How Might a Reforming U.S. Healthcare Marketplace Threaten Balance Sheet Liquidity for Community Health Systems?

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On the basis of any conventional methods of evaluating balance sheet liquidity for U.S. health systems[1], it might appear that some of the larger systems, as measured by asset base and operating revenue performance, are getting stronger. Even some midsized community health systems seem to be performing better in terms of such liquidity measures as cash-to-debt ratios, days cash on hand, and other related metrics. However, a closer look at the future of strategic investment plans for U.S. community health systems should cause leaders to reconsider perspectives and conventions on balance sheet liquidity sufficiency.

According to Jay Sterns, director at Barclays Capital:

> If the largest, U.S. not-for-profit health systems were to consolidate, forming a unified "firm," this new entity would generate an estimated $77 billion in annual operating revenues and hold an estimated $35 billion in cash and cash equivalents—an estimated 198 days cash on hand (approximately $0.50 of cash on hand for every dollar of operating revenue generated annually). By comparison, a large, U.S. public company, such as Apple, may have an estimated $0.77 of cash on hand for every dollar of annual operating revenue earned.

Rating agency medians for days cash on hand for AA-category health systems, as published in 2011 by Moody's and Standard & Poor's, were 226 and 215, respectively. If the governing board of our fictitious consolidated healthcare firm elected to maintain a AA credit rating, it would have little, if any, discretionary cash to invest in the organization without pressuring its liquidity ratios to the point of a potential downgrade.

This perspective on liquidity should lead executives of U.S. healthcare systems to question the conventional methods for evaluating financial strength and sufficiency of liquidity positions, especially as health systems encounter market environments that could call for unprecedented levels of liquidity to fund a range of strategies, strategic capital needs, and clinical programming redevelopments.

Steve Proeschel, managing director at Piper Jaffray, comments:

> There is little doubt that many of the likely "reform era" strategies will pressure health system balance sheets. Implementation of [electronic health record] systems, together with other strategic investments, will strain cash positions for many health systems. Balance

> sheet liquidity will be at risk for a growing number of health systems. While some health systems have experienced improving liquidity positions since 2008, Moody's notes that 18 percent of hospitals it rates experienced operating losses in 2011 (Standard & Poor's, 2013). Moody's also reports that most [chief financial officers] predict future cash flow declines in the new environment.

Proeschel also believes that regeneration of cash positions will be challenging in the marketplace ahead, due in part to costs related to transitions from fee-for-service business models to risk-based contracting strategies. This challenge will be especially acute for organizations that lack sufficient knowledge of their total costs of care.

While some portion of the U.S. healthcare system marketplace is experiencing improving liquidity positions, the issue addressed in the rest of this article is the sufficiency of these positions in an uncertain, reforming U.S. healthcare marketplace—a marketplace that could require U.S. health systems, especially not-for-profit, tax-exempt community health systems, to draw down on balance sheet liquidity as they pursue strategies that are not amenable to traditional means of strategic investment financing.

A question important to U.S. community health systems is: Are some—or perhaps all—heading toward a "liquidity cliff"?

MOVING INTO UNSTABLE MARKETS

The prospect of a U.S. healthcare marketplace in the process of reform presents great potential for economic uncertainty and instability. Market instability can produce unexpected and swift negative effects. In 2008 and 2009, for example, U.S. health systems sustained hundreds of millions of dollars in liquidity destruction from an unexpected disruption in the auction rate bond markets' performance caused by the following factors (Moody's 2009):

- Declines in the values of the equity markets
- Related losses on defined benefit plan pension funds
- Bank failures
- Aggressive use of derivative financial instruments

Few, if any, health system executives—or bond market experts, for that matter—saw this instability coming. Although the bond markets stabilized, significant damage to health system balance sheets occurred.

Future threats to community health system balance sheet liquidity may not be as catastrophic as the bond auction disruption was, but the effects could loom larger and be systemic in scope. The arguments for this assertion are twofold.

First, the nature of this risk is driven by how U.S. health systems will be encouraged to pursue strategy as market dynamics and related reforming economics play out.

Second, evidence supports accelerating consolidation of the provider side of the industry and a shift in payer contracting strategies toward their assumption of financial risk—contracting strategies that are designed to move market share in a positive direction for health systems taking the risk (Zismer, Sterns, & Claus, 2011).

IMPACT ON LIQUIDITY

How do these and related strategies negatively affect balance sheet liquidity?

1. Established, independent physicians are seeking employment by community health systems in increasing numbers. The way such "integrating events" play out is often that the health system acquires practice assets and future funding of related practice operating expenses at rates higher than preacquisition levels. The addition of operating revenues related to the integration of physicians typically dilutes balance sheet liquidity from at least two perspectives: (a) the costs related to the integrating events and, (b) in as much as the integration of physician practices virtually never brings a positive cash result to the balance sheet of the entity acquiring the practice assets and the operating costs postacquisition are almost always greater than preacquisition levels, due in part to the reason for the sale of the practice in the first place; that is, the financial productivity of the practice for the owners (the physicians) was unsatisfying or at least at risk for a downturn.

   Consequently, many practice acquisitions dilute balance sheet liquidity until the organization determines how to optimize the value of the integrated model. The same effect can derive from the merger of two health systems when one brings useful market share to a transaction but may have impaired liquidity.

2. Significant investments are being made to enhance connectivity of the health system's component parts and sites. Take, for example, the electronic health record: Published reports on the financial impact of the electronic connection of health systems demonstrate productivity "down drafts" that must be financed from current operations and/or cash reserves (Bhargara & Abhay, 2011).

3. The assumption of financial risk through new types of contracting strategies with third-party payers is moving from the known economics of fee-for-service reimbursement to the unknown economics of accepting financial risk for defined populations (at expected use and cost rates lower than those customarily realized in the fee-for-service markets).

4. Clinical care model transformations are encouraging less expensive ambulatory service use over more expensive inpatient care. Integrated health systems (IHSs), for example, typically generate the majority of operating revenues in outpatient methods of care (Zismer & Cerra, 2012).

5. Health system consolidations will occur through mergers, whereby the acquired entity may deliver useful market positions to the acquirer, but the balance sheet condition of the acquired may dilute liquidity for the consolidated entity. These problems can be exacerbated when the acquired has a history of underfunded defined benefit, qualified retirement plans; anemic operating margins and cash flow performance; and aggregations of numerous, undersized clinical programs.

According to Sterns, a substantial proportion of the costs related to the strategies summarized above are not financeable by traditional means, that is, by the use of publicly financed tax-exempt bond proceeds.

Sterns notes:

> Health systems, while long on strategy, are often short on capital, constrained by the rules governing tax-exempt borrowing, unable to raise equity due to nonprofit ownership, and limited in the use of their liquidity by potential rating agency downgrades. Health systems will (in the future) search for creative financing techniques or more complex partnership structures that can deliver alternative third-party capital.

So, if the central contention of this column holds, much of the future costs related to U.S. health system consolidation, integration, and strategy redirection will be financed from current cash flows; cash on hand; and/or other financing methods, including less traditional, alternative methods of financing strategic facilities.

According to Ronald Smith, cofounder and principal of Frauenshuh HealthCare Real Estate Solutions, in Minneapolis, Minnesota, a growing number of large, financially strong not-for-profit U.S. healthcare systems are financing the building of strategic facilities (e.g., one or several large ambulatory care centers) through alternative methods to establish positions in market-relevant locations with greater speed and capital efficiency than they could have done otherwise.

Smith comments:

> Community health systems with strong balance sheets and significant geographic footprints are becoming increasingly interested in partnerships with firms like ours that develop, own, and lease larger, clinically sophisticated ambulatory "destination strategies" to house strategic clinical programs and physicians. These health systems see value in opting for the advantages of third-party capital offering flexibilities provided by innovative facility leasing options, including the syndication of facility ownership to employed and independent physicians who are aligned (or are aligning) with health systems.

If not for profit U.S. health systems draw down balance sheet liquidity for all the reasons cited, the obvious question is, "How is it replenished?"

REBUILDING LIQUIDITY

Tom Marr, MD, associate medical director of HealthPartners in the Twin Cities area of Minnesota, offers insight on the application of the IHS model. HealthPartners is a large, integrated health system that owns financing and provider components of the system. He says:

> HealthPartners has visibility and experience on the financing and production aspects of healthcare delivery in multiple markets served. We appreciate the speed with which downward pressures on healthcare costs translate to demands for clinical care process and total cost of care innovations and transformations. Our ability to generate sufficient levels of total organization balance sheet liquidity does hinge, largely, on our ability to manage total costs of care to lower levels at a rate that exceeds the downward pressures on healthcare premiums at related reimbursements, all while maintaining the highest levels of clinical care and assurance of evidence based best practices.

Other leaders of longstanding and operationally mature IHSs see value in a marketplace in which third-party payers transfer financial value (and attributed lives)

by way of risk contracts. In fact, these leaders see balance sheet liquidity rebuilding potential in such arrangements, as long as the imputed annual financial inflation rate of the agreements creates positive cash flow margins as the IHS (1) reduces its per unit clinical care costs and (2) slows the rates and levels of inefficient care use patterns (e.g., unnecessary hospital readmissions, unnecessary physician's office visits, nonproductive diagnostic procedures). Under such financial arrangements, the third-party payers can be satisfied with suppression of the medical loss ratios[3] while the contracted provider organizations reduce total costs of care at rates that are greater than are the downward pressures on the imputed financial value transferred by the payer contract.

CONCLUSION

While many health systems have strengthened their balance sheets over the last several years, future balance sheet liquidity requirements will increase to unprecedented levels. Health systems will need to operate from models that effectively control all the moving parts of care and related production costs. IHSs will likely need to adopt more integrated models of community healthcare delivery and greater control over operating economics and total costs of care performance.

NOTES

1. Liquidity represents the ability of a business to meet all cash obligations as they become due. Related metrics include days cash on hand and cash-to-debt ratios.
2. The total cost of care is a measure of the total cost of treating a population in a given period, expressed as a risk-adjusted per member per month value. The measure includes all services associated with treating a patient: inpatient stays, outpatient services, professional services, pharmacy operations, ancillary services, and all other related costs of health services consumed. Appropriate risk adjustments permit fair comparisons between providers, insurers, and geographic regions over time (HealthPartners, 2012).
3. Medical loss ratio refers to the total costs of medical care incurred by the party holding the related financial risk—either the insurer or the provider.

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