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Key Credit Factors For The Health Care Services Industry

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*(**Editor's Note:** We originally published this criteria article on April 16, 2014. We've republished it following our periodic review completed on April 1, 2016. As a result of our review, we updated the author contact information, updated criteria references, and deleted outdated sections that previously appeared in paragraphs 2, 8, and 9 related to the initial publication of our criteria, and which are no longer relevant.)*

1. This article describes Standard & Poor's Ratings Services methodology and assumptions for rating health care services companies. This article aims to help market participants better understand the key credit factors in this industry. These criteria are related to our criteria article "Principles Of Credit Ratings," published on Feb. 16, 2011, as well as our global corporate criteria (see "Corporate Methodology," published Nov. 19, 2013).

2. This paragraph has been deleted.

SCOPE OF THE CRITERIA

3. These criteria apply to ratings on issuers in the global for-profit health care services industry, specifically for-profit companies that provide health care to patients. The industry includes the following subsectors:

- Hospitals;
- Ambulatory surgery centers;
- Skilled nursing facilities;
- Outpatient facilities (physical rehabilitation, etc.);
- Psychiatric hospitals, substance abuse rehab facilities, other behavioral health care services;
- Home health care services;
- Urgent care clinics;
- Hospice services;
- Dialysis services;
- Dental services;
- Laboratory and diagnostic services, including imaging;
- Radiation oncology;
- Ambulance and other medical transport services;
- Other human health care services; and
- Veterinarian services.

4. These criteria do not apply to not-for-profit health care services providers, although some elements of these criteria are common to both for-profit and not-for-profit providers (See "U.S. Public Finance: Not-For-Profit Health Care," June 14, 2007).

SUMMARY OF CRITERIA UPDATE

5. This article describes our criteria for analyzing health care services companies, applying our new corporate criteria. We view health care services as an "intermediate risk" industry under our criteria, given its "low risk" cyclicality and "intermediate risk" degree of competitive risk and growth environment.

6. When we assess the competitive position of health care services providers, we emphasize diversity of: services provided, markets, and revenue sources.

7. Our assessment of the financial risk profile considers the debt-to-EBITDA and funds from operations (FFO)-to-debt ratios. We usually use the ratio of debt to EBITDA as the primary core ratio of cash flow/leverage for health care services companies. Because many health care services companies rely on leased facilities, and therefore have significant rent expenses, we may use EBITDAR (lease-adjusted EBITDA) coverage of interest and rent as a supplemental ratio.

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METHODOLOGY

Part I--Business Risk Analysis

Industry risk

10. Within the framework of Standard & Poor's corporate criteria for assessing industry risk (see "Methodology: Industry Risk," published Nov. 19, 2013), we view health care services as an "intermediate risk" industry (category 3). We derive this industry risk assessment from our view of the industry's "low risk" (category 2) cyclicality, and our view that the industry warrants an "intermediate risk" (category 3) assessment for competitive risk and growth.

11. The existence of important third-party payors (governments, private insurers, and employers) creates an unusual environment in which the customer (patient) often does not directly or fully pay for health care services. For example, in the U.S. in 2012, patients or a family member paid for only 12% of health care services (Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group), while government paid for 44%; private insurers and employers paid for most of the remainder. This three-dimensional relationship affects price elasticity of demand, pricing, a patient's selection of a service provider, and other aspects of industry risk and competitive position, discussed below.

Cyclicality

12. We assess cyclicality for health care services companies as low risk (category 2). Historical data supports this view, showing no cyclicality of revenues and low cyclicality of profitability, which are the two key measures used to derive an industry's cyclicality assessment. Based on our analysis of global Compustat data, health care services companies experienced no peak-to-trough (PTT) decline in revenues during recessionary periods since 1968, including the severe

2007-2009 recession. The EBITDA margin of health care services companies experienced an average PTT decline of 6.2% during the longer period, and a smaller decline of 3.8% in the 2007-2009 recession.

13. Demand for health care services is somewhat shielded from general macroeconomic cycles because disease occurrence and prevalence (in developed countries) do not vary with the economy. Government-paid or provided health care provides a large safety net, though patient eligibility and prices paid to providers are often pared when government budgets are strained. Changes in government spending on health care tend to lag changes in GDP, and the PTT data above take account of this timing. In the U.S., overall demand is modestly sensitive to the employment rate, in part, because lack of a job may mean lack of health insurance (although this phenomenon could be lessened by the Affordable Care Act). Routine check-ups and elective procedures may be deferred for economic reasons.

14. Within the broad health care services industry there are some differences in cyclicality among subsectors, which affect our analysis of companies' credit quality (discussed below in Competitive Position). For example, demand for life-sustaining kidney dialysis (for which there is extensive government coverage) is insensitive, while demand for orthodontics (for which there is typically very limited government coverage) exhibits meaningful sensitivity to economic conditions.

15. Volatility in revenues and profitability of health care services providers is often more affected by changes in reimbursement rates paid or procedures covered by government or private insurers than broad macroeconomic conditions. This is a key factor in our credit analysis for companies in the U.S. and many other countries.

Competitive risk and growth

16. We view health care services as warranting an "intermediate risk" (category 3) competitive risk and growth assessment. To evaluate competitive risk and growth, we assess four subfactors as low, medium, or high risk. These subfactors are:

- Effectiveness of industry barriers to entry;
- Level and trend of industry profit margins;
- Risk of secular change and substitution by products, services, and technologies; and
- Risk in growth trends.

Effectiveness of the health care services industry's barriers to entry--Medium Risk

17. For health care services providers, in general, we believe barriers to entry are limited and only partially effective in excluding competitive entrants, but there is significant variation among subsectors and geographic markets. We recognize these differences in our assessment of a company's competitive position. In some Spanish and Swedish cities, for example, government authorities award companies exclusive multiyear contracts to provide acute care hospital services in a specified territory. After a contract is awarded, the provider is protected from competition for the duration of the contract. By contrast, the U.S. dental services and home health care industries are highly competitive with very low barriers to entry.

18. Even in markets where barriers to entry are substantial and competition is limited, pricing flexibility is restrained by the power of third-party payors or the terms of the service contract.

19. In some geographic markets and subsectors, industry consolidation is underway. Large market participants may be

able to negotiate more favorable terms from private insurers and major employers that pay for health care. Strong relationships with these payors also enhance the provider's ability to attract and retain both patients and professional staff, hindering potential competitors.

20. High initial and ongoing capital requirements for large complex facilities may deter new competitors. Some U.S. states require a certificate of need for certain new facilities, such as hospitals, which limits competition.

Level and trend of the health care services industry profit margins--Medium Risk

21. In general, over the next few years, we expect a continued modest decline in profit margins of rated health care services providers in the U.S. and Europe, as downward pressure on prices is mitigated by cost controls and efficiency improvements. We also see potential for greater profit margin compression associated with evolving business models in the U.S.

22. Health care services are provided through two fundamentally different business models and hybrids that combine the two approaches. The traditional and still most common business model in the U.S. is fee-for-service care. Under this model, the provider generally is paid for each specific service it provides. More services result in more revenue, fewer services rendered result in less revenue. In essence, the (government or private) insurer bears the burden if utilization is high and enjoys the benefit if utilization is low. By contrast, under the population health management model (sometimes called capitation), a service provider contracts to receive a flat fee (per month or year) to care for a specified population (or catchment area). The provider keeps the benefits if utilization and costs are less than expected, and bears the burden if costs and utilization are higher than expected. Service contracts/licenses in some European markets are examples of population health management.

23. In the U.S., value-based purchasing and accountable-care are hybrid models in which some opportunity and risk is transferred from the payor to the provider. Private insurers, which are usually the biggest source of revenue for U.S. hospitals, negotiate contracts with hospitals and the payment method is often on a fee-for-service basis. For the most part, Medicare pays U.S. hospitals a fixed fee (with adjustments for local labor costs and other factors) per case based on the patient's medical condition (disease-related group). Therefore, U.S. hospitals often operate with a blend of the two business models.

24. The profit dynamics and business strategies are different for each of the two main business models. A fee-for-service provider generally wants to boost volume, while a population health manager generally wants to minimize total utilization. Over the medium-term, the evolution from fee-for-service to population health management could significantly affect (positively or negatively) the profit margins of many U.S. health care services providers. Those that successfully adapt could become more profitable, and those that encounter problems could experience a profit margin decline. We believe there are execution risks when a company migrates from one business model to the other or combines the two.

25. Health care services providers have limited, if any, price flexibility because of powerful third-party payors. This is sometimes called "reimbursement risk." Both government and private third-party payors in the U.S. and other developed economies are striving to reduce payments (or the payment growth rate) to health care providers to offset demand (volume) growth stemming from an aging population and technological advances. Providers are truly price-takers from government payors for some services in some countries. Price flexibility with private payors depends

in part on negotiating leverage. Third-party payment or reimbursement rates are not a function of supply and demand. In fact, the price paid to the provider may be lowered to discourage demand (often the provider, not the patient, decides which services the patient should receive).

26. However, long-term contracts, which are awarded by government authorities in some countries, can afford a predictably growing revenue stream. For example, payments under government contracts in some European jurisdictions provide price increases in line with inflation. The U.S. system is less predictable and prone to periodic changes in payment rates, service classifications, and payment structures, which can significantly affect profit margins.

27. Payment rates from private third-party sources may be influenced by government payment rates, but are typically higher. We expect private payment rates, in general, to keep pace with inflation. Health care services companies often strive to increase the percent of revenue derived from private sources, and thereby enhance profit margins.

28. Volume is heavily affected by third-party payors, which often influence or dictate a patient's selection of a service provider. In the U.S., an insured patient often bears an economic penalty if he chooses an out-of-network provider (which has not agreed to accept a discounted price from the insurer). A patient using benefits from Medicare, Medicaid, and other government programs is limited to providers that accept these government payment rates, unless the patient opts to pay the portion of the cost not covered by the government. Providers choose to accept lower payment rates in the expectation of higher volume. If this strategy succeeds, operating leverage can lead to increased profit margins. In many countries, two-tiered systems exist (to varying degrees) in which a patient can use a government-paid or provided facility/doctor at minimal cost to the patient or choose to pay for "better" services, e.g., quicker appointments or advanced genetic testing.

29. Competition among health care providers is based partly on the quality and convenience of service, as well as the effects of third-party payors noted above. Price plays an important role when providers compete for contracts with private insurers, and to some degree when they compete directly for patients. However, price has less influence on the patient's purchase decision than for many other consumer services for several reasons. The patient typically pays only a small portion of the cost (often a fixed flat fee). Patients don't shop around for emergency services. Given the serious consequences of good and bad health care, patients who can afford it are often reluctant to trade quality for price. There are also "switching costs" that contribute to a patient's reluctance to change doctors when he has been pleased with past service.

30. Competition is largely local; patients are reluctant to travel far for services needed urgently or frequently. In many geographic markets and subsectors there are a significant number of competitors, but concentration exists for some services in some markets, and there is a general trend toward consolidation among health care service providers in the U.S., Brazil, and other countries. (Private payors are also consolidating in the U.S.)

31. Health care services providers typically have the ability to adjust their cost structures, particularly labor costs. Advanced information technology promises improved productivity, efficiency, and quality, but service providers must make a substantial investment and may need sufficient scale to achieve benefits. Health care services companies are heavily regulated, which imposes administrative costs. Providers can face severe penalties for violating regulations (e.g., improper billing and self-referrals).

32. We address variation in profit margins among subsectors in our analysis of competitive position.

Risk of secular change and substitution of health care services by products, services, and technologies--Low Risk

33. There is minimal risk of obsolescence or substitution. Hands-on professional care will remain the norm while technologies used by providers evolve. We expect continued shifts in the type of facility in which care is provided (e.g., inpatient to outpatient surgery).

Risk in health care services industry growth trends--Low Risk

34. The health care services industry is well established and we expect its revenues to grow at or above the nominal rate of GDP growth, over the medium term, although the rate of growth in the U.S. has slowed. It was 4.3% in 2012, down from high-single-digit annual growth 2000-2007 and double-digit annual growth in the previous three decades (includes services from not-for-profit providers; Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group).

35. Health care services growth benefits from favorable demographic and economic trends. In developed economies, long-term demand is fueled by the growing number of older people, who require more care, and increased prevalence and diagnosis of diabetes and hypertension. An expanding middle class aids growth in developing economies. Growth is also spurred by innovation, new diagnostic techniques, and new treatments for diseases or conditions that were previously undetected or treated less effectively.

36. Positive global trends are somewhat offset by utilization controls imposed by government and other third-party payors in developed markets, and in the U.S. by the shifting of more costs to patients who have private insurance, which we believe has dampened demand in recent years.

Country risk

37. Country risk plays a critical role in determining all ratings on companies in a given country. Country-related risk factors can substantially affect company creditworthiness, both directly and indirectly. A key factor in our business risk analysis for corporate issuers is the country risk assessment, which includes the broad range of economic, institutional, financial market, and legal risks that arise from doing business in a specific country. In assessing country risk for a health care services company, our analysis uses the same methodology as with other corporate issuers (see global corporate criteria).

38. We primarily measure a company's exposure to country risk based on the percent of its revenues generated in each significant country or region, unless the percent of EBITDA is available, in which case we use the percent of EBITDA.

Competitive position (including profitability)

39. Under our global corporate criteria, a company's competitive position is assessed as (1) excellent, (2) strong, (3) satisfactory, (4) fair, (5) weak, or (6) vulnerable. In assessing the competitive position of health care services companies we review an individual company's:

- Competitive advantage;
- Scale, scope, and diversity;
- Operating efficiency; and
- Profitability.

40. The first three components are independently assessed as either (1) strong, (2) strong/adequate, (3) adequate, (4) adequate/weak, or (5) weak. Profitability is assessed through the combination of level and volatility of profitability.

41. After assessing separately competitive advantage; scale, scope, and diversity; and operating efficiency, we determine the preliminary competitive position assessment by ascribing a specific weight to each component. The applicable weightings will depend on the company's Competitive Position Group Profile (CPGP).

42. The CPGP assigned to health care services providers is "Commodity Focus/Scale Driven" because scope and diversity are extremely important analytical factors and they are given heavy weight in this CPGP. Our assessment of diversity includes a company's payor profile (revenue contribution from each source), which is typically a key credit factor. This CPGP also gives little weight to competitive advantage, which is appropriate because competitive advantages often don't confer premium pricing in this industry. Among health care services providers there is limited differentiation of services, another element of competitive advantage.

43. Under the "Commodity Focus/Scale Driven" CPGP, the component weightings are as follows: competitive advantage (10%); scale, scope, and diversity (55%); and operating efficiency (35%).

44. Beyond the risks captured in our country risk assessment, the health care services industry is heavily dependent on and controlled by central, regional, and local governments. The influence of these specific factors on a company is addressed in our assessment of its competitive position (for instance, a company's dependence on government and other third-party revenue in the diversity component of scale, scope, and diversity; aspects of government regulation and payment mechanisms in competitive advantage).

45. A company's competitive position assessment takes account of the competitive dynamics (fragmentation/consolidation, barriers to entry, risk in growth trends, level and trend of profitability, etc.) within its subsector. In some markets (mainly outside the U.S.) specified services are provided under long-term licenses or contracts typically with a (local, regional, or central) government. Our evaluation of these contracts may affect our assessments of the three components. The company's business model (fee-for-service or population health management) may influence our assessments of some factors. For example, growth in the volume of services provided is not necessarily a sign of strength for a population health manager.

Competitive advantage

46. When we analyze the competitive advantage of a health care services provider, we consider:

- The subsector/market's competitive environment and the company's position in it;
- Payment and reimbursement mechanisms, including the company's relationships with private payors; and
- Service differentiation, including demonstrated quality.

47. When we analyze a company's competitive environment (recognizing that it operates in numerous local markets), we pay special attention to the number of competitors and the degree of consolidation. Our assessment of the competitive landscape in a specific market includes government-owned and other not-for-profit facilities that often compete with for-profit health care providers. Not-for-profit facilities may enjoy tax advantages, subsidies, or other benefits that give them competitive advantages. Government-owned facilities may provide services at little or no direct cost to patients, but may be inferior in some respects (e.g., long wait-time for an appointment). We compare the company's growth rate

to growth of its subsector/market, including "same-store" volume and revenue growth trends. We assess its track record of winning and retaining contracts (where relevant).

48. At the subsector/market level, we evaluate the regulatory framework that specifically applies to a company (e.g., renal dialysis in Germany or ambulatory surgery in the U.S.). The transparency and predictability of government payments, including those under contracts, can bolster or limit a company's competitive advantage. We also review whether the payments it receives from private insurers compare favorably or unfavorably with those of other providers in its subsector/market.

49. We consider how effectively the company differentiates itself in its market, including indicators of service quality (e.g., readmission rates, rates of hospital-acquired infections, patient satisfaction scores, star ratings for Medicare managed care) and location of its facilities. Demonstrated quality can affect both a company's competitive advantage and operating efficiency.

50. Given the pervasive government influence, limited price flexibility, and often insignificant market shares in fragmented local markets, we believe few providers would merit a "strong" assessment of competitive advantage.

51. A health care services company with a "strong/adequate" (or more rarely "strong") competitive advantage assessment typically has some of the following characteristics:

- It competes in markets with few participants;
- It operates in a regulatory environment and government payment regime that is transparent and predictable;
- It has a dominant share of its local markets, which gives it a strong bargaining position with private insurers or other private third-party payors (e.g., employers) and facilitates attraction and retention of professional staff;
- Its payment/reimbursement mechanism is stipulated under long-term government contracts that include upward adjustments for external economic factors (e.g., inflation) or upward-only adjustments;
- It obtains favorable payments from private insurers, compared with those of other providers in its subsector/market;
- Its volume and revenues grow faster than its subsector/market's; it has a favorable trend of "same-store" volume and revenue growth;
- It has a good track record of winning and retaining contracts (for companies in markets that use contracts);
- It has above-average quality measures and is able to positively differentiate itself in the eyes of the consumer, professionals and government agencies that provide referrals, those who award contracts to provide services, or other third-party payors;
- Its patient loyalty has been demonstrated (e.g., repeat visits, which are relevant in some subsectors); and
- If it chooses to compete for payors/patients on the basis of price, it is a low-cost provider.

52. A health care services company with an "adequate" competitive advantage has some of the following characteristics:

- Its markets are moderately competitive;
- The regulatory environment and government payment regime are somewhat transparent, but may be unpredictable;
- There is limited opportunity for service differentiation;
- It grows at the subsector/market rate;
- Its payments from private third-party payors are similar to those of other service providers in its subsector/market; and
- Its quality measures are in line with subsector/market norms.

53. A health care services company with a "weak" or "adequate/weak" assessment of its competitive advantage has some of the following characteristics:

- It competes in a subsector/market with numerous competitors and low entry barriers;
- The regulatory framework or national health care system is volatile or underdeveloped; government policies could result in material "stranded assets;"
- It is exposed to competitive bidding;
- Its volume and revenues grow more slowly than its subsector/market's; or its revenues are subject to meaningfully higher-than-average volatility, compared with the overall health care services industry or its subsector/market;
- It receives unfavorable payments from private insurers, compared with those of other providers in its subsector/market;
- Its facilities are poorly located; it has a reputation for low quality or its quality metrics are weak;
- It uses a population health management business model, but its cost structure, operating practices, or quality are poorly suited for this approach.

Scale, scope, and diversity

54. Our assessment of a health care services company's scale, scope, and diversity focuses on:

- Diversity of services offered, including diversity of subsectors served;
- Diversity and stability of revenue sources (payor profile); and
- Geographic diversity.

55. Breadth or narrowness of services offered is important because a significant reduction in government reimbursement rates for a particular service can cause a sharp drop in earnings and cash flow of a provider that concentrates in that service ("stroke-of-the-pen risk"). A narrowly focused provider is also exposed to changes in medical practice in a single field. In most countries, prices paid by private sources (insurers and patients) generally are higher than prices paid by government sources, and therefore we often view private revenue more favorably than government revenue. We also consider whether a company participates in multiple subsectors (e.g., psychiatric hospitals and nursing homes).

56. A company's payor profile is a key credit factor. Governments, private insurers, and patients are the main sources of revenue for health care services providers. Some health care services companies also receive a material percent of revenue from employers and other health care services providers, such as hospitals and doctors, and they typically have some flexibility in negotiating prices with these customers. In evaluating the diversity and stability of revenue sources we consider the percent of revenue from any one government source (e.g., Medicare, Texas Medicaid, U.K. local authority, Spanish central government, U.K. National Health Service; by country or state if relevant). For companies that provide services under contracts, we evaluate the percent of revenue from its largest contracts. We also look at revenue concentration from private insurers.

57. Geographic diversity can reduce profit declines that may result from unfavorable economic, reimbursement, regulatory, or other developments in a specific country or region. We have a favorable view of companies that operate in geographically diverse markets that have different demographic trends, economic environments, payment regimes, and payors. Payment rates (and other criteria) for Medicaid, a government program in the U.S. that pays for health care of the poor, are established by each state. Therefore, we consider state-by-state concentrations for health care

service companies with significant Medicaid revenues. Geographic concentration by state is also meaningful for providers of workers' compensation care. Although the payor is typically an employer or insurer, payment rates for this care are established by each state.

58. Market share per se is typically not a meaningful credit factor because many health care services markets are fragmented, data is often unavailable (one company may serve dozens or more distinct local markets), and health care services providers generally lack pricing power. However, we may consider market share, and view it favorably, for companies that are typically the sole or a leading provider in markets with very few competitors. These circumstances would also be incorporated into our competitive advantage assessment.

59. Scale is generally a less important subfactor, although large scale can provide a platform for good operating efficiency.

60. Due to payor concentration (which results in revenue and profit concentration), we expect very few health care services companies to merit a "strong" assessment of scale, scope, and diversity.

61. A health care services provider with a "strong/adequate" (or more rarely "strong") assessment of scale, scope, and diversity has most of the following characteristics:

- It offers a wide range of services; it treats or monitors patients with a wide variety of medical conditions (e.g., acute care/general hospital, clinical lab with extensive test menu);
- It operates in several subsectors;
- It has a low dependence on government revenue (or higher dependence that is mitigated because the payment mechanism provides multiyear revenue and profit stability, as in some contracts);
- No more than 35% of revenue from any one government source;
- No more than 25% of revenue (or EBITDA if available) from a single government contract;
- No more than 10% of revenue from Medicaid (combining all U.S. states);
- No more than 15% of revenue comes from any one private insurer;
- No more than 5% of revenue comes from any other customer (excluding governments and insurers);
- It operates in many geographic markets and meets at least one of the following: It has operations in two or more countries and at least two each contribute 30% or more of revenue (or EBITDA if available); it operates in 20 or more local markets (catchment areas; if data available); and it operates in more than 10 states/regions. The top state/region accounts for less than 20% of revenue; the top five for less than 50%;
- If the company is paid (by employers) under state-regulated workers' compensation rates, no state accounts for more than 10% of revenue; and
- The company has the flexibility to set prices for 20% or more of its revenue.

62. A health care services provider with an "adequate" assessment of scale, scope, and diversity does not meet conditions for "strong" or "weak" and has some of the following characteristics:

- It treats or monitors patients in somewhat limited medical specialties (e.g., only psychiatric hospitals, pediatric hospitals, cancer centers);
- Its payor mix is similar to the average for its subsector/market;
- 85% or more of its revenue (or EBITDA if available) is derived from one country; and
- It operates in more than 10 local markets/states; the top three account for less than 50% of revenue.

63. A health care services company that warrants a "weak" or "adequate/weak" assessment of scale, scope, and diversity

has at least one of the following characteristics:

- It treats or monitors patients with only a few narrowly defined medical conditions (e.g., end-stage renal disease, substance abuse, anatomic pathology laboratory services);
- It has a high dependence on government revenue (not mitigated by a payment mechanism that provides multiyear revenue and profit stability) or a small number of contracts;
- More than 50% of revenue comes from one government source or a single government contract;
- More than 80% of revenue comes from its top two contracts;
- More than 25% of revenue comes from Medicaid (all U.S. states combined);
- One commercial insurer accounts for more than 30% of revenue;
- Another customer (excluding governments and insurers) accounts for more than 25% of revenue;
- It operates in fewer than 10 local markets/states; its top two account for 80% of revenue or more; and
- If the company is paid (by employers) under state-regulated workers' compensation rates, one state accounts for more than 25% of revenue.

Operating efficiency

64. When we assess a health care services company's operating efficiency we generally compare its profitability and cost structure to those of its peers in the same subsector and country, which provide similar services and receive similar payment rates.

65. Operating efficiency is especially important for companies that use a population health management business model. They may have more opportunity than fee-for-service providers to garner a favorable assessment or to fall short in this subfactor. Accurately estimating utilization and costs (good underwriting) and skilled price negotiation are indicators of strong operating efficiency.

66. When we analyze the operating efficiency of a health care services provider, we consider its:

- Profitability (EBITDA margins or return on capital) compared with subsector peers;
- Supplier terms;
- Economies of scale (centralized billing, sophisticated revenue cycle management, inbound/outbound call centers, sophisticated electronic health records, etc.);
- Labor costs and flexibility; professional staff turnover;
- Capacity utilization relative to its subsector;
- Bad debt management;
- Uncompensated care (if relevant in subsector);
- Service quality (readmission rates, hospital-acquired infection rates, patient satisfaction scores, star ratings for Medicare managed care, etc.; if aggregated data available) relative to peers in its subsector;
- Ability to estimate utilization and costs (most relevant for population health managers); and
- Lease terms (if relevant).

67. A health care services company with "strong" or "strong/adequate" operating efficiency has many of the following characteristics:

- It has higher EBITDA margins or returns on capital than peers in its subsector;
- It obtains favorable terms from suppliers;
- It benefits from other economies of scale;

- It has less costly or more flexible labor compared with peers in its subsector or direct competitors; it adjusts staffing to reflect volume changes while maintaining quality;
- It has above-average capacity utilization for its subsector; it sustains solid profitability when capacity utilization is subpar;
- If it uses a population health management business model, it has a track record of accurately estimating costs;
- It accurately estimates bad debt losses; it has had fairly stable bad debt expenses without significant adjustments;
- Relative to peers in its subsector it has well-above-average quality measures; and
- It has below-average professional staff turnover for its subsector.

68. A health care services company with "weak" or "adequate/weak" operating efficiency typically has several of the following characteristics or one that is an especially severe shortcoming:

- It has lower EBITDA margins or returns on capital than its peers in its subsector;
- It has inflexible labor with rigid union or government work rules; it is unable to adjust staffing for volume changes; it has burdensome pension costs;
- It has below-average capacity utilization for its subsector;
- It is less efficient than peers and other direct competitors in its subsector; it has a limited ability to reduce variable or fixed costs; it has a history of unsuccessful cost reduction programs;
- It has higher-than-average uncompensated care (with no mitigants) for its subsector;
- It has higher-than-average professional staff turnover for its sub-sector;
- It has onerous lease terms (e.g., steep rent escalation) for its core facilities;
- Its reimbursement has been meaningfully reduced because of its substandard quality; and
- It has had erratic bad debt expenses.

Profitability

69. The profitability assessment can confirm or modify the preliminary competitive position assessment. The profitability assessment consists of the level and volatility of profitability. The two components are combined into the final profitability assessment using a matrix (see our global corporate criteria).

Level of profitability

70. The level of profitability is determined on a three-point scale: "above average," "average," and "below average."

71. We use the EBITDA margin to assess the level of profitability because it is indifferent to the mix of debt and equity in the capital structure and it is not distorted by acquisitions and leveraged buyouts that are common in the industry. Consistent with the global corporate criteria, we generally use two years of historical data and our forecast for the current year and the following two years. We use the guidelines shown in Table 1, below, to classify the level of profitability for a health care services company.

Table 1

EBITDA Margin Guidelines For Health Care Services Companies

	EBITDA Margin
Above average	Greater than 25%
Average	15% to 25%
Below average	Less than 15%

72. We derive those measures from the full range of rated health care services companies. In many subsectors we rate

only a small number of companies from which it would be difficult to derive meaningful, specific profitability ranges. We use the above guidelines for all health care services companies even though there are differences among subsectors, and variances from country to country. This allows us to take into account the phenomena that lead to differences in profit margins, such as low barriers to entry in home health care and reimbursement risk for U.S. nursing homes. We believe these factors should be fully incorporated in our assessment of a company's overall competitive position (not just in the subfactors') and business risk.

Volatility of Profitability

73. We assess the volatility of profitability on a six point scale, from: "1" (least volatile) to "6" (most volatile).

74. In accordance with our global corporate criteria, we generally assess the volatility of profitability using the standard error of regression (SER), subject to having at least seven years of historical annual data. We use the EBITDA margin to determine the SER for health care services companies because this measure tends to be less affected by merger and acquisition activity than absolute EBITDA or return on capital.

Part II--Financial Risk Analysis

Accounting and Analytical Adjustments

75. In assessing the accounting characteristics of health care services companies, the analysis uses the same methodology as with other corporate issuers. Our analysis of a company's financial statements begins with a review of its accounting to determine whether the statements accurately measure its performance and position relative to its peers and the larger universe of corporate entities. To allow for globally consistent and comparable financial analyses, our rating analysis may include quantitative adjustments to a company's reported results. These adjustments also enable better alignment of a company's reported figures with our view of underlying economic conditions. Moreover, they allow a more accurate portrayal of a company's ongoing business. Adjustments that pertain broadly to all corporate sectors, including this sector, are discussed in "Corporate Methodology: Ratios And Adjustments," published Nov. 19, 2013.

76. The most significant adjustments we employ for health care services companies are for operating leases, which comprise a significant portion of adjusted debt for many companies in this industry (see our ratio and adjustments criteria, paragraphs 174-180).

Cash flow/leverage Analysis

77. In assessing the cash flow and leverage of a health care services company, our analysis uses the same methodology as with other corporate issuers (see global corporate criteria). We assess cash flow/leverage on a six point scale ranging from (1) minimal to (6) highly leveraged. We determine these assessments by aggregating the assessments of a range of credit ratios, predominantly cash flow based, which complement each other by focusing attention on the different levels of a company's cash flow waterfall in relation to its obligations.

Core ratios

78. For each company, we determine (in accordance with our ratios and adjustments criteria) two core credit ratios: FFO to debt and debt to EBITDA. We usually use debt to EBITDA as the primary leverage measure for health care services companies, but we also consider the FFO-to-debt ratio.

Supplemental ratios

79. In addition to our analysis of a company's core ratios, we also consider supplemental ratios in order to develop a fuller understanding of a company's credit risk profile and fine tune our cash flow analysis.

80. If the preliminary cash flow and leverage assessment indicated by the core ratios is "significant" or weaker, we place more emphasis on EBITDA interest coverage as a supplemental ratio. We may also consider FFO plus interest to cash interest coverage when a company has payment-in-kind (PIK) debt, PIK preferred stock, or low-coupon convertible debt. These ratios recognize the low or lack of cash expense on an ongoing basis.

81. Health care services companies often carry a high adjusted debt burden and their ability to meet cash interest and lease payments is critical. Therefore, when rent expense is large, and to take account of a company's ability to cover all fixed charges, we may use, as a supplemental ratio, EBITDAR (lease-adjusted EBITDA) coverage of interest plus rent expense (sometimes called fixed charge coverage). This ratio is especially important for companies at the lower end of the credit spectrum with only marginal coverage of interest and rent. It also helps us compare companies with higher property ownership (which may be financed with debt) with companies that lease most of their properties. When calculating this ratio we use reported rent expense for historical periods and our estimate of actual rent expense for future periods.

Table 2

EBITDAR Coverage Of Interest And Rent Scale	
Minimal	>8.0x
Modest	>5.0x-8.0x
Intermediate	>3.0x-5.0x
Significant	>2.5x-3.0x
Aggressive	=>2.2x-2.5x
Highly leveraged	<2.2x

82. We use the supplemental debt payback ratios (cash flow from operations to debt, free operating cash flow to debt, and discretionary cash flow to debt) infrequently. These measures are more meaningful for the few health care services companies that have a preliminary cash flow/leverage assessment of "intermediate" or stronger, but usually do not provide additional insight, in part, because health care services companies generally have moderate fixed and working capital requirements relative to all other industries.

Part III--Rating Modifiers

Diversification/portfolio effect

83. In assessing the diversification/portfolio effect on a health care services company, our analysis uses the same methodology as with other corporate issuers (see global corporate criteria).

Capital structure

84. In assessing a health care services company's capital structure, we use the same methodology as with other corporate issuers (see global corporate criteria).

Financial policy

85. In assessing the financial policy of a health care services company, our analysis uses the same methodology as with other corporate issuers (see global corporate criteria).

Liquidity

86. In assessing the liquidity of a health care services company, our analysis uses the same methodology as with other corporate issuers (see global corporate criteria and "Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers," Dec. 16, 2014).

Management and governance

87. In assessing management and governance of a health care services company, our analysis uses the same methodology as with other corporate issuers (see global corporate criteria and "Management And Governance Credit Factors For Corporate Entities And Insurers," Nov. 13, 2012).

Comparable ratings analysis

88. In assessing the comparable ratings analysis of a health care services company, our analysis uses the same methodology as with other corporate issuers (see global corporate criteria).

RELATED CRITERIA AND RESEARCH

- Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers, Dec. 16, 2014
- U.S. Not-For-Profit Acute-Care Stand-Alone Hospitals – Methodology And Assumptions, Dec. 15, 2014
- Corporate Methodology, Nov. 19, 2013
- Methodology: Industry Risk, Nov. 19, 2013
- Corporate Methodology: Ratios And Adjustments, Nov. 19, 2013
- Country Risk Assessment Methodology And Assumptions, Nov. 19, 2013
- Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012
- Principles Of Credit Ratings, Feb. 16, 2011
- U.S. Public Finance: Not-For-Profit Health Care, June 14, 2007

APPENDIX: MATERIAL RELATED TO INITIAL PUBLICATION OF THIS CRITERIA

These criteria became effective on April 14, 2014.

These criteria supersede "Key Credit Factors: Business And Financial Risks In The U.S. For-Profit Health Care Facilities Industry," Jan. 21, 2009.

These criteria represent the specific application of fundamental principles that define credit risk and ratings opinions. Their use is determined by issuer- or issue-specific attributes as well as Standard & Poor's Ratings Services' assessment of the credit and, if applicable, structural risks for a given issuer or issue rating. Methodology and assumptions may change from time to time as a result of market and economic conditions, issuer- or issue-specific factors, or new empirical evidence that would affect our credit judgment.