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Allocating Capital – Critical Choices

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Since the advent of Medicare in the mid-1960s, most hospitals and health systems across the country – other than small and rural hospitals or hospitals operating in certain highly-regulated northeastern States – have been able to finance needed capital projects, especially those directly related to patient services. Their financial capability, including both internally generated funds, debt financing, and philanthropic support, resulted in the Board making capital decisions focused more on timing than on "which ones."

Today, however, health care Boards and executives face a markedly different situation. Generally, health care organizations – even the most successful and financially strong – realize that the list of potential capital projects greatly exceeds their financial capability. For example, one AA rated non-profit health system recently undertook an assessment of the capital needs of its hospitals over the next seven to ten years and determined that it could fund no more than 60 percent of those needs.

The fundamental questions for the Board, therefore, are "How should the organization determine which capital projects get funded?" and "Which projects should be funded first?". The usual answer is to use return on investment (ROI) as the primary criterion and to fund those projects with the greatest ROI first. While appealing, this approach is often

too simplistic for complex health care organizations. While using ROI is a necessary and essential component of the decision, it is not sufficient because a) there is a tremendous amount of capital needed simply to replace existing facilities and outdated clinical and information technology; b) at the core of not-for-profit hospitals and systems is a mission of community service, not profits; and c) there is great inter-relatedness among many health care services (e.g., the hospital cannot run a successful surgery program without strong medical sub-specialists and an adequate primary care base, both of which may require subsidization).

We recommend that the Board incorporate the three processes identified below into its capital planning and allocation process in order to create a more disciplined approach:

- Target key financial performance indicators or a desired bond rating for 2005 - 2009.
- Identify the size of your organization's "financial gap" over the next 5 – 10 years.
- Based upon your strategic plan, develop and utilize objective evaluation criteria for comparing dissimilar capital projects.

Target Key Financial Performance Indicators

As Step 1, the Finance Committee and Board should clearly articulate its desired future financial performance for the organization including key indicators for liquidity, capital structure, operating efficiency/performance, and balance sheet strength. Benchmarks are readily available through the two major rating agencies, Standard & Poor's and Moody's Investors Service. In particular, we recommend that hospital and system Boards target four key indicators as a foundation for capital planning: two key liquidity ratios, *days cash on hand* and *unrestricted cash*

to long-term debt; a capital structure ratio, *long-term debt to capitalization*; and an operating indicator, the *debt service coverage ratio*. Most organizations also target an operating and/or cash flow margin, since this is a key source of cash as well as a primary determinate of how much the organization can borrow. However, operating margin is a means to an end – that is, to ensure that the organization has sufficient cash to maintain liquidity, repay its borrowings, and invest in needed capital projects.

Some organizations target a specific bond rating level as their financial performance indicator. Other organizations instead select specific targets for the indicators listed above, based upon the median performance of a current group of credits in a targeted bond rating level (for example, in 2004, the median days cash on hand for Standard & Poor's A+ rated health care systems was 169 days[1]). Regardless of which approach is selected, the Board should establish targeted financial performance that is sufficient to ensure the long-term financial integrity of the organization – ideally, resulting in a stronger financial position in five years than today.

The Financial Gap

Next, the Finance Committee and Board should understand the magnitude of the "financial gap" facing the organization over the next several years. This requires that executive management develop a set of "most likely" *pro forma* financial statements for a five to ten year period. From these projections, the organization can then identify its anticipated sources of funds. *Sources* of funds (financial capability) include: starting unrestricted cash/investments, anticipated income on investments over the period, expected contributions, net funds from operation after repayment on existing debt, and funds provided by additional borrowing. The Board may also want management to develop some sensitivity analyses ("what if" scenarios)

which indicate the financial impact of a change in assumptions (e.g., "What if there is another Balanced Budget Act passed in 2006?" or "What if the stock market is sluggish over the period?") in order to establish its baseline financial capability.

As indicated in Figure 1, we recommend that the organization identify its *Uses* of funds by identifying capital required to accomplish its strategic plan organized into four distinct categories. First, the Board should target ending cash/investment balances based upon the targeted liquidity indicators established in Step 1 and/or during its strategic planning process. This approach assumes that the first use of cash is to maintain targeted levels of financial liquidity/flexibility. Ending cash should not simply be the result of "closing" the financial gap by depleting the organization's cash/investments.

[Insert Figure 1 here.]

The organization then should identify its capital needs, including both routine capital and capital needed to implement the strategic plan, and categorize these based upon their proposed uses:

- "Mission" related capital – This is capital for projects which consume cash with no expectation of ever providing a return (e.g., a free pre-natal clinic). Such projects, despite their other merits, permanently deplete the organization's coffers.
- "Replacement" capital – This is capital used to support the current range and scope of services while enhancing quality, safety, or satisfaction (or simply to meet licensure requirements or provide needed infrastructure). Capital in this category supports programs and services which themselves, over time, provide a return on investment. This category

tends to dwarf the other categories and often cannot be justified through an ROI calculation. For example, while an investment in upgraded patient rooms or clinical information technology may support profitable surgery services, unless capacity and volumes are significantly increased by the project, the project itself may not generate a positive ROI.

An assessment of potential ROI – even if small or zero – should accompany major replacement capital requests. All too often, organizations avoid any financial/ROI assessment on replacement capital, in part because they fear the results. The same rigor should be applied to replacement capital decisions as to strategic capital decisions.

- "Strategic" capital – This is capital which supports specific initiatives identified in the strategic plan that seek to re-position the organization, add services or new volume, or serve new markets. Generally, Boards review ROI analyses for these projects.

Too many organizations invest little to nothing in true "strategic" capital because replacement capital and mission capital are consuming all of their financial capability. In other words, they are "closing" their financial gap by eliminating the very projects with the greatest potential for ROI. In addition, many Boards do not differentiate between "mission" and "replacement" capital. It is essential that these two be separated to ensure the financial integrity of the organization, since replacement capital supports programs and activities which are self-supporting, over time. The more "mission" capital that the organization invests, the greater the ROI required of its other capital investments.

For example, today many organizations target an overall ROI of 8 – 10 percent for their capital projects. Suppose the organization then allocates 10 percent of its capital to mission-

related projects with no return and 60 percent of its capital to replacement projects, with an expected return of only 3 percent, since most of these will enhance infrastructure not expand capacity/volumes. This means that "strategic" capital projects would need to provide a return of 27+ percent. This is not a realistic expectation for most investments, even if they are strategically sound.

Once the financial gap has been identified, the organization should seek to close the gap both by identifying opportunities to increase sources of funds (e.g., improve operating cash flow or philanthropy) and by making critical decisions related to how much capital can prudently be allocated during the forecast period. The latter is best achieved by developing and using objective project evaluation criteria.

Evaluation Criteria

Boards should approve a set of evaluation criteria which balance the mission, strategic, and financial intent of the organization. The weighting given to each criterion and category depends upon the organization's strategic and financial positioning. However, the financial criteria generally account for over half of the total score (and, in financially challenged organizations, are given even greater weighting).

Good evaluation criteria should have clear definitions of how points can be earned toward a maximum score and should be able to be measured objectively. Management should quantify how each project scores against each of the criteria and overall. However, criteria alone will never "make the decision," since even the best criteria will never replace managerial and Board judgment.

Participating in the process of developing project evaluation criteria can be valuable for Board members, as it forces them to articulate "what is most important to us" in determining how to allocate limited capital. Typical evaluation criteria include the following:

- *Mission:* Documented community need for service; ability to enhance access to services for specific populations on which the organization focuses (e.g., the elderly, those who are poor, children, etc.).
- *Strategic*: Quality, safety or service enhancements; increases in volumes directly related to the project for selected services or geographic areas; physician and/or nursing staff support; management's track record of success.
- *Financial*: Risk adjusted return on investment; number of years until project becomes self-sustaining or a breakeven on investment is obtained; economies of scale/cost-effectiveness.

Key questions for the Board related to developing and using project evaluation criteria include: Are the categories and evaluation criteria appropriate? Do the proposed weightings reflect our purpose as well as our strategic and financial intent? Will we be willing to make the difficult decisions related to turning down projects that have emotional appeal based upon the results of the evaluation process – and, if not, what will be the long term impact on our organization?

Summary

Board members will be faced with making difficult decisions related to capital allocation over the next several years. It will be important for the Board to make informed decisions based

upon sound financial policy – both to satisfy constituents that the process has been fair and objective and to ensure that the long-term capital decisions made now further the organization's mission and vision, long term strategic positioning, and financial flexibility. The goal is for Board members in 2014 to say, "Thank you, Board members of 2004, for making the sound capital allocation decisions back then that created the foundation for our current success."

[1] Standard and Poor's, *U.S. Not-for-Profit 2004 Health System Medians*, June 10, 2004, page 5.