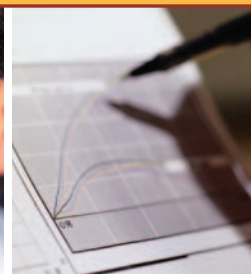


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GE Healthcare Financial Services

How Are Hospitals Financing the Future?

Where the Industry Will Go from Here

**Financing the Future Report 6:
How Are Hospitals Financing the Future?
Where the Industry Will Go from Here**

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Research conducted by HFMA and
PricewaterhouseCoopers

September 2004

Table of Contents

financing the future

Report 6:

How Are Hospitals Financing the Future?
Where the Industry Will Go from Here

How Are Hospitals Financing the Future? Where the Industry Will Go from Here	1
What Will the Future Health System Look Like?	3
What Can an Individual Hospital or Health System Do to Survive—And to Thrive?	6
What Should Be the Government’s Role in Helping Hospitals Improve Access to Capital?	9
Financing the Future	11

How Are Hospitals Financing the Future? Where the Industry Will Go from Here

With apologies to “Pogo” comic strip creator Walt Kelly, hospitals today realistically can say, “We have met the future, and it is us.”

For hospitals, the future will be a creation of their own unique circumstances. It will stem from payment trends, local market dynamics, and relationships with physicians and patients. Each hospital’s decisions about capital and risk also will shape the future.

Over the course of the yearlong *Financing the Future* project, it has become clear that a capital gap exists between U.S. hospitals that have capital to invest strategically and those that no longer produce operating margins sufficient to support their capital needs. Without access to capital, these “have-not” hospitals are falling behind in the market and may never be able to improve their financial performance.

This report culminates our *Financing the Future* research by exploring where the industry will go from here.

Regarding the current state of capital access, the first *Financing the Future* report found that:

- The deteriorating financial condition of hospitals is making capital access more difficult.
- The gap between the “haves” and the “have-nots” is widening when it comes to creditworthiness, access to capital, and ability to finance the future.

With respect to the current state of capital need and spending, the second report found that capital spending had been relatively flat between 1997 and 2001, a period in which many hospitals underinvested in plants as managed care squeezed inpatient stays.

Regarding the future need for capital spending, research in the third report showed that:

- 72 percent of CFOs expected their capital spending to increase in the next five years, with the average increase (weighted based on current capital spending) expected to be 14 percent.

- Nearly half of CFOs said they were not keeping up with the capital needs of their deteriorating plants.

With respect to the future of capital access, discussed in the fourth report:

- 85 percent of hospital CFOs surveyed said they thought it would be more difficult for their organizations to fund capital expenditures in the future.
- 63 percent of CFOs surveyed said they expect to be more dependent on cash from operations to fulfill future capital needs.

“I think the endangered species are the second- and third-tier hospitals in metropolitan areas. In 10 years, 20 percent of those hospitals will close.”
— E. Preston Gee

Building on the research of the previous four reports, the fifth report provided tools for:

- Integrated strategic and capital planning
- Managing the balance sheet
- Selecting expert advisers

Now, in this final report, we leverage that knowledge by looking forward. What will the future health system look like? What can individual hospitals do to survive—and even to thrive? And what should be the government’s role in helping hospitals deal with shrinking access to capital?

To help us with these questions, we assembled a diverse panel of thought leaders with unique points of view about the future of health care, particularly as it relates to capital. Three hospital system CFOs were interviewed for this article: Tom Meier, corporate treasurer and CFO, Kaiser Permanente, a system that plans to spend \$8 billion between 2003 and 2005, including \$1.8 billion on an electronic medical record system; Michael Cottrell, CPA, senior vice president and CFO,

Bon Secours Health System, a 24-hospital system involved in several innovative partnerships; and Lydia Jumonville, CPA, senior vice president and CFO, Baylor Health Care System, which is implementing a clinical transformation and IT project and is building a new hospital. In addition, the panel includes healthcare executive and author E. Preston Gee, senior vice president, strategic planning, St. David's HealthCare Partnership, which is embarking on a \$100-million capital expansion. Balancing the hospital views are Martin Arrick, managing director, Standard & Poor's, Not-for-Profit Health Care, whose ratings help

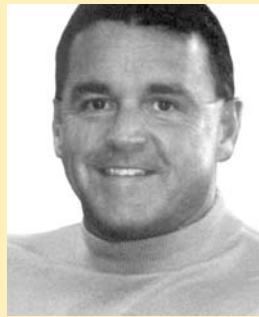
determine how much capital hospitals access; Paul B. Ginsburg, Ph.D., president, Center for Studying Health System Change; and Randy Fuller, hospital segment manager, GE Healthcare Financial Services.

Financing the Future, led by the Healthcare Financial Management Association (HFMA) in partnership with GE Healthcare Financial Services, is a yearlong project whose mission is to help hospitals and other stakeholders understand capital needs now and in the future and learn how to access capital to meet those needs. Research for the project was conducted by HFMA and PricewaterhouseCoopers.

Participants:



Martin Arrick
Managing director, Standard & Poor's, Not-for-Profit Health Care, New York



Michael Cottrell, CPA
Senior vice president and CFO, Bon Secours Health System, Marriottsville, Md.



Randy Fuller
Hospital segment manager, GE Healthcare Financial Services, Orchard Park, N.Y.



E. Preston Gee
Senior vice president, strategic planning, St. David's HealthCare Partnership, Austin, Tex.



Paul B. Ginsburg, Ph.D.
President, Center for Studying Health System Change, Washington, D.C.



Lydia Jumonville, CPA
Senior vice president and CFO, Baylor Health Care System, Dallas



Tom Meier
Corporate treasurer and CFO, Kaiser Permanente, Oakland, Calif.

What Will the Future Health System Look Like?

The *Financing the Future* project found that hospitals are increasingly separating into two capital categories: the “haves” and the “have-nots.” Given those findings, we asked our industry experts for their views of what the healthcare system may look like over the next decade, what effect the struggle to access capital might have on quality, whether they expect an increase in hospital closures, and what the tipping point might be for significant changes in the configuration of our healthcare system.

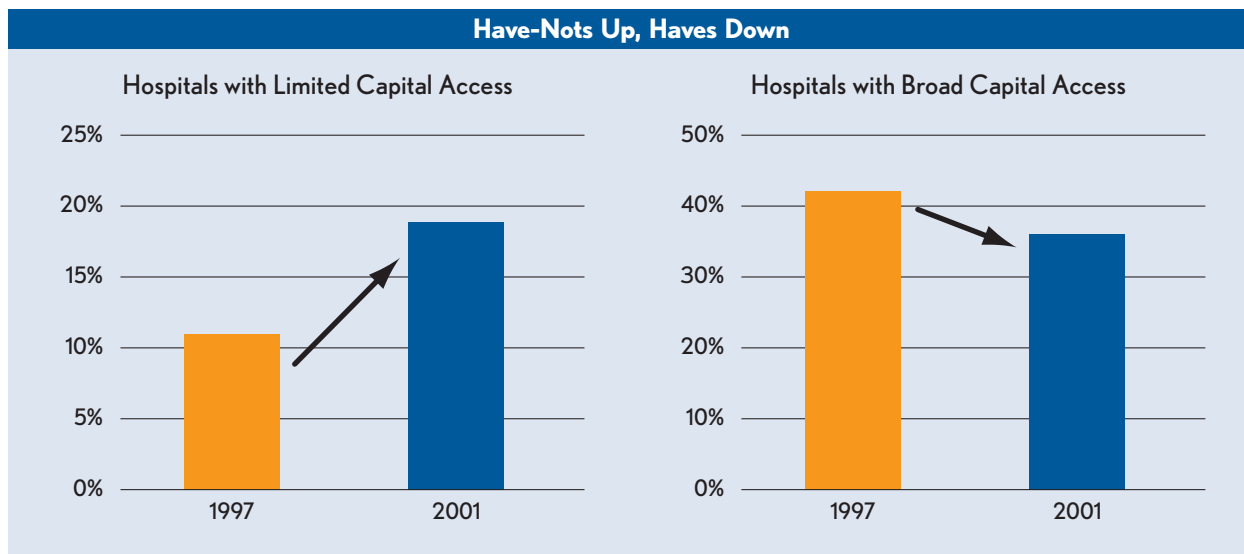
The consensus presents a troubling picture. In general, our experts believe that the “have-nots” will fall further behind, that more hospital closures are likely, and that quality could suffer in hospitals that fail to keep up with technologic developments. According to our experts, market conditions that could force significant change in the healthcare system include the growing numbers of uninsured and the outsourcing of jobs by employers who find it increasingly difficult to offer affordable healthcare insurance.

Michael Cottrell: The very strong are getting stronger and the weak are getting weaker. The non-rated and below-investment-grade institutions are going to be struggling more and more. They’re not putting in what they need to put in to maintain the business. They may not know it, but they’re slowly liquidating their organizations.

Martin Arrick: This year’s financial medians are beginning to show the divisions between the “haves” and “have-nots.”

Randy Fuller: The “haves” will have flexibility and the options to build facilities and portfolios. They will do well—they can pick the services they want to be in. On the other side, the “have-nots” will have little relief because they can’t even keep up with depreciation. Right now there are new capital dollars flowing into health care, making capital fairly accessible to most providers. If the condition of the “have-nots” worsens due to adverse reimbursement changes or other industry events, this new capital may exit the market as it did

Exhibit 1



Source: *Financing the Future* research

Between 1997 and 2001, the percentage of hospitals with broad access to capital declined, from 42 percent to 36 percent of the total hospitals reporting. The percentage of limited-capital-access hospitals rose even more sharply, nearly doubling from 11 percent to 19 percent.

after the Balanced Budget Act of 1997. In this scenario, the "have-nots" may find their access to capital severely limited.

Implications for Quality

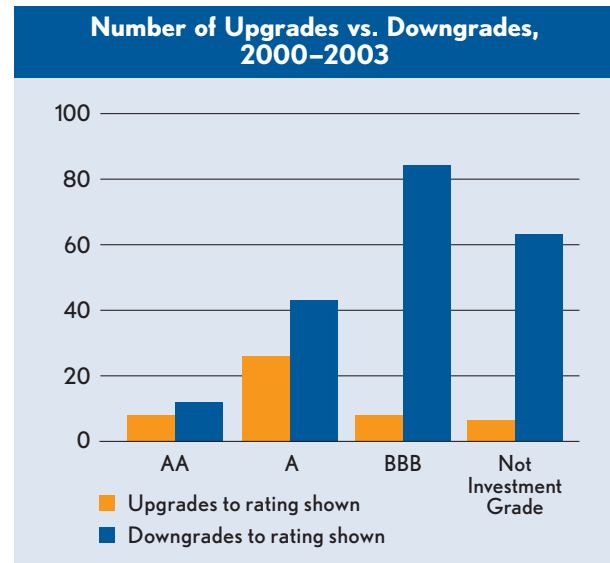
Paul Ginsburg: With successful incorporation of information technology likely to lead to quality improvement, those hospitals that do not make investments in this area, whether they are "haves" or "have-nots," will fall behind.

Lydia Jumonville: As the larger systems invest in clinical transformation, the quality is going to increase. It will get them to a different level. Our pathway is a seven-year journey to full implementation across the system. It's going to improve our quality. The "have-nots" will fall further behind.

Impact on Hospital Closures

Paul Ginsburg: Inability of some institutions to raise funds will lead to closures and mergers into stronger institutions. They may be purchased if they can bring some value to a system. There may be some joint ventures with for-profit systems. For hospitals that are performing way below their potential, the question will come down to what type of value they will bring to

Exhibit 2

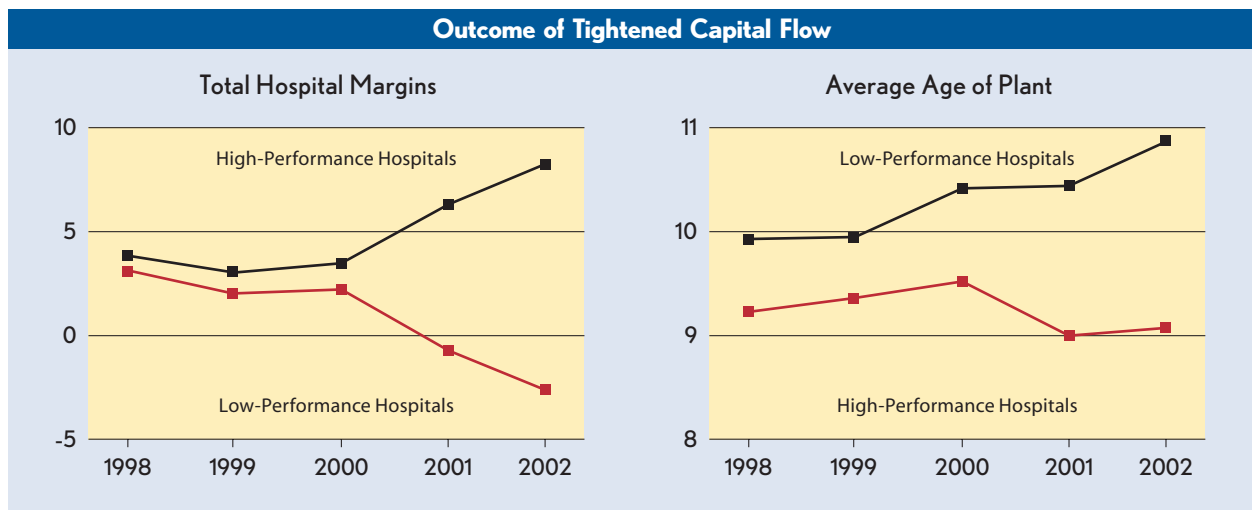


Source: Standard & Poor's, 2004.

During the past four years, credit downgrades have outnumbered upgrades by nearly five to one. Although hospital CFOs have no control over interest rates, their ability to manage risk in their hospital investment portfolios has been an increasing concern to ratings agencies.

another hospital. A not-for-profit hospital that isn't in the right community might not have much value. Some of them will close, and the healthier hospitals will grow faster as a result.

Exhibit 3



Source: Ingenix

The gap between low-performance and high-performance hospitals widened considerably between 2000 and 2002, with operating margins among low-performance hospitals dropping more than 75 percent and among high-performance hospitals increasing around 60 percent. Just over a quarter of all hospitals have a negative total margin. The average age of plant has increased over the past few years; however, high-performance hospitals have been able to offset some aging by strategic capital allocation for facility improvement.

Preston Gee: I think the endangered species are the second- and third-tier hospitals in metropolitan areas. In 10 years, 20 percent of those hospitals will close.

Lydia Jumonville: There are a lot of small hospitals out there that know they need to be a part of larger systems to survive. But systems like ours are picky; you cannot absorb all these distressed facilities. You have to make sure they ultimately bring value. We have had several hospitals come to us, and we had to say, “No, we’re just not in that market.”

Randy Fuller: One outcome of this downward spiral will be more merger-and-acquisition activity and maybe a slight uptick in closures. For instance, we may see a small spike in both M&A activity and hospital closures in California due to the financial pressures from the seismic requirements and staffing ratios.

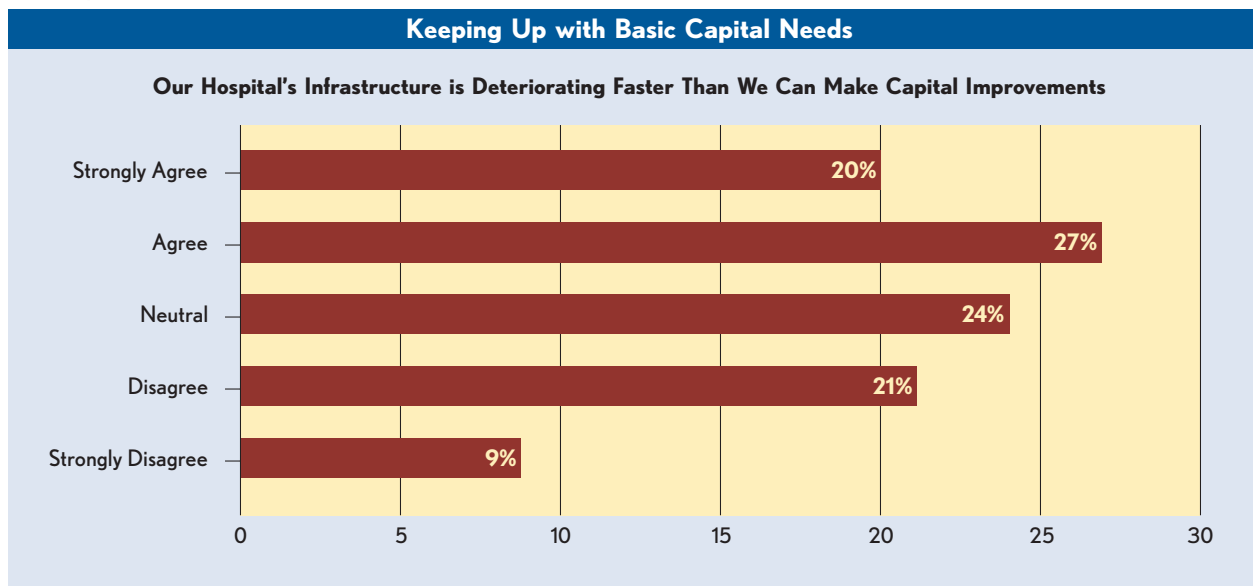
Tipping Points for Change

Martin Arrick: I think we’re at an inflection point now. There are more and more uninsured and underinsured. In addition, the sustainability of the revenue growth seen over the past few years is not going to be there.

This is currently being combined with a spate of lawsuits about self-pay collections and renewed governmental interest in the tax-exempt status of hospitals. Taken together, there are a number of forces in the market that will push down profits. Despite these emerging pressures, for those hospitals in the top rating categories, 2003 was a great year. Managed care pricing has been wonderful. However, the sector as a whole appears to have peaked despite the success of the strong institutions.

Preston Gee: This year, we’ve seen a phenomenal increase in the number of people not paying. The industry didn’t see this coming from the higher deductibles to the increase in co-pays. Lately, we heard the head of GM say that U.S. manufacturers can’t compete globally. The employers are going to push hard; we’re seeing that here locally [in the Austin, Tex., area]. There’s fear about jobs being outsourced. As more employers say that health care is what’s forcing them to go overseas, we’re going to see this mad scramble to curtail health-care costs. People can argue that either way, but what matters is the perception that we’re going to lose jobs to overseas.

Exhibit 4



Almost half of hospital CFOs surveyed say they can’t keep up with the basic need for capital improvements. Yet 72 percent of those surveyed predict that capital spending will increase—by an average of 14 percent annually, compared with the 1 percent average annual increase of recent years.

What Can an Individual Hospital or Health System Do to Survive—And to Thrive?

We next asked our experts what steps hospitals could take to survive such a dark healthcare forecast. Despite the bleak outlook, all our panel members had positive suggestions. Some emphasized outsourcing and better use of resources; others saw joint ventures and rationalizing of assets as ways for hospitals to strengthen themselves by combining forces. Our experts also recommended that hospitals focus on a few core service lines—on the things they do best, rather than stretching themselves too thin. Technology too will play a strong role in whether hospitals thrive, said our panel; those hospitals that invest in the digital hospital concept and IT systems will be ahead of the curve. Although the pace of technological advancement poses a huge challenge to hospitals to find ways to acquire the needed equipment, it is these advancements that are providing the tools to enhance productivity and raise the quality of care.

“We’re one of the few industries that have not been successful in rationalizing assets. Back-office functions such as billing and collecting are the same and could be shared. It would standardize the system.”
—Tom Meier

Paul Ginsburg: First, hospitals will have to be distinctive—either they have to be the only provider in a segment of the market, or they have to have a strong reputation. I expect we are going to see a narrowing of networks; CalPERS said it saved 3 percent on premiums by dropping some hospitals from its HMO network. Second, hospitals need to hold on to their doctors and discourage them from going out on their own.

Preston Gee: Hospitals need to focus on their core services, their priorities. What are their three to four strong service lines? I don’t mean that they have to shut everything else down, but they need to devote their intellectual and financial capital to those service lines, which may be orthopedic, or ER, or oncology. That’s such a different mindset from the blanket strategy of a lot of hospitals.

Randy Fuller: Hospitals need to be disciplined in what they are doing. Too often they are locked in a battle with competitors and lead with a “me too” strategy. We see too many instances where hospitals get into business lines that are not core to them as a result of these competitive strategies. Hospitals should listen to the customers—the patients and physicians. They also need to make sure they’re dialoging with insurers to establish their “value proposition” in the market and avoid being marginalized due to being the high-cost provider. This disciplined approach may also lead to more effective balance sheet management through trimming or monetization of non-core assets and can enhance capital access.

Tom Meier: We’re one of the few industries that have not been successful in rationalizing assets. There are a number of services that are common to every hospital, such as pharmacy, parking, and cafeterias. If we were going to rebuild here in Oakland, why not build a common megacentre with different areas for Kaiser and other healthcare providers? Back-office functions such as billing and collecting are the same and could be shared. You could have the same staff serve all the facilities. It would standardize the system. Our industry hasn’t gone through the same evolution with services as other industries have—that is, standardize, consolidate, outsource, then possibly off-shore certain functions.

Lydia Jumonville: Hospitals need to look outside the box. We believe there are benefits to having our surgery centers and the heart hospital as joint ventures. It's a more efficient model; the physicians are happier. At our heart hospital, the quality measures are so much better. We're able to deliver a superior product.

*"We're looking more at relationships in which someone else brings capital. It mitigates the kinds of dollars we have to spend."
—Michael Cottrell*

Michael Cottrell: Be very strategic in deployment of resources. We had vendors selling at the hospital level. We've eliminated that by establishing system-level partnerships. We've shut off the ability of the local hospitals to make those buying decisions; we are the only ones who can release the invoice. One of our hospitals bought a light-speed CT scanner; it doesn't need a light-speed CT. Now, the light-speed CT may spend the first two years in market A, and then go to market D where the service line is not so competitive. It's a more thoughtful approach to the life cycle of equipment.

Also, hospitals need some different models of working with partners. For example, we've become more outsourcing oriented. These vendors want to get their scanners off their docks, and we want them; we just have to figure out how to pay for them. When the sales stop coming, the vendors will look for these partnerships. For example, we're not buying picture archiving and communications systems. We have an outsourcing relationship, and the vendor is running it; they're doing it all. We're also looking at what cash flow is needed to pay for this technology; it needs to be 13 to 15 percent EBIDA. We go to our vendors and say, "How are you guys going to help us solve this problem?"

We're looking more at relationships in which someone else brings capital. It mitigates the kinds of dollars we have to spend. We're also outsourcing our plant costs. We don't own our own boilers and chillers; we contract for 70 degrees and 70 percent humidity. They can come in and manage the business—that's not a core competency for us.

Martin Arrick: Hospitals need to make tough decisions about what services to provide and what locations they want to be in to protect their profit margins. This is essential if they want to be able to fund their future capital needs. However, that runs directly counter to what these recent charity care lawsuits are trying to do. Every hospital needs to have a tuned-up charity care policy. Unfortunately, many of these policies are fairly informal right now.

The Role of Technology

Paul Ginsburg: There are a lot of things you can do to make capacity go further, including IT deployment. IT is a substitute for building more bricks and mortar. But building more bricks and mortar is easier and less risky than reorganizing your processes. Bold leadership is needed to realize the potential of information technology.

What Can an Individual Hospital Do to Survive—and Thrive?

- Be strategic in deployment of resources
- Outsource
- Form joint ventures
- Rationalize assets
- Provide more information that investors and stakeholders want and need
- Be distinctive
- Hold on to physicians
- Focus on core service lines
- Improve quality of care
- Protect profits
- Integrate strategic and financial plans
- Establish—and tune up—policies regarding charity care

“The bigger, successful systems are going to electronic medical records. Do you really want to be the refugee hospital for all the physicians who think technology is overrated?”— Martin Arrick

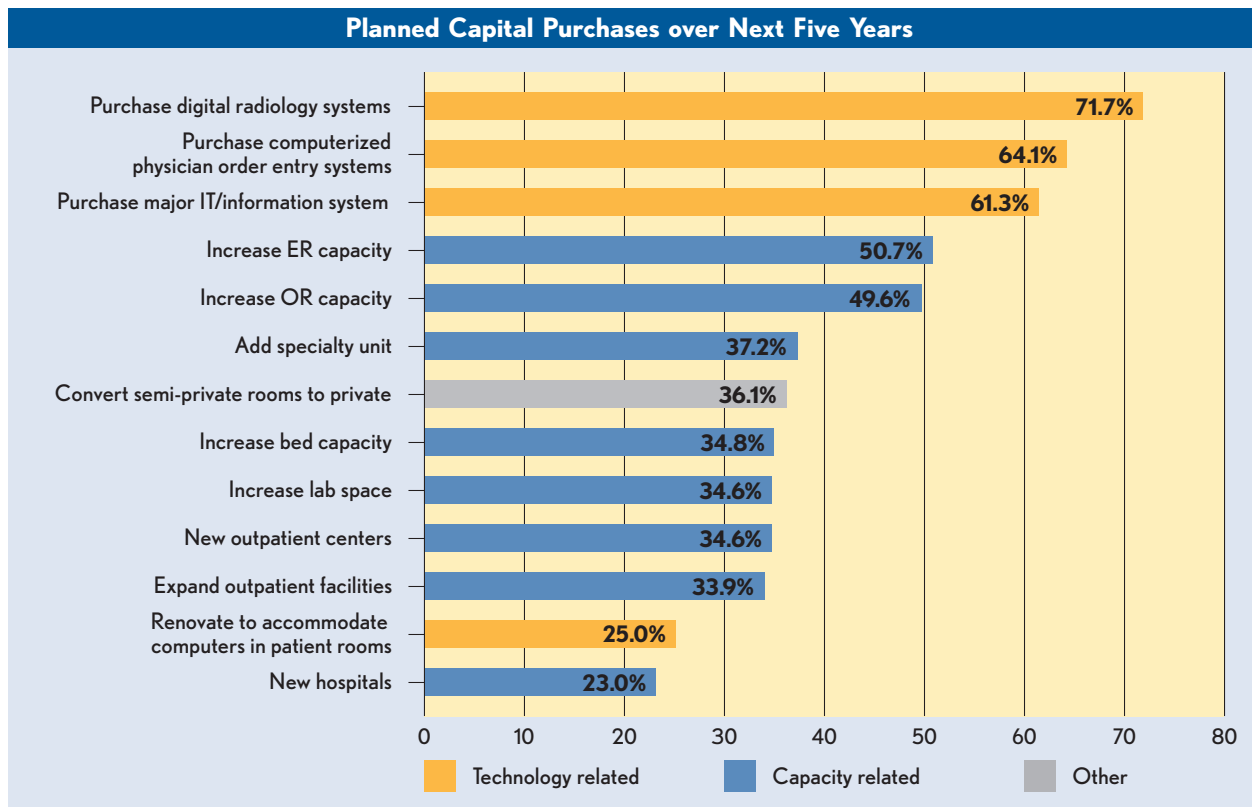
Michael Cottrell: The technology issue is killing us. You buy a 16-slice CT and 30 months later, there’s a 32-slice. You’re being forced competitively to upgrade. Our physicians are relatively loyal, but you have to have reasonably current technology. I think that’s the biggest problem. Add to that the advances in genomics, DNA therapy, and the drug-eluting stents, which are decreasing the amount of invasive cardiology.

Tom Meier: Kaiser is investing heavily in technology, and I hope we’re in a position to share some of that with others. If we have the tools and data that can improve the quality of life, I’m hoping we can share that knowledge with other hospitals and physicians.

Lydia Jumonville: CFOs around the country all struggle with IT and what return it should have. Although it’s difficult to prove the ROI, we really can’t afford not to invest in the new clinical technology if we are truly committed to improving the quality of patient care.

Martin Arrick: The bigger, successful systems are going to electronic medical records. Do you really want to be the refugee hospital for all the physicians who think technology is overrated?

Exhibit 5



Source: Financing the Future survey

The three most frequently cited capital projects that hospitals intend to fund in the next five years are all technology acquisitions. Of the next 10 most frequently cited projects, eight involve expanding capacity.

What Should Be the Government's Role in Helping Hospitals Improve Access to Capital?

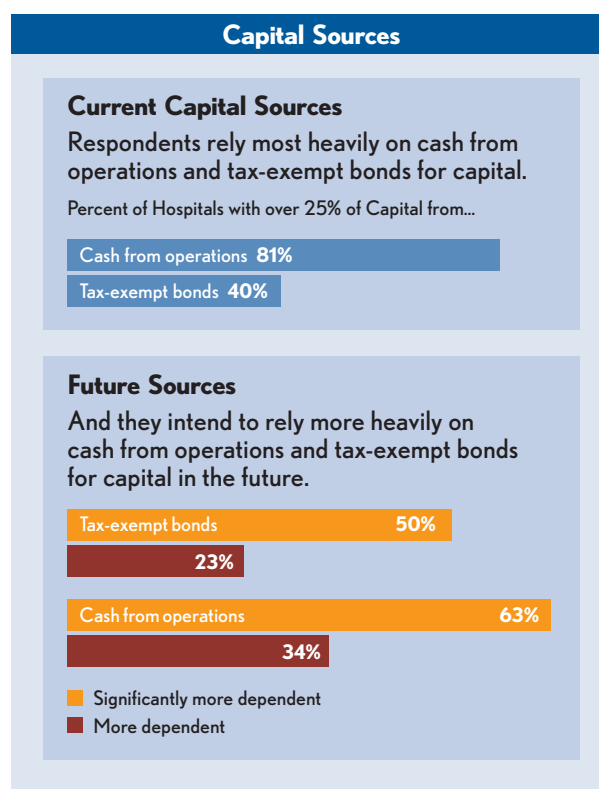
The foregoing questions have dealt with what individual hospitals can do to finance their future. With our last question, we turn outside—to ask what role government should play in helping hospitals deal with the capital gap. Fixing the payment system was primary among our panel's suggestions, followed by grants or subsidies for technology implementation. Our experts also said they would like to see more government attention to quality issues and tort relief.

“The payment system is 40 years old and it was designed around the old healthcare system. The move to Medicare Advantage is an effort to bring something new into the system, but it's only a small step.”
— Randy Fuller

Randy Fuller: It's really difficult to envision the government's leaving its incremental approach to healthcare financing. The payment system is 40 years old and it was designed around the old healthcare system. The move to Medicare Advantage is an effort to bring something new into the system, but it's only a small step. Technology implementation is probably limited to some degree by government funding, but having government pay for 100 percent of it is not the right thing, either. With adequate margins and stable and predictable payment systems, capital would likely be available to fund the needed acquisitions. In addition, the government needs to address quality issues and continue to provide tort relief, especially with the latest round of lawsuits regarding the provision of charity care by the not-for-profits.

Martin Arrick: If we are to postulate that the number of uninsured in this country is going to go up, whose responsibility is that? There's an implication that ultimately, it's the responsibility of government. But the government doesn't hesitate to pass laws like EMTALA, which are unfunded mandates to take care of the uninsured.

Exhibit 6



Respondents currently rely most heavily on cash from operations and tax-exempt bonds as sources of capital. Sixty-three percent of CFOs surveyed said they expect to be more dependent on cash from operations in the future, and 34 percent say they will be significantly more dependent on cash from operations. In addition, 45 percent said they would be more dependent on philanthropy.

Paul Ginsburg: Government can contribute through grants for IT and other investments that reduce medical errors, but it should focus these grants on innovative projects. Once we get to the point that we have effective models that clearly work, government can step out and leave IT investments to the market. The key thing for a grant program is its ability to be selective and focus on high-risk endeavors with large potential. The danger is if it becomes like an entitlement.

Lydia Jumonville: Healthcare systems need to be financially healthy so they can invest in the right things. But when they lose money on Medicare and Medicaid and when the uninsured and underinsured numbers keep rising, they simply don't have the cash to invest in capital. I'm not sure I want the government to come in with some prescription to fix capital. We need to fix the payment system! If we can't make a profit, we can't keep up with capital needs.

Preston Gee: We need a very sophisticated and objective evaluation of small specialty hospitals. You can't just step back and say it's good competition. Health care is atypical of other industries; it's the only one that has to serve people for free. And you can't just say that what works in other industries is good for this one. Also, we need to look at how the government can assist by backing off. We had two psych units and neither could make money because of regulations around staffing. But when we tried to combine them, we couldn't because of antitrust. The government needs to look at whether it's more of a help or a hindrance. One branch says, "We want to encourage competition," and the other says, "Don't compete."

If you could ask a top health system analyst one question about the economic direction of our health system, what would that question be?

Michael Cottrell: With people living longer, how much more health care are they going to consume? How much are we leaving to our children to pay for this aging population?

Lydia Jumonville: What is the best way to handle the growing problem of uninsured and underinsured in this country?

Randy Fuller: Do economists think that employers will continue to accept high insurance premium growth and consumers will continue to accept this cost shifting? What will break us out of this mode of cost shifting?

If you could ask a hospital CFO one question about his or her plans to ensure future success for his or her organization, what would you ask?

Paul Ginsburg: How can you effectively get staff physicians to work together with the hospital to address its challenges and defuse their motivation to go out and compete with the hospital?

Martin Arrick: What is your long-term strategic plan and what assumptions are you making about how you will be able to afford it?

Financing the Future

For a simple but eloquent summary of the state of healthcare capital access today, one has only to glance at exhibits 1 through 4 of this report. The gap between low-performing and high-performing hospitals in terms of operating margins has widened enormously since 2001 as a result of tightened capital flow; the numbers of “have-nots” are up; the number of downgrades in hospital bond ratings has greatly surpassed the number of upgrades; and 47 percent of hospital CFOs say they can’t keep up with the basic need for capital improvements.

Access to capital is unlikely to get any easier in the future. Throughout this project, there are examples of hospitals that are finding creative ways to get the capital they need. Those hospitals are following best practices, exercising discipline in their strategic planning, focus-

ing on core services at which they excel, investing in technology, outsourcing, and/or forming joint ventures—in short, they are already doing what our experts have recommended in this report.

The capital is out there, and it will always be out there—although there may be less of it, the competition for it may increase, and the sources for it may change. The challenge for hospitals will be to create a clear vision of their futures, to create a strategic and capital path leading to that future, and to follow the path with energy and discipline. Healthcare executives perennially are challenged to work smarter and to work harder. With an appropriate vision and plan, healthcare executives can help ensure that, despite a capital crunch, their work can secure a future that is bright for providers and patients alike.

financing the future

Financing the Future is a yearlong project that will give healthcare professionals the perspective and tools necessary to meet the capital challenges of today and tomorrow. Led by the Healthcare Financial Management Association (HFMA) in partnership with GE Healthcare Financial Services and with research conducted by HFMA and PricewaterhouseCoopers, Financing the Future is bringing together key stakeholders in the industry to quantify capital need and access, identify best practices for capital planning, provide tools for determining capital need, recommend innovative techniques for capital access, and suggest areas for policy change. www.financingthefuture.org



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