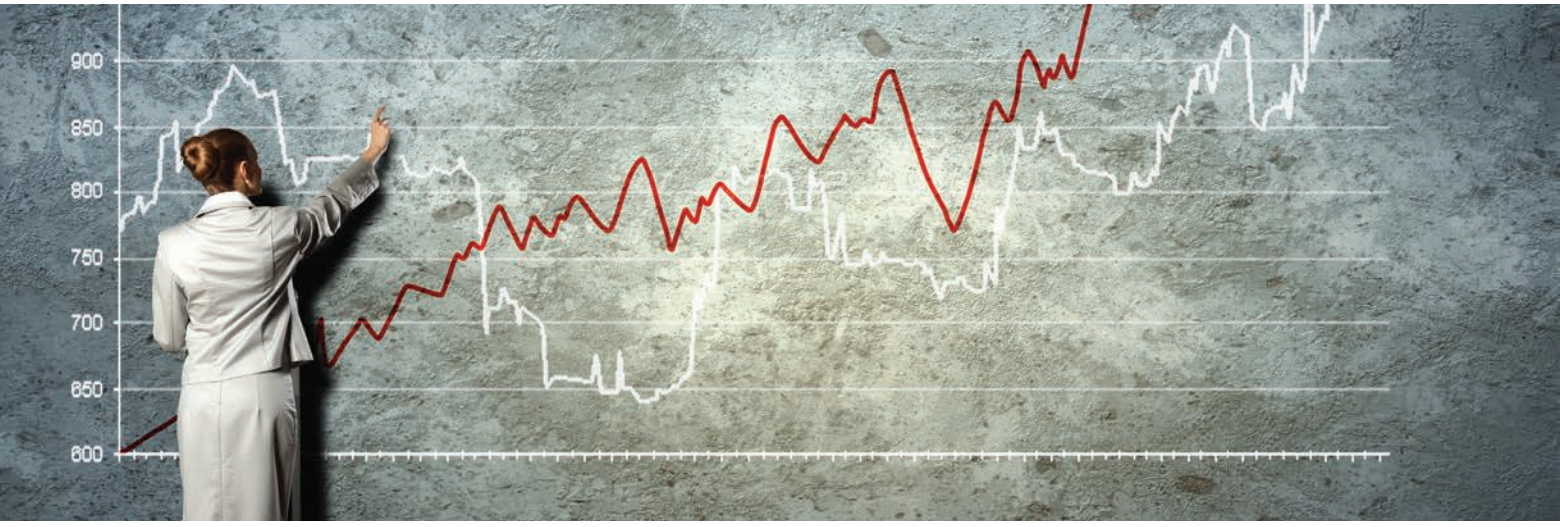
ROUNDTABLE

Financing Integration: Tapping New Sources of Liquidity

Health systems are positioning themselves for new reimbursement models amid shaky financial, regulatory, and political environments. The uncertainty leaves providers more focused on liquidity. Many have found medium-term capital an attractive alternative in their strategic capital formation to fill the gap between short- and long-term investments. Matching credit term length with the useful life of assets such as electronic medical records systems, clinical integration with outpatient care settings, and infrastructure enhancements (e.g., renovations, energy projects) presents many economic, accounting, and compliance benefits.



PANELIST PROFILES

ALICE POPE
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Wellmont Health System
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Roundtable Highlights

HEALTHLEADERS: *If the top goal for any healthcare organization is to improve the health of their community, Goal 1-A might be to marshal its financial resources such that it's able to continue to do that work. How difficult is that given the upheaval we're seeing?*

WILLIAM M. SNAPP III: It's very difficult to estimate the impact of certain facets of reform. One example is the decrease in disproportionate share payments. You can project the impact, but trying to incorporate that impact into your budget and make sure your costs are in line is very difficult. And then to communicate to your nonfinancial people that you have to control your labor cost is a challenge as well.

ALICE POPE: We think we are financially sound and we'll be able to meet our obligations over the short term, but over the longer term, there are concerns. That is what's led us to look for a strategic alignment partner. When we review our cost structure, we don't see significant opportunities in cost reduction. When we review our average cost per adjusted discharge, we don't see any further opportunities without becoming part of something bigger to drive down cost.

HEALTHLEADERS: *Despite the fact that interest rates are so low, capital access still seems to be a problem for a lot of hospitals. Has anything changed with the rating agencies?*

MJ KLIMAS: The three major ratings agencies have negative outlooks on the not-for-profit healthcare sector right now. How do providers move from volume to value, make money, and keep a strong balance sheet? Cash metrics are critical. There is a focus on building cash reserves to uphold bond covenants and weather cash flow issues surrounding volatile reimbursements or the impact of the pending ICD-10 conversion. Providers always have an eye on maintaining or improving agency ratings. Debt and credit are vehicles to improve liquidity. There will be some impact on Maximum Annual Debt Service. That's often offset when the resulting Days Cash on Hand metric moves a provider closer to their targeted agency rating standard. Another issue is that, historically, a firm could put assets on a FASB13 operating lease that would be off–balance sheet. The Financial Accounting Standards Board is in the process of revising its operating lease and capital lease criteria. On small pieces of equipment, that's not much of a game changer, but for some health systems, leases on more expensive equipment and real estate are truly moving the needle.

POPE: There's definitely a lot of noise about whether the lease is a form of debt or an operating expense item. Most of our leases are recorded as capital leases. It's a fair amount of money. While capital is certainly a challenge for us, we're just as concerned about borrowing money as our ability to get money. We see it as our fiduciary duty not to jeopardize our balance sheet by over-leveraging. That said, we've done some interesting financing with taxable and tax-exempt private placements. Our Epic project was $100 million. We borrowed $55 million at a very low rate, but we made sure that we earmarked the $45 million that we received in meaningful-use funds to pay the balance. It would have been very easy to borrow the full hundred million.

SNAPP: I believe in lower leverage as well, especially in uncertain times. We just recently exited the letter of credit market as an enhancement vehicle. We refinanced everything into non-bank-qualified debt. I consolidated all of our issues into one, and also had the opportunity to reserve an additional $6.5 million for some renovations on a drawdown basis.

LEIF MURPHY: I'll share a little different perspective. We have been fortunate that the rating agencies have adopted a more stable outlook on tax-paying hospitals than on non-tax-paying hospitals. As a result, we have benefited from favorable access to capital markets. Because of our size, we typically don't look at our financing needs on an individual project basis, but instead evaluate our financing needs on a companywide basis. Although we invest heavily in our markets, in projects such as a $300 million replacement hospital in Marquette, Mich., and the recent replacement hospital in Winchester, Kentucky, a significant portion of our investment capital is generated from cash flow. As we identify investment projects that exceed our free cash flow, that's when we will tap the capital markets.

Alice Pope
Chief Financial Officer
Wellmont Health System

HEALTHLEADERS: *So the purposes for which organizations are borrowing money are very different. How do lenders evaluate some of these on risk and term, especially if you're lending for things like EMRs?*

KLIMAS: It's been an interesting journey. The HITECH Act forced us all to take a step back and evaluate this asset. EMR flipped the collateral percentages lenders are accustomed to; typically

80% hard costs and 20% soft costs were acceptable. EMR is composed of 80% soft costs and 20% hard costs, creating a double-edged sword. The HITECH Act and incentives increased the essentiality of EMR to every health system. Secured lenders like to have a security interest in something they can repossess, whereas these projects are mostly software and implementation and inherently tough to collateralize.

William M. Snapp III
EVP and CFO
Ephraim McDowell Health

HEALTHLEADERS: *So how are you secured? You can't go and repossess the EMR, can you?*

KLIMAS: Lenders have a perfected security interest in the entire EMR system. Lenders are choosing to underwrite appropriate healthcare providers.

HEALTHLEADERS: *I hear a lot about moving to a value-based future, but we often find that not many organizations are receiving overt pressure from employers or payer groups in their area. To what extent are your revenue streams changing?*

POPE: Over the past few years, we have experienced a 10% reduction in inpatient utilization. So our revenue stream isn't coming from growth in inpatient. We are seeing some growth in outpatient, and certainly growth in outpatient from physician practice acquisitions. The other revenue stream growth is coming from is strategic relationships with the managed care payers. So we're receiving our traditional reimbursement, but we're putting in place arrangements to get some of the premium dollar if we're able to show cost and quality improvement, especially with Medicare Advantage business—about 23% of our revenue. These arrangements are typically upside only, but we have proposals in front of us now that would be both upside and downside. We want some collars around that, because some of these arrangements have fewer than 15,000 lives.

SNAPP: How significant are those dollars?

POPE: It's not significant yet, but it could be. Any money that you earn goes straight to your bottom line. So while it's insignificant as a percentage of revenue, it can improve your operating margin.

SNAPP: We are not as far along as Alice, but we are having those discussions as well and we are picking Medicare Advantage plans to explore the journey to full at-risk contracts.

MURPHY: We see long-term movement toward a population approach to healthcare. There's a significant amount of risk involved in transitioning to this new approach, so we have been deliberate about the steps we're taking to get there. For several years, we have focused on understanding our care delivery models in our markets, including related costs—the goal being predictability. This knowledge across our markets will position us to get closer to the premium dollar with the smallest amount of risk. We're fortunate that we don't have to go with one initiative or structure across the company. Instead, we are able to test different approaches in different markets.

SNAPP: I haven't heard that term, *transition risk*, but you're exactly right. I'm not sure I understand how that transition happens. Paying for quality is a very different concept in my mind from the traditional economic model.

MURPHY: It's a demand-destruction model being introduced into fee-for-service contracts.

HEALTHLEADERS: *Let's get into the cost differential of various debt structures. How have you recently evaluated your options in this area?*

KLIMAS: Many providers still utilize cash. Others use traditional credit offerings—either going to the public market or using a bank product—whether it's tax exempt or taxable. Growing in popularity is medium-term capital. Many providers are creating a place for a tranche of 5- to 10-year amortizing credit in their capital strategy. Outside of the Master Trust Indenture, there's no increased cost provision, so the rate at commencement won't change. With equipment finance, a secured financing, it's easy to match the tenor to the useful life. So there's a world of difference in the three products. Taxable or tax-exempt medium-term capital has a very low cost of issuance—much lower than costs associated with more complicated transactions.

HEALTHLEADERS: *Alice, let's use your Epic installation as an example. How did you weigh all of these factors in deciding to borrow for the expense?*

POPE: The first factor is we want the debt to match the asset life. When we looked at Epic, we didn't want to have an asset life beyond 10 years for an EMR. Epic might be the premier EMR right now, but in 10 years we have no idea whether we'll be implementing a new one or not. We also couldn't overlook the cost of debt. It made no sense to pay cash for any of this given that the all-in cost for the financing, even with the taxable piece, was just going to be a little over 2%. Generally, if it's a short maturity, then we're going to lean toward bank debt. If it's something longer, then bonds. But with bonds, costs are $6 to $10 per thousand borrowed,

not to mention the administrative burden. And banks are being very aggressive right now, especially if we can leverage our relationship with that bank.

SNAPP: As I mentioned previously, in June, we refinanced and consolidated all of our debt into tax-exempt non-bank qualified debt. Most of that represented consolidating a $50 million debt issue that we used to expand the main hospital and to build a replacement hospital for our critical access hospital. The issuance costs were less than $100,000 including attorney fees. So the cost of issuance was very reasonable, and it does simplify our debt structure. Also, it provides us an opportunity, on a drawdown basis, to reserve another $6.5 million for renovations to patient care areas, moving our data center, and integration of services in the cardiology area. Additionally, we lowered the cost of debt slightly.

MURPHY: Our goal is making sure that we manage leverage very conservatively. Fortunately, as acquisition opportunities come available to us, we have been able to secure financing fairly easily. We have an advantage as a publicly-traded company in that we have access to the public markets for debt or for equity. As we look at the timing of being able to turn around financing, it's actually been very quick.

HEALTHLEADERS: *How difficult is it to determine the "useful life" of some of these investments so you can match that to credit term length?*

KLIMAS: The American Hospital Association has guidelines on useful life. Providers have to look to their historical experience and what their expectations are for the asset. Hospitals are investing in outpatient facilities with technology that is prone to obsolescence. You can finance high-tech equipment for 10 years or much longer—but do you want to? We are seeing providers move toward medium-term capital with 5- to 10-year terms to tie useful life of equipment to tenor.

POPE: It is interesting when you think about the trend, because what is going to happen to the bond market, especially in the healthcare space, for not-for-profits? There will likely be less and less bricks-and-mortar financing. And it's probably going to stay that way for a period of time. Maybe you'll do a major refresh of a hospital with bonds, but hospitals are going to look very different in the future. It's less inpatient towers and more outpatient availability.

"Growing in popularity is medium-term capital. Many providers are creating a place for a tranche of 5- to10-year amortizing credit in their capital strategy."

HEALTHLEADERS: *So the lion's share of new debt will trend toward lower-dollar stuff. Where will you be spending that capital strategically?*

SNAPP: Over the past few years we've emphasized cardiology. For many years we had two cardiologists and now we have five. So this has been a nice growth area for us. Another example is oncology. A year or so ago we purchased the local oncology outpatient center. In addition to oncology and cardiology, we are focusing on adding specialists in neurology and pulmonology and physician practices. Those areas are really driving our growth.

POPE: In the recent past, we have focused on developing an ambulatory care network. That includes urgent care centers that we've put in place or strategic outposts for infusion centers and rehab centers—those types of things. But I think our market is fairly saturated between what we've done and what the primary competitor has done.

Leif Murphy
EVP and CFO
LifePoint Hospitals

MURPHY: We're also investing in our service lines and expanding them in our markets so that we can keep people close to home for the care they need. We continuously ask ourselves how we can invest to grow services in our markets, and we consistently evaluate our recruiting needs to support needed expansions and new services. We're also working to create strength and collaboration in our communities by building regional networks of hospitals and services.

HEALTHLEADERS: *Let's talk about the challenges you are seeing from competitors that are gnawing at you in pieces and bits. How is that affecting your financing needs?*

POPE: It's not only the fact that the Walmarts are getting into primary care, but it's Walmart getting into primary care for their employees and their customers. In our market, we've seen quite a few urgent care clinics and as a result our ED volumes are down 15% to 16%. So that's forcing a shift

away from the model of volume, volume, volume, to getting patients into an appropriate care setting where it is lower cost. But it's complicated. For example, we have long-term contracts with our emergency department physicians. We have an emergency department that's structured for a certain amount of volume, and it's staffed that way. Being able to rightsize that for the fact that we've seen such a significant reduction in ED volumes is a challenge.

MJ Klimas
Managing Director
Banc of America Public Capital Corp
Healthcare & Institutions Finance

SNAPP: In Danville, Walmart has had a clinic for three or four years. In fact, we talked to Walmart about being the operator of that clinic, but they struck a deal with one of our statewide competitors. They run all of the Walmart clinics in Kentucky. But we really haven't seen much impact from this clinic. One significant impact on ED services in Kentucky is that some of the managed care companies are paying a $50 triage fee for seeing a nonemergent patient. That's creating some problems, because they won't divulge what protocol they're using to make that determination and the determination occurs after the fact.

MURPHY: As a rural provider, we have an advantage being the only hospital in our primary service areas, making us a necessary part of most networks. Having a big provider across town with all the same service lines would certainly create a much different, more competitive environment.

SNAPP: In Kentucky, one payer in particular has really reduced reimbursements. This payer is, by far, the largest payer in the state, so it has a lot of leverage. So generally speaking—and I believe this applies to Tennessee as well—if you compare Kentucky, Tennessee, and some other states to the broader market, our reimbursements are lower. So it's a challenge to keep maintain reimbursements and to increase net revenue.

POPE: The risk that I see with some of these narrow network contracts is sometimes the payers can use those as a tactic to reset the rates with the competition. They'll narrow a network, and they'll get a discount to the exclusion of competition. And then patients are redirected. After a period of time the competition seems to come back to the table and then all you've really done is lowered overall reimbursement.

HEALTHLEADERS: *So what are lenders looking at differently?*

KLIMAS: There are no new metrics used in determining risk. Lenders still are looking at leverage, liquidity, and cash flow. To determine viability, there's more focus on trends—utilization stats, volume, and payer mix, and also, market share and the importance of the facility in the community. For sole providers and community hospitals, sustainability and growth are key along with the potential for alignment with a larger health system.

MURPHY: The community has to be large enough to support the operation of a hospital. Also, the hospital has a duty to flex down if the population of a community is diminishing or flex up if it's growing. From an economic development perspective, when companies are looking for communities to relocate or build their operations, one important factor they assess is the quality of the healthcare services in the area. From a community perspective, the absence of first-class healthcare has a negative impact on economic growth and development.

> **"We've seen a strong and steady shift from inpatient to outpatient services.** We've embraced this trend and have benefited from higher margins on the outpatient side."

POPE: But don't you see that changing? And what is first class healthcare? Does it necessarily mean a hospital? In these smaller communities, I think it's unrealistic to expect that you're going to have a hospital in every community. And do you have to have a hospital for economic development? Or do you just need access to a certain level of healthcare?

MURPHY: We believe that the hospital is a critical part of the continuum of care. Does all care need to be provided in an inpatient environment? Absolutely not, and we've seen a strong and steady shift from inpatient to outpatient services. We've embraced this trend and have benefited from higher margins on the outpatient side. Our goal is to maintain acute care services in our communities and to deliver that care in a high-quality, cost-effective manner.

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