Constraint)

Source: Kaufman, Hall & Associates, LLC.

Cash Flow

The starting point for any calculation of capital availability, cash flow is an analysis of past, present, or prospective cash activity. Cash flow often is determined simply by adding income and depreciation. Executives must decide whether income should reflect only income from operations or should include all non-operating sources, such as investment income, contributions, and gains on sale of assets.

A focus solely on operating income creates an automatic reserve to increase balance sheet liquidity at the expense of current-year capital spending. On the other hand, including income from all sources maximizes current-year capital availability but requires greater discipline in establishing and meeting rigorous balance-sheet cash-reserve targets in the strategic financial plan.

Debt Proceeds

This component includes proceeds from debt that will be issued in the upcoming year and the unspent but still available proceeds of debt issued previously. An organization must be careful not to take on a level of debt that will have a negative effect on its credit rating, thus limiting its optimal capital access.

The amount of debt the organization is capable of supporting within the desired credit-rating profile is its *debt capacity*, as defined in Chapter 4. Executives must conduct a rigorous debt capacity analysis before commencing their annual capital allocation process. Typically, this analysis occurs as part of the organization's strategic financial planning process.

Philanthropy

Most not-for-profit healthcare organizations benefit from ongoing donations generated as a result of their community, academic, or faith-based affiliation, which appear as non-operating revenue on their income statements. Depending on the definition of income adopted by the organization (see the section, *Cash Flow,* above), this revenue stream may already be part of the capital constraint calculation.

Extraordinary philanthropy, typically associated with a particular capital initiative or a capital campaign, is the main focus of this capital constraint component. This source of cash flow often is not recorded as an income item, but flows directly to the balance sheet. Thus, the inclusion of such philanthropic funds in the calculation of the capital constraint is critical.

Working Capital

A healthcare organization whose net current assets are growing will have different year-to-year needs to fund working capital, defined as the capital required for day-to-day operations. These year-to-year changes flow through the balance sheet and cash-flow statement, but not through the income statement, meaning that an organization that determines capital spending by simply figuring a percentage of operating income overlooks a potentially significant source or use of cash.

Principal Payments

Payments of principal on existing and new anticipated debt constitute direct uses of cash that also are not accounted for on an organization's income statement. Depending on the amortization structure of the organization's outstanding debt, principal payments could have a material impact on cash available for capital.

Carry-Forward Capital

Generally, carry-forward capital is defined as approved capital expenditures that have or will have an impact on cash flow over more than one year and should be a direct deduction from available cash flow. Organizations must identify and quantify specific types and amounts of carry-forward capital to accurately calculate how much impact it will have on cash flow in the future. There are three basic types of carry-forward capital:

- *Type 1:* Capital dollars originally committed for approved capital projects with a planned, multi-year implementation schedule
- *Type 2:* Capital dollars required to complete an initiated, approved project whose completion was originally anticipated to occur within the current fiscal year but will not actually occur until the subsequent fiscal year
- *Type 3:* Capital dollars allocated in the current year to projects or other types of capital requests whose implementation has not commenced at the end of the current fiscal year

Hospitals and health systems should establish policies specific to their organization on how each type of carry-forward capital will be funded. This is critical to calculating and managing the current-year capital constraint and ensuring deployment of capital dollars according to the organization's strategic financial plan.

As an example, a community hospital might determine its net cash available for capital spending based on its long-range strategic financial plan and the following parameters:

- *Type 1 carry-forward capital:* Funding will be managed by the capital management council, which will receive project updates at the beginning of the subsequent years' capital management process. Previously approved and initiated projects may be placed on indefinite hold or terminated under extreme circumstances only (for example, financial deterioration or change of strategic direction).
- *Type 2 carry-forward capital:* Funding will be managed by the capital management council on the basis of project updates received at the beginning of the subsequent years' capital management process. Based on the actual schedule, the council will reaffirm expected completion dates of those projects that have been initiated, and unspent capital from the current year will be carried forward to fund completion of the project unless the project is over budget. If the overrun exceeds a predefined budget variance limit, the council will determine if the project should continue and the source of the funding required for completion.
- *Type 3 carry-forward capital:* Approved capital projects that have not been committed via purchase order or other written commitment in the year of approval will not be considered carry-forward capital, and they must be resubmitted to the capital management council for review in the subsequent allocation year.

Note that Type 3 carry-forward capital typically generates the most complex issues, such as: the organization's ability to quantify the approved capital spending that has not yet been committed; how an organization with large carry-forward amounts can support future capital initiatives; how to address a potential "use-it-or-lose-it" attitude or approach; and the discipline and rigor of the organization's project management process.

Cash Reserve Requirements

The financial planning process identifies operating performance and balance sheet targets associated with meeting the capitalization needs of the organization while maintaining access to capital within the context of credit availability and the associated risks. Liquidity—the minimum level of required cash reserves—is a key balance sheet target. Uncertainties associated with healthcare's new business model have increased the amount of cash organizations retain as reserve requirements. The median days cash on hand rose from approximately 149 in 2004 to 208 in 2014, according to an analysis of overall medians published by Fitch Ratings, Moody's Investors Service, and Standard & Poor's.

As the executive team projects operating performance, it also should define the specific amount of cash flow to be held on the organization's balance sheet, with an increase or decrease in cash reserves included in the capital constraint calculation. In this way, leaders can be certain that the amount of capital to be spent will not jeopardize the organization's balance sheet liquidity, or the minimum level of required cash reserves.

If capital availability is calculated as a percentage of depreciation or income, however, there is no correlation to the balance sheet and no way to accurately understand the impact of a particular spending level on the organization's access to capital.

Other Sources and Uses of Cash

This catch-all category directs attention to the many other non-income statement calls on organizational cash that ultimately impact liquidity and cash available for capital spending. These sources or uses of cash typically include:

- Funding of pension or benefit-related shortfalls
- Payouts to unaffiliated organizations, such as joint venture partners or corporate members
- Dividends received from unaffiliated organizations

These items can be either additions to or deductions from the capital constraint. Their inclusion in the calculation ensures that the ultimate capital constraint reflects true levels of cash available for capital spending.

Practical Application

Table 5.2 illustrates a five-year capital constraint calculation performed by a two-hospital system based on its strategic financial plan. The numbers for sources and uses of capital reflect the output of the financial plan and quantify the organization's strategic initiatives through volume, expense, and reimbursement projections that result in projected levels of net income, working capital, and cash reserves.

The system defined total cash available for spending in 2016 as approximately $31.1 million, but subtracted from this a 10 percent capital contingency for system-wide emergency investments, yielding net cash available for allocation of nearly $28 million.

Defending the Constraint

After calculating the capital constraint, the organization's governing capital management council must be vigilant about ensuring that organizational spending does not exceed this sum and that capital investment does not occur outside of the capital management process. If the process breaks down and authorization of capital occurs outside of the comprehensive process, the validity of the organization's capital constraint will be undermined and the integrity of the process diminished.

Healthcare executives must be aware of three significant challenges to the capital constraint—information technology, physician enterprise, and leasing—and how to manage these challenges effectively.

Information Technology and Physician Enterprise Investments

Many hospitals and health systems are making substantial investments in information technology (IT) and their physician enterprise in preparation for value-based care and payment. As previously mentioned, allocation of capital for IT projects and purchase or support of physician practices should be part of the organization-wide capital management process. This ensures comprehensive consideration of the benefits and costs within the organization's overall portfolio of investments.

Analysis of IT and physician-related capital should quantify, to the extent possible, all potential incremental operating costs and efficiencies over the life of the investment. If executive and board leadership wishes to proceed with the investment based on qualitative rather than quantitative reasons, leaders will be fully aware of the costs involved with the expenditure and the likely financial implications of the investment.

Table 5.2: Calculating the Capital Constraint: Net Cash Available for Spending *(dollars in thousands)*

		2016	2017	2018	2019	2020
	Operating Income	$ 17,587	$ 12,950	$ 13,035	$ 14,104	$ 16,664
Add:	Non-operating income (excluding interest)	6,364	9,864	7,989	8,064	11,039
	Depreciation, amortization, and loss on disposal	25,167	29,226	33,335	36,677	39,309
	Operating cash flow	49,118	52,040	54,359	58,845	67,012
Plus:	New debt proceeds (net of restriction)	-	43,096	-	-	-
	Non-income statement philanthropy	-	-	-	-	-
	Interest income	4,885	4,583	4,820	5,431	6,177
	Total sources of cash available for capital	54,003	99,719	59,179	64,276	73,189
Less:	Working capital requirements	(1,012)	(1,083)	(1,748)	(1,999)	(2,195)
	Principal payments	(9,400)	(7,444)	(8,254)	(8,209)	(7,243)
	Other sources/(uses) of cash	-	-	-	-	-
	Carry-forward capital	(23,104)	(12,949)	-	-	-
	Pre-committed capital	-	-	-	-	-
	Contributions to cash reserves	10,604	(9)	(15,710)	(20,882)	(30,251)
	Total uses of cash available for capital	(22,912)	(21,485)	(25,712)	(31,090)	(39,689)
	Total cash available for capital	31,091	78,234	33,467	33,186	33,500
	Less: 10% system capital contingency	(3,109)	(7,823)	(3,347)	(3,319)	(3,350)
Net cash available for capital allocation		**$ 27,982**	**$ 70,411**	**$ 30,120**	**$ 29,867**	**$ 30,150**

Source: Kaufman, Hall & Associates, LLC.

Leasing

Operating leases frequently represent the most expensive source of capital for an organization. However, some executives or managers use leases to bypass the capital management process, especially if the process does not include a clear definition of capital. For example, should the value of a lease for a medical office building, an outpatient facility, or an MRI scanner be subject to the capital constraint?

The answer is "yes." According to the separation theorem of corporate finance, an organization's investment decisions must be independent both of the preferences of executives and of financing decisions. In the context of the capital management process, leasing is clearly a financing decision which, by definition, should be under the purview of the organization's corporate-level financial management—not a department manager or even a COO.

Some managers label leasing "opportunities" inappropriately, however. Consider an organization that has established a capital constraint of $30 million and has allocated the full $30 million. Two of three requested CT scanners were not included in those allocations. To appease a vocal department chair, or because an executive really wanted the CT scanners approved but was overruled by the council, the executive decides to lease the two scanners for a total of $5 million.

Ostensibly, the leases create a zero footprint against the capital constraint; however, the use of leasing in this instance has allowed capital spending *beyond* the capital constraint. Spending is now $35 million rather than the approved $30 million. In addition, since the capital constraint is a direct function of the organization's expected financial performance, the leasing-produced higher level of spending will ultimately have negative financial consequences for organizational cash flow.

If the organization proceeds with the equipment leasing, its executives need to ask themselves two hard questions to ensure the organization doesn't get too far off track:

1. Why did we establish the $30 million capital constraint?
2. Given the infraction of the spending limit, at what risk have we placed ourselves related to other capital-intensive projects that also might be approved outside of the established capital management process?

The rating agencies look closely at an organization's use of operating leases to determine the effect on debt capacity and overall credit quality. According to the agencies, leasing activity—regardless of its accounting treatment—is another form of external financing that has a claim on an organization's existing liquidity and future cash flows.[33]

Concluding Comments

A clear definition of how much capital the organization can afford to spend is a critical prerequisite to identifying what initiatives deserve funding. Without an answer to the how-much-can-we-afford-to-spend question, organizations are at significant risk for either over-spending or under-spending, which can quickly result in diminishment of financial or competitive performance. Healthcare's new business model is making extraordinary demands on hospitals and health systems to develop new competencies and infrastructure. The oversight role played by an organization's capital allocation council perhaps has never been more important.

Chapter 6:
Strategic Market and Position Assessment

The integration of strategic planning and financial planning involves analysis of the current market, forecasting of changes related to payment arrangements, demographics, and many other factors, and defining the role the organization will play in its community based on these factors.

STRATEGIC FINANCIAL PLANNING BASED ON SOLID DATA AND analytics proactively prepares the organization to direct its resources to best-fit options. Given the high level of change occurring in the industry, such assessment is critical, and ongoing analyses enable organizations to course-adjust as needed.

Using Comprehensive Data

Effective plans are based on strategic and market realities. Thorough analyses of comprehensive data enable hospitals and health systems to identify financially viable competitive strategies.

The assessment process is cumulative. Numbers in isolation may not tell the story, but the combination of data provides the needed big picture about an organization's performance in its competitive environment. Numerous market and strategic position variables are vital to building the required quantitative fact base. Trends, which show track record and momentum, are important in addition to annual numbers. Hospital and health system leaders need to do their homework. Key questions that will be answered through analysis are listed in the sidebar, "Key Questions Answered During an Ongoing Assessment Process."

Key Questions Answered During an Ongoing Assessment Process

- Which areas/regions does the organization currently serve? What is the organization's market share? How has this changed over time and how might it change as networks form to manage population health?
- What are the current and projected future characteristics of the population and the local economy?
- What changes are anticipated in demand for healthcare services within the market? How will changes in the payer/employer environment, demographics, and emerging technologies affect future demand for the inpatient and ambulatory services the hospital provides?
- What is the organization's current service-delivery configuration, and what is the condition of its physical assets? How might this change to meet new needs for services in ambulatory and home settings?
- Who are the principal competitors? How are these competitors positioned and what strategies are they pursuing? How will these strategies affect the organization's position?
- What important trends are occurring related to value-based contracting, and inpatient and ambulatory service utilization?
- What is the organization's desired role in population health management? What are its program/service strengths, weaknesses, and development opportunities relative to that desired role?
- What is the structure of the physician market and the organization's physician staff? How might the organization need to develop its physician enterprise for the provision of clinically integrated services in new networks that are forming?

Market Evolution Toward Value

As described in Chapter 1, a major transformation is underway in healthcare, as the nation moves to enhance patient care quality, access, and experience, and reduce costs. The nature of such change is now more revolutionary than evolutionary, threatening and transforming business as usual for all participants. In particular, hospital-centric service delivery likely will not meet the ease-of-access and lower-cost requirements of consumers

who are shopping for health services much as they would retail purchases. Such consumers, employers, and other stakeholders are moving the healthcare marketplace with lightning speed from the patient sick-care model to a consumer- and population health management (PHM)-focused model. Understanding PHM provides a foundation for assessing the extent and rate of a market's evolution toward value.

Population health management has many definitions, but the most succinct is an approach to improving health and the quality of care delivered while managing the cost of care. The services delivery-oriented definition is as follows: "Population health management occurs when a healthcare system or network of providers works in a coordinated manner to improve the overall health, health outcomes, and well-being of patients across all defined care settings under risk-bearing arrangements."[34]

Population health management is *the* business challenge and opportunity for today's hospitals and health systems, and the means to transform healthcare from a silo-like treatment of services to coordinated care across the care continuum. PHM is the direction healthcare is moving. Simply stated, if participating in Medicare or Medicaid, all hospitals and health systems nationwide are in the PHM business.

An assessment of the market's evolution toward the PHM/value model includes analysis of payers and employers; providers and new-market entrants; consumer preference and competitive costs and charges; utilization trends and demand projections; and the regulatory environment. A description of each follows.

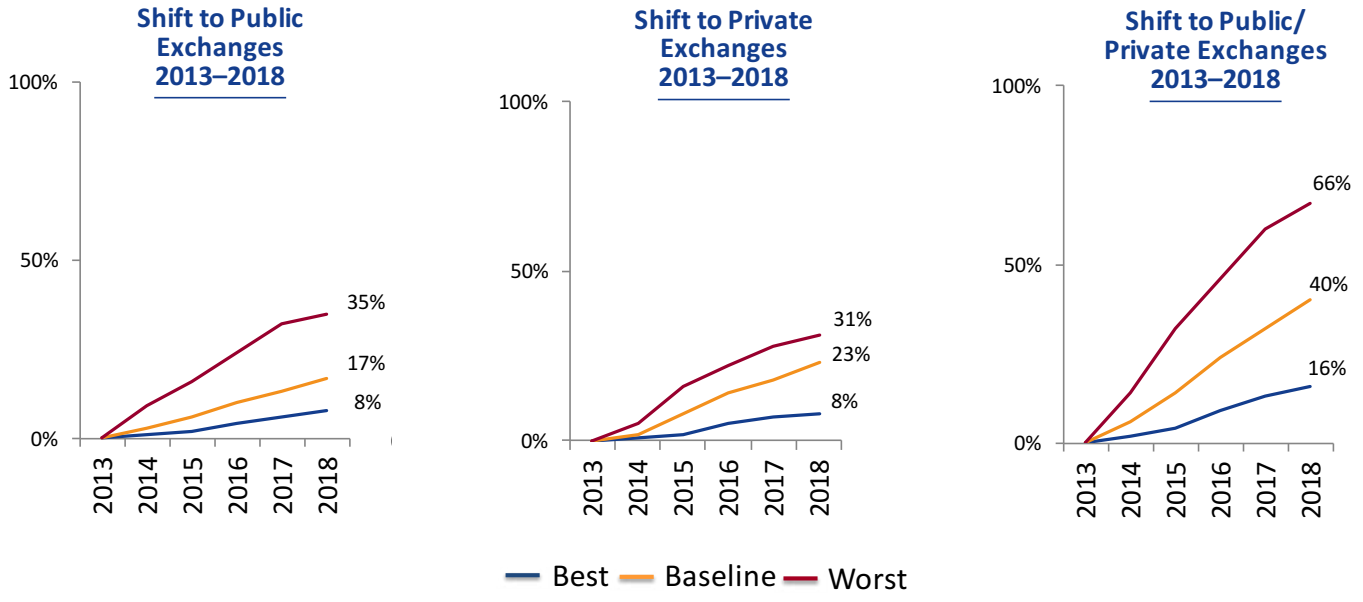
Payers and Employers

Market readiness for PHM and how quickly the market is moving toward value can be gauged through analysis of the payer and employer market environment. Key considerations include:

- *Employer healthcare benefits structure:* The shifting of employees into high-deductible/consumer-driven health plans that are available through traditional insurers and private exchanges is boosting transparency, along with cost sensitivity. Quickly evolving markets have a high penetration of consumer-driven healthcare purchasing. Data on major employers in the service area, job growth and industry concentration, and current and projected employment statistics are helpful.
- *Enrollment in exchanges and level of insurance product/network sophistication:* Enrollment in public and private exchanges and high deductibles available through tiered-benefit programs also are increasing the level of consumerism and price sensitivity.

For example, **Exhibit 6.1** shows the baseline, best-case, and worst-case projected impact on a sample hospital of a range of assumed changes in payer mix resulting from the projected shift of commercially insured patients into public and private exchanges. The underlying analysis, completed in 2012, incorporated the hospital's specific market dynamics, including employer profiles, likelihood of employers moving employees into exchanges, and the relative sizes of the commercial and non-commercial markets.

Exhibit 6.1: Anticipated Shift of Commercial Lives to Public and Private Exchanges



Source: Kaufman, Hall & Associates, LLC.

Data on participation in high-deductible health plans, narrow networks, and other plan designs will be helpful, as will information on major private payers, their relationships with area employers and providers, and their position relative to risk-based contracting.

Providers and New-Market Entrants

In some markets, leading providers and new-market entrants are playing a significant role in moving their regions to value-based arrangements. Of relevance to the pace of a market's change are the following:

- *Level of organization among hospitals and physicians*: Indicators typically include the extent of hospital consolidation, physician group size, provider network size, degree of clinical integration, and geographic coverage/number of covered lives by specific entities.
- *Amount of vertical collaboration and new-entrant activity:* Vertical networks that pair providers and payers typically use integrated care models with new, value-based incentive structures for financing, delivery, and clinical care management. Network inclusion or exclusion has or can have major implications for hospitals and health systems in the covered area, so scenario analysis will be important.

- *Supply of providers:* If the number of hospitals, beds, and physicians in a region is too high, providers will experience significant "pricing and/or reimbursement pressure" as utilization falls and demand shifts to ambulatory settings and virtual care delivery. When there is an oversupply of providers, pricing pressure also results from provider willingness to take on discounted fee-for-service arrangements in order to guarantee patient and referral volume.

Analysis of these factors using quantitative and qualitative data is critical.

Consumer Preferences and Competitive Costs/Charges

Hospitals and health systems should identify and understand consumers in their local markets—including their attitudes and needs, and what they value in choosing and experiencing healthcare services. The goal for healthcare providers is to build a relationship with consumers, as consumers identify, compare, and select specific networks, clinicians, and facilities.

The kinds of questions that need to be answered to indicate a market's pace of change toward managing the health of a population under a risk-bearing payment arrangement include:

- Which members of a population are most likely to require which kinds of healthcare?
- Which members are most likely to require focused outreach to avoid unnecessary emergency department visits or hospitalizations?
- What demographic factors, environmental conditions, behaviors, and beliefs are associated with individuals requiring more intensive levels of care?
- What techniques would be most effective to engage high-risk individuals in their own care?

Answering these questions requires a sophisticated mix of demographic, socioeconomic, behavioral, attitudinal, and psychographic information. That information can be used to create consumer segments related to various factors, such as consumers' health status, type of condition(s), health risk, degree of engagement in care, price sensitivity, physician loyalty, acceptance of digital care, and use of non-traditional care settings. Understanding the factors that constitute these segments allows healthcare organizations to construct predictive models that inform decisions about issues such as network structure, pricing, and staffing.

Information about competitive costs and charges—adjusted for outpatient volumes and case mix complexity—provides insight about an organization's operational efficiency and pricing policies. Price will be a key competitive differentiator into the future, as individuals continue to bear greater cost burdens for their own care. Pricing and care quality information is increasingly available to the public via transparency tools intended to help guide patients in the selection of preferred providers and/or facilities.

Demand for Services

Given lower utilization of inpatient services, shifting demand for ambulatory services, and the proliferation of Web or mobile-based services, providers will need to reposition their delivery networks, as described later. Notwithstanding population aging trends and the newly insured, considerable hospital inpatient utilization is "vulnerable" (i.e., likely to decline further as healthcare costs are reduced).

Relevant demographic data include current and projected population, age and gender distribution, and median household income. In any given market, one or two of these elements could assume prime importance because of trends that suggest good growth or weak socioeconomics.

Regulatory Environment

Federal and state legislation and regulations materially affect the way providers conduct business, at times slowing the pace and degree of change. Providers operating in localities where regulatory factors are more abundant and limiting often face challenges in building the structures and relationships necessary to drive value-based care delivery.

Putting It All Together

Exhibit 6.2 illustrates the high-level view of an example market's pace of change toward value and PHM as compared to the national rate of change. The pace of change in the example market is significantly ahead of national averages in terms of the level of provider organization, payer competition, and vertical collaboration, among others. The market lags national averages in the sophistication of networks and products, and pricing sensitivity, among others.

The definition of market share is shifting as organizations transition from a focus strictly on patient volumes to covered populations. Under fee-for-service payment, more services equals more revenue for providers. Under the new business model, however, an organization's market share refers to the number of individuals covered under risk- or value-based contracting arrangements.

Organizational Position and Role

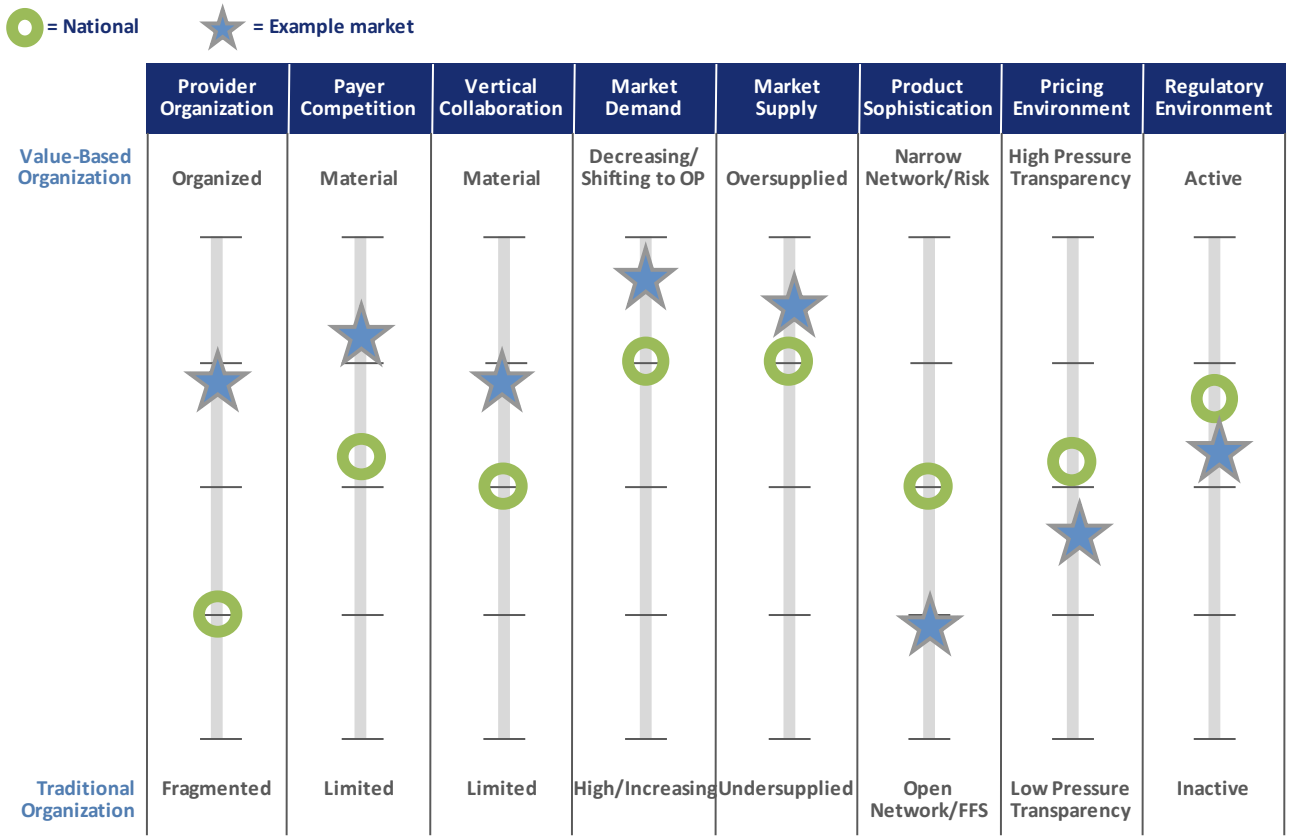
PHM has significant business and economic dimensions for hospitals and health systems. These include responsibility for physician/other clinician engagement; quality, access, and cost of care; incentive structures that reward high performance related to these measures; and patient and family education/engagement on healthy behaviors and lifestyle. New competencies are required to meet these responsibilities. Organizations must assess their current position related to these competencies.

Key Competencies

To meet and sustain PHM goals of coordinated and managed care across the continuum, hospitals and health systems must have strong capabilities in nine areas. These areas are particularly important to establishing the organization's value to consumers, payers, clinicians, employers, and other stakeholders:

- *Network strength (development, configuration, and relevance)*: A robust network—with hospitals, physicians, post-acute providers, and other providers—has an appropriate breadth of specialist and primary care offerings, scope of geographic coverage, and overall accessibility.

Exhibit 6.2: The Pace of Evolution in Example Market



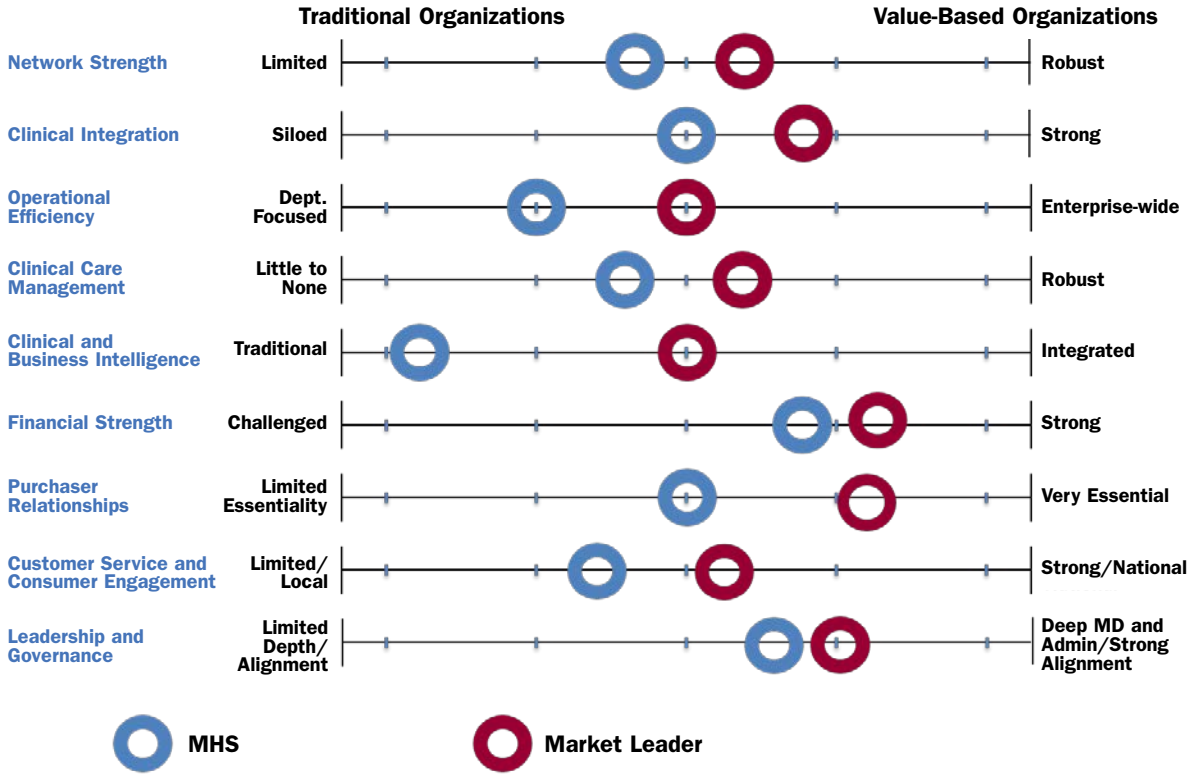
Source: Kaufman, Hall & Associates, LLC.

- *Clinical integration (CI):* Patient care services that are coordinated across people, functions, activities, processes, and sites maximize the value of services delivered.[35] Clinical and economic integration/alignment of physicians, nurses, and other providers across the care continuum furthers organizational goals around quality improvement, cost reduction, and strategic and financial sustainability. CI typically is achieved through the use of strong incentive structures and contracting mechanisms that reward improvements related to these metrics.
- *Operational efficiency:* Considerations include operating costs, structural costs, service rationalization, and clinical variation.
- *Clinical care management:* This is characterized by team-based, coordinated care delivery that includes utilization management, referral management, transitions of care, chronic disease management programs, and use of evidence-based practices and protocols to better manage patient care, especially for high-risk, high-use patients.
- *Clinical and business intelligence:* To set appropriate goals and intervention targets, clinical and business data must be collected, analyzed, and applied.
- *Financial strength:* Strong cash flows and a solid balance sheet enable organizations to invest in what is needed to compete, while managing overall enterprise risk.
- *Purchaser relationships (and managed care contracting):* Considerations include size and scope of arrangements, level of consumer engagement, strategic pricing, and ability to accept and distribute risk, incentives, and prepaid claims.
- *Customer service and consumer engagement:* Differentiation and recognition in the market is achieved through consumer engagement and strong brand presence.
- *Leadership and governance:* Deep bench strength of clinical, administrative, and governance leadership drives operational, strategic, and cultural change.

Hospital and health system leadership teams should evaluate the organization's current position relative to the nine critical capabilities, using both qualitative and quantitative data. Each has specific indicators. For example, clinical care management can be assessed based on availability of protocols and clinical order sets for high-cost clinical procedures and high-incidence/impact chronic conditions. Financial strength can be assessed through profitability, liquidity, and leverage ratios, among others. Identification of appropriate opportunities to manage population health must be based on the organization's competitive strengths and weaknesses in each area.

For example, **Exhibit 6.3** provides the summary of an in-depth assessment comparing one multi-hospital system's (MHS)

Exhibit 6.3: Assessment of a Multi-Hospital System's Current Readiness in Nine Competency Areas



Source: Kaufman, Hall & Associates, LLC.

current performance to that of the market leader along the nine competencies, using qualitative and quantitative measures.

Desired Role in PHM

Different provider roles have emerged and likely will continue to emerge, with variations in capabilities and functions in a PHM network. General categories reflect the organizations' ability to incur risk in managing a specific segment of the population's health—extending from no risk, as is common in a fee-for-service system, to the ability to assume full prepaid payments and/or capitated provider and/or plan risk.

Exhibit 6.4 summarizes the requirements of each provider role. An organization's desired PHM role must be firmly grounded in its strategic-financial condition, its organizational competencies, the readiness for PHM in its community, and the current and emerging PHM environment.

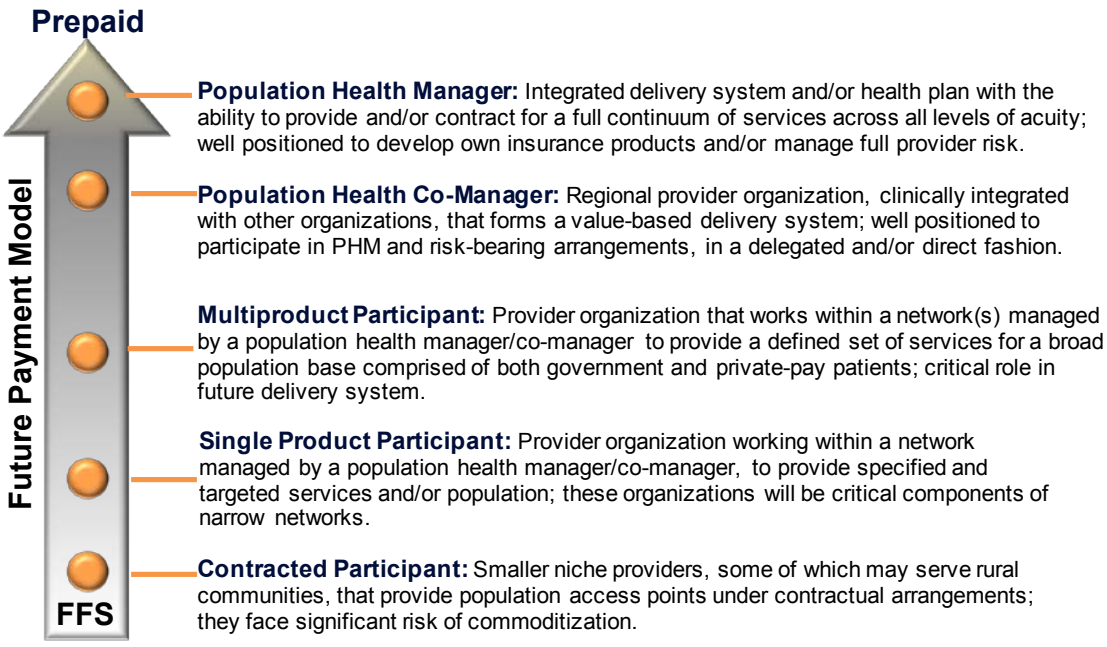
Market Share and the New View of Volume

The definition of market share is shifting as organizations transition from a focus strictly on patient volumes to covered populations. Under fee-for-service payment, volume for hospitals and health systems is defined by the number of discrete services provided to patients. More services equals more revenue for providers because payments are based on services delivered to insured patients.

Under the new business model, however, an organization's market share refers to the number of individuals covered under risk- or value-based contracting arrangements that typically pay a fixed revenue per managed or attributed life.

Health systems and plans with more covered lives typically have stronger performance. This could be attributed to attaining a level of population coverage that limits operating performance variability under risk-based reimbursement models, or having high relevance to purchasers (employers, insurers, patients) through offering the right mix of services and locations, at the right cost, thereby offering one-stop shopping.

Exhibit 6.4: Provider Roles in Population Health Management



Source: Kaufman, Hall & Associates, LLC.

Physicians and other Clinicians

Because physicians and allied clinicians are the primary revenue drivers that make or break an organization's ability to achieve its strategic and financial objectives, the clinician portion is a vital component of the strategic organizational assessment.

Economic and clinical alignment between hospitals and physicians will be essential to make needed changes to the way patient care is delivered, improve each element of the value equation (i.e., quality, access, outcomes, patient experience, and operating/capital efficiency), succeed under value and/or risk-based arrangements, and enhance patient, family, and provider satisfaction and engagement.

The growing need for coordinated care and rapid technological advances also are enabling a larger role for non-physician team members, such as physician assistants, nurse practitioners, pharmacists, and others.

Components of the clinician assessment that provide crucial indicators of a hospital's financial performance include:

- Physician and other clinician supply and demand in the market
- Medical staff profile, including physician age and primary/specialty mix
- Organization of the physician market (i.e., multi-specialty groups and/or single-specialty groups; independent practitioners and/or hospital-employed and hospital-based physicians)
- Proportion of revenue by specialty/physician
- Quality of relationships in referral base (loyalty, satisfaction)
- Physician employment/compensation model
- Physician practice losses/gains
- Recruitment and retention strategies
- Current physician/management relationships
- Existing physician and other clinician economic and strategic relationships

The shift toward value-based payment and population health management has spurred hospitals and health systems to acquire physician practices to build scale, enhance physician relations, and expand their physician networks. Trends in physician employment by hospitals and health systems show steady growth, with more than 25 percent of active medical staff now employed and growth expected to continue.[36]

The importance of a demonstrated track record of effective physician engagement, recruitment, and retention cannot be underestimated. Assessment of an organization's track record with physicians should include: degree of alignment of organizational and physician economic interests; level of physician input into and participation with decision making that impacts clinical service lines; and the extent that the organizational culture supports physicians through the facilities, clinical support staff, and technology needed to ensure high-quality patient care and patient satisfaction.

Delivery Network

Success under the new business model will be defined by an organization's ability to offer the right mix of services and locations at the right cost to the populations it serves. In moving away from pure fee-for-service care delivery and financing models, organizations must scrutinize their delivery networks in a new light. Although many of the traditional strategic criteria for a viable network still apply (e.g., demand for services, access points and footprint, competitive market positioning), additional criteria will be needed under a PHM construct. Criteria include: network essentiality and PHM care continuum; network "adequacy"; service distribution right-sizing; and delivery network growth strategy. These criteria are not mutually exclusive and each has certain nuances that will be important for hospitals and health systems to understand and evaluate.

Additionally, the criteria will need to be looked at on a population-by-population basis, whether Medicare, Medicaid, commercial, insurance exchange, employer, or other insurance products. Each population likely will have unique demand and risk factors driven by demographics, socioeconomics, and a variety of other considerations. These various demands will need to be accounted for in order to meet different service and network requirements.

Utilization Trends and Demand Projections

Utilization trends indicate the increasing or decreasing demand for services in years past. Under value-based arrangements, utilization growth is not "good" growth, while the opposite generally is true under fee-for-service arrangements, so a review of utilization numbers in isolation doesn't tell the whole story. Payer mix and case mix should be looked at as an adjunct to utilization.

Projecting future inpatient and outpatient demand is essential. Organizations should consider multiple factors, including current and projected market conditions, the degree of projected inpatient migration from surrounding areas, anticipated shifts in market share, the impact of Medicaid expansion, public and private exchanges, and other payment model changes, and market-level use rates by service line, payer, and age group. Anticipated changes in underlying inpatient and outpatient service utilization rates driven by insurance, technology, demography, and cultural changes also must be included in projections.

An organization's ability to generate reliable volume demand projections is integral to its ability to model, evaluate, and prioritize strategic initiatives and to effectively manage its long-term competitive market and financial position. Demand projections must be grounded in market realities.

A best-practice approach for projecting and evaluating baseline inpatient demand for healthcare services includes development of the following:

- Service area use rates by geography and service line
- Service area volume projections by geography and service line
- Reasonable and defensible assumptions regarding market share changes
- Organization-specific volume projections at the same level of detail

High-quality software tools enable planners to seamlessly integrate multiple data sources, such as commercially available data

and internal data, to produce projection results by service line and/or geographic area. Projections must be based on assumptions that are plausible, defensible, and in line with past actual performance (see sidebar, Characteristics of Credible Utilization and Financial Projections and Assumptions). Software tools can build in sensitivities related to use rates and overall demand in order to understand and analyze the high-side (best case) and low-side (worst case) impact of projections for specific strategic scenarios.

Characteristics of Credible Utilization and Financial Projections and Assumptions

- Market-based utilization projections versus extrapolation of historical trends
- Reliable and, if possible, locally developed or sensitized population projections
- Age/sex-specific use rates that consider the impact of emerging technologies
- Market share growth targets that are linked to strategy and are not overly aggressive
- Consistency in utilization projections used in strategic planning and financial planning
- Changes in payer mix consistent with demographic trends and development strategies
- Reasonable assumptions around rate/payment changes for key payers
- Reasonable assumptions regarding cost inflation assumption by expense category
- Reasonable variable/fixed expense relationships by category
- Capital spending that is consistent with the strategy and levels required to maintain asset base and desired competitive position
- Sensitivity analyses prepared for key variables—volume, payment, expense inflation, and capital spending

Source: Kaufman, Hall & Associates, LLC.

Finance's Role in Strategic Assessment

In a management environment characterized by difficult strategic and financial challenges, contemporary hospital and health system CFOs must play a significant role in analyzing and formulating organizational strategy. There must be regular interaction between strategy and finance throughout the strategic market assessment process. Concrete activities conducted or directed by the CFO during strategic market assessment include:

- Analysis of the financial performance of programs and services
- Analysis of the profitability of insurance plans/payers
- Identification of the financial contributions of individual physicians and specialties
- Analysis of the organization's current credit profile
- Definition of the organization's capital and debt capacity
- Analysis of the organization's cost position
- Development of baseline financial projections for operations "as usual"

These activities help ensure that the strategic "solution set" that emerges during the direction-setting stage has solid financial underpinnings.

Concluding Comments

Analyses built on a thorough fact base enable fully informed decisions about strategic opportunities that will position the organization for success into the future. Directors must be asking the following questions of their hospital leadership:

- Does our organization have high-quality data sources and information-gathering mechanisms to monitor market and strategic trends closely?
- Is the organization converting such information into meaningful strategies and specific action (the topic of Chapter 7)?

Strategic assessment and planning is an ongoing process that is integrated with and continuously informed by finance. Uncertainties about the business-model arrangements that will take shape suggest that organizations should plan for a range of revenue and risk models, and thus build flexibility into their planning models. Such an approach enables healthcare leaders to routinely monitor shifting market conditions, and to be agile in adapting their organization's strategic direction as needed.

Chapter 7:
Setting Organizational Direction

The strategic financial planning process continues. Chapter 5 outlined the process an organization uses to determine how much it can afford to spend within an acceptable credit context. Chapter 6 described how an organization develops and analyzes a strategic market and organizational position fact base. The fact base is used to select and pursue financially viable competitive strategies that will ensure the organization's future. Setting organizational direction is extremely difficult, given the many unknowns and increased risks during the transition to value-based care and payment arrangements. This is a top 10 financial issue and the topic of Chapter 7.

The Strategy–Finance Connection

The financial plan, or the financial planning portion of an integrated strategic financial plan, assesses the feasibility of identified strategies. The plan has a long time horizon—most commonly five years. It quantitatively identifies the profitability and liquidity requirements of the organization's strategic initiatives and addresses the issues of funding and financing required to meet such objectives.

Multi-year planning to set organizational direction is not an optional activity. To capital market players who rate and purchase healthcare debt, the absence of realistic integrated, multi-year planning discredits an organization's strategy. Credit position and capital access are at risk. The sidebar entitled "Assessing the Planning Process" provides comments on this topic from one rating agency.

Assessing the Planning Process: Comments from Moody's Investors Service

"We look for a number of critical factors and use of best practices when assessing the plans and planning process of a hospital, and consider the following positive attributes:

- Integrated strategic, capital, and financial plans
- Use of detailed multi-year financial plans and budgets that tie to audited financial statements
- Conservative budgeting, producing consistent operating surpluses
- Financial and capital scenario evaluation and stress testing
- Prudent endowment management and sustainable endowment spending policies that are regularly reviewed in the context of overall hospital risk assessment and multi-year financial plan (most applicable to children's hospitals and some academic medical centers)
- History of meeting or exceeding internal forecasts for budget performance, volume trends, and quality measures
- Recognition of key risks in multi-year plans and development of contingencies for addressing them"

Source: Moody's Investors Service, *Not-for-Profit Healthcare Rating Methodology,* March 2012.

An organization that links strategy to financial projections demonstrates that it is using a disciplined process to set priorities and make tough decisions about required profit margins, capital expenditures, debt levels, and other financial issues.

As during the strategic market and organizational assessment process described in Chapter 6, the hospital's strategy and finance staffs should be working collaboratively to address the strategic and financial effects of identified strategies. Activities

performed by the finance staff during the strategic direction-setting process include:

- Quantifying the capital requirements of identified strategic initiatives
- Establishing assumptions for financial projections
- Developing detailed financial projections for identified strategies
- Participating actively in an iterative process to establish priorities and identify viable operating and strategic initiatives, given financial goals

How does an organization identify and select competitive strategies that are financially viable?

Finding the Balance

Identifying the strategies or initiatives that will enable the hospital to achieve market strength, differentiation, and sustainable competitive financial performance involves finding the balance between strategic needs and financial capabilities. The equilibrium lies in a "corridor of control" where the organization balances two opposing goals:

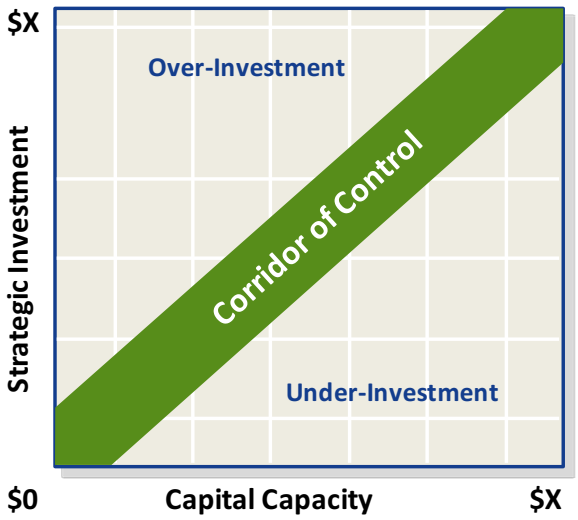
- Compete as effectively as possible, which requires aggressive investment of capital and commitment of operating dollars, but
- Respect the fiduciary role of management and the board to maintain the long-term financial integrity of a community asset.

Exhibit 7.1 illustrates this equilibrium. Note that the organization's financial capability lies along the x-axis and the strategic financial requirements lie along the y-axis. The corridor of control represents a balance between the two.

If an organization falls above the corridor of control in the area labeled "over-investment," its financial need or strategic capital appetite exceeds its financial capability. In the extreme, this can cause a liquidity crisis and trigger a default on debt. More commonly, the organization puts itself in a position where it is unable to respond to opportunities and threats because its available capital is fully committed and its financial performance precludes access to additional capital.

An organization whose position appears below the corridor of control in the "under-investment" area might have a fair amount of money, but lacks a strategic plan that outlines how to grow and spend that money. It may be at risk of losing relevance in its community because it is not investing sufficient capital to pursue strategic opportunities to meet new needs—for example, conveniently located ambulatory clinics. Over time, under-investing leads to a loss of profitable business, which erodes operating performance, which reduces capital capacity, which diminishes the level of strategic investment that can be made.

Exhibit 7.1: Balancing Strategy and Financial Capability



Source: Kaufman, Hall & Associates, LLC.

Evaluating Initiatives

The long-term success of a healthcare organization depends upon the capital investment decisions made today. Such decisions must be based on solid analysis; "gut feel" is not enough in today's dynamic and competitive healthcare environment. The costs of making bad capital investment decisions can be severe, if not fatal.

Organizations must establish and implement criteria for the evaluation and selection of strategic capital investment opportunities. Without such criteria, strategies or initiatives run the risk of being approved on a subjective, political, or first come-first served basis rather than on their ability to meet the organization's strategic and financial objectives.

Recent data from The Governance Institute's Biennial Survey indicate that significant progress has been made in this regard.[37] Nearly 94 percent of the surveyed organizational boards *generally* evaluate proposed new programs or services on factors such as financial feasibility, mission compatibility, market potential, impact on quality and patient safety, and other factors; another 5 percent of boards *are considering* adopting such criteria. In the current environment, there are no mitigating excuses for not having adopted such criteria.

The Need for Business Plans

To facilitate informed decision making, each strategic capital initiative should benefit from the development of a business plan that describes the business or investment concept and its financial effect in significant detail. This provides the basic documentation and analysis necessary for a valid capital decision. A uniform review process, using standardized templates or formats, creates a level playing field and ensures true comparability of capital investment opportunities.

The sidebar entitled "Core Elements of Comprehensive Business Planning" outlines the elements vital to business planning. Such planning integrates data from numerous sources, including market assessments, demand and utilization projections, strategic plans, operating budgets, financial projections, and capital estimates, in order to generate a complete, risk-adjusted view of an initiative's potential return on investment (ROI).

Analyses of projects that have a negative ROI are just as (if not more) important than analyses of projects with a positive ROI. Leadership teams deciding to proceed with investments based on qualitative or other reasons should make those decisions with full awareness of the costs involved and the likely outcomes of the expenditure. As long as the investments are measured and strategic, the rating agencies view such investments as positive and the right thing to do.

Core Elements of Comprehensive Business Planning

- Definition of the proposed business/investment and the specific strategic objectives it will address
- Quantification of the capital resources required to initiate and complete the proposed investment
- Delineation of the potential population to be served and the means by which that population's health or care needs will be enhanced by the investment
- Projection of the initial and ongoing operating requirements associated with the proposed investment
- Calculation of the potential return on investment, including analysis and quantification of key risks associated with the investment
- Identification of potential exit strategies and related performance measures

Source: Kaufman, Hall & Associates, LLC.

Determining ROI

Due to the high level of investment organizations will need to make in developing new competencies and infrastructure during the transition to a value-based business model, returns on investments may require a significantly longer payback period. Nonetheless, quantifying ROI continues to be important. Standard measures for ROI calculation include net present value (NPV), internal rate of return (IRR), payback period, annual return on capital (ROC), and annual return on equity (ROE).

The typical way to consider projects according to corporate finance theory is to rank them, placing the project with the highest NPV first, followed by projects of lesser NPV in order of value. Issues that leaders must address related to quantitative analyses include project life and appropriate discount rate, and cash flow timing.

A project with a positive NPV represents an investment whose inflows are greater than its outflows when all such flows are viewed in today's dollars assuming a specified interest rate. In comparing two or more projects, a project with a higher NPV would be more attractive from a strictly financial perspective.

The projections supporting NPV analysis are based on a set of planning assumptions including incremental volume, revenue, expense, cost and revenue inflation, and cost of capital, all of which may or may not be accurate. If the assumptions are optimistic and overestimate the financial return of a project, the organization may be at considerable risk for over investing relative to its financial capability, which could lead to spending more capital than can be afforded.

In addition to analysis of individual projects, *portfolio analysis,* a technique that has been applied effectively on Wall Street to develop and maintain investment portfolios, should be used to analyze the impact of projects on each other. Organizations then look at whether the portfolio of initiatives represented by the whole list has a negative or positive NPV.

Considering Risk

NPV analysis can be made more powerful by integrating risk assessment techniques, such as a Monte Carlo simulation, available with many software tools. Monte Carlo simulation bombards projections for an individual project or a portfolio of projects with a range of risk elements and generates a distribution of possible outcomes. Using simulation to further analyze projects creates a much more accurate estimate of the range of potential outcomes and, therefore, the risk-adjusted value of projects under consideration, called the expected net present value (ENPV).

Each and every investment opportunity, whether for a quality initiative, new ambulatory clinic, decision-support system, or a primary care practice, should be considered within the entire portfolio of potential investments on the table. Analyses of projects that have a negative ROI are just as (if not more) important than analyses of projects with a positive ROI. The overall process does not rule out profitless projects. Many current investments demand significant capital upfront, but are intended to provide long-term benefits.

Leadership teams deciding to proceed with such investments based on qualitative or other reasons, rather than quantitative reasons, should make those decisions with full awareness of the costs involved and the likely outcomes of the expenditure. The potential ramifications on an organization's credit rating and capital access also should be considered since credit ratings, which provide access to capital, are assets to be managed. Rating agency representatives have noted that investments designed to build capabilities for population health management typically

have not dramatically affected credit. As long as the investments are measured and strategic, the agencies view such investments as positive and the right thing to do.[38]

Making the Right Decisions

Understanding the risk parameters of a project and a portfolio of projects through use of ENPV as the ROI method of choice will enable healthcare executives to make high-quality decisions regarding which investments to pursue.

Selecting projects with the NPV rating system in-hand is critical, but a 100 percent reliance on financial return to support decision making is very rare in healthcare. Most organizations include financial return as *one* of the significant decision-making criteria. The weighting of its importance varies by organization. Some organizations establish a weighting system that captures mission, strategy, and financial issues in a composite ranking.

As recommended for the strategic planning process, key stakeholders, including physician leaders and operating vice presidents, must be involved in ranking and scoring capital items.

During the decision-making process, the decision-making team also should look closely at expected cash flow and its timing: when large projects are layered on top of each other, cash flow becomes essential. Many projects push NPV cash flow out into far future years. Multiple projects with negative cash flows in the early years can significantly harm an organization. Looking at expected payback period is a way to rank projects with similar internal rates of return (IRRs) but potentially very different cash flow scenarios.

Clearly, no organization can carry a series of investment decisions that adversely affect its value. Decisions must add to the organization's value—to its ability to raise capital for future projects, maintain or improve its creditworthiness, and accomplish its mission.

Integrated Decision Making

Decision making about value-based positioning, physician alignment, and other organizational strategies should occur within a comprehensive planning process that takes an integrated look at the "layered effect" of a portfolio of strategies. Requests for capital related to the portfolio of selected options should be evaluated through the organization-wide capital allocation process, as described earlier.

Once such a portfolio is approved, the organization must commit the capital needed to achieve the plan's success (the topic of Chapter 8) and ensure that the plan is properly implemented, monitored, and achieved. Successful healthcare organizations define indicators of success of strategies, measure performance against these indicators, and devise and implement plans to respond to less-than-anticipated performance.

Decision-Making Leadership

Financially successful organizations have leaders who can envision, engage, and execute. They know how to move a group of people forward on a common mission and deliver results that exceed rather than meet expectations. They respond quickly and appropriately to a rapidly changing environment and at the same time address new realities in internal operations. They set concrete goals and objectives and lead the team toward goal attainment.

The boards of financially successful organizations govern around explicit financial expectations and metrics and are guided by an attitude that senior management will deliver expected results on a consistent basis. The board's comprehensive view of the organization's overall financial target enables it to manage all events toward reaching that objective. The whole is clear; so are the pieces that make up the whole. If one area underperforms, the board knows that other areas must do better than forecasted, or new revenue-generating programs, cost controls, or exit strategies must be added to the puzzle.

This holistic approach organizes decision making by the entire leadership group around one and only one financial philosophy. The principle that has proven most effective and that is restated here is: 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.

Board members and executives use this principle to guide their strategic decision making and measure their success. Their goal is to ensure that the organization's financial condition at the end of each fiscal year is at least as good as and hopefully better than it was at the beginning of the year. *Every decision* is made with this principle in mind.

Chapter 8:
Financing Organizational Strategy

As described up to this point, an organization's leadership team has identified how much it can afford to spend and has selected strategies determined most likely to meet strategic goals while maintaining or improving the organization's financial integrity.

A HOSPITAL OR HEALTH SYSTEM'S LEADERSHIP TEAM MUST now secure sufficient capital to support selected strategies while meeting ongoing operating requirements. This chapter describes financing options and the process hospital leaders should use to evaluate such options.

Equity and Debt Financing

Equity capital and debt capital comprise the two broad categories of capital. *Equity capital* is money invested in a company in exchange for a share of its ownership. Due to the nature of tax exemption and unlike public corporations, not-for-profit healthcare organizations cannot access the equity markets. Their non-debt-financed capital can come from only four sources: operating cash flow, cash reserves, philanthropic contributions, and sale of assets.

To build operating cash flow and cash reserves, an organization must minimize costs and grow net revenues. Leaders in successful not-for-profit hospitals and health systems pay rigorous attention to cash position, assuring the organization availability of sufficient cash to meet operating needs, adequate reserves to weather economic and market changes, and funds for emerging strategic opportunities. Such opportunities may include mergers, acquisitions, and other strategic affiliations, and investments in information technology and the physician enterprise, all of which will likely demand significant capital.

Philanthropy can represent an important piece of the capital pie and is used by many not-for-profit organizations as a means to help meet growing capital needs. Additionally, the timely sale of non-core assets may yield significant capital, which, in turn, can be used to fund core activities.

Few healthcare organizations today have the operating cash flow and available cash reserves needed to fund short- or long-term strategic initiatives. They must borrow capital and incur debt on an ongoing basis to implement the strategies required to maintain a strong market position.

Debt capital is money obtained through borrowing from external sources. Debt capital comes in many different forms. As new financing and interest-rate management instruments emerge in the industry, healthcare leaders must carefully select the best option for their organization and then implement that choice in a highly directed manner. Financing decisions significantly impact the organization's short- and long-term financial position. To support the organization's future growth and development, borrowing must be timely, cost effective, and structured with the organization's best interests in mind.

Debt capital can be accessed through bond offerings (tax-exempt and taxable), Federal Housing Administration (FHA) financing, private placements (bonds, notes, loans, or leases), and non-traditional debt instruments. A description of these follows.

Public Bond Offerings

Publicly offered tax-exempt bonds are the most common form of debt for hospitals. A public offering means that the debt is structured to be offered and sold by an underwriter to any interested purchasers—individuals or institutions. Certain rules must be followed to qualify as a public offering, such as securing the required legal opinions and providing adequate disclosure to potential investors regarding the credit and bond structure.

Public bond offerings can have fixed or variable rates. As their name implies, the interest rate associated with a *fixed-rate bond* does not change during its lifetime. The rate typically is based on a borrower's credit rating.

Variable-rate instruments, whose rates change based on market conditions, fluctuate periodically—for example, daily, weekly, or monthly—and can take various structures, such as put bonds and commercial paper. Put bonds can be "put," or redeemed by bondholders for their full face amount when they come due (typically daily, weekly, monthly, or semi-annually, depending upon the program). Traditional variable-rate bonds require a bank letter of credit securing the bonds, unless a borrower is rated "AA"/"Aa" or better and is highly liquid. Such borrowers also can issue variable-rate instruments, which have index-based resets but without a bank letter of credit.

FHA Financing

Federal Housing Administration financing is a form of public offering available through the U.S. Department of Housing and Urban Development. While not commonly used in the industry, such financing is an added option, particularly for hospitals with limited resources. FHA Section 242-insured loans are offered to acute care hospitals for construction financing, refinancing, remodeling, or expansion. Rates are fixed for the length of the mortgage, but variable-rate swap structures may be considered. The permanent loans are fully amortizing for up to 25 years after completion of the construction project. The FHA 223(f) program allows the FHA to provide hospitals with refinancing of previously non-FHA debt on a taxable or tax-exempt basis. Organizations pursuing FHA financing should be aware that the loans come with significant restrictions and conditions. The process is rigorous and requires more time compared to other financing.

Private Placements

Private placements—which take the form of bonds, notes, loans, or leases—can be taxable or tax exempt and can carry fixed or variable rates. Private placements or direct bank loans differ from other bond offerings in that they require no public disclosure of information about the borrower. Additionally, the debt

incurred by the hospital through the private placement is offered to a very limited number of lenders—typically banks, leasing or equipment companies, insurance companies, or other large institutional investors. Applicable rules require certain legal opinions and investment letters from the lenders.

Private placements are typically quicker to implement because there are fewer regulatory hurdles compared to public offerings—which typically have multiple requirements, such as due diligence procedures, the auditor's agreed-upon procedures for updated financial and operating data disclosure, and process updates on bond ratings. However, the investors sometimes demand a shorter term, higher rate of return, potentially tighter covenants, and a shorter amortization period than in a public offering.

Non-Traditional Debt Offerings

Up through the 1990s, healthcare organizations relied almost exclusively on tax-exempt financing. Since then, financing options have increased and organizations' financing portfolios have become increasingly complex. Financing options include off-balance-sheet (OBS) options, real estate investment trusts (REITs), receivables financing, and subordinated securities. Although these options can be taxable or tax exempt, most are taxable because of the hurdles for tax exemption. Healthcare providers typically access these options if they want to preserve their debt capacity for traditional vehicles or are limited in their ability to access traditional options.

OBS options. Historically, U.S. healthcare providers have viewed hard assets as something to be owned and, thus, have significant equity tied up in property, facilities, and equipment. With increasingly tight capital markets and credit challenges, however, hospitals and health systems may be considering OBS financing of real estate or equipment as a way to finance capital needs.

OBS financing structures—such as operating leases, sale/leasebacks, synthetic leases, and joint ventures or master leases—effectively let a hospital use an asset that is owned by a third-party investor. As such, neither the asset nor the liability is recorded on the hospital's (the lessee's) balance sheet. However, that may soon change. The Financial Accounting Standards Board has proposed accounting treatment changes designed to aid transparency and consistency by essentially bringing long-term leases onto the balance sheet in coming years.

Even off-balance-sheet as they are currently, these financing options have long been scrutinized by the agencies that rate healthcare debt. Each rating agency has well-established methods for adjusting leverage measures to factor this type of debt into their credit evaluations. For example, Standard & Poor's assesses "lease-adjusted MADs coverage," which takes into account a hospital's ability to cover all financing payments regardless of the financing vehicle, including capital leases and operating leases.[39] Moody's Investors Service conducts an additional analysis to address the particular risks posed by leases, such as the risk of default by the underlying borrowers or lessees, and the operational and financial stability of the lessor to gauge its ability to fulfill its contractual obligations.[40]

Healthcare executives considering OBS financing structures should be aware of both the potential benefits and risks, and the implications of increasing pressure for transparency around these financing vehicles. The four basic methods of OBS financing all involve an operating lease, but each has subtle distinctions and separate accounting treatments. Each offers different tradeoffs, such as higher control with less walk-away ability versus less control with easier walk-away ability. Getting accountants involved early is the best strategy.

In a *sale-leaseback transaction*, the third-party investor purchases the hospital's project (or property) and then leases it back to the hospital or a related organization. The sale gives the hospital a cash infusion, which is then available for use with its general needs or for the generation of additional investment income.

The investor typically purchases the building only, and usually has a ground lease of 50 years. Ownership of the building reverts to the hospital or an appropriate affiliate at the end of the ground lease. Closing costs are shared by the investor and hospital, and transaction fees are usually significant.

Synthetic lease structures are highly dependent on the lessee's credit, and typically are structured with relatively short initial terms and lower lease payments. This reflects "interest-only" economics on the underlying debt, unlike other lease types that include amortization of principal. Synthetic leases contain purchase options concurrent with the renewal dates. The purchase price equals the fair market value of the leased asset, which can never be less than the amount of outstanding underlying debt. This requirement often causes termination payment to become a contingent liability on the lessee's balance sheet.

Master leases can be used for real estate or ongoing equipment programs and involve a direct agreement between the lessee and the owner of the property or equipment.

For real estate transactions, master leases typically involve joint ventures with a developer in order to spread the financial risk and ensure the involvement of someone who understands the real estate business. The developer usually puts up the capital, supervises the construction of the project, and operates it once it is complete. The provider obtains the certificate of need, if required, offers services, and develops referral networks to ensure a steady business flow. The less capital a provider contributes to the joint venture, the less profit it stands to make, but the objective often is vertical or horizontal integration without significant financial risk.

Many equipment vendors use master leases for the ongoing lease of equipment. After the master lease is executed, various schedules with specific terms are appended when particular equipment is leased and payments are to begin. Equipment leases often are not centrally managed as part of an organization's primary finance functions. As such, healthcare executives may be unaware of the full extent of their organization's equipment leasing obligations or the associated financial risks. The sidebar entitled "Smart Equipment Leasing Practices" describes eight practices to help hospitals avoid significant risk exposure.

Not every venture lends itself to OBS financing, nor does every healthcare entity have access to all these types of financing. Moreover, the extent to which the capital markets view OBS financing as debt depends on whether the assets financed are strategic or ancillary to the core business and the overall magnitude of lease exposure. Because the rating agencies look closely at an organization's use of leasing to determine its effect on debt capacity and credit quality, hospitals should evaluate their overall leasing program using criteria reviewed by the rating agencies.

Healthcare financial leaders should carefully weigh whether a project lends itself to OBS financing and the tradeoffs among the balance-sheet benefits, income-statement effects, and any potential loss of control over the asset. Lastly, double-checking on the availability of less expensive ways to finance the asset and/or project is always a good idea.

Smart Equipment Leasing Practices

Equipment leasing is an important financing option that is widely used by not-for-profit hospitals and health systems. It serves as an alternative to longer-term financing structures that may not be viable or practical. When managed well, equipment leasing can provide a number of benefits, such as the opportunity to secure an attractive base funding rate in an easy and cost-effective manner, shifting of technology obsolescence risk and disposition of equipment to third parties, and assistance in physician-alignment initiatives.

However, since equipment leasing often occurs outside of an organization's established capital allocation and financing processes, leases frequently are incurred without a robust comparative analysis of the full costs (or potential costs) relative to other sources of capital. Equipment leases may be managed in a fragmented and ineffective manner, which can expose the organization to significant financial risk.

An effectively managed equipment leasing function—that pays equal attention to upfront incurrence and back-end management—can reduce risk exposure and help organizations achieve optimal leasing performance. Eight recommended leasing best practices follow:

1. *Develop and maintain a comprehensive lease catalog.* This provides transparency into all of the organization's lease obligations, and the leasing language, conditions, and processes that create financial risks.
2. *Measure lease performance and evaluate rationale for current lease activity.* This identifies any excess associated expenses, and can reveal potential savings and risk-reduction opportunities.
3. *Drill down on risky leases.* Poorly managed lease programs may generate realized all-in costs of equipment lease funding that are 10 to 20 percent more than expected. Developing strategies to address particularly problematic leases is critical.
4. *Evaluate leases that are past or nearing the end-of-term date.* As a lease nears the end of its regular term, lessees can be exposed to significant financial risk and added costs. Organizations should routinely track when lease terms end, and have a plan for evaluating best next steps on a case-by-case basis.
5. *Understand the accounting and credit implications of leases.* Leases can pose significant accounting and credit-rating issues for an organization. Understanding the basic principles of these implications and factoring them into routine decision-making processes for reviewing existing leases or considering new contracts are critical.
6. *Include leasing decisions in the centralized capital allocation and financing processes.* Inclusion ensures a better leasing platform and likely improvement of leasing performance going forward.
7. *Centralize leasing management and develop specific leasing policies and procedures.* Management of other balance sheet resources, such as investments and long-term debt, has long been centrally managed by the finance staff. Integrating lease management with these functions and establishing appropriate leasing policies and procedures helps in building critical institutional expertise.
8. *Ensure a thorough performance monitoring program.* An effective leasing program requires continuous monitoring of leasing performance, and clear delineation of responsibilities between the clinical, procurement, and finance teams.

Source: M. Robbins and E. Jordahl, *Reduce Costs through Eight Smart Equipment Leasing Practices,* Kaufman, Hall & Associates, LLC, 2014.

REITs. A real estate investment trust (REIT) is an entity whose primary activity is to purchase a portfolio of real estate assets, such as hospitals, nursing homes, or medical office buildings, and lease the property to one or more operators. REIT investors earn their return through lease payments and the eventual sale of trust properties. They typically are interested in high-performing properties that do not need to be directly owned by a healthcare entity.

REITs permit healthcare organizations to obtain cash for real estate property, reduce overall cost of development transactions, achieve OBS financing, and under certain circumstances, maintain control of facilities and property. Depending on the hospital's goals, transactions can be structured in various ways, including outright purchase or sale-leaseback.

Receivables financing. Receivables financing is a securitized funding mechanism that historically could be characterized as "an option of last resort." It involves the sale or transfer of an organization's accounts receivables and the securing of financing against such receivables. Typically, commercial paper is issued and the administrative requirements are extensive. The seller (the hospital in this case) has limited recourse, must meet the requirements of financial accounting standards, and must qualify for OBS treatment of the receivables financing.

Subordinated securities. Subordinated securities are usually available only for organizations rated in the "A" category or higher. The existing security and covenant package and the scale of the capital structure also are major determinants. Typically, these securities involve issuing long-term callable subordinated debt with an option to defer interest for up to five years. Obviously the interest rate is higher than senior debt. Subordinated securities are *not* OBS debt.

Evaluating Debt Instruments

When considering which debt vehicle is most appropriate for the organization's circumstances and credit position, leaders should start by defining the borrowing goals, and then keep those goals in mind throughout the process. All capital decisions

must support the organization's strategic plan, provide as much flexibility as possible given existing and pending laws or restrictions, involve the lowest overall cost for the risk of the asset and liability portfolios, and allow for future financing needs. The following 12 factors should be weighed when considering each debt instrument:

- ***All-in borrowing rate.*** The all-in borrowing rate represents the total cost of capital, including interest and ongoing fees involved with maintaining the financing. Historically, all-in rates have on average been lower with variable-rate debt than with fixed-rate debt, and also lower with traditional bond offerings than with non-traditional offerings.
- ***Interest-rate risk.*** When incurring fixed-rate debt, the borrower is insulated from interest rate fluctuations post-issuance. Variable-rate debt, characterized by periodic rests of the interest rate, exposes the borrower to risk related to rising rates. The best course is to achieve a mix of fixed-rate and variable-rate that minimizes interest-rate risk.
- ***Costs of issuance.*** Tax-exempt bonds typically have higher costs of issuance than do taxable bonds, but in either case, organizations should carefully evaluate these costs. Tax law permits tax-exempt borrowers to finance costs of issuing bonds in an amount up to 2 percent of the principal issued. Such financing can cover any expenses incurred in preparing and implementing the plan of finance.
- ***Use of proceeds.*** The tax status of the financing option depends on the tax status of the entity for which the financing is being sought. For example, if a hospital wants to use the financing proceeds to build a medical office building, the transaction will likely be a taxable one, unless both the building is to be owned by, and the physicians to be employed by, a nonprofit corporation. Hospitals should seek guidance from legal counsel in this area.
- ***Credit position.*** The financial strength of an organization largely determines the credit available to it and the vehicles it can access.
- ***Document structure and underlying security requirements.*** The weaker the credit, the more security is required. With some financing vehicles, such requirements can limit an organization's ability to issue debt in the future.
- ***Covenants.*** There are two basic categories of covenants—maintenance and incurrence. *Maintenance covenants* are routine requirements that the borrower must meet on an annual and sometimes quarterly basis, for example, the liquidity covenant of days cash on hand. *Incurrence covenants* are special requirements that must be met to undertake a particular action, such as mergers, acquisitions, or the sale or disposition of property. Organizations should always seek the least restrictive covenants possible.
- ***Principal amortization.*** The amortization schedule for the financing vehicle is critical to cash flow and maintenance covenants and should closely mirror the life of the assets being financed. The schedule outlines the periodic payments due on an amortizing loan, and includes the principal and interest owed for each payment.
- ***Average useful life versus average maturity.*** Tax-exempt financing rules require that projects eligible for tax exemption be specifically delineated in the documents that support the borrowing. The weighted economic maturity of the bonds cannot currently exceed 120 percent of the weighted average project asset life to be financed. Organizations should check with bond counsel to certify the tax-exempt eligibility of each project and the weighted average life of the financing.
- ***Disclosure requirements.*** Tax-exempt vehicles also require organizations to provide prompt, accurate, complete, and continuing disclosure of certain financial and utilization information. With increased use of direct bank loans and other private placement financings, the importance of timely disclosure of at least basic information relative to the issuance of parity debt also has increased. Parity debt includes bonds or other debt securities that have equal rights as defined by the Master Trust Indenture, the document which governs the current and future borrowing provisions for most not-for-profit hospitals and health systems.
- ***Prepayment penalties and unwind provisions.*** Different financing vehicles have differing premiums or prepayment penalties associated with an early redemption date.
- ***Put risk and renewal risk.*** Put risk is the risk that an investor or bondholder will call or redeem a bond before it reaches maturity. Renewal risk is the risk that renewal of a bank letter of credit will come at an inopportune time and the bank will either be unwilling to renew the existing financing or will want to renew under less favorable terms for the organization.

Leaders in successful not-for-profit hospitals and health systems pay rigorous attention to cash position, assuring sufficient cash to meet operating needs, adequate reserves to weather economic and market changes, and funds for emerging strategic opportunities. When considering debt vehicles, leaders should start by defining the borrowing goals, and then keep those goals in mind throughout the process.

Selecting the Best Financing Strategy

All financing transactions occur within the context of an organization's long-term financial plan. By weighing each financing option against the factors outlined in this chapter, organizations can narrow the field to the most appropriate financing alternatives. The best strategy in choosing debt vehicles is to stick to the basics, looking toward more complex debt vehicles only if they would provide known and measurable benefits.

As the 2007 to 2008 credit crisis demonstrated, flexibility of selected vehicles is critical in a changing environment, but so is a fundamental understanding of the underlying benefits and risks of each instrument. One rule of thumb applies in all cases:

if a hospital's financial leaders and the board members on its finance committee cannot understand the financing approach, the organization should not pursue it.

Achieving the Best Possible Bond Pricing

As part of their fiduciary duties and core responsibilities, board members provide financial oversight, which by definition encompasses any debt issuance. One specific debt-related responsibility identified by The Governance Institute reads: "The board monitors the organization's debt obligations and investment portfolio."[41]

Because issuance of tax-exempt bonds is the most common way not-for-profit hospitals and health systems finance major strategic capital needs, board members should have a basic understanding of the bond selling and pricing process and its participants.

The financing process involves a multi-disciplinary financing team that evaluates the organization's capital structure, formulates the right plan of finance, guides the organization through the ratings process, evaluates credit support options, ensures compliance with regulatory and legal due diligence requirements, drafts documents, negotiates covenants, and executes the overall financing transaction. The sidebar entitled "The Financing Team" outlines the team members and their basic roles.

Use of strategies outlined here will help hospital borrowers achieve the lowest net interest cost possible consistent with the successful sale of the bonds.

The Financing Team

The borrower: The actual hospital or healthcare system "obligor" that is contractually required to repay the debt.

The borrower's counsel: Represents the borrower's legal interest in the transaction and provides required corporate legal opinions.

The borrower's financial advisor: The borrower's objective and independent financial advocate throughout the financing transaction, counseling the borrower about final bond and/or swap pricing terms and conditions, and guiding the borrower through the financing process described earlier.

The issuer's counsel: Represents the issuer's legal interest and provides required legal opinions on behalf of the conduit issuer.

Underwriter (investment banker): Working closely with the financial advisor, the underwriter provides overall technical analysis and recommendations related to plan-of-finance decisions and acts as a broker in the marketing and sale of bonds to investors. Additionally, the underwriter actively participates in credit and some direct loan or private placement conversations.

Underwriter's counsel: Represents the underwriter's legal interest and provides required legal opinions regarding the adequacy of disclosure and the underwriter's responsibilities.

Bond counsel: Provides the overall opinion that the bonds are tax exempt and drafts many of the basic financing transaction documents, ensuring that the bonds conform to federal and state tax code requirements, and coordinates required regulatory approvals.

Master trustee and bond trustee: The master trustee assumes certain fiduciary responsibilities on behalf of all master note holders under the Master Trust Indenture. The bond trustee represents bondholder's interests within certain parameters on a specific series of debt and coordinates payments from the borrower to the bondholders.

Auditor: Typically conducts certain accounting reviews and procedures, as required by the underwriter and underwriter's counsel, to ensure adequate disclosure of the borrower's financial position to the investment community.

Note: In the case of direct bank loans and private placements, the role of several of these financing participants may be restricted or nonexistent. For example, bank and bank/lender counsel would replace the underwriter and underwriter's counsel. Or a lending bank may not wish to engage the bond trustee for debt service payments, preferring direct payments instead.

Devise an Optimal Plan of Finance

Interest rate costs incurred by hospitals are the result of numerous factors. Public market conditions at the time of the bond sale and the approach to, and structure of, the hospital's debt transaction can affect the cost of that debt. Essential aspects of a plan of finance include fixed-rate or variable-rate debt, taxable or tax-exempt debt, call or prepayment terms, security and covenant provisions, final maturity, useful lives of the underlying assets being financed, and the amortization schedule.

Ensure a High-Quality POS and Rating Reports

The transaction moves into the bond pricing/selling stage after the borrower has constructed an appropriate plan of finance, obtained credit ratings and bank credit/liquidity, if applicable, and completed documentation. Technically, the borrower (through its issuer) sells the debt obligations at particular agreed-upon rates and terms to an underwriter, who in turn, sells the debt obligations to investors. The underwriter, who functions as the broker between the borrower and the investors, establishes a market for the debt.

To achieve maximum bond marketing value, the borrower must tell the best credit story possible to potential bondholders through two documents: a high-quality Preliminary Official Statement (POS) and the rating reports distributed by the rating agencies. The POS is the central document circulated to investors during the bond marketing and sales process. Its purpose is to generate interest in the bonds and to provide all of the information that would be material to a prospective purchaser.

Participate in Investor Calls

Depending on the nature of the plan of finance (fixed-rate versus variable-rate debt) and credit support, it typically is in the borrower's best interest to participate in investor calls, and potentially in an in-person "road show." In each case, the underwriter or financial advisor arranges a structured forum in which the borrower can provide potential investors with a brief overview of the organization and key credit attributes. Potential investors typically ask the borrower direct questions. Many institutional investors *require* direct communications with the borrower in advance of investment decisions and on an ongoing basis. As such, investor calls and road shows can greatly enhance the interest in and market competition for the bonds.

Keep Apprised of Rates

On a regular basis, the borrower should keep informed of current market rates and conditions during the bond pricing/selling process. Financial advisors, investment bankers, and others who negotiate deals daily can properly apprise the borrower.

Evaluate Underwriter's Scale

If the plan of finance calls for fixed-rate bonds, the underwriter presents a "scale." A scale is a matrix of expected maturities of serial or term bonds along with a coupon rate, dollar price, and effective yield, based on the optional call provisions of each maturity. The proposed scale reflects where the underwriter believes investor interest in the bonds is likely to occur and at what rate. Occasionally, a single maturity is split between alternative couponing structures to increase particular investor interest and lower the overall borrowing cost. The borrower should ensure objective evaluation of the underwriter's scale by its independent financial advisor.

Keep Informed of Bond Sale Progress

On the day of pricing, the underwriter requests authorization to enter the market using an agreed-upon scale. This opens an order period during which the underwriter obtains bond purchase orders from investors, oftentimes based on certain priorities of orders that were defined earlier in the marketing plan. The order period can run several hours to more than one day depending upon market conditions and the size of the financing. The orders are not binding; the investors "subscribe" for certain bonds but are not committed to purchase those bonds until the purchase contract is signed. The underwriter assumes the risk.

During the order period, the underwriter provides the borrower and financial advisor with a progress report on the orders, and recommends maintaining or adjusting the interest rate scale. Once the underwriter believes it has sufficient orders for bonds, it will propose a final scale at which it agrees to underwrite the bonds. In certain circumstances, such as difficult market conditions, the underwriter will commit some of its own capital and will inventory unsold bonds for a period of time. The underwriter asks for the borrower's verbal approval, which constitutes an award of the purchase contract. Final numbers are run, and the sale is essentially complete.

Close Deal and Provide Continued Disclosure

Closing generally occurs within two weeks of the pricing date for fixed-rate bonds, or within a day or two for variable-rate demand bonds. Final documents are signed and bond proceeds are delivered to the bond trustee and disseminated across different funds, as appropriate.

The borrower is proactively obligated to provide prompt, accurate, complete, and continuing disclosure as outlined in a continuing disclosure agreement. Capital market constituents often consider the timeliness and quality of information provided by the borrower as an indicator of management quality. Capital market confidence in a hospital's governance and management teams can make the difference in future credit ratings, interest in the borrower's future debt issues, and increasingly, bank interest in providing credit support and direct lending.

Concluding Comments

Access to and cost of financing options is entirely credit dependent. Strong organizations with a high rating have access and a broad range of offerings. Weak organizations with declining creditworthiness have a more limited number of such options. All hospitals and health systems should identify and evaluate financing mechanisms that will positively impact their organizations' strategic and financial position and work with their financial advisors to secure such financing at the best possible terms within appropriate risk and credit contexts. Organizations also should establish practices that ensure continued monitoring of financing mechanisms.

A broad debt management policy that outlines approved parameters for the financial transactions is strongly advised. The sidebar entitled "Elements of a Comprehensive Debt-Management Policy" outlines elements that can be included in such a policy. The capital markets, particularly the rating agencies, have recommended that organizations maintain a policy on the use of derivatives and other complex financing options, whose inherent risks may or may not be well understood by every member of the management team and board. A comprehensive policy can provide a road map for capital structure management going forward, the topic of Chapter 9.

Elements of a Comprehensive Debt-Management Policy

Principles/Scope and Authority

- Overall debt-management objectives
- Scope of the policy, such as debt, lease financing, swaps, and other derivative products
- Policy review and approval process and administration authority

Analytical Requirements

- Credit rating goals and targets
- Elements of the long-range strategic financial plan related to debt issuance and debt service requirements
- Specific requirements of debt strategy, including asset/liability management analysis, tiered liquidity and other business risk analysis, diversification of financing vehicles, and management of specified risks

Approved Financial Products

- Debt and derivative instruments
- Process for adding or deleting specific instruments

Debt Policy

- Use of long-term debt, short-term debt, variable rate debt, lease financing, real estate financing, and guaranties
- Qualified credit banks, dispersion of bank credit exposure
- Purpose of new money financing and refunding bonds
- Approved uses of credit enhancement
- Responsibility for maintaining capital market relationships and continuing disclosure

Derivatives Policy

- Overall philosophy and rationale for using derivative products
- Required risk analysis and risk limits
- Appropriate derivative counterparties
- Authority for derivatives management

Source: Kaufman, Hall & Associates, LLC.

Chapter 9:
Managing Capital Structure and the Balance Sheet

Capital structure is the combination of debt and equity that funds an organization's strategic plan. In not-for-profit healthcare organizations, capital structure includes debt and other sources of capital invested in the organization over time.

THE EFFECTIVE MANAGEMENT OF CAPITAL STRUCTURE, THE topic of this chapter, requires focus on the type of debt incurred by the organization, the cost and terms of debt capital, its flexibility and risk, and its overall ability to support the organization's competitive position and financial performance. Capital structure management involves creating, shaping, and directing the debt and equity portfolio in response to changing market and financial conditions. At any point in time, there *is* an optimal capital structure.

An organization's *balance sheet* provides a snapshot of its assets, liabilities, and resulting net worth at one point in time. Through a strategic approach to balance sheet management, healthcare organizations can achieve the asset and liability mix that yields the best return given the organization's capital flexibility needs and risk tolerance.

The Benefits of Effective Management

The key benefits of effective capital structure management are increased capital access, added flexibility, and lower overall cost of capital. Organized properly in an organization of any size, a capital structure can be adjusted to meet changes in interest rates and capital financing priorities, and the changing shape of interest rate yield curves. Capital structures by themselves can lower the overall cost of capital and can maximize the return of assets versus the cost of liabilities. Deliberately and proactively managed, capital structure has become a competitive advantage.

Perhaps most importantly, over a 10- to 20-year planning horizon, the quality of a hospital's capital structure can cost or save the organization millions of dollars, regardless of interest rate cycles and credit spreads. Consider a hospital with total debt of $300 million. If the hospital's executives can lower the cost of capital by 1 percent, the hospital saves $3 million per year. Over a 10-year period, savings amount to a very significant $30 million. Most hospital executives would be hard-pressed to identify other improvement strategies that could yield that level of savings, which is increasingly critical given the continued pressure to reduce costs.

Consider also the effect of such savings on competitive position. Perhaps the hospital is located in a two-hospital town, and both hospitals have a similar level of debt. Hospital A, which has lowered its overall cost of capital to 3 percent, has a distinct competitive advantage over Hospital B, which is paying 4 percent or more. The lower the cost of capital, the more capital capacity will be available to fund key strategic initiatives.

Organizing for Effective Management

Achieving success with any management effort requires laying the appropriate groundwork. Education ensures that the board of directors and senior leaders are on the same page about the benefits and importance of effective capital structure management to the organization's competitive financial performance and future positioning. All board members and senior leaders may not need to be familiar with capital structure intricacies, such as the many available derivative and swap vehicles. However, they do need to know enough to ask questions, such as whether a capital structure decision or vehicle might expose the hospital or health system to inappropriately high risk or whether the debt portfolio is being monitored to achieve the lowest possible interest costs.

Healthcare financings have become increasingly complex and sophisticated in recent decades. Some hospitals now have the largest and most complex capital structures in municipal finance, a category that includes universities, public power companies, city and state governments, airports, turnpikes, and others. Whether developed internally or sought beyond the organization, capital markets expertise is essential.

Capital structure decision making should reflect the level of risk the organization wishes to assume. Organizations have differing levels of comfort with risk, just as some private investors want to limit their investments to vehicles such as treasury bills, while others gladly purchase individual stocks and futures. Each organization must determine its own risk tolerance, a topic described more fully in the next chapter.

Key Management Strategies

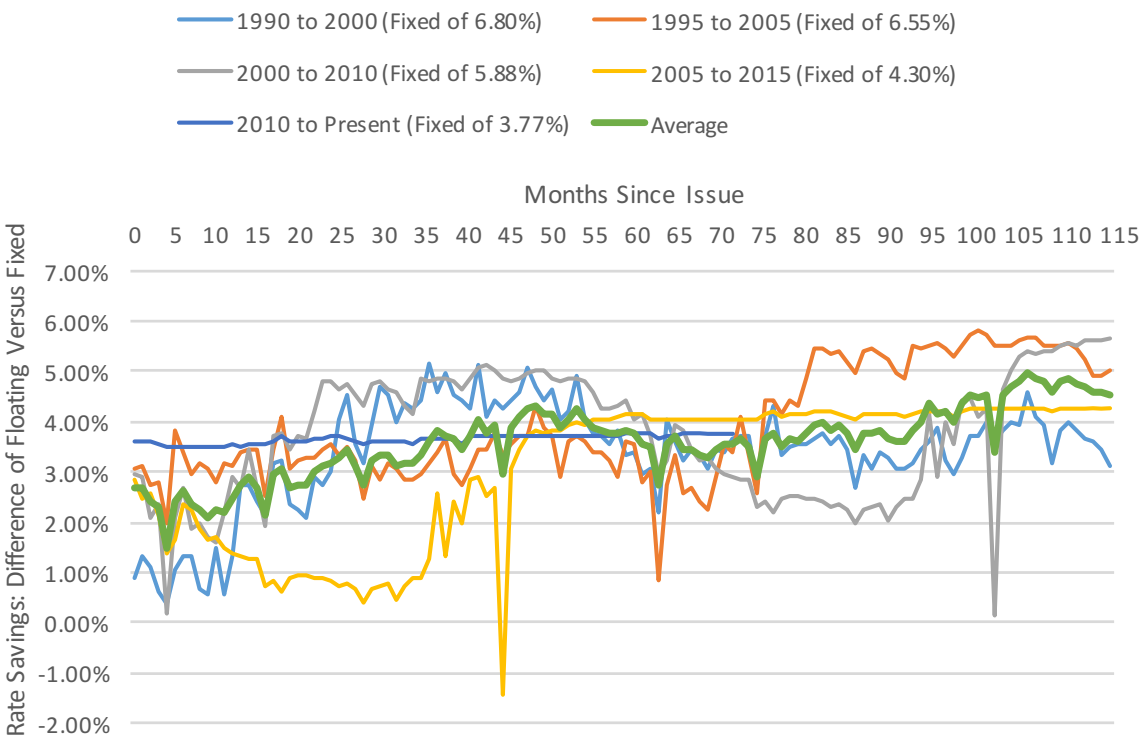
Effective capital structure and balance sheet management can be achieved by healthcare organizations of any size through consistent use of 10 strategies:

1. Determine the appropriate level of debt capacity.
2. Determine the optimal mix of traditional and non-traditional financing.
3. Select and achieve the "right" relationship between fixed-rate debt and variable-rate debt.
4. Diversify variable-rate debt to avoid exposure to any one form of risk.
5. Use swaps and other derivatives carefully and appropriately to manage the cost of capital and the capital structure.
6. Pursue a level debt structure with the longest possible final maturity.
7. Monitor and continuously adjust the debt portfolio.
8. Optimize return on assets.
9. Consider how best to use asset liability management.
10. Regularly review and update the organization's debt and swap policies to reflect current circumstances.

Strategies 1 and 2 have been covered in previous material (see Chapters 4 and 8). Strategies 3 through 10 will be the focus of the remainder of this chapter.

The key benefits of effective capital structure management are increased capital access, added flexibility, and lower overall cost of capital. Organized properly, a capital structure can be easily adjusted to meet changes in interest rates and capital financing priorities, and the changing shape of interest rate yield curves. The lower the cost of capital, the more capital capacity will be available to fund key strategic initiatives.

Exhibit 9.1: Fixed-Rate and Variable-Rate Interest Cost Yields



Notes: Analysis compares 20-year MMD rate as a proxy for fixed and weekly SIFMA as proxy for floating; credit spreads, fees, and other costs may significantly influence results. Data as of February 2016.

Source: Analysis by Kaufman, Hall & Associates, LLC, based on data from Thomson Reuters and the Securities Industry and Financial Markets Association (SIFMA).

The Right Mix of Fixed-Rate and Variable-Rate Debt

Every organization has a different "right mix" of fixed-rate to variable-rate debt. The mix is dependent on the organization's bond ratings, availability of external credit support, the amount of free cash, changing interest rates, the investment policy, and the board's attitude toward risk. *Selecting* the appropriate relationship of fixed-rate and variable-rate debt is one of the most important capital structure decisions an organization's financial leaders will make.

Achieving the right mix requires planning, timing, and proper execution. A 15-year look at fixed-rate and variable-rate interest cost yields shows that, overall, variable-rate interest costs have been lower, and at many points significantly lower, than fixed-rate costs (see **Exhibit 9.1**). This has especially been true in the years following the credit crisis.

Diversification of Variable-Rate Debt

Choosing the correct mix of different variable-rate products is also a high-priority task for the hospital's financial leaders. Diversification of the variable-rate debt portfolio can consistently lower the organization's overall cost of capital. A diversified program could include variable-rate demand bonds backed by a bank letter of credit, investment bank proprietary products such as "direct lending" or "direct funding," and in the cases of the strongest credits, unenhanced variable-rate demand bonds.

A high-quality, variable-rate debt program avoids excessive exposure to any one form of risk, including the following:

- ***Basis:*** Risk resulting from interest rate variance between yields on assets and costs on liabilities due to different bases, such as the London Interbank Offered Rate (LIBOR) versus the Securities Industry and Financial Markets Association (SIFMA) or the U.S. prime rate
- ***Put:*** Risk that bonds can be "put" back to the hospital by the lender
- ***Bank:*** Risk that the bank's underlying credit rating will negatively impact the cost or stability of the loan
- ***Renewal:*** Risk that renewal of a bank letter of credit will come at an inopportune time or be unobtainable for a variety of reasons

- ***Credit:*** Risk that an organization's credit rating changes while it is using certain programs that are dependent on the organization being at a certain credit level
- ***Failed extension:*** Risk that the bank or other lender fails to offer a new term at acceptable rates and/or business terms for a direct loan
- ***Failed auction:*** Risk that occurs when there are more sellers of an issuer's paper on an auction date than there are buyers, and the whole offering is not resold and then is set via formula at an unacceptably high rate

The turmoil in the credit markets resulting from the sub-prime mortgage crisis beginning in 2007 vividly illustrated to hospitals and health systems the effects of credit risk and of products reliant on well-functioning markets. The downgrading of "AAA"-rated bond insurers and failed auctions increased the costs of certain variable-rate products for hospitals and health systems. Given resultant dislocation in the floating-rate markets, organizations reexamined risk tolerance, assessed alternatives, and conducted controlled contingency planning.

As the Federal Reserve lowered the Federal Funds Rate (the bank-to-bank lending rate) in late 2007 and repeatedly in 2008, and the capital markets gradually resumed more normal operations in 2009, many hospitals decided to lock in long-term, fixed-rate financing, believing that interest rates were near historic lows. Moreover, banks shifted their provision of floating-rate credit to the direct loan space, either on a taxable or tax-exempt basis. Growth in bank direct floating-rate loans has served to largely replace the decreased amount of outstanding traditional variable-rate bank debt supported by bank letters of credit.

Swaps and Other Derivatives

As an organization's capital structure increases in complexity, the importance of using derivative strategies also increases. A *derivative* is any sort of contract that manages or adjusts the character of underlying securities, whether debt or equity. Derivatives provide a mechanism to maintain a flexible capital structure and to make real-time adjustments to the capital structure as demanded by both the interest rate and competitive environments. Derivatives also permit appropriate matching of assets to liabilities as interest rate and stock market conditions change.

An *interest rate swap,* a type of derivative, is a contract between two parties to exchange interest rate modes on a specific amount and type of debt. In the healthcare world, the hospital borrower is one counterparty, and a commercial or investment bank is the other counterparty. Swaps are common tools of treasury management in the private sector and have become increasingly common in the public, not-for-profit sector.

Swaps offer a means of synthetically changing the fundamental interest rate characteristics of debt, but importantly, swaps and derivatives are financial products, *not* debt. Like other contracts, they can be reversed at any time, but like bonds, the value of the contracted trade changes as interest rates go up and down. There are three basic types of interest rate swaps:

- ***Fixed payer swaps*** convert variable-rate debt to fixed-rate debt. A hospital with variable-rate debt contracts with a swap

counterparty to provide fixed payments over the life of the swap in exchange for receiving variable payments based on a defined index.

- ***Fixed receiver swaps*** convert a hospital borrower's fixed-rate debt into variable-rate debt. A hospital with fixed-rate debt contracts with a swap counterparty to provide variable-rate payments over the life of the swap in exchange for receiving fixed-rate payments.
- ***Basis swaps*** result from combining a tax-exempt fixed-to-floating (SIFMA) swap with a LIBOR floating-to-fixed swap. LIBOR is the rate of interest paid on U.S. dollar deposits at major London banks. It reflects short-term *taxable* interest rates and is the most widely used index in the swap market.

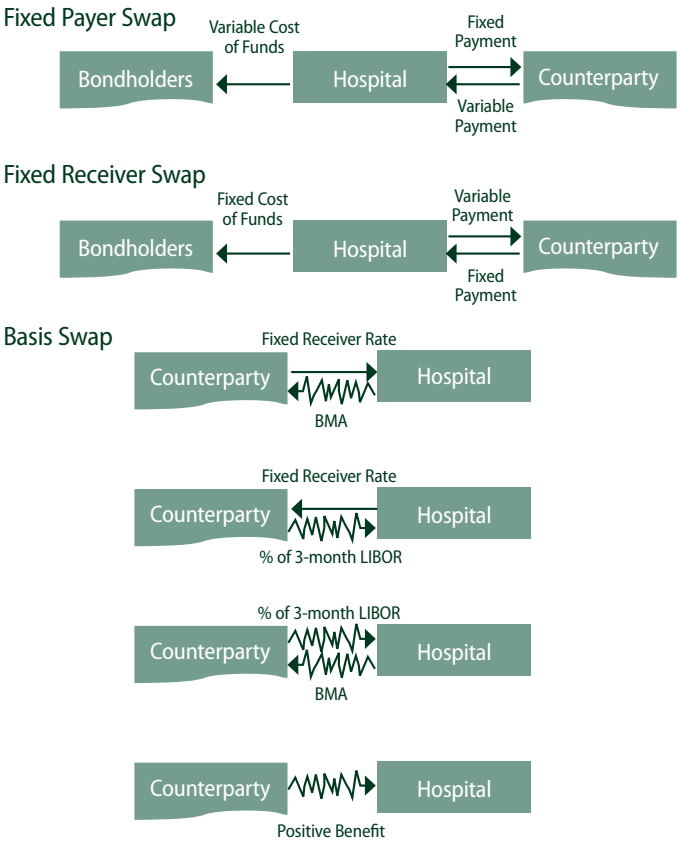
Exhibit 9.2 illustrates how each type of interest-rate swap works. The usefulness of swaps and other derivatives to tax-exempt healthcare organizations depends almost entirely on the relationship of taxable to tax-exempt interest rates. This relationship changes all the time, so the right derivative one day may not be right the next. Swap values change as market conditions change. As interest rates increase, for example, the value of a fixed receiver swap decreases; as rates decrease, the value of the swap increases.

Education about and proactive management of swaps and derivatives are critical. A high-quality swap program starts with the solid education of the board and senior leaders about swaps' benefits and risks, and assures clear objectives, a rationale, an implementation plan, and post-implementation monitoring and management. Because derivatives come in a multitude of forms, it has become more difficult for healthcare financial leaders and board members to determine which trades are appropriate for the organization and which are either speculative or subject the organization to excessive risk. A high level of independent capital markets expertise is required.

Debt Structure and Maturity

The average life of an organization's overall debt and its amortization and maturity structure have a significant impact on current and predicted cash flow and debt capacity. The lowest net present value of any payment structure is generally the longest amortization obtainable in the capital markets and permitted by tax law.

Exhibit 9.2: Three Types of Swaps



Source: Kaufman, Hall & Associates, LLC.

However, as capital structures are built through the issuance of additional debt, amortization schedules tend to "shorten up"—i.e., the average life of the debt in number of years to maturity decreases—and annual payments become uneven. With each new series of bonds, it is important to pay special attention to the total average life of the debt and the actual payment schedule. Attention to this issue can have a powerful cash flow impact on an organization from year to year. This is magnified by the current increased capital investment in IT, physician practices, and ambulatory strategies, which have much shorter lives than the property, plant, and equipment investments emphasized in decades past.

Organizations that are shortening up their debt and paying that debt over 15 and 20 years are usually paying a higher cost for the debt on a present value basis than those organizations paying over a 30-year period. Similar to how a home mortgage works, stretching out the amortization period for the longest possible period of time produces the lowest net present value of payments.

Monitoring and Adjusting the Debt Portfolio

In order to maintain maximum flexibility, lowest possible interest costs, and acceptable levels of risk, organizations must proactively and regularly adjust their portfolios as changes occur in the market and in the portfolios themselves. Healthcare leaders should revisit their financial assumptions on at least an annual basis and assess the portfolio's performance relative to current financial performance. Monitoring the market regularly for interest rate changes, and identifying and evaluating new opportunities to enhance capital structure are ongoing leadership responsibilities.

Optimizing the Return on Assets

Optimizing the return on assets is absolutely central to an organization's ability to achieve and sustain competitive financial performance. Targeted productivity of all assets—whether property, plant, and equipment (PP&E), cash reserves, or the investment portfolio—must be identified and achieved within the organization's risk, flexibility, and credit parameters.

Revenue and profitability growth ensure the continued expansion of a hospital or health system's capital capacity and optimized return on operating capital and assets. Organizational earnings face unrelenting pressure from the ever-expanding opportunities for capital spending. Especially with increasing pressure to reduce costs and demonstrate high-value care delivery, all managers must carefully manage their departments' capital needs and bottom-line contribution to the income statement through productivity, efficiency, and expense control initiatives.

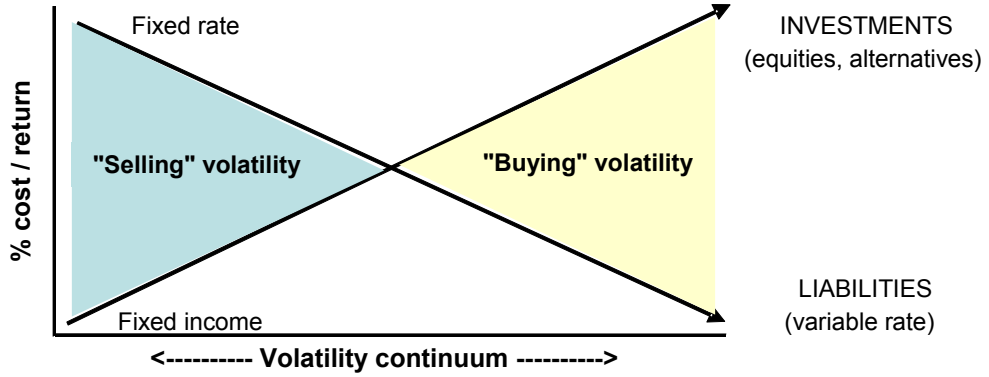
Income from the investment portfolio represents a sizeable proportion of most organizations' net earnings and is a key factor in enabling hospitals and health systems to implement their strategic plans. Organizations take different approaches to investment management, but rigor, discipline, and data-informed analytics are common to all best-practice approaches. Achieving a realistic balance of risk and rewards is critical.

Sensitivity analysis enables organizations to better understand the financial risk associated with specific investment portfolios. Fixed-income and cash-type investments, which traditionally have been considered "safe," can actually represent significant risk related to the interest rate and the shape of the yield curve. Organizations are looking to other financing options as a result. Alternative investments, such as hedge funds, real estate, private equity, and venture capital, are gaining consideration as not-for-profit healthcare organizations diversify their portfolios to fund strategic capital and lower overall portfolio risk.

The Asset and Liability Management Approach

A best-practice approach for many organizations to balance sheet management requires careful management of assets and liabilities in concert with one another rather than as separate

Exhibit 9.3: Investment and Liability Volatility



management functions. An increasing number of healthcare organizations are using *asset and liability management* (ALM) to ensure a concurrent and integrated approach to managing both sides of the balance sheet.

ALM's goals are to optimize capital capacity and investment returns and minimize debt expense and volatility and risk related to interest rates, credit, market, and liquidity. *Volatility* is the standard deviation of the change in value of a financial instrument with a specified time horizon. Increasingly, healthcare treasury management is concentrating on managing or buying and selling capital structure volatility or risk (see **Exhibit 9.3**). Pursuing liability benefits likely reduces asset opportunities; pursuing asset benefits likely reduces liability opportunity.

ALM optimization studies or models focus on return by asset class—for example, cash, short-term and long-term fixed income, real estate, domestic equity, alternative investments, and debt expense by type (such as variable rate, synthetic variable rate, taxable variable rate, long-term fixed rate, and synthetic fixed rate).

Depending upon the organization's goals, such studies might look at managing or mitigating interest-rate risk inherent in variable-rate instruments through balance sheet (cash and investments), income statement, and other financial resources to build a liability portfolio that responds to expected asset performance or vice versa.

There is no single best-practice standard to determine the right amount of financial volatility. The solution set is organization-specific. An extension of the "efficient frontier" portfolio theory would suggest finding the "optimal" point of balance (the efficient frontier) given a taxable investment portfolio matched against tax-exempt debt. In general, this means that:

- To take advantage of *falling rates,* organizations might wish to be fixed on the asset side and variable on the liability side.
- To protect against *rising rates,* organizations might wish to be variable on the asset side and fixed on the liability side.

Credit considerations related to ALM center around whether allocation and level of risk properly correlate with financial flexibility. Rating agency analysts generally view the use of ALM as a best management practice that is having a positive impact on the healthcare sector.

Effective risk management processes within a corporate risk framework ensure that an organization's balance sheet resources appropriately support core operations. Invested assets mitigate risk *first* and then pursue return based on each organization's individual characteristics, assessed on a comprehensive, integrated basis.

Regular Review and Updating of Debt and Swap Policies

Having up-to-date policies regarding debts and swaps is essential to effectively managing assets and liabilities. These policies provide a baseline and define the parameters for what an organization can and cannot do relative to pursuing debt and swaps. As such, they serve as an important roadmap for the board and finance committee.

However, debt and swap policies typically are established at a specific moment in time, based on the organization's present position, financial goals and objectives, and market conditions. Hospitals will want to avoid having policies that might restrict them from taking swift action if needed under changing conditions. For this reason, healthcare financial leaders should ensure routine review of debt and swap policies—preferably annually—to account for changes in the market, organizational structure, credit rating, or other factors that might affect debt- and swap-related decision making.

Concluding Comments

The importance of effective and efficient capital structure and balance sheet management to an organization's long-term competitive strategic-financial performance cannot be over emphasized. To obtain the significant financial and competitive advantage achievable through effective management, hospitals and health systems must consistently use the strategies outlined in this chapter and throughout this publication. In an era of slim operating margins and/or volatile investment markets, healthcare organizations can ill afford to neglect any aspect of the capital management cycle, in which capital structure assumes a major role. Use of the strategies described here will increasingly reward organizations with the know-how and muscle to achieve a strategic financial competitive advantage.

Chapter 10:
Understanding and Managing Risk

Risk is a common focus in clinical medicine, but the topic has not yet received the financial focus it deserves in many of the executive suites and boardrooms of the nation's hospitals and health systems.

THIS IS A SERIOUS PROBLEM. IN ORDER TO NAVIGATE THE reform agenda and healthcare's new business model, healthcare leaders will need to move quickly to strategically reposition their organizations for a fee-for-value environment. New strategies related to physician alignment, network participation, coordinated care infrastructure, partnerships, and other considerations, will be expensive and pose significant financial risk to many organizations.

Directors and management teams can prepare themselves to better manage and mitigate risk proactively by understanding the basic principles of risk, the different types of risk that occur across an organization, and the interrelationship of those risks.

The need to be proactive in understanding and managing risk is magnified in today's rapidly changing healthcare environment, but effective risk management is important under any market or economic conditions and for any entity at any stage it its development. This chapter describes the different types of risk that healthcare organizations might encounter, and practical strategies leaders can use to effectively manage risk.

Risk Defined

In its simplest form, *risk* is defined as variability to expected outcomes. It can be upside or downside, depending on whether the variability is positive or negative. *Downside risk* implies harm to something of value that may arise from a present process or condition, or a future event. It typically receives the most attention in healthcare due to the challenges it can create for an organization. If left unchecked, downside risks can pose barriers for achieving organizational goals, and can expose hospitals and health systems to significant financial, strategic, and/or operational stress—any of which can significantly diminish performance in these domains. *Upside risk* typically represents opportunity for an organization, whether strategic, operational, financial, or a combination thereof.

Types of Risk

Different types of risk exist in every industry, but three notable forms of risk should be of concern to every healthcare director and executive: business risk, financing risk, and event risk.

Business Risk

Business risk is the risk incurred by operating the healthcare organization each and every day. The central downside to hospital business risk is that cash flow will be inadequate to meet the organization's operating expenses, making it increasingly difficult for the hospital to maintain competitive performance.

Factors creating business risk derive from both internal and external factors. *External* factors include the state of the global economy and capital markets, natural disasters, public infrastructure, new competition, and other elements that hospitals cannot control. *Internal* factors include the businesses/services offered, staffing, market, the physician enterprise, strategic initiatives, partnerships, facilities, and pension arrangements.

Consider the following example of business risk: with the goal of increasing access to care in an underserved community, a community hospital borrows significant capital to build a large ambulatory center. However, a well-funded non-traditional competitor enters the market with plans to open a large urgent care/retail facility nearby. This facility is likely to reduce the volume of non-acute services provided in the hospital's ambulatory center, thereby significantly lowering the projected revenue targets needed to make timely and adequate payments on the debt service funding for the center, creating downside business risk for the hospital.

Exposure to external factors tied to the industry or the national or world economy all contribute to the business risk faced by the organization. For example, a health facility operated by a public hospital whose tax revenue base in the district has sharply declined in the last decade has increased business risk due to the district's underlying financial condition. Business risk could be further exacerbated by how hospital executives

respond. If they build their organization's strategic plan and its funding based on unrealistic utilization projections, they subject the hospital to higher business risk; the organization simply cannot earn the revenue needed to meet operating expenses.

Contracting Risk

Contracting risk is a subset of business risk that likely will be experienced by organizations as the industry shifts toward risk- or value-based payment models. Contracting risk is incurred when an organization accepts responsibility for delivering defined services at a predetermined price and quality level to a specific population within a specific network, as defined in the contract. Most contracts will incorporate downside risk and upside incentives based upon current performance.

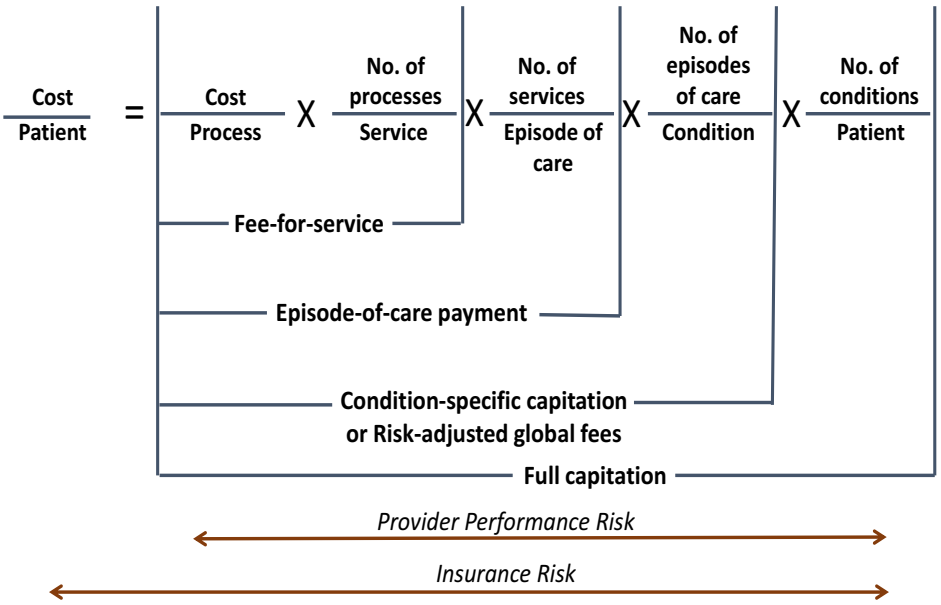
Value-driven contracts are fundamentally transforming how many hospitals conduct their business with physicians, other healthcare organizations, and payers. They are designed to shift "performance risk" for care quality and costs to healthcare providers, and away from insurers or payers. Insurers or payers traditionally have assumed the risk that a patient will need services or a greater level of services than projected, but this risk shifts to healthcare organizations under full risk-bearing contractual arrangements.

To build or participate in a care-delivery network, hospitals and health systems will need to invest in physician integration, technology, and care-management infrastructure. When, with whom, and how to start managing population health and assuming performance-based risk contracts are important considerations with critical implications to the total risk assumed by hospitals and health systems. In general, risk-based contracting involves some expansion of potential downside financial risk for the cost of care through bundling of payments, varying degrees of capitation, or full assumption of both administrative and clinical costs (for example, with a system-owned health plan).

To properly analyze contracting risk, a variety of disciplines must be involved, including financial planning, actuarial support, managed care contracting, and others. **Exhibit 10.1** shows the variables contributing to care costs, and which of these variables the provider could be at risk for under a sampling of different payment models.

Numerous variations in payment arrangements exist, and new contracting models are continuing to emerge nationwide.

Exhibit 10.1: Variables for Which the Provider Is at Risk under Alternative Payment Systems



Source: H. D. Miller, *From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs,* Robert Wood Johnson Foundation and Network for Regional Healthcare Improvement, January 2009. Reprinted with the author's permission.

Healthcare leaders should understand the risk of any proposed contract as they assess which is most appropriate for their organization.

Each of the payment systems inherently creates incentives and disincentives for the provider and the payer, with systems to the left side of the exhibit having risks of higher costs for the payer, while those on the right side shift the risks of costs to healthcare providers. Various contractual controls and incentives can be developed to counteract the risks, but the organization should be cognizant of its risk tolerance, as discussed later in this chapter.

Providers will assume downside financial risk for not meeting targeted population health measures for costs above expenditure benchmarks, and for not meeting quality thresholds. Conversely, upside financial incentives will accrue when providers exceed the measures, achieve a lower cost of care than target levels, and exceed quality thresholds.

Four sources of risk are inherent in value-based contracting: strategic and operating; actuarial or insurance; financial/asset and liability; and comprehensive.

Strategic and operating risk involves the organization's ability to successfully execute its contracting plan into the future, given both internal and external influences. Risk related to potential care-continuum partners should be considered as part of this. The contracting entity usually assumes risk for its network partners and out-of-area services.

Actuarial or insurance risk involves the organization's ability to properly estimate use rates and costs for serving a defined population, and to mitigate risk of inaccurate projections through specific initiatives. Also important is the ability to meet capital reserve requirements for assuming risk.

Financial/asset and liability risk is incurred due to the significant capital that is required to build the resource capacity to meet the organization's obligations. Among the requirements mentioned earlier, health systems must build physician networks, enhance technology, develop care-management infrastructure, and maintain minimum cash reserves. Capital commitments also are a factor in the organization's flexibility with capital structure decision making, including asset and liability management as described in Chapter 9.

Comprehensive risk represents the sum of the three risks described here. Hospitals and health systems need to be thoughtful and realistic about the skills and infrastructure needed to manage different types of payment arrangements. Having a risk contracting strategy is essential, and should be integral to an organization's comprehensive business plan.

Financing Risk

Financing risk, sometimes called "funding risk," is the risk that the cost to capitalize a project or the enterprise as a whole deviates from baseline expectations. Often defined as the unexpected variability or volatility of cost of capital or return on capital, financing risk could include both better-than-expected and worse-than-expected scenarios. In general usage, however, financing risk typically applies to negative scenarios.

As discussed in the previous chapter, financing risk is built into the capital structure of hospitals and health systems on both the liability and asset sides of the balance sheet, and on the interrelationship between the two.

Liability-side risks include basis, put, bank, credit, market access, and interest rate risk, among others. The risk of interest rate fluctuations and credit quality deterioration can be reduced through use of fixed-rate debt. Variable-rate debt, characterized by periodic resets of the interest rate, exposes the borrower to risk related to rising interest rates and credit risk, which may result from organizational or credit enhancer downgrades.

Many capital market risks do not "evaporate" with the choice of fixed versus floating rate. Rather, they are borne either by the borrower or by the lender. The cost of the financial product typically is correlated with the expectation of risk consequences. For example, floating-rate debt has been cheaper than fixed-rate debt historically, since the borrower remains exposed to more capital market risks. Many borrowers choose to diversify with a mix of fixed-rate and variable-rate debt suited to their target capitalization.

Asset-side risks include the above-mentioned risks as well as market and liquidity risk often sourced from investments in equities (stocks), bonds, private lending, commodities, real estate, hedge funds, private equity, and others.

The interrelationship of asset-side and liability-side risks is a critical issue for hospital leadership. As described in "The Asset and Liability Management Approach" section in Chapter 9, best practice balance sheet management for many organizations requires careful management of asset/liability risks and returns *in concert with one another* rather than as separate management functions. To ensure thorough and accurate results, a plan for asset and liability management should be developed only after a full risk framework has been established to map risks organization-wide.

Financing risk often must be addressed when an organization is least equipped to deal with it and limited in its options. For example, most interest rate swap positions require posting based on a progressive schedule tied to the corporate ratings. If an organization is downgraded due to poor operating performance, the entity may be forced to tender a collateral posting, placing even greater strain on the organization's cash/capital resources.

Event Risk

Event risk is the risk of an unexpected external or internal event, such as a severe economic downturn, facility fire, natural disaster, or major regulatory change. While other types of risk may be "bullets to the hull" of a ship, event risk could be a torpedo, which likely is harder to recover from. It often triggers a domino effect of other risks, such as a large and sudden decline in cash, which in turn triggers acceleration of bond or higher interest payments.

The preeminent example of event risk in recent years was the 2007–2008 financial crisis, which rolled through the capital markets and caused widespread economic turmoil. The crisis

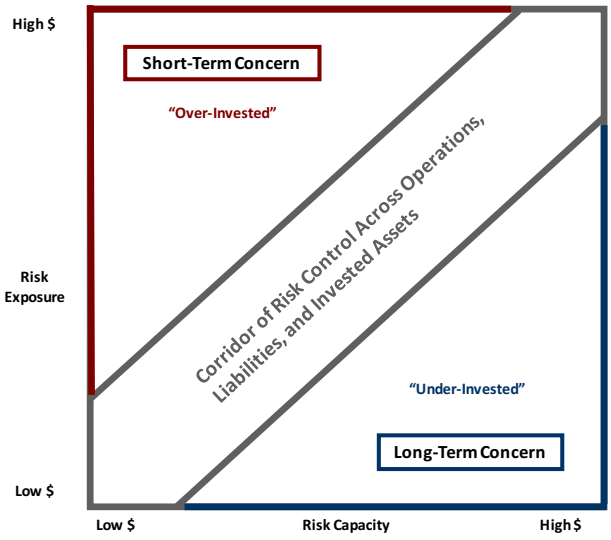
significantly impacted hospital capital access and cost and variable-rate debt programs.

Total Risk

An organization's total risk is the sum of all of the previously discussed types of risk.

Organizations compete most effectively when there is relatively little difference between their financial position and actual level of risk on the total risk/financial strength continuums (see **Exhibit 10.2**). Directors and executives must understand the organization's risk profile and its financial ability to handle that risk, so that the two are in sync.

Exhibit 10.2: Risk/Financial Strength Continuum and Effective Risk Management



Source: Kaufman, Hall & Associates, LLC.

> Hospitals and health systems need to be thoughtful and realistic about the skills and infrastructure needed to manage different types of payment arrangements. Having a risk contracting strategy is essential, and should be integral to an organization's comprehensive business plan.

The Risk of Not Understanding Risk

Experience suggests that hospital boards and senior executives often don't understand their hospital's risk position. This can lead to strategic and financial decisions that greatly increase the day-to-day risk of operating the hospital.

For example, consider the situation faced by a hospital in a highly competitive region that is seeing an influx of new industry entrants vying for market share. To address market challengers and solidify its competitive position, the hospital has made significant investments in information technology, preventive care programs, ambulatory care facilities, and physician-alignment strategies. Because this hospital has been borrowing and spending aggressively, the strength of its balance sheet is starting to be challenged. This is an increasingly common situation in today's healthcare environment.

Hospital leaders must focus on the total amount of risk the organization is taking as it tries to move to its desired strategic position. The organization's risk position should be appropriate to its financial position. When an organization with high total risk encounters an unanticipated event risk, it is operating in a highly risk-leveraged space with increased exposure to diminished competitive performance.

The goal of understanding risk is not solely to avoid it. To do so is often very costly. Rather, the goal is to seek balance between the organization's risk exposures and its capacity for risk.

Achieving a Manageable Risk Position

Proactive planning to ensure that available financial resources are appropriately balanced between the pursuit of financial sustainability and the management of enterprise risk are critical challenges for healthcare executives and directors. A clear understanding of the organization's risk tolerance, and avoidance of taking on too much or too little risk, are the objectives at any given moment.

Risk tolerance refers to an organization's capacity to carry a defined amount of risk without endangering its strategic, operational, or financial performance, or a combination thereof. Different organizations will have varying capacity and tolerance for risk. Board and managerial preferences certainly play a role in defining risk tolerance, but the capacity for risk provides the overriding constraint.

The starting point, which informs all strategies, is to understand the hospital's financial condition. Risk incurred must be appropriate to the organization's financial condition and credit position. Chapter 3 outlines the elements of financial and credit analyses that enable directors and executives to identify their organizations' financial strengths and weaknesses. An organization rated "AA," with an operating margin of 5 percent and 300

days cash on hand, will be able to take on more financing and business risk, for example, and better able to handle a certain amount of event risk than an organization with a "BBB" rating, a 1 percent operating margin, and less than 100 days cash on hand.

The use of an integrated corporate framework to define risk tolerance, identify risk capacity, and manage risk is recommended and described next.

An Integrated Corporate Risk Management Approach

A successful approach to integrated and enterprise-wide risk management requires a solid framework, which:

1. Is complementary to the financial plan; the baseline financial plan should set realistic expectations, the risk framework should test and proactively adjust for, and often anticipate variabilities to expectations
2. Is cohesive and straightforward, enabling communication among all stakeholders, and sustainable over time
3. Clearly differentiates between tools and strategies (for example, Monte Carlo is a tool; it can be helpful to the description of an appropriate risk strategy)
4. Recognizes the many roles of cash and investments in support of the broad enterprise, including the role of a "hedge of last resort," which mitigates risk

Such an approach offers a platform to build a comprehensive understanding of the healthcare organization's risks and risk-bearing capacity, and to identify how that capacity can best be deployed against the array of risks. Implementing this approach involves three essential activities:

- Understand and catalog the risk portfolio
- Define available resources to manage risk
- Integrate operating and balance sheet analyses

Descriptions of each of these follow.

Understand and catalog the risk portfolio. Organizations benefit from developing a comprehensive catalog of net risks organization-wide, across operations (including physician enterprise and strategic growth initiatives), liabilities, capital position, and invested assets. To develop a cohesive and actionable catalog, it helps to define a unifying risk metric—such as days-cash-on-hand impact—and identify the organization's overall risk tolerance relative to this metric.

The comprehensive risk catalog helps healthcare executives and directors quantify organizational risk over time. It further allows healthcare leaders to identify unhedged risks that may be offset by external hedges or reliant on management interventions. Ultimately, most realized risks not abated by other means must be absorbed with available cash.

Define available resources to manage risks. Once risks are identified organization-wide, healthcare leaders can evaluate what resources are available to manage or otherwise mitigate those risks. Examples include the organization's debt capacity (i.e., ability to borrow) and invested assets. Healthcare leaders should assess whether the hospital or health system has the ability to access outside capital to hedge those risks, and if so, how much capital it might realistically and responsibly access.

In considering available resources to manage risks, a recommended approach is to consider the role of balance sheet resources as supporting the operating core, and invested assets as mitigating risk first and then pursuing investment return.

Integrate operating and balance sheet analyses. Once healthcare leaders have clearly mapped risks across the organization and thoroughly evaluated available resources for managing risk, the next step is to determine how best to reconcile the two. Using a portfolio approach is recommended.

Since development of the portfolio theory in the 1950s, diversification has been recognized and used as the mainstay of risk reduction. The theory holds that investors can reduce the standard deviation of portfolio returns by choosing stocks that do not move in exactly the same way together. Diversification works to reduce the unique risks represented by one company's stock, but market risk, which threatens all businesses, cannot be trimmed.

As sophistication of the products offered by the capital markets increases, it often is very difficult to determine which asset and debt instruments are linked and likely to be moving together. With the sub-prime mortgage turmoil of the 2007–2008 financial crisis, for example, numerous asset classes, such as real estate, equity, and bonds, all moved in the same direction—downward. "When you have systems with lots of moving parts, some of them are bound to fail. And if they are tightly linked to one another—then the failure of just a few parts cascades through the system," noted one financial writer.[42] Diversification of both debt and investment portfolios is highly recommended as a strategy to increase the margin of safety.

Hospitals and health systems should conduct sensitivity analyses around variables that create operating and balance sheet risk throughout the capital management cycle, from strategic initiatives to investment options for capital returns and their interrelationship. For instance, relying on best-guess averages for planning assumptions—such as volume, revenue, and inflation—during the strategy-assessment phase, can be dangerous. Use of simulation and sensitivity techniques, available with

numerous software tools, enables executives to obtain a more accurate estimate of the true risks associated with the options they are considering. Such techniques assess the broad range of risk elements and indicate a distribution of possible outcomes.

For example, due to the high level of uncertainty about new payment models, one hospital used sensitivity analysis to assess the range of possible payment options, setting the deviation for reimbursement at plus or minus four percentage points. The analysis showed hospital executives that given potentially higher payment variation, the most likely scenarios for operating income and operating margin were significantly lower than they were projecting.

As a result, management updated its baseline financial plan to factor in that reality. The danger of not doing so would have been that the organization overstated its financial capability, which ultimately would lead to an overstatement of what it could afford to spend on capital. The financial impact of upside and downside scenarios projected through such analyses can be dramatic and should inform management decision making.

Concluding Comments

Hospital and health system leaders operating in the current healthcare environment should assure a renewed focus on risk. This begins with building a foundational understanding of the various types of risk and their potential impacts, and then applying that understanding to a comprehensive assessment of their organization's risks and available risk management resources.

The overarching goals of building a sustainable integrated risk approach should be to:

1. Identify material risk exposures across the operating enterprise and ascertain the corporate response
2. Balance and optimize balance sheet resources to address potential for non-mitigated risks while addressing other strategic objectives
3. Operationalize the framework to maintain an appropriate relationship between resources and risk over time

An integrated corporate risk framework, as described here, provides a decision support tool for healthcare executives and directors. It helps healthcare leaders define the organization's risk "corridor of control," whether risk resources are adequately allocated, and the impact of different risk-hedging scenarios. Expert advice in establishing the integrated risk management approach organization-wide is strongly recommended.

The sidebar entitled "Questions Directors Should Ask Hospital Executives" outlines key questions that directors can ask their organization's executives to help ensure they are taking a best-practice approach to risk.

Questions Directors Should Ask Hospital Executives

- What risks should healthcare leaders address as part of their financial oversight responsibilities?
- Who should be involved in oversight and management of risk, and discussions related to risk?
- What are the significant internal and external sources of organizational risk and how might these be mitigated?
- What might occur if risks are not properly understood or effectively managed?
- How much debt capacity and liquidity are required to allow greater tolerance for negative variation in expected performance?
- What steps are the organization taking to assess the competitive landscape and risk related to activated consumers, retail care, and arrangements with payers that will affect revenues and at-risk contribution margins at a local level?
- How is the organization positioning itself to bear financial risk for the health of a population and for the efficiency and effectiveness of treatment across settings?
- How is the organization preparing to assume value- and risk-based payment mechanisms?
- What process will the organization use to balance its risk across operations, investments, and capital structure?
- Can risk be managed to the organization's strategic advantage, and if so, how?

Conclusion

To achieve the best-possible financial results in an environment with a high level of risk and uncertainty, healthcare leaders must set the bar high for performance. That bar should be grounded in a disciplined and continuous strategic, financial, and capital planning process, whose output is real, market-based business plans with financial goals and objectives that accurately reflect the expectations articulated by the board.

STRATEGIES THAT WILL GENERATE CAPABILITIES FOR VALUE-based care and population health management should be appropriately funded and pursued at a pace that is both proactive and responsive to specific market conditions. Now more than ever, leadership teams must closely manage costs and maintain an appropriate level of capital spending and the right balance of cash and debt. Disciplined financial management ensures the most effective use of limited resources.

At this point in history, healthcare directors and executive teams should be asking and answering three key questions:

- How fast does our organization need to move to effectively reposition for a fee-for-value environment?
- Are we moving fast enough, and if not, what strategies should we be pursuing?
- Do we have the necessary financial resources to compete in the fast changing environment, and if not, what partnerships or relationships might be necessary?

For continued competitive positioning, directors must insist that their hospitals and health systems identify best-fit strategic options based on thorough and integrated strategic financial planning. An organization *must* maintain a minimum cash position needed during the transition to value-based care and payment. As always, cash is critical, but so is taking exceptional care of the overall balance sheet to achieve the lowest possible cost of capital, maximize return of cash and investments, create capital capacity, and diligently manage risk.

Each of the 10 issues described in this publication is a prerequisite for competitive financial performance going forward.

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