

Strategies in Healthcare

**The Impact of the
Capital Markets Crisis and
Economic Slowdown on
Hospitals and Health Systems**

Fall 2008



A Division of Morgan Keegan

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The Impact of the Capital Markets Crisis and Economic Slowdown On Hospitals and Health Systems

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Introduction

The market and reimbursement environments for healthcare providers will be extremely challenging over the next several years. Economic pressures will likely cause significant levels of consolidation in a market that remains relatively fragmented. All providers will need to work aggressively to maintain operating margins, access to capital and, in some cases, viability. They will also need to target capital and programmatic investments that will earn rapid and significant returns. Freestanding institutions and small health systems with weaker balance sheets and limited access to capital may need to partner with stronger players or sell in an environment of declining value. Some hospitals may be forced to close. Hospitals and health systems with strong financial performance will find opportunities to add new assets, but they will need to act quickly in determining whether these opportunities will strengthen their organization over the long term.

This analytical review provides hospital and health system leaders with perspectives on the current capital markets crisis and the impact that a projected economic slowdown will have on their operations, financing options and strategic plans. The paper is organized in three main sections:

- Section I summarizes the historic changes taking place in the capital markets and the implications for hospitals and health systems.
- Section II details the anticipated impact of this economic slowdown on healthcare providers, including a review of the key factors that will affect economic performance.
- Section III outlines the strategies that hospitals and health systems should deploy to address the challenges presented by a potentially severe and long capital markets crisis and economic slowdown.

I. Changes in the Capital Markets Affecting Not-for-Profit Hospitals and Health Systems

The U.S. capital markets are experiencing a credit crisis of historic proportions. The credit markets remain essentially frozen. A lack of investor confidence has caused widespread dislocation in the tax-exempt market, driving up both short and long-term rates. Most new tax-exempt bond issues have been postponed, at least temporarily, and the municipal bond market remains especially wary of weaker credits. Despite efforts in government intervention, no one can say with any certainty how the current crisis will play out in terms of severity or duration. However, we can conclude that access to the capital markets for hospitals and health systems has been altered drastically over the last several quarters. There is broad evidence to support this conclusion.

Bond insurers falter

Since the early 1970s, issuers of municipal debt have used bond insurance to enhance credit ratings and reduce borrowing costs. The value of bond insurance varies depending on market conditions and the credit strength of the borrower and the insurer. Until recently an A rated hospital might typically use bond insurance to reduce net interest costs by 25-30 basis points, representing \$5.7-\$6.8 million in interest savings over the life of a \$100 million 30-year fixed rate bond.

Prior to 2007, no bond insurer had ever been downgraded or defaulted. However, over the last three quarters as exposure to CDOs and other mortgage-backed securities weakened their balance sheets, most bond insurers lost the AAA and AA ratings that enabled them to provide credit enhancement to issuers with lower ratings. Ambac and MBIA, two of the three largest insurers of healthcare bonds, lost their AAA/Aaa ratings in June. Four other insurers have been downgraded below investment grade this year. Today, only Assured Guaranty, FSA, and a new entrant, Berkshire Hathaway Assurance, maintain AAA ratings. Of these, only Berkshire Hathaway, which has yet to insure a healthcare issue, carries a stable outlook with Moody's and S&P.

Investors have lost confidence in bond insurance, making it of little or no value to issuers. As a result, the use of bond insurance by healthcare issuers has plummeted from 39% of total issuance in 2007 to less than 5% in the 3rd quarter of 2008.¹ Until investor confidence is restored and bond insurance can be obtained at a reasonable cost and under acceptable terms, health systems will be forced to issue new debt solely on the basis of their own credit ratings, which, for many, will increase their cost of capital.

Collapse of the auction rate securities (ARS) market

Beginning in the late 1980s, many not-for-profit hospitals had the option of issuing auction rate securities (ARS), a form of variable rate debt with interest costs comparable to more traditional variable rate demand bonds (VRDBs), but without requiring a bank liquidity facility. In February 2008, when it became apparent that the financial condition of bond insurers was rapidly deteriorating, the \$330 billion taxable and tax-exempt ARS market essentially collapsed. Auctions repeatedly failed, investors could not sell their bonds, and many borrowers were forced to pay a default rate as high as 12% or 15%. In the ensuing months, most borrowers restructured or refinanced their ARS bonds, in many cases converting them to VRBDs supported by bank letters of credit. This in turn has consumed most of the available capacity for bank liquidity facilities. The ARS market is closed, potentially permanently, as an option to help hospitals reduce their cost of debt capital.

A virtual halt to the issuance of new debt and dislocation in the variable rate market

In the absence of investor demand, virtually all new healthcare bond issues have been postponed. This has created a backlog of supply that the market will have to absorb in the future, most likely with price concessions for borrowers. Concurrently, the tax-exempt variable rate demand bond market has also been severely affected. In a flight to quality, tax-exempt money market funds saw outflows of \$44 billion during the last three weeks of September. As a result, rates on VRDBs spiked up from under 2% to as high as 10% in some cases during September before sliding back

1 Thomson Financial.

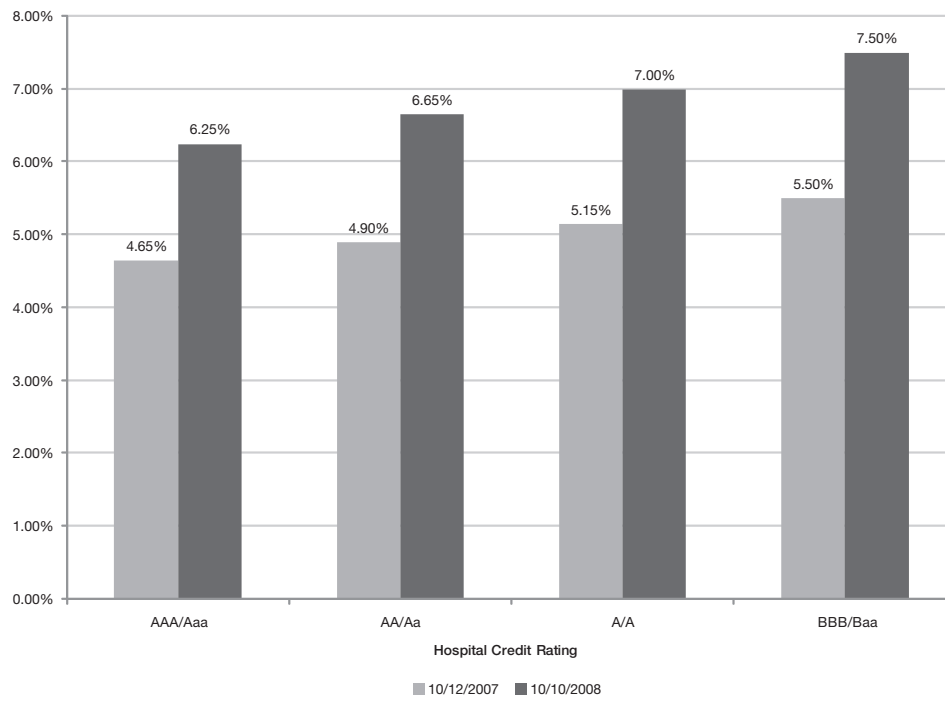
somewhat in the first weeks of October. As the lack of liquidity in the market persists, we are seeing a dramatic increase in the number of bonds being put back to liquidity providers. In many cases, these bonds will become bank bonds that take the form of variable rate term loans of short duration at taxable rates. As a result, some health systems will be forced to pay much higher interest rates and repay variable rate debt on an accelerated basis.

The severe dislocation in the bond market will presumably ease as government interventions take hold and confidence returns. But even in the event of effective government intervention, for the foreseeable future credit and liquidity facilities from banks to support new issues will be more difficult and more costly to obtain.

Swap market has become less attractive

Over the last decade, hospitals and other not-for-profit borrowers have increasingly employed interest rate swaps and other derivative structures to lower their overall cost of borrowing. Borrowers benefit by swapping one type of risk (e.g., variable rate risk), for others (such as counterparty risk, event risk, or, in the case of a LIBOR-based swap, tax risk and basis risk). The stresses and upheavals in the current market have revealed the potential magnitude of these risks (e.g., the collapse of the underlying ARS market, the failure of counterparties such as Lehman Brothers, and the current extreme disjunction between taxable and tax-exempt interest rates). While interest rate swaps may remain a viable tool for some tax-exempt borrowers, fewer hospitals will have an appetite for these types of transactions. Those that do will find fewer viable counterparties and more stringent terms and conditions.

Figure 1: Generic 30-Year Hospital Bond Interest Rate Comparison – October 2007 vs. Current

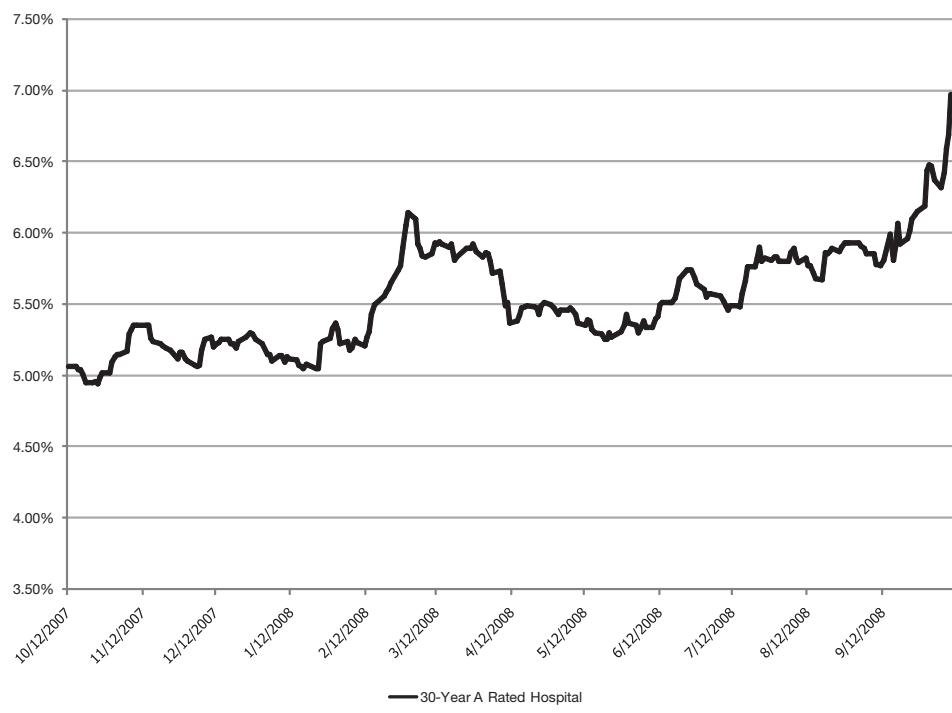


Source: Shattuck Hammond Partners, Trading Desk Estimate.

Prior to the developments outlined above, hospitals could access the capital markets through a diverse array of products. Now, the severe contraction in credit enhancement options has made debt capital less available and more expensive, especially for weaker credits (see Figure 1). Most health systems will migrate back to traditional long-term fixed rate bonds as the primary source of debt capital because other sources will be either too costly or too risky. Bond insurance will not be available or economical. The use of variable rate debt and swaps to achieve a lower blended cost of debt will decline as these options prove less beneficial. The factors noted above will increase the cost of long-term debt for many health systems, and investors will no doubt demand stricter financial covenants. We also expect that conventional bank and vendor financing for equipment and supplies will be less available and more costly over the next few years.

As Figure 2 shows, the 30-year fixed rate for an A rated hospital bond has climbed 185 basis points from 5.15% to 7.0% in the last twelve months. In 2007, the median A rated not-for-profit hospital or single-state health system had roughly \$165 million of debt, debt service of \$12.4 million and a 35% debt to capitalization ratio.² Each increase of 100 basis points in average borrowing costs would increase annual interest expense for the median hospital by \$1.6 million. The phased timing of these higher borrowing costs for an individual health system will depend on the timing of its borrowing needs and the types of debt it has previously utilized. Nevertheless, the increased cost and more limited availability of debt along with prevailing operational challenges will require health systems to be much more judicious in making capital investments.

Figure 2: Interest Rate Trend for Generic 30-Year A Rated Tax-Exempt Hospital Bond



Source: Thomson Financial. Municipal Marketplace Data.

2 Moody's, "Not-For-Profit Hospital Medians for Fiscal Year 2007" (August 2008).

II. Slow Economic Growth Resulting from the Lack of Credit Availability Will Impact Operating Performance

Medicaid reimbursement will remain flat or decline

A number of states are anticipating massive budget shortfalls in fiscal 2009. New York State has already announced a \$5+ billion budget shortfall. Connecticut is trying to cut \$350-450 million from its budget. California is projecting a \$22 billion budget shortfall and Florida has a projected budget shortfall of \$5 billion.³ Medicaid represents the most significant cost in most state budgets and has continued to grow more rapidly than other budget areas in recent years. Many states may be unable to balance their budgets without freezing or reducing Medicaid reimbursement over the next several years. In addition, cash flow problems caused by dislocations in the variable debt market could cause short-term slowdowns in Medicaid payments as states attempt to conserve cash. We expect continued efforts by the federal government to eliminate or reduce reimbursement enhancement methodologies developed in some states to increase federal Medicaid matching dollars. We also foresee continued pressure to eliminate graduate medical education support through Medicaid.

Medicaid represented 11% or roughly \$40 million of annual revenue for a typical Moody's A rated hospital in 2007.² Medicaid already pays well below cost in most states, reimbursing for only 60-70% of cost for many patients. Three years of flat Medicaid reimbursement would reduce annual revenue by \$4 million in year three against a target increase of 3% per year. A \$4 million payment reduction represents a full percentage point of operating margin for the average A rated hospital, or a staggering 37% decline in operating income. In addition, Medicaid enrollment typically tracks unemployment rates. Medicaid enrollment has increased by more than 2% in 2008. Every 1% increase in the national unemployment rate translates to one million more enrollees in Medicaid and the State Children's Health Insurance Program (SCHIP) and \$1.4 billion in additional state Medicaid costs, according to one study. A 5% increase in the unemployment rate will add 2-3 percentage points to a typical A rated hospital's Medicaid payer mix. Depending on the level of cost shifting, a typical hospital would be forced to make up 2-3 percentage points of operating margin caused by a shift of patients from commercial insurance to Medicaid.

Utilization will decline and bad debt will rise as employers continue to shift costs to employees and the number of working uninsured increases

Cost shifting and economic uncertainty may already be causing employees to reduce their use of health services while increasing bad debt exposure for providers. Healthcare demand has been relatively inelastic in previous downturns. However, an accelerating trend in employers shifting costs to employees appears to be changing this equation. Several recent reports suggest that patient volumes are declining in some communities. According to a recent *Wall Street Journal* article: "The number of prescriptions filled in the U.S. fell 0.5% in the first quarter and a steeper 1.97% in the second, compared with the same periods in 2007 – the first negative quarters in at least a decade, according to data from market researcher IMS Health. The number of physician office visits also has been declining since the end of 2006. Between July 2007 and 2008, the most recent month for which data are available, visits fell 1.2%, according to IMS."

³ Center for Budget and Policy Priorities, Report on State Budget Shortfalls (October 10, 2008)

While these reductions may be temporary, a downtrend or flat utilization rates could prevail for the next few years. The steepest declines may occur in elective procedures that are typically more profitable for physicians and hospitals.

The number of working uninsured reportedly stabilized in 2007. But as commercial health insurance becomes less affordable for employers and employees, the number of working uninsured is likely to increase. Some employees are declining health insurance because they cannot afford the employee premium contribution. Continued growth in the uninsured population will contribute to further reductions in healthcare utilization and increased bad debt for providers, with broad potential results.

Bad debt levels will increase. A rated hospitals had a median bad debt expense of 6.2% of net patient revenue in 2007, which is equivalent to \$25 million annually on \$400 million of net revenue.² If bad debt exposure increases to 7% of net patient revenue, this would result in an additional \$3.2 million of bad debt annually or a loss of 0.8 percentage points of operating margin.

ED volumes will grow. Emergency department (ED) volumes will continue to rise as more patients avoid routine care and lose access to primary care services. ED patient volumes in the U.S. grew by an average of 2.5% per annum over the past decade, from 92 million visits in 1997 to more than 119 million in 2006.⁴ This trend should continue or accelerate as more patients consider emergency rooms as their only source of care. The inefficiencies in this scenario coupled with the challenges in collecting payment for these services will significantly increase bad debt profiles for hospitals that carry this burden.

Inpatient volumes will likely decline in the near-term. Inpatient volumes have been stable at approximately 34.6-34.8 million discharges per year for the past several years.⁵ Many hospitals expanded capacity in anticipation of increasing inpatient volume due in part to the anticipated healthcare needs of an aging population. However, we expect total admissions in the U.S. to decline slightly over the next few years before increasing again. This trend will not affect all hospitals equally, however. While inpatient volumes overall have been stable, many large tertiary care hospitals have experienced significant growth while smaller community hospitals have experienced stable or declining volume. There will be continued redistribution of volume as large tertiary centers expand activity while patients at small, community hospitals delay elective and lower acuity care or seek treatment in lower cost settings.

Outpatient activity will flatten. Outpatient activity currently represents 38% of net revenue for a typical hospital, and the percentage is growing each year.⁶ These services also represent a disproportionate share of operating income. A major portion of outpatient revenue is derived from ambulatory surgery, cancer treatment and imaging, including elective care that patients may decline or delay in an economic downturn. On October 13, 2008, *USA Today* reported: "One in eight people with advanced cancer turned down recommended care because of the cost, according

4 National Health Statistics Reports, #7, August 6, 2008, NAMCS: 2006 Emergency Department Summary by Stephen R. Pitts, M.D., M.P.H., F.A.C.E.P.; Richard W. Niska, M.D., M.P.H., F.A.C.E.P.; Jianmin Xu, M.S.; and Catharine W. Burt, Ed.D., Division of Healthcare Statistics

5 2006 National Center for Health Statistics, National Hospital Discharge Survey

6 AHA TrendWatch Chartbook, 2007

to a new analysis from Thomson Reuters.” We expect the growth of outpatient activity to slow. However, if the current economic climate causes physician and investor owned outpatient centers to close, hospitals could recover some lost outpatient activity directly and through acquisition of facilities from physician owners.

No major change in the growth of negotiated managed care rates expected

Commercial insurance (including Blue Cross, managed care and other carriers) represents approximately 47% of the typical A rated hospital’s gross revenues and a higher percentage of net revenues in most hospitals.² While employers will continue to pressure insurers to manage premiums, we expect little or no change in the rate of growth of negotiated rates between hospitals and insurers. Continued consolidation in the insurer market could put greater pressure on provider reimbursement. At the same time, a new wave of provider consolidation could maintain the current negotiating balance between payers and providers in most markets.

Medicare is unlikely to change direction over the near term, but longer term prospects remain unclear

The underlying demographic challenges leading to projected insolvency for Medicare by 2020 have not been addressed. These challenges could be further exacerbated by reduced payroll contributions caused by a prolonged economic slowdown. They could also be mitigated if many Medicare-eligible seniors keep working and retain access to employment-based health insurance for several years beyond age 65. The trends toward pay for performance and bundling of hospital and professional fees will continue.

Non-operating income will be under pressure due to shortfalls in philanthropy and weaker investment returns

In 2007, the typical Moody’s A rated health system earned operating income of 2.6% and earned total excess margin of 5.6%.² The three percentage points of non-operating income were primarily derived from philanthropy and investment earnings on endowments and other reserves.

Investment income is off significantly in 2008. Most health systems have already seen a steep decline in investment income over the past year. Among our clients, a strong AA rated hospital in the Midwest experienced a total excess margin decline of roughly 20% in fiscal year 2008 due entirely to reductions in non-operating income. Income from operations increased over the prior year, but that growth was insufficient to offset reductions in investment income.

Philanthropy will decline over the next several years. Philanthropic support for not-for-profit health systems represents 1.5% of revenue,⁷ or \$6 million annually for the typical A rated hospital. Given the current environment, this amount could conceivably decline by as much as 15-20% over the next few years, reducing income by approximately \$1 million annually on average, though the extent to which not-for-profit healthcare providers depend on philanthropy varies widely. Many high profile academic medical centers depend on philanthropy to fund facility

7 Health Affairs Volume 25 , Number 2, “Unleashing the Untapped Potential of Hospital Philanthropy,” Association for Healthcare Philanthropy interview

development and other capital needs. Some of these health systems have raised more than \$50 million annually in recent years to support capital needs. A few specialty hospitals depend almost entirely on contributions to fund their operations. These funds will be increasingly difficult to access for the next several years.

Reduced upward pressure on wages

Upward pressure on some operating costs will abate, although not as quickly as the adverse effects on capital costs and reimbursement described above.

- Labor cost increases will soften, especially in the white collar and non-clinical segments, as the supply of available labor expands during the economic slowdown. Labor rate growth is likely to mirror the inflation rate.
- Clinical labor unit costs will also slow, but less rapidly than in non-clinical areas given the current and projected shortages of staff in many of these disciplines. While the economic downturn will expand the pool of clinical staff, it may take several years to train nurses and other clinicians to meet future staffing needs.
- Non-labor inflation should track the general softening of price increases seen in industries outside of healthcare.

While these trends clearly reflect the negative pressures on the industry, in some circumstances they may also support rapid structural and operational transformations that will allow a stronger and more competitive industry to emerge within several years.

III. Strategic Responses

The impact and significance of the credit crisis and a deep and prolonged economic downturn will differ dramatically for individual hospitals and health systems. In each case, a customized, accurate and unbiased assessment of the likely impact is critical. Careful analysis of all likely changes is essential to determine the optimal strategies to address these challenges effectively. The available strategies can be divided into three groups as outlined below. The first section reviews options related to the expected market consolidation including potential sale, merger, acquisition or transition in ownership and asset structure. The second section reviews strategies to manage balance sheets to improve access to capital under prevailing conditions. The third section outlines the most effective strategies to maintain strong operating performance.

Develop a Strategy for Market Consolidation

- Assess acquisition opportunities
- Consider sale or affiliation opportunities
- Evaluate asset performance to determine if ownership is required
- Evaluate physician network strategies

Manage the Balance Sheet

- Deploy cash judiciously
- Manage relationships with rating agencies, banks and investors
- Restructure long-term debt
- Monitor balance sheet closely
- Update strategic capital plan

Strengthen Operating Performance

- Improve throughput to increase capacity and revenue
- Fine tune growth strategies and other strategic investments
- Rationalize programs and operations

Develop a strategy for market consolidation

We believe that the constrained capital environment and concomitant economic pressures will result in a wave of hospital consolidations across many markets. While it is unlikely that the number of mergers will approach the peaks witnessed in the 1990s, this wave of consolidation could potentially occur more rapidly. Several investor-owned health systems have indicated a renewed interest in acquisitions. For-profit Legacy Health Partners, for instance, has noted that the current credit crunch plays well with their joint-venture approach to community hospital ownership.⁸ Another investor-owned system recently told us they were actively seeking acquisition

8 "Prospering in the Crunch; Startup Legacy Has Three Joint Ventures on Tap," Modern Healthcare (August 18, 2008).

opportunities for hospitals with sufficient scale (e.g., \$80 million of net revenue) and a compelling business case.

Before market developments eliminate certain options, every hospital and health system should determine whether they can best strengthen their operations as a potential buyer or seller, or whether they should work to maintain the status quo and improve efficiencies based on current assets. Several fundamental assessments are essential to inform and define this strategy:

Assess acquisition opportunities. Strong players may have opportunities to acquire competitors and other assets in their markets, in many cases without much advance warning. These organizations should scan their markets proactively to identify potential acquisition targets. They should also assess market conditions and the likely impact that consolidation will have. All hospitals should be prepared to move quickly to take advantage of merger or acquisition opportunities while continuing to make strategic investments that position their health systems as local market leaders.

Consider sale or affiliation opportunities. Organizations with weak balance sheets or challenges in operating performance may need to evaluate a sale or affiliation with another health system to access capital, build leverage with payers, and take advantage of other benefits available to a larger health system. While this may seem to be a disadvantageous time to consider a sale of assets, value could decline further without access to capital for investments in equipment, facilities, and programs. In addition, antitrust regulations and other constraints can quickly make strategic options unavailable if a market consolidates rapidly. For example, among our clients with strong balance sheets and operating performance, several are building new facilities and consolidating their local physician markets, which will make it difficult for weaker institutions in those markets to compete. Over time, this could reduce the value of many weaker institutions. Boards may need to take action as a result of their fiduciary responsibility to preserve an organization's mission before a weakened competitive or financial position makes recovery impossible.

Evaluate asset/line of business performance to determine if ownership is required. All health systems should evaluate the performance of their assets and determine whether non-core assets should be retained or monetized. For example, some health systems have sold on-campus and off-campus medical office buildings, long-term care facilities, and other assets to independent operators while retaining ground leases to control the strategic use of these assets. Despite the current credit crunch, the value of these types of assets appears to be holding steady. One client, a AA rated health system in the Midwest, recently divested four clinics, attracting more than two dozen bids from a broad spectrum of buyers. Capitalization rates for these types of transactions have remained very stable for the last four quarters, averaging approximately 7%. Similarly, hospitals and other businesses that do not represent core assets should also be assessed to determine if they can be used more effectively by other organizations. For example, one large regional health system client has several rural hospitals that make modest contributions to the overall health system performance. The potential sale of these assets could provide additional capital to invest in core urban facilities, strengthening the system's overall performance. Long-term care facilities, hospice, home health, DME, labs and other non-core assets also represent potentially advantageous divestiture opportunities.

Evaluate physician network strategies. Increasing numbers of physicians are becoming employees of health systems. Economic challenges are likely to cause more physicians to abandon or avoid private practice. While practice acquisition and employment are important strategic investments for health systems, they rarely make money as a stand-alone business. In a period of limited access to capital, health systems will need to determine whether this strategic investment is critical to future success and should remain a priority. In most cases, health systems are likely to determine that a well managed physician network is a worthwhile investment of scarce capital, especially if Medicare moves to bundled reimbursement for hospital and physician services. On a case-by-case basis it will be necessary to assess the relative capital requirements and risk/benefit profiles in practice acquisitions versus other investments. The support for a practice acquisition strategy and opportunity should be clear and compelling. Some hospitals will also see increased numbers of physicians selling interests in joint venture ASCs and other businesses. These potential uses of capital will also need to be assessed on a case-by-case basis.

Manage the balance sheet

Aggressive management of the balance sheet and adherence to a rigorous capital allocation methodology can help improve operating performance and access to capital. Approaches that hospitals and health systems can use include:

Preserve cash. Preserving liquidity is crucial when capital is scarce. In addition to the divestiture and MOB monetization strategies discussed above, organizations should consider additional cash conservation strategies such as managing both revenue cycle and payables, which can provide a one-time boost to liquidity. Some health systems are using third party developers to finance projects and conserve their own cash. For example, some of our clients are using outside partners to develop off-campus cancer centers and other outpatient facilities. While the presence of outside partners can introduce additional management challenges, the opportunity to retain capital for more important investments will often outweigh these challenges.

Actively manage relationships with rating agencies, banks and investors. Because the cost of capital for lower-rated credits increases disproportionately, the need to preserve credit ratings and communicate effectively with rating agencies takes on added significance during a credit crunch. In addition, in difficult credit environments, agencies are likely to be more cautious in their ratings, making it increasingly important to take all available steps to achieve the best rating possible. Maintaining a strong relationship with one or more commercial banks is critical. Where feasible, health systems should push to increase the capacity on their lines of credit. Similarly, managing relationships with investors can help improve access to capital. Many investors do not understand the underlying business of hospitals and were previously willing to purchase bonds based on the enhanced credit rating achieved through bond insurance. In making investment decisions based on a hospital's own credit rating, investors will want a more detailed understanding of business operations and market potential. One New York area health system meets regularly with institutional investors that hold its debt to review business operations and progress in a model that reflects the relationship between public companies and shareholders and analysts. Importantly, this health system maintains this communication channel even when they have no immediate

plans to access the capital markets. They meet with investors at least every six months and have been able to access capital while maintaining a credit rating of Ba1. Managing investor relationships is new to most health systems (and their CFOs), which historically have managed rating agency relationships on an as-needed basis. This strategy represents an important new opportunity and responsibility that most health systems should consider.

Restructure long-term debt. The optimal strategies in restructuring long-term debt will be unique to each organization. Health systems that have not already converted or refinanced existing auction rate securities will need to do so, though the range of options has narrowed considerably. Systems with debt that is backed by a bank letter of credit due for renewal within the next year need to assess the risk of non-renewal and evaluate refinancing options. Where feasible, it may be appropriate to preserve capital by refinancing existing debt to extend the average life of maturities.

Monitor all aspects of the balance sheet. Monitoring aspects of the balance sheet including but not limited to long-term debt can help to identify opportunities and potential risks that are the result of changes in the capital markets. For instance, the changing interest rate environment can have a potentially significant impact on the valuation of unfunded pension liabilities. Interest rate swaps should also be monitored closely. Hospitals concerned about the risks of a previous swap transaction that is still on the books may find windows of opportunity to unwind the swap at a nominal termination cost or to convert it to a SIFMA swap to eliminate basis risk. On the asset side of the ledger, health systems should take the time to revisit their investment policy and reconsider whether assets used to hedge certain liabilities are still adequate.

Establish/update your strategic capital plan. Every organization should have a well developed and up-to-date capital plan that harmonizes strategic objectives and financial performance with the prevailing conditions and opportunities in the capital markets. This need is critically important during turbulent and rapidly changing capital markets. Plans that were on track even a few weeks or months ago may need substantial revision. A capital plan should establish a methodology for investment and financing decisions and provide a set of guidelines for overall capital structure and financial risk. It should include target credit quality benchmarks for profitability, liquidity and leverage as well as an overall target credit rating. Ultimately, the capital plan should be a roadmap for financing the organization's strategic plan.

Strengthen operating performance

Most health systems have done well financially over the past several years. The average A rated health system made an operating margin of 2.6% and a total margin of 5.6% in 2007; for Aa rated health systems the margins were 3.9% on operations and 7.8% overall.² While some of these organizations have been aggressive in managing operating performance, most still have substantial and achievable opportunities to reduce costs, improve outcomes and service, and increase revenues. For example:

Improve throughput to increase capacity and revenue. Many clients have been able to increase capacity by 5-12%, resulting in significant increases in volumes and revenues. These efforts typically involve strategies to improve patient throughput in the ambulatory setting, surgical services

and inpatient beds.⁹ Economic pressures combined with a greater degree of integration between hospitals and physicians could set the stage for more sophisticated solutions such as demand management to improve throughput even further. Most major tertiary centers, particularly academic medical centers, have sufficient demand for their services. As a result, they can readily increase volumes and revenues if they are able to improve throughput and expand capacity. Operational throughput improvement can also delay and reduce the capital needed for expanded capacity.

Fine tune growth strategies and other strategic investments. Most hospitals and health systems are attempting to expand a few key service lines and, in some cases, to extend their geographic reach. Identifying and moving forward with the optimal growth strategy can be challenging. However, it will be critical to focus on those few programs that are most likely to succeed and provide a rapid and significant return on investment. While most clinical program investments that successfully grow volume also add to margins, there can be dramatic differences in the ROI, scale and timing. Leadership must assess and acknowledge these differences in making investment decisions, with a primary focus on assuring a timely return on investment. Some attractive longer term investments might need to be deferred until more promising near term investments succeed in producing additional capital. Similarly, investments in new equipment and facilities will need to achieve higher and more certain returns. Within this framework, aligning physicians, boards, and executives in support of an organization's investment priorities is a significant and critical undertaking.

Rationalize programs and operations. Many health systems have integrated back office functions including IT, accounting and revenue cycle management. For most health systems, further integration opportunities remain as options in other areas:

- Few health systems have consolidated clinical programs because such strategies often lack the support of physicians and local communities and result in volume/revenue loss. However, some health systems are now evaluating opportunities to rationalize services with high fixed costs such as maternity, pediatrics and oncology to gain economies of scale and improve quality.
- Real estate management and facility operations functions have historically been under the control of local or regional management. Based on increasingly stringent regulatory requirements, IT-enabled management solutions, and higher cost of capital, there is growing support for central control of these functions to improve performance.
- Improved management strategies and discipline in department staffing decisions, combined with aggressive identification and application of best practices within a health system, could yield operating cost reductions of up to 5% annually.

Moving Forward

In light of the severe contraction of credit in the capital markets, the economic factors that are currently affecting hospitals and health systems, and the prospects for continued economic instability in the months and years ahead, the future is likely to present an unparalleled mix of challenges and opportunities for executives, physicians and boards of not-for-profit health systems. Organizations that take proactive steps to prepare for these changes and are positioned to act quickly will have a significant competitive advantage. The reduced availability and higher cost of capital will result in a wave of hospital consolidation and, in some cases, a new round of closures. We may be faced with declining healthcare utilization over the short term. Health systems that address these challenges successfully will have an opportunity to emerge from this period with expanded scale, improved market strength, and broader capabilities. Succeeding in this environment will require a clear and accurate assessment of where the market is headed, a willingness to take risks and act quickly, and a continued focus on an organization's core mission and long-term business strategy.

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