COVER STORY

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capital planning for clinical integration

Hospitals should view physician alignment and clinical integration initiatives as investments, requiring in-depth analysis of financial implications and the impact on the organization's financial profile.

Hospitals and healthcare systems are still feeling the effects of the economic crisis on their operations, financial position, and creditworthiness. Even though industrywide operating profits have resumed a positive trend, a multitude of projects still compete for limited capital.

At the same time, industry and market developments are producing another round of consolidation and integration of hospitals and physicians. The Affordable Care Act is catalyzing the shift to a value-based purchasing model. Hospitals and healthcare systems will need to assume a leadership role in improving the management and coordination of patient care as pay for performance is expanded and bundled payment and full capitation mechanisms are introduced, or one could say *reintroduced*, to the healthcare marketplace. Meanwhile, in the near term, providers should expect no more than nominal fee-for-service payment increases from Medicare and Medicaid, and they can expect the same from commercial payers.

Physicians are under similar pressures, facing near-term reductions in fee-for-service payments and continued cost increases—especially for IT, care coordination, and regulatory compliance. As a matter of preference, many physicians, especially new entrants to the profession, are seeking lifestyles that offer more personal and leisure time. And that makes employment attractive to these physicians.

Hospitals and health systems recognize that to navigate these pressures successfully, they must take advantage of physician receptivity and become more closely aligned with physicians. Hence, many are pursuing strategic initiatives aimed at clinical integration.

But such activity comes with an important, all too easily overlooked caveat: In pursuing such initiatives, financial and strategic planners will need to give full attention to the funding the initiatives will require and how they fit into each organization's

AT A GLANCE

> When assessing the financial implications of a physician alignment and clinical integration initiative, a hospital should measure the initiative's potential ROI, perhaps best using a combination of net present value and payback period.

> The hospital should compare its own historical and projected performance with rating agency median benchmarks for key financial indicators of profitability, debt service, capital and cash flow, and liquidity.

> The hospital should also consider potential indirect benefits, such as retained outpatient/ancillary revenue, increased inpatient revenue, improved cost control, and improved quality and reporting transparency.

overall capital plan. Just because many of these integration expenditures may actually be expensed instead of being capitalized does not mean that the expenditure is not an investment. Whether a hospital is capitalizing or expensing such an initiative, it will demand rigorous financial evaluation.

Physician and clinical integration initiatives require capital and long-term financial planning, in the same way as does constructing a building or purchasing new diagnostic technologies and equipment. Healthcare financial leaders need to carefully evaluate physician alignment and clinical integration initiatives in terms of their current and future financial impact on the organization. This planning should be performed within the context of the requirements of the capital markets and should include an evaluation of the major risks inherent in the plan. In fact, the credit markets and analysts are carefully monitoring the implications of healthcare reform as a driver of integration initiatives:

> Preparations for major reform programs will continue and intensify prior to implementation in 2012 through 2014, and Fitch expects moderate credit benefits to be realized by many providers through closer integration with medical staffs, enhanced information technology, and improvements in quality and safety (FitchRatings, Jan. 24, 2011).

The Internal Competition for Capital

The past two years have seen drastic limitations on the ability of most hospitals to fund capital projects. Bottom line margins dropped significantly to approximately 2.5 percent from previous industry norms in the more favorable 5.5 percent range. As the economy gradually improves, the pent-up demand for routine replacement of facilities and major equipment will generate plenty of internal competition to secure available capital funds. However, history teaches us that it is difficult, if not impossible, for hospitals to fund both traditional capital expenditures and integration investments at the same time. When the hospital industry embarked upon the first round of "integration" activities in the 1990s, attempting to form and operate the integrated delivery systems (IDSs) of that era, organizations redirected capital investment from bricks and mortar to "softer" physician practice acquisition and related activities. They formed the first-generation physician-hospital organizations (PHOs), and many invested in the infrastructure to manage commercial and Medicare Advantage type risk contracts. The start-up costs and often-ensuing operational losses on owned practices and risk arrangements, coupled with the then Medicare payment reductions associated with the Balanced Budget Act, were almost impossible to tolerate, and ultimately resulted in the reversal and termination of these initiatives.

This historical precedent underscores the need for hospitals and health systems today to indentify and quantify the capital outlays associated with physician alignment and clinical integration, because these initiatives will be competing with other strategic initiatives for available investment dollars. This time around, in the final analysis, it is critically important that these initiatives generate a financial return. Today, the stakes are even greater, and hospitals can ill afford to fail.

The Financial Requirements of Physician and Clinical Integration

The fact that many hospitals are pursuing physician integration initiatives on an opportunistic basis, responding to expressions of interest from physicians in becoming employed or having their practices be acquired, is an important factor in the resurgence of integration activity in health care. Of course, hospitals understand that these opportunities require a financial analysis. Too

often, however, hospitals are making the mistake of considering such opportunities in isolation, with a focus on initial capital outlays, rather than evaluating them in the context of the organization's total available capital and the ongoing financial demands.

The simple fact is that the "investment" required to achieve physician alignment and clinical integration is long-term, multifaceted, and multiphased.

The initial phase of investment focuses on organizational and financial integration. During this period, hospitals expend funds on building employed physician enterprises or establishing clinically integrated PHOs with independent physicians. As these entities move through the formative phase, substantial investments are required to achieve operational and clinical integration.

Whatever physician alignment strategy a hospital decides to pursue, its leaders need to properly understand and quantify the financial implications of the arrangement and how it will affect the organization's financial profile. To this end, thorough planning and analysis are required. A critical factor to consider, for example, is the ongoing cost associated with continued operating losses on certain activities. Most hospitals generate losses on their owned physician practices, subsidizing them in the range of $50,000 to $100,000 annually. In the case of multiple initiatives, it is all the more important that the collective impact be fully incorporated into the hospital and health system's financial plan.

When physicians are employed by a hospital, they focus more readily on hospital cost management efforts related to support staffing, supply chain, and patient length of stay.

Assessing the Initiative's Potential Impact

In assessing the financial implications of the initiative, a hospital's analysis should consider:

> Anticipated initial outlays
> Funding for working capital
> Ongoing operational subsidies

CAPITAL AND OPERATIONAL COST CONSIDERATIONS FOR INTEGRATION INITIATIVES

Organizational and Financial Integration Phase

Physician practice acquisition/physician employment:

> Practice asset purchases
> Recruitment and relocation expenses
> Signing bonuses
> Compensation model redesign
> Legal, consulting, and accounting transaction-related fees
> Working capital requirements
> Operating loss subsidies during start-up and beyond

Clinically integrated physician hospital organization:

> Legal and consulting fees
> Solicitation effort
> Other organizational costs

Operational and Clinical Integration Phase

> Licensing and implementation of electronic health records
> Licensing and implementation of common practice management systems
> Use of disease registries
> Health information exchange
> Creation of a clinical integration team including medical director, nurses, and other staff
> Design and implementation of a care management program
> Selection and implementation of outcome and process performance metrics
> Application of data and reporting system and analytics
> Design and monitoring of risk-sharing models

> Potential incremental revenues from pay for performance and risk contracts, and from market share gains and resultant inpatient and outpatient business
> A delineation of risk factors associated with the initiatives

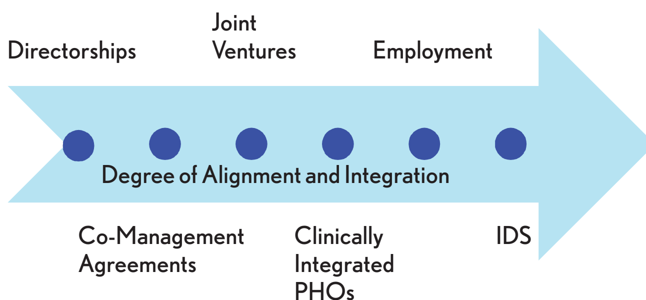
Each initiative should be evaluated to measure its potential ROI. Many different approaches are available for evaluating an initiative's potential for financial success. Popular measures of ROI are average rate of return (ARR), payback period, net present value (NPV), and internal rate of return (IRR).

Types of Hospital-Physician Integration Initiatives

Practice acquisition and physician employment are among the most common current alignment models. More than ever, both mature and young physicians are opting for hospital employment. However, some physicians do not wish to be employed, and prefer to remain independent, resulting in other substantial arrangements on the alignment continuum, including:
> Co-management arrangements
> Joint-ventured clinical services
> Clinically integrated physician-hospital organizations

These aim toward ultimately achieving more integrated delivery models and will need to be coupled with a range of capital-intensive operational and IT initiatives around electronic health records, disease registries, health information exchanges, and common financial and clinical IT systems.

PHYSICIAN-HOSPITAL ALIGNMENT CONTINUUM



Source: DGA Partners.

For instance, a hospital acquires a new piece of medical equipment for $2 million with an expected life of seven years. This piece of equipment is expected to generate $500,000 of annual cash flow for each of those seven years. This example produces the following ROI analyses.

ARR. This measure, defined as the ratio of average net earnings to average investment, is the simplest measure of profitability. Its drawback, however, is that it disregards cash flows and the time value of money. The ARR in the example described above is 25 percent, which is equal to the average annual earnings ($500,000) divided by the investment ($2 million).

Payback period. An assessment of the payback period—the amount of time required to recover the initial investment—also has limitations in that it too does not consider the time value of money and does not measure profitability (cash flows after the payback period are omitted). The payback period in the example described above is four years, which is equal to the annual earnings accumulated over four years totaling the original investment ($2 million).

NPV. As a measure of the present value of a series of future cash flows minus the initial investment, NPV is a more complete measure of an initiative's financial impact than ARR and payback period because it considers the time value of money when discounting the future cash flows of an initiative. Initiatives with positive NPVs should be undertaken while those with negative NPVs should be avoided. The NPV in the example described above is $230,000 assuming a 15 percent discount rate and a project life of seven years.

IRR. This measure also considers the time value of money. IRR is the discount rate that makes the present value of cash flows equal to zero, or the value of the initial investment. Using this

approach, a hospital would set a predetermined hurdle rate and approve an initiative only if its IRR is higher than the hurdle rate. The drawback to using IRR to measure the financial impact of an initiative is that IRR is impossible to measure if an initiative has no initial investment. The IRR in the example described above is 19 percent, which is the discount rate needed to make the present values of the cash flows equal to zero.

Because these measures tend to be time-consuming to evaluate, it is impractical for organizations to use all of them. A good alternative for evaluating the financial impact of an initiative is to use a combination of NPV and payback period (if NPV is positive).

Assessing Integration's Effect on the Organization's Financial Profile

As was suggested previously, it is not enough just to analyze the initiative as a separate undertaking: To understand the potential financial impact of a physician integration initiative, hospital strategic and finance leaders also should assess its impact on the organization's financial profile. This evaluation should be performed as part of an ongoing financial planning effort, in which the hospital's historical and projected performance is compared with rating agency median benchmarks for key financial indicators. Generally, these key indicators measure profitability, debt service, capital and cash flow, and liquidity.

The integration initiatives being considered need to be incorporated into baseline financial projections for the hospital and the resulting projection evaluated within the aforementioned parameters. In addition, the initiative's impact on the organization's total available capital needs to be evaluated. An organization can all too easily overlook important considerations, including the following indirect benefits:

> Retained outpatient/ancillary revenue
> Increased inpatient revenue
> Improved cost control
> Improved quality and reporting transparency

Retained outpatient/ancillary revenue. Physician employment can yield ancillary services revenue with a significant positive impact on the hospital's bottom line. Depending on market circumstances, this benefit may result from new volume and revenue that flow to the hospital as employed physicians change ancillary service providers, or from an end to diversion of hospital volume by independent physicians.

Increased inpatient revenue. This benefit results from capturing 100 percent of admissions from employed physicians who previously had split their admissions between two hospitals.

Improved cost control. When physicians are employed by the hospital, they focus more readily on hospital cost management efforts related to support staffing, supply chain, and patient length of stay. These reductions in operating costs go straight to the bottom line.

Improved quality and reporting transparency. Quality measurement and public reporting continue to gain in strategic importance. A network of employed physicians can both actively participate in development of evidence-based guidelines and be directly encouraged, with appropriate incentives, to implement these and other quality measures.

Case Study: Planning and Evaluating an Integration Initiative

Let's consider these points in the context of a mid-sized acute care community hospital located in a competitive market, which we will refer to as "Community Hospital." The hospital has a traditional medical staff—mostly physicians in small independent group practices who interact with

the hospital in only very basic ways. Recently, however, primary care physicians and specialists have requested help and may be interested in employment.

Meanwhile, mostly because of the passage of the Affordable Care Act and the new prospects for accountable care organization (ACO) arrangements, Community Hospital's senior leaders have determined that the organization needs to develop a clinically integrated delivery system to prepare for the changing model of health care and remain viable into the future.

The senior executives set out to evaluate the financial implications of the strategy of becoming a clinically integrated system that is capable of participating in Medicare ACO arrangements and similar risk contracts with commercial payers. As the local market unfolds, this strategy will require an intense physician alignment and integration effort, as well as the development and implementation of extensive care management and information systems. The initiative will require investment for several years before any return can be realized.

Because of this need for extensive up-front investments and the implications for operating profitability, Community Hospital's leaders recognize that the strategic plan for this initiative must be grounded in financial realities. Maintaining the organization's current credit rating is crucial: Dropping below an investment grade rating would have serious ramifications for access to debt financing, and the associated costs and covenants. Therefore, to fully grasp the financial implications of this strategy, Community Hospital's finance leader, at the request of the board, has conducted a thorough evaluation. Here are some findings of that evaluation.

SUMMARY OF KEY FINANCIAL INDICATORS: BASELINE FINANCIAL PLAN

	Median Benchmark		Hospital					
				Projected				
Key Financial Indicator	S&P "BBB" Rated	Fitch "BBB" Rated	Bond Covenants	Year 1	Year 2	Year 3	Year 4	Year 5
Profitability								
Operating Margin	1.6%	1.9%	N/A	1.8%	0.2%	–0.2%	0.3%	0.9%
Operating Cash Flow Margin	8.6%	9.0%	N/A	4.8%	3.9%	6.0%	6.6%	7.0%
Excess Margin	1.8%	2.3%	N/A	3.1%	1.5%	1.1%	1.5%	2.0%
Debt Service, Capital, and Cash Flow								
Maximum Annual Debt Service Coverage	2.5	2.7	1.5	2.2	2.3	3.5	4.4	4.8
Debt to Capitalization	42.1%	50.1%	N/A	60.2%	58.3%	56.7%	54.4%	51.4%
Average Age of Plant (years)	10.0	10.5	N/A	11.4	9.8	6.6	7.0	7.7
Liquidity								
Days Cash on Hand	121.2	122.2	N/A	105.8	105.4	111.5	127.9	134.4
Cash to debt	87.0%	75.9%	N/A	59.3%	65.7%	73.3%	93.9%	110.7%

Hospitals are transitioning to a new business model, where revenue will derive more from value than from volume.

Community Hospital's baseline financial profile. Community Hospital has recently completed its annual budget cycle and updated its five-year financial plan. This baseline financial plan is based on a "status quo" scenario, but does incorporate the anticipated results of several recently implemented clinical program initiatives. The board has approved this financial plan. A summary of key ratios and indicators for the baseline financial plan, compared to key benchmarks is shown in the exhibit on page 6.

Community Hospital is currently rated "BBB" by both S&P and Fitch. Profitability is in line with the BBB-rated medians in most years, although there is a brief period of suppressed earnings.

The debt position of the organization reflects a relatively high leverage position in the early years of the projection and then improves to meet or exceed the medians. The debt-to-capitalization ratio is higher than BBB-rated medians. In addition, the maximum annual debt service (MADS) coverage ratio is below the BBB-rated medians in the first two years of the projection. A more critical concern, however, is that the MADS coverage ratio in Years 1 and 2 of the projection is encroaching upon the hospital's bond covenant. It is imperative that this covenant is not violated.

The liquidity position of the organization is below medians in the first two years of the projection and then increases to meet or exceed medians thereafter. Days cash on hand, a measure of operating liquidity, is weaker than the medians in Years 1 and 2 of the projection and then stabilizes around 130 days cash. Cash to debt is significantly below the medians in the first two years of the projection due to the increased debt load. As time passes, cash is generated and debt is paid off, this ratio improves to exceed the median.

Requirement for developing a clinically integrated delivery system. To succeed under health reform, Community Hospital's leaders determine that the hospital must become more clinically and financially integrated with its physicians. They plan to drive this integration through practice acquisition and employment of independent physicians, as well as by building the hospital's employed medical staff. They also plan to establish a PHO, which will serve as a vehicle for the remaining independent physicians and as a focal point for clinical integration and risk contracting.

In addition to the acquisition of the independent practices and employment of the physicians, the investment required to accomplish this strategy includes:

- Recruitment, relocation, and signing bonuses for employed physicians and practice start-ups
- Subsidies to cover operating losses on the practices
- Legal, consulting, and transaction fees

These costs are to be staged and spread over several years, though they will be more intense in earlier years.

Community Hospital also will need to develop its care management systems, requiring investment in the following:

- An IT infrastructure
- EHR record and practice management systems for employed physicians

INCREMENTAL IMPACT OF CLINICALLY INTEGRATED DELIVERY SYSTEM INITIATIVE ($ IN THOUSANDS)

	Year 1	Year 2	Year 3	Year 4	Year 5
Organizational and Financial Integration					
Practice Integration*	_	$187	$430	$163	$45
Physician Employment†	$2,166	$3,034	$2,804	$789	$70
Operational and Clinical Integration‡	_	$4,518	$3,649	$3,901	$3,265
Total Cost	$2,166	$7,739	$6,883	$4,853	$3,380
Incremental Profit					
Risk Contracts and Care Management	_	_	$2,399	$2,662	$3,083
Increased Market Share	_	$950	$1,900	$2,375	$2,851
Total Incremental Profit	_	$950	$4,299	$5,037	$5,934
Net Cash Flow	**$(2,166)**	**$(6,789)**	**$(2,584)**	**$184**	**$2,554**

* Includes the acquisition of two specialty and two primary care practices, associated transaction costs, and ongoing capital expenditures.
† Start-up and operating losses associated with 30 new employed physicians and associated recruitment expenses.
‡ Includes the cost of electronic health record and practice management systems for all employed physicians and the development of a health information exchange for independent physicians. Also includes the expenses associated with the clinical integration team: a medical director, nurses and clinical resources, and the necessary data analytics and financial experts.

> A health information exchange for independent physicians
> Recruitment of and salaries for personnel to provide medical management services (including disease management and utilization management), medical director oversight, and data analytics and reporting services

Community Hospital's leaders understand that they must invest heavily before reaping any benefits from these initiatives. Under these initiatives, the hospital could offer a clinically integrated system by Year 3, at which time, the hospital could enter into risk contracts with upside potential. Moreover, through acquisition and employment of physicians as well as development of a better system to manage care, the hospital would see an increase in market share. Conversely, the care management programs, if successful under the risk arrangements, would result in volume decreases with a corresponding loss in marginal revenue and profit.

The analysis in the exhibit above depicts what might happen were Community Hospital to invest a total of more than $25 million during a five-year period in building the clinically integrated delivery system. Understandably, there are no returns in Year 1, but by Year 2, the initiative begins to generate some incremental profits to offset the investments. The resulting cash flows for the initiative produce a positive NPV of approximately $200,000 assuming a 17 percent discount rate and a 2 percent perpetuity growth rate factor.

Various scenarios are produced with modifications to selected assumptions to identify an anticipated range of values and to identify the key risk factors influencing financial performance.

Given the positive NPV and, arguably of greater importance, the strategic merits of the initiative, Community Hospital would likely choose to pursue this initiative. However, to fully understand how the initiative might affect the financial

SUMMARY OF KEY FINANCIAL INDICATORS: CLINICALLY INTEGRATED DELIVERY SYSTEM INITIATIVE

	Median Benchmark		Hospital					
				Projected				
Key Financial Indicator	S&P "BBB" Rated	Fitch "BBB" Rated	Bond Covenants	Year 1	Year 2	Year 3	Year 4	Year 5
Profitability								
Operating Margin	1.6%	1.9%	N/A	0.9%	−2.2%	−1.0%	0.4%	1.6%
Operating Cash Flow Margin	8.6%	9.0%	N/A	4.0%	1.4%	4.9%	6.4%	7.4%
Excess Margin	1.8%	2.3%	N/A	2.3%	−0.9%	0.2%	1.5%	2.7%
Debt Service, Capital, and Cash Flow								
Maximum Annual Debt Service Coverage	2.5	2.7	1.5	1.9	1.4	3.2	4.4	5.1
Debt to Capitalization	42.1%	50.1%	N/A	60.9%	61.2%	60.4%	57.8%	53.9%
Average Age of Plant (years)	10.0	10.5	N/A	11.4	9.8	6.6	7.0	7.7
Liquidity								
Days Cash on Hand	121.2	122.2	N/A	101.4	83.4	81.5	96.6	106.6
Cash to Debt	87.0%	75.9%	N/A	57.3%	54.4%	56.4%	74.5%	91.4%

profile of the organization, it is necessary to evaluate it in the context of the organization's larger financial plan and compare the resulting key financial indicators with rating agency median benchmarks and bond covenants.

Community Hospital's financial profile including the clinically integrated delivery system initiative. Factoring the integration initiative into Community Hospital's baseline financial projections, as shown for one of several of the hospital's evaluated scenarios in the exhibit above, discloses that profitability and MADS coverage could deteriorate from Year 1 to Year 3 but improve in Years 4 and 5. As discussed, the integration initiative is expected to incur operating losses in Years 1 to 3, but thereafter, it is expected to operate profitably. Liquidity, as measured by the number of days cash on hand and cash to debt, worsens in every year compared with the baseline scenario due to the cash flow losses associated with the integration initiative in the early years of the projection.

The most critical component of the organization's credit profile is the weakened MADS coverage ratio as the projected ratio Year 2 falls below the organization's bond covenant, as shown in the exhibit at the top of page 10.

Factoring various scenarios into the baseline financials discloses that in two of the four scenarios evaluated by Community Hospital, the bond covenants in Year 2 are violated, as shown in the exhibit at the bottom of page 10. These scenarios varied the number of physicians employed, the number of practices acquired, and the number of physicians participating in the clinical integration initiative.

Bond covenant violations need to be avoided at all costs. Although the initiative is found to be

PROJECTED MAXIMUM ANNUAL DEBT SERVICE (MADS) COVERAGE RATIO COMPARED WITH BOND COVENANT

MADS Coverage	Bond Covenants	Projected				
		Year 1	Year 2	Year 3	Year 4	Year 5
Baseline	1.5	2.2	2.3	3.5	4.4	4.8
Including Integration Initiatives	1.5	1.9	1.4	3.2	4.4	5.1

appealing from an NPV perspective, to proceed with it, Community Hospital must identify immediate cost savings or revenue enhancements for either the initiative being contemplated or the current operations to mitigate the risk of a potential bond covenant violation.

Community Hospital also could evaluate other options, including merging or collaborating with a healthcare system, which would bring additional resources or perhaps allow savings in building and implementing the clinically integrated delivery system, given that the investment requirements and financial challenges associated with its implementation are substantial.

Imperatives for Action—and Analysis

Hospitals are transitioning to a new business model, where revenue will derive more from value than from volume. It will be critically important for them to align closely with physicians, and to be much more clinically integrated, if they are to succeed in this new paradigm. These initiatives will require substantial investment, competing with more traditional capital requirements for bricks and mortar. Hospital finance leaders should apply rigorous financial analysis in evaluating and finalizing alignment and integration strategies, and fully understand the impact on their organizations' overall financial position and creditworthiness. ●

PROJECTED MADS COVERAGE RATIO FOR YEAR 2, VARIOUS SCENARIOS COMPARED WITH BOND COVENANT

MADS Coverage	Bond Covenants	Projected Year 2
Baseline	1.5	2.3
Including Integration Initiatives	1.5	1.4
Integration Scenario II	1.5	1.7
Integration Scenario III	1.5	1.3
Integration Scenario IV	1.5	1.5

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