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financing your strategic plan finding the right tool for the right job

New facilities, new IT, and physician integration are three key goals requiring different approaches to financing.

AT A GLANCE

- > Financing options available through the private sector and government agencies can fund facility renovations or new construction.
- > To upgrade IT, hospital leaders have three major financing options: purchase, use cloud-based services for a fee, or lease.
- > Hospital leaders may finance physician integration like other capital projects, but there are risks to diverting dollars from buildings.

A one-size-fits-all approach just doesn't work when it comes to financing strategic projects, such as facility expansion, new technology, and physician integration. When developing a capital funding plan for each goal, hospital leaders should be aware of the financing options and strategies available to them and determine which best fits their needs. This analysis should always be included as part of the strategic planning process.

Let's look at each of these strategic goals separately: renovation or construction, IT upgrade, and physician integration.

Strategic Goal: Hospital Renovation or New Construction

When deciding whether to renovate or replace a facility, the hospital's board, medical staff, and management team often form a facilities committee, which reports to the strategic planning committee, to direct the decision-making process. This committee often will recommend a course of action based on the hospital's unique credit profile, facility assessment, and cost estimates. The facilities committee will evaluate available financing options, keeping in mind how much the organization can afford and the current state of the capital markets. In many cases, renovating or replacing facilities can require debt financing for 25 or more years.

Private-sector financing options. A not-for-profit hospital generally has a number of private-sector options available for funding long-term capital projects, including unenhanced fixed-rate bonds, variable-rate demand bonds, private placements, and floating-rate index notes.

An unenhanced fixed-rate bond offering will provide a hospital with a long-term fixed rate. A 30-year term and amortization is typical, with transactions often requiring a debt service reserve equal to about one year of debt service to be funded at closing. This offering can be rated or not rated.

Variable-rate demand bonds backed by a bank letter of credit (LOC) provide the borrower with access to short-term, variable interest rates. This structure enables a hospital to borrow on a bank's short-term credit rating, as opposed to borrowing on the hospital's credit rating. The cost of capital to the hospital primarily consists of the cost of the LOC and the interest rate on the bonds.

A private placement involves the private placement of tax-exempt bonds with a bank or banks, or with a bond fund. These bonds permit the borrower to negotiate the terms with a select group of investors. Disclosure requirements can sometimes be minimized, and covenants are tailored to the individual credit. If the private placement is designated "bank qualified" by the issuer (a qualified municipal entity), banks can deduct 80 percent of their carrying costs and can pass along the savings to borrowers by means of a reduced interest rate. However, a single issuer can designate only \$10 million of bonds as bank-qualified in a given year.

A floating-rate index note is similar to a private placement, but its documents make it more easily remarketed to various investors. The index floater has an initial mode or period (typically three to seven years) during which the bond pays an interest rate equal to a short-term index plus a fixed-credit spread. The bond amortizes over a period

of up to 30 years and can be a public offering or privately placed directly with a bank or investor. Similar to an LOC-backed offering or a private placement, an index note is subject to renewal risk at the expiration of its initial term.

Government-sponsored financing options. Financing alternatives provided by government agencies have become increasingly popular for hospitals. Examples included Federal Housing Administration (FHA) Section 242 mortgage insurance, U.S. Department of Agriculture (USDA) loan programs, and the U.S. Department of the Treasury New Markets Tax Credit Program.

FHA Section 242 mortgage insurance issued through the U.S. Department of Housing and Urban Development offers nonrecourse debt at fixed interest rates. The maximum term is 25 years after construction completion, and the loan-to-value (LTV) ratio is capped at 90 percent. In some cases, the 10 percent equity requirement can be met without a cash contribution because the existing net property, plant, equipment, and land value can be counted as equity.

The USDA offers two loan programs for rural hospitals: the Business and Industry (B&I) Guaranteed Loan Program for communities up to 50,000 people, and the Community Facilities (CF) Loan and Grant Program for communities

Case Study: Funding a Facility Renovation at Cameron Memorial Community Hospital

Cameron Memorial Community Hospital, a critical access hospital in Angola, Ind. (www.cameronmch.com), had gradually accumulated investment-grade liquidity ratios while maintaining a relatively unlevered balance sheet. Executives realized the hospital's aging and inefficient physical plant would be an impediment to continued operational success. They faced two major choices: Build a replacement hospital on a new site, or renovate and expand on their current campus.

After much due diligence, the hospital decided to invest in its current location because it is a critical anchor project of the city's redevelopment plan. To finance the project, the hospital is using a creative combination of private-sector and agency financing, involving a USDA direct loan, a USDA-guaranteed loan via a community bank, and bond anticipation notes (BANs). The BANs provide construction capital, while the USDA loans provide the permanent capital after completion of the construction.

with populations of no more than 20,000. The B&I program offers terms up to 30 years and is best suited for projects of \$10 million or less. Depending on the loan size, the guarantee varies between 60 percent and 80 percent, and proceeds can be used for refinancing or new construction. The CF program provides direct and guaranteed loans (up to 90 percent) with a maximum term of 40 years. New money must make up at least 50 percent of loan proceeds. For both programs, the funding is generally issued upon construction completion, requiring separate construction financing, typically a bank construction loan or underwritten bond anticipation note.

The Department of the Treasury's New Markets Tax Credit Program may be used to finance capital projects for the healthcare sector. This program attracts investment capital to eligible low-income communities—rural or urban—by providing investors with a tax credit against their federal income tax return in exchange for making equity payments into community development entities (CDEs). CDEs, which receive the tax credit awards, must demonstrate a mission of serving low-income projects and/or communities.

Strategic Goal: Updating IT Infrastructure

Technology will play an increasingly important role in improving quality of care, patient safety, and operational efficiency. However, a changing regulatory environment and rapid rates of innovation mean that finance leaders need to plan for escalating technical complexity and costs.

IT assets in a hospital include:

- > Software, such as electronic health record (EHR), enterprise resource planning, and departmental systems
- > Imaging equipment/solutions, such as magnetic resonance imaging, computed tomography, and digital mammography equipment; picture archiving and communications systems; and vendor-neutral archives
- > Pharmacy equipment, such as automated dispensing machines and mobile cabinets
- > Point-of-care solutions, such as computers/

workstations on wheels, wall-mounted central processing units, and tablets

- > IT infrastructure, such as servers, storage, routers, networking equipment, Wi-Fi, and radio frequency identification

Forces of change. Finance leaders should be mindful of the forces of change that can affect the future viability of new technologies from IT and medical equipment vendors, including:

- > Changing market forces (e.g., shifting payment models, declining payments, and regulatory/economic factors)
- > Emerging technologies (e.g., innovations, updated standards, and clinical equipment advances)
- > Changes to the hospital environment (e.g., mergers and acquisitions, recruiting/retaining of physicians, and market competition)

Finance leaders also should prepare for potential ripple effects that can occur when new technologies require upgrades to other equipment, such as when the addition of digital mammography requires extra storage and increased network capacity. Another important consideration is the expected useful life of a new technology, which is based on its projected effectiveness and whether the hardware will support future software versions.

Understanding these forces of change can help organizations apply the appropriate IT financing options so they can stay agile as technology evolves.

IT financing options. The value of IT assets is derived from their use, because they generally depreciate rapidly and quickly become obsolete. This consideration should be at the forefront in finance leaders' deliberations on how best to acquire the technology for a particular project. There are three primary options available to nearly all organizations: purchase the technology, access it in the "cloud," or lease it.

Ownership may be the best option for technologies that remain useful and cost-effective for more than six or seven years, such as magnetic resonance imaging devices, electrocardiograms,

and linear accelerators. However, in today's low-interest environment, a hospital can acquire IT assets with a briefer lifespan, such as servers, phone systems, computers, and imaging equipment, with a short-term bond or private placement to take advantage of the relatively steep yield curve. This approach is especially attractive when pursued in conjunction with a renovation or new construction project that uses long-term (spread over 25 years), fixed-rate "bricks and sticks" financing. Within the long-term financing structure, a short or intermediate tranche of bonds (i.e., a subset with common characteristics) can be structured to match the life of the IT assets. However, finance leaders should be aware that the financial benefits of using an IT asset over the long term might be reduced by increasing maintenance costs over time.

The cloud offers a newer method for acquiring these technologies in which organizations pay a fee to access technology services and storage over a network. The cloud phenomenon benefits users that want to stay current with rapidly changing technology innovations, but have limited capital resources. However, there is a trade-off to using cloud technology. Users must cede control of critical and dynamic technology issues, including security, software

licensing, transitioning of applications to the cloud, the ability to adapt to size/volume requirements, lost time (latency) in accessing the cloud, and accountability for data stored in the cloud.

Finally, leasing can be attractive because it minimizes up-front capital outlays, maintains cash flow, and provides the agility to change technology as conditions dictate. It becomes an organization's "financial cloud," whereby users pay for the use of technology without giving up the control or flexibility to customize how and where technology and services are delivered. Leasing, however, is not an optimal strategy for assets that have relatively long projected useful lives. Ownership is a better option in such instances.

Strategic Goal: Hospital-Physician Integration

Today, a well-defined physician-integration plan—including a credible means of funding it—is essential for a hospital's strategy.

Since the enactment of the Affordable Care Act, the emphasis of many hospitals' integration efforts has been on improving the quality and efficiency of care that is delivered across the spectrum of inpatient and outpatient settings.

Case Study: Financing Strategic Capital Projects at Kennedy Health System

Kennedy Health System operates a 621-bed, three-campus hospital system in New Jersey (www.kennedyhealth.org). In recent years, system leaders had funded Kennedy's strategic capital projects through operating cash instead of debt. Although this approach allowed the system to carry little debt, it compromised Kennedy's overall financial profile by reducing the organization's liquidity position.

In 2012, executives at Kennedy altered their approach and decided to finance select projects to take advantage of the system's strong, low-leveraged balance sheet. After exploring multiple funding options, the CFO and board selected a public offering of tax-exempt, fixed-rate bonds to finance approximately \$20 million in new projects. With a reimbursement resolution in place, Kennedy was able to reimburse itself for approved prior capital expenditures, further strengthening its balance sheet.

As the municipal market improved, the system chose to take advantage of the low-interest-rate environment to refund its existing fixed-rate, tax-exempt debt. Kennedy entered the tax-exempt municipal bond market with a \$66 million offering at an opportune time, as the refunding was able to generate more than 15 percent in debt-service savings.

As third-party payers experiment with new ways to engage clinicians in their efforts to eliminate unnecessary or ineffective care and to reward care that is likely to achieve desired outcomes, hospitals and physicians that have embraced the principles of clinical and financial integration stand to perform better financially than those that have not.

Developing an integration plan that aligns both clinical and financial interests is critical as payment methods and policies continue to change, transitioning from volume-based to value-based measures.

Currently, there are several integration methods and organizational models competing for a hospital's attention. The degree of integration may vary from very little (as is true when self-employed, private practitioners maintain an "arm's length" contractual relationship with the hospital) to full integration (robust forms of direct employment through hospital subsidiaries and evolving structures, such as accountable care organizations). Somewhere along this spectrum are contemporary models, such as comanagement, which seek to make hospitals and physicians "partners" in a serious effort to improve performance within specific service lines or facilities.

Whatever model is selected by a provider community, successful integration requires investing in several key activities:^a

- > Conducting appropriate market analysis
- > Setting realistic objectives to support a hospital's strategic goals
- > Recruiting physician champions
- > Promoting physician engagement and soliciting input from group practice leaders
- > Continually improving administrative and clinical processes to control costs

Although this investment is not purely financial, physician integration does require a substantial financial outlay. To be truly integrated, both clinically and financially, hospitals need to help physicians with a range of initiatives, including:^b

- > The provision of IT hardware/software and training

- > The latest in medical technology
- > Credible data on utilization, cost, and quality
- > Adequate space in clinical facilities, both dedicated and shared
- > Legally sound governance models
- > Appropriate compensation and incentives

So how do health systems make it happen?

How a health system finances its integration strategies depends on its unique financial circumstances, as well as its specific integration model. A system with plentiful reserves and strong credit obviously is able to fund physician practice acquisitions, joint ventures, and other alignment strategies more readily than a system that needs to direct its finances to other priorities. However, not all integration strategies require deep pockets. For example, many contractual relationships like professional service agreements and clinically integrated networks can be developed with relatively modest expenditures.

A medical practice acquisition can be as daunting as replacing an aging facility or launching an advanced IT system linking physicians and patients more closely with the hospital. And just like any other capital-intensive initiative, practice acquisitions should undergo a rigorous assessment and approval process. When acquiring the assets and staff of a medical practice, a system needs to perform adequate due diligence, obtain independent valuations from qualified sources, and assess the system's ability to integrate the practice, with minimal disruption of clinical and administrative operations. Moreover, before any transaction is approved, it should be supported by a thorough legal review, community benefit analysis, and whatever additional justification a board of directors or board committee will require to approve an investment of this size. The challenge for finance leaders is that such initiatives may compete directly with more routine business priorities, such as developing new facilities.

There is, of course, some risk in diverting capital away from buildings to fund integration. For

example, some hospitals have wagered their futures on acquiring numerous physician practices only to fail at attaining true integration. By the same token, however, hospitals' substantial investments in custom IT solutions also have been known to fail. In either case, finance leaders require a deep level of understanding: They not only should know when to incur the cost of a customized IT strategy and when to go with a tried-and-true methodology, but also should understand how to fund physician-integration efforts—and at what level.

Physician-integration financing options. Most hospitals and health systems use cash reserves to fund physician-integration efforts because there are no physical assets (land, buildings, and equipment) to lend against, as in traditional debt financing. That being said, accommodating

physicians who become integral parts of a hospital or health system almost always entails some financing to carry out integration plans. Examples include adding an EHR and building a new wing onto existing facilities or a specialty hospital.

The Need for Discernment

As the psychologist Abraham Maslow once said, “If the only tool you have is a hammer, you tend to see every problem as a nail.” To his way of thinking, if you are not aware of all the solutions, you will use the same strategy again and again. No matter which goal is at hand—a new facility, new technology, or physician integration—understanding the tools available, and having the acumen to put them to effective use, is a key step for successful planning and obtaining capital at the lowest possible cost. ●