ROUNDTABLE

Capital Concerns

In a period of turmoil and transformation in the healthcare industry, access to capital has become a critical issue. Hospitals and healthcare systems face declining revenues and pressure on margins, while competition and the shift to pay-for-performance are driving executives to seek security for their organizations. The result is a boom in mergers, acquisitions, joint ventures, and new and unusual partnerships. Access to capital, or lack thereof, underlies these strategic concerns and has the potential to create haves and have-nots in the industry. HealthLeaders Media convened a panel of healthcare executives with deep expertise in capital issues and M&A to discuss how access to capital is driving healthcare business strategy today.

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Roundtable Highlights

HEALTHLEADERS: *Is the current pace of acquisition, consolidation, and partnerships happening fast enough?*

GREGORY PAGLIUZZA: I think they are moving at the pace at which people are ready to accept them. ... I think ultimately what will happen is that those who do not get on board quickly enough will find themselves left out, and will wish they had done it sooner. They will be either forced into a fire sale, or more likely they will just go out of business—one or the other. But you cannot force individuals and corporations who are not ready to make that move. You can have dialogue, you can have discussion, you can have education, but you do not necessarily have buy-in.

TOM CONGORAN: What I see in the market is a lot of rushing around not knowing where to go next. There are certain hospitals that are so well-established and well-capitalized that their business strategy is trying to figure out how to live in a world of lower reimbursement, but by far there is a larger number of hospitals that are just so uncertain about the future that they are scrambling. ... They don't want to be the last ones without a chair; when the music stops, they want to have someplace to go. I think that is really what's driving a lot of the activity.

"There needs to be consolidation, **there needs to be collaboration,** there needs to be a basis for paying fewer providers."

TOM ANDERSON: I think a big part of the reason for that uncertainty is external pressures. The pace at which consolidation will occur is somewhat driven by these external pressures, specifically reimbursement. ... There's a recognition that there needs to be fewer providers in order to be able to control costs. ... That in turn will force some type of collaborative, cooperative decision on the part of hospitals.

JIMMY PETERSON: There's plenty of demand. There's plenty of money chasing good assets. Supply is building up. Hospital boards may be moving slow, but consolidation or looking for a partner is on every finance committee's agenda. ... A lot of those discussions end up with the conclusion that a partner is what is needed, or a transaction is imminent.

HEALTHLEADERS: *Healthcare reform is uncertain right now. Will the pace of consolidation continue regardless of what happens with reform, or could the Supreme Court decision change the drivers [behind hospital consolidation]?*

ANDERSON: The pieces of health reform that are in place are there for a reason. I think the federal government recognizes that there needs to be fewer hospitals. There needs to be consolidation, there needs to be collaboration, there needs to be a basis for paying fewer providers. That's part of what health reform is about. The accountable care organization is in effect a methodology to be able to consolidate, or at least have hospitals collaborate to the extent that there's less competition. There are fewer multiple-service hospitals that provide the same services in the same area. The purpose of that is to try to reduce cost.

CONGORAN: We are one of the first 30-plus Pioneer ACOs. If the [Patient Protection and Affordable Care] Act fails, I think we will go on pretty much the way we are. Right now we're at risk for about 60% of our patients and probably 75% of our dollars. ... I do think that if the bill fails, the pressure is going to be more relentless, because the bill in a way sort of stabilizes and gives people a [direction] to go in the market. ... If the bill fails, then I think the reimbursement pressure is going to be so great that it's actually going to accelerate the consolidation in the market.

Tom Anderson
Cofounder, Vice Chairman
Capella Healthcare

PETERSON: Health reform is just one of the catalysts that are driving the consolidation we see in the industry. It's a very convenient rationale for boards to use, because it's a big-ticket item you can throw on a PowerPoint. However, it is pure economics: forecasts of compound annual spending are approaching 6% while the economy is only growing at 3%, which means market forces drive margins down and balance sheets into distress. Employers can't afford it, and individuals who shoulder more of the cost burden will seek other options while leaving health bills unpaid (driving up bad debt). Solvency is the issue—there will be winners and losers in every sector. Reimbursement pressures are not going to go away, and access to capital is driving decisions. If health reform somehow magically disappears,

these other economic factors do not. So at least in the next two to three years, I don't see a slowdown.

PAGLIUZZA: [People] focus on the federal government, but you also have the state governments, the commercial insurers, the self-insured programs. Companies are saying, "We can't keep paying 6% increases. My wage rates are going up, too."

HEALTHLEADERS: *What is driving healthcare systems to say that the complexities coming down the road are going to be too much for them to want to face alone?*

ANDERSON: Individual hospitals are seeking system affiliation because they recognize that they do not have in place the expertise, the understanding, the ability to cope with health reform and the needs of value-based healthcare, the understanding of how to navigate those waters. I think it's going to get very, very complicated. … Hospitals, particularly stand-alone hospitals …

Gregory Pagliuzza
Chief Financial Officer
Trinity Regional Health System

need someone to affiliate with that will understand this and help them navigate these waters. That's what I'm finding now. I've been in the acquisition of hospitals for over 20 years, and there has been no greater pipeline than exists today. … And those are not hospitals that are facing financial woes at this point. Many of those hospitals are doing very, very well financially, but they recognize that that may not be the case in the future.

PAGLIUZZA: Two examples that I am very familiar with are of organizations [that] decided to spend major dollars on capital expansion. They did so, but within a matter of 15 to 24 months, they figured out that they cannot manage the debt that they have now taken on, and the revenue stream is not going to be there to offset it. Where they were going to be heartily fighting for independence, they are now saying, "All right, it's not going to work, we need a partner."

CONGORAN: When you look at all the requirements of not just electronic medical records but all the infrastructure that's required to support these kinds of activities, this is not a trivial undertaking. … You can't run the businesses that we're talking about without infrastructure, and scale is important, because you can't generate enough margins in smaller practices or in smaller hospitals to support this kind of activity.

HEALTHLEADERS: *How far will consolidation and partnership go? What kind of landscape will shake out in healthcare 10–15 years down the road?*

PETERSON: I think there will be a big shake-up; there will be a whole lot fewer stand-alone or smaller hospitals in the market 10 or 15 years from now. But I'm not convinced that traditional healthcare is just going to evaporate in the next decade. It's just too big and too stuck. A lot of health systems and physicians will need to be forced into drastic change. … As long as fee-for-service is available and the rates are good and going up, a hospital is going to choose that, right? They will have to be forced out of that behavior. It depends on a lot of variables—the economy, the [federal government], state governments, etc. If they start turning the revenue off, that's going to start driving behavior.

ANDERSON: A phenomenon that is occurring right now is the collaboration between not-for-profit and for-profit systems. You see that with Duke LifePoint and with Capella and Saint Thomas. We have forged a relationship with Saint Thomas, which is owned by a branch of Ascension. There are strengths that each has. The for-profit industry has more access to capital because we have access to both equity and debt. But there are strengths that the not-for-profit systems have. They have, for the most part, the greater majority of the teaching institutions, the ability to provide specialty care through physicians, and an understanding of how those physicians help generate and convert to the value-based method of service. I think that you're going to see collaborative efforts between what have been foes, in some sense. That's going to occur more and more across the country.

PETERSON: We see a tremendous amount of deal flow and a lot of strange bedfellows. For-profits, tax-exempts—you've got tax-exempts and for-profits and private equity coming together to form joint ventures. We see a lot of competitors deciding, "Hey, let's become partners versus competing, because it's too expensive. It's too expensive for me to build a hospital at a million and a half dollars, plus a bed across the street from you, and duke it out." We've even seen large, sophisticated health systems willing to take minority interests or give up control of their stand-alone hospitals in certain markets to become partners with their historical competitors because it's not worth the capital. It's not worth the effort and the capital to compete in that market anymore. They'll go focus on the bigger footprints, make nice in the smaller markets where they're not dominant, and move on.

HEALTHLEADERS: *What about haves and have-nots in the future? If hospitals need to take out beds, where does that come from—*

primarily rural hospitals, or in urban areas with a lot of hospitals? And how do those beds come out? Do hospitals shut down, do they become smaller?

PAGLIUZZA: I think long-term you are going to have facilities that shut down because of redundancy. If you say, "We will cut out this service," you are still left with 100 beds as opposed to 150. The infrastructure costs, the administrative costs of managing, the overhead costs of still keeping 100 beds open is not economically feasible over the long haul. Ultimately I believe you will see fewer facilities but more concentration in the ones that are standing.

PETERSON: We see JOAs [joint operating agreements], where four hospitals will come together with the intent that in five years, there will be two. They're going to mothball a lot of the older facilities and build smaller, more efficient hospitals. Older facilities will be abandoned. But it takes a lot of capital to make those changes.

CONGORAN: I think it's going to be really tough for a lot of hospitals, particularly the big-city hospitals where there are probably too many beds. They will start by closing floors, but in the end, it's going to be very difficult to support those old buildings. There is a lot of deferred maintenance. ... I don't know where a lot of these not-for-profit hospitals are going to get that kind of capital.

HEALTHLEADERS: *Capital markets have stabilized from a few years ago, but it's still not easy for small hospitals to gain access. What is the situation with access to capital now?*

ANDERSON: One of the things that's impacting [capital access] is the outlook since 2007 at the rating agencies. The rating agencies have really impacted a single hospital's ability to acquire debt. They recognized, "Hey, we have been a little bit lenient here, and we're cracking down." For that reason, a lot of individual hospitals are not able to keep up with the construction costs that they need, with replacement of equipment, with a number of different things.

PETERSON: There is a lot of capital out there. If you really want to know who the haves and the have-nots are, the haves are the ones that can access it. There's high levels of private equity overhang. There is also a buildup of corporate profits on balance sheets, particularly in managed care companies. The big public for-profits or private for-profits, and the large tax-exempts, have big balance sheets and a lot of cash. Capital for them is not the problem—it's how they deliver it and where they put it to work. When you get to the smaller systems, even if they have excessive days of cash ... making a big bet on a big spend, like building a new tower, is really daunting. Boards are smartening up; they're not willing to make that bet unless they have someone backing them who can make a mistake and not fail.

"I think it's going to be really tough for a lot of hospitals, particularly the big-city hospitals where there are probably too many beds."

ANDERSON: Ultimately, anyone and everyone's ability to borrow is predicated on their margin and their profitability. You have to be able to make certain that this investment is going to have a return in order to be able to borrow in the future, and you have to be effective and successful in running and operating the hospitals well. That's key to being able to borrow.

Tom Congoran
Chief Financial Officer
Atrius Health.

PAGLIUZZA: We are a member of a much larger system, Iowa Health, which is rated AA-. So our access is at a very good rate, but the requirement is that every affiliate have its financial performance. Of all the markets within Iowa Health, we are probably in the one that is the most challenging because we have such a heavy Medicaid population. ... If we were stand-alone, we would be okay, but we definitely would be challenged. My guess is BBB. We would have access to capital, but limited. Right now, we are going through some plans for significant renovation for an older facility that was built in 1970 and has not been touched in all the 40-plus years. If we had to do that on our own, we would be very challenged. Being part of a system is good business sense; it positions us long-term the right way.

HEALTHLEADERS: *Who is leading this charge [for change]: the CFOs, CEOs, boards?*

PETERSON: We would generally say the C-suite. It's going to be the CEO or the CFO or the finance directors. Really, it depends on the size of the organization. If it's a one-off hospital, it's the CEO and CFO. If it's a larger system, they may have more sophisticated people they can delegate some of the number-running to. But at the end of the day, it's the chief financial officer. It falls

on his shoulders when it comes down to how much capital they can spend or what the margin can be and how they're going to get there.

PAGLIUZZA: I do believe the role of the CFO is to force those kinds of financial discussions much earlier than later. The key is whether or not you have the receptivity of the CEO. If you get receptivity of the CEO, it makes all the difference in the world. I have been in a situation personally where I was in conflict with the CEO, and I said, "Okay, can we find the flaw in the numbers?" The response [from the CEO] was "No, but it can't be right." So you have it done with a third party. Sometimes you need validation from a third party to say, "Yes, we vetted this, it does make sense, you need to do this plan of action, and the sooner the better for the good of the organization."

Jimmy Peterson
Principal
Deloitte Financial Advisory Services LLP

ANDERSON: The Joint Commission now is expecting that there be more board education, that there be more board understanding of the external factors in place for a hospital. ... Boards are becoming more educated to the fact that "We need to understand where we are financially, because we do have a fiduciary responsibility here." Not only that, most boards have seen evidence of hospitals failing, so they recognize that this possibility exists.

CONGORAN: Our boards are dominated by physicians. They're sort of wearing two hats: They do the work during the day and generate the revenues, but they have to take off their physician hat and recognize the fiduciary responsibility and look at the bigger picture to make sure that the practice is really doing what needs to be done given the market pressures. Part of this is educating them about their business and part of it is educating them about the markets we serve.

HEALTHLEADERS: *With the uncertainty facing healthcare right now, what constitutes sustainability in the market today, and how do you plan for sustainability?*

ANDERSON: Lenders want to make certain that two components are in existence in order to be willing to lend money. Those two are sustainability and growth. First of all, they want to know that you have a model that is sustainable, that you have in place a system that will allow you to repeat successes. They basically want to know that you know what you're doing. They want to understand that you have in place a process, a system, a plan that will allow you to effect the changes that are needed to give rise to the margins and the profitability that is necessary. The second thing they want to see is growth. They want to know that they can feel comfortable about being repaid and have an opportunity to reinvest. So the key element to access to capital is being able to cope with the outside pressures and be able to generate a margin that is effective and necessary to meet the capital needs and the debt service needs that you defined. That's why [lenders] have all of the metrics that they use, all the ratios, etc.; that's their measure of your ability to do that.

PETERSON: I think the willingness to be flexible and nimble is more important than ever. ... The solution in one market isn't the same solution for another market. It's wildly different across the country and by region. Strategic planning and really good foresight is what's going to be necessary to achieve sustainability and be a system that survives. I think it goes back to partnerships: physicians partnering with hospitals, hospitals partnering with managed care companies, maybe fully integrated health systems appearing more often. [Partnerships] gives those players more options when it comes down to taking costs out and becoming more efficient.

PAGLIUZZA: When you are talking about sustainability, the key is who are you serving, which is the patient. Healthcare is not going away; it is an industry that's going to be around. So long as the demand is there, it is a question of how well you can provide that service cost-effectively. So I think if you focus on the patient, focus on how well you execute in caring for the patient ... you absolutely will have sustainability. But you cannot lose sight of the patient and who provides the care, which is still primarily the physician.

CONGORAN: In the value-based market, it's really the people who provide high-quality, appropriate care at the most efficient, effective setting. For us, since we're taking global capitation and we're taking global risk all the time in our markets, it's not just being most efficient and it's not the lowest cost per service, it's really the lowest total medical expense that's going to drive that equation. It's providing lower-cost services and the right sort of level of services to deliver what's effective and needed for the patient. That's a very different world, which is why we can't do it without the hospitals. We can do a lot of it by ourselves, but we can't do it without hospital partners. And I don't think the hospitals can possibly do it without physicians, which is why this is such a culture shift.

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Rx: *Next*

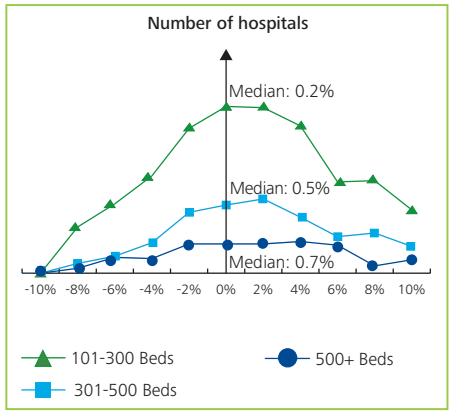
Is bigger really better?

Market evolution

Today's healthcare delivery environment, in some regards, resembles a game of musical chairs: Many providers are dancing to the tune of reimbursement reform, knowing that there will not be enough places for each of today's players to sit down when the music stops. In response, many providers naturally gravitate toward horizontal integration: Mid-sized providers, plagued by the fear of being too small to claim a chair of their own, are reaching for the hand of a stronger partner. Likewise, most larger health systems are seeking to gain further scale in an attempt to solidify their spot in the marketplace.

However, scale in and of itself does not automatically create efficiency. In fact, it can easily add unanticipated complexity and extra fixed costs. A review of U.S. acute care providers, grouped by total number of beds, shows a similar margin distribution for the three size groups and no major skew[1]. The median operating margin for larger providers is just 20 basis points higher than that of mid-sized facilities. So while bigger may appear to be marginally better, the difference is not as large as could be assumed. And the slight margin improvement may not necessarily be attributed to efficiencies of scale. Instead, the spread could simply be a manifestation of larger providers featuring a greater share of more profitable non-acute and ancillary services. Larger providers are also more commonly located in urban settings, and have affiliations with academic centers and participate in graduate medical education, which can in turn affect profitability. And even where scale is pursued for performance, the value of growth is sometimes limited by a lack of aggressive cost savings from Shared Services, as well as an apprehension toward program rationalization, i.e. the elimination of inefficient and duplicative services to create a truly integrated delivery.

Operating margin distribution



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Beyond the questionable economics of scale, a concern for Providers should be that most mergers are primarily focused on bringing together hospital fixed assets, which most expect will be less essential for effectiveness in 2020. Between 2005 and 2009, Medicare measured a 4% annual rate of increase for outpatient services, while inpatient admissions declined by 1% per year[2]. Extending this shift in site of care could easily recalibrate the ambulatory-to-inpatient ratio from 35:1 today to over 50:1 tomorrow[3]. Is the fixed cost and debt burden associated with aggregating physical assets helpful or inconsistent with this trend?

Many of today's hospital consolidations are an attempt to apply economies of scale theory borrowed from 20th century manufacturing practices. Perhaps providers should reconsider their appetite for scale in light of 21st century's shifting demand for ambulatory services – lest hospitals become afflicted by the very 'weight management' problems many of their patients suffer from…

Implications for health providers

Health systems and hospitals should not confuse mergers for the sake of achieving scale, with entering well-planned strategic relationships. The latter are essential for hospitals to build differentiating capabilities, to gain access to strategic markets, and to secure long-term financial viability.

The real questions are therefore: who are organizations with which to develop such fruitful alliances? and how should the relationships be structured? Acute care hospitals could choose to collaborate with health plans and form integrated delivery systems. Or they could tighten their relationships with regional physician networks to secure their referral base. Or they could reach out to post-acute and wellness providers to expand along the continuum of care. And perhaps they indeed need to ally with other acute care hospitals to make forays into strategic markets.

Beside the choice of horizontal versus vertical integration, various business structures are conceivable that range from virtual partnership to full merger or acquisition. If an M&A approach is selected, it will require unemotional discipline to realize theoretical efficiencies. The combined entity will need to focus on a serious rationalization of fixed cost and internally competitive services, and the consequent deployment of Shared Services across the organization. Other strategic acquisitions, such as physician practices and non-acute businesses require ongoing critical evaluation, and are subject to a distinct set of business criteria altogether.

Questions to consider?

To effectively define their future market position, healthcare providers should confront key questions pertaining to growth and strategic relationships:

- Does your current asset strategy equip you to effectively serve the future demand for health services?
- Would vertical or horizontal integration most effectively expand your portfolio of capabilities, and who are the critical players you should enter strategic alliances with?
- How comfortable and experienced are you with various collaborative structures ranging from Joint Ventures to full M&A?
- Are you ready to engage in serious rationalization of fixed costs to remain competitive as you grow in scale?

[1] Source: Chart: Deloitte analysis of U.S. acute care facilities, FY09 Cost Reports, N=1,403

[2] Source: Medicare Payment Advisory Commission, Report to The Congress, March 2011

[3] Deloitte Analysis, based on Centers for Disease Control and Prevention (CDC) http://www.cdc.gov/nchs/fastats/hospital.htm