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Cost Pressures Could Force Distressed M&As in U.S. Hospital Market

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Ever since its passage in 2010, discussions regarding the Patient Protection and Affordable Care Act (the ''Act'') have focused primarily on its effects on patients. What has been less discussed, but is equally as important, is the Act's effects on hospitals, particularly, stand-alone community-based hospitals. These stand-alone hospitals, unaffiliated with larger, consolidated hospital networks, account for over one-fifth of U.S. hospitals, providing health care to millions of patients each year. For these hospitals, taking the actions required or encouraged under the Act means incurring additional costs when revenues (and profits) already are tight. Indeed, implementing just one of the Act's most significant technology-based initiatives, electronic medical records (EMR) systems, is likely to drive up costs considerably. This increased cost burden comes at a time when these hospitals' significant payors, Medicare and Medicaid, in light of federal and state budget tightening, are reducing hospital reimbursement rates, and when an increasing number of patients cannot pay for (or simply are forgoing) health care. These cost and revenue pressures have challenged, and are likely to continue to challenge, stand-alone hospitals' capacity to continue to operate on their own. Facing these financial pressures, stand-alone hospitals have been, and are likely to continue to be, targets for acquisition.

Cost Pressures of Implementing Health Reform

As has been widely reported, the Act's purpose is to expand access to health care to all Americans while seeking to lower the overall cost of health care in the United States. This comprehensive health care reform is designed to reduce the number of uninsured Americans by 32 million by 2019, at a net cost of $938 billion over 10 years, while reducing the national budget deficit by $143 billion. The Act contains several mandates to achieve those ends, including provisions that incentivize, and in some cases require hospitals to implement EMR technology to provide health care to patients more efficiently. These mandates are designed ultimately to lower overall health care costs. However, in the near term, the implementation and other start-up costs associated with EMR initiatives actually have placed considerable cost pressures on stand-alone hospitals.

The Act requires health care providers to adopt electronic medical recordkeeping systems that allow doctors and hospitals to share patient information more efficiently.[1] This initiative is designed to reduce paperwork and administrative burdens, cut costs, reduce medical errors, and improve the overall quality of care. The Act requires not only that medical providers implement systems of EMRs, but also that they achieve a level of proficiency known as ''meaningful use'' with respect to EMRs.[2] A host of factors are taken into account in determining whether meaningful use has been achieved, which involves meeting 22 transactional standards and a security standard to protect patient privacy.[3] The Act initially incentivizes the use of EMRs by providing for $19 million in Medicare subsidies from 2011 to 2015 for making meaningful use of EMR systems, including using approved systems to write notes and electronic prescriptions, maintain electronic medication lists and electronic medication lists, and electronically exchange information.[4] However, beginning in 2015, hospitals and other health care providers

that fail to meet the meaningful use requirements face escalating cuts in Medicare reimbursements, thereby, in essence, compelling hospitals and other health care providers to bear the burden of implementing EMRs now rather than over a longer period of time.[5]

While the benefits associated with the Act's EMR initiative are aimed at making the provision of health care

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[1] 45 C.F.R. 164.308, Jan. 23, 2010.

[2] The Centers for Medicare & Medicaid Services (CMS) defines meaningful use using three main components: ''1. The use of a certified [EMR] in a meaningful manner; 2. The use of certified [EMR] technology for electronic exchange of health information to improve quality of health care (including e-prescriptions in outpatient settings); and 3. The use of certified [EMR] technology to submit clinical quality and other measures.''

[3] Fiscus, Kevin. Hospitals and Physicians Can Receive Billions in Subsidies with Meaningful Use of EMRs; Three Security Firms Create Consortium to Automate and Lower Cost of Compliance Services. Marketwire, Inc., March 9, 2010.

[4] Id.; Larino, Jennifer. Medical Professionals Question Cost, Pace of Electronic Medical Records. Dolan Media Newswires, New Orleans City Business, Aug. 9, 2011.

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more efficient and less expensive, the up-front cost to hospitals, particularly hospitals unaffiliated with larger hospital networks, to implement these new initiatives is significant. Industrywide, the cost of transitioning from paper records to EMRs is estimated to be as high as $13 billion per year.[6] For a 500-bed hospital, the time frame from adoption to meaningful use is approximately five to seven years at a total cost of approximately $50 million.[7] Assuming timely adoption under the Act, such a hospital would be eligible for approximately $5 million to $6 million in incentive payments from the federal government, only covering about 10 percent of the overall cost of the transition to EMRs.[8]

Further, in addition to the implementation costs associated with EMR technology, operation of EMR systems requires IT support staff and coordination among several hospital teams and executives to oversee implementation of the new systems, which is likely to add further costs. In particular, hospitals face a shortfall of about 51,000 technical experts trained in EMR software, a limited number of software vendors providing approved EMR programming, and an insufficient pool of certified products available for implementation.[9] In sum, as one recent study found, the Act's incentives to comply with the EMR requirements do not come close to compensating hospitals and other health care providers for overall implementation and start-up operational costs associated with EMRs.[10] Indeed, roughly half of all U.S. hospitals are projected to be at risk of failing to implement the required technology initiatives by 2015 and, therefore, incurring penalties.[11]

This risk is particularly acute with respect to stand-alone hospitals. In contrast to larger consolidated hospital networks, stand-alone hospitals have tight operating margins and tend to have lower credit ratings, making it more difficult to secure the funds needed to acquire and implement new initiatives such as EMRs.[12]

Revenue Pressures in Light of Declining Reimbursement Rates and Patient Volumes

At the same time stand-alone hospitals face increased costs to institute EMR systems (and uncertainty over how they will fund these costs), their revenues are being squeezed by lower reimbursement rates from their significant payors, Medicare and Medicaid. Widespread federal and state budget deficits are leading to decreased government spending, which is resulting in lowered Medicaid and Medicare reimbursement rates. In late July 2011, the Centers for Medicare & Medicaid Services announced that it would cut Medicare reimbursements to health care providers in fiscal year 2012 by an average of 11.1 percent.[13] States across the country, including South Carolina, New York, and Tennessee, have announced reductions in Medicaid reimbursements. South Carolina cut Medicaid reimbursements by 3 percent.[14] New York State's Medicaid panel proposed a $2.3 billion reduction in Medicaid spending for 2011-2012, representing a 2 percent reimbursement rate reduction.[15] TennCare, Tennessee's state Medicaid program, is contemplating reimbursement rate cuts for next year of as much as 5 percent and already has cut more than 350,000 people from the TennCare program.[16] As a result of these cuts, stand-alone hospitals already facing the prospect of increased costs now also are experiencing declining revenues, which have eroded operating margins for 60 percent of community hospitals to 1 percent or less, putting pressure on their capacity to continue to operate independent of larger hospital networks.[17]

Decreasing patient volumes and simultaneously increasing deductibles and patient copayments only have further strained stand-alone hospital revenues. Faced with job losses and lower paying work in light of the recent economic downturn, many Americans are underinsured or simply have forgone health care coverage entirely.[18] From 1999 to 2011, employee contributions to health plan premiums have increased 168 percent from 1999 contribution levels.[19] In addition, employees' cost-sharing obligations under employer-sponsored health benefit plans has grown, such that today nationwide 22 percent of employees pay $1,000 or more in deductible, copayment, or coinsurance payments.[20] As patients face uncertain job prospects and increasing health care cost obligations, they have, in part, simply stopped seeking care or paying for it. This has resulted in a significant increase in unreimbursed care costs for U.S. hospitals and has caused the median hospital revenue growth rate to reach its lowest point in two decades.[21] For example, in 2009, U.S. hospitals wrote off $39.1 billion of expenses as uncompensated care, nearly double

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[5] Id.; American Hospital Association, Trendwatch, The Road to Meaningful Use: What It Takes to Implement Electronic Health Record Systems in Hospitals, April 2010.

[6] Knickehm, Mark and Ficery, Kristin. Secrets of Success on the EMR Journey to Meaningful Use: Leading Hospital CIOs Reveal Key Lessons Learned. Accenture (2011).

[7] Id.

[8] Id.

[9] Hersh, M.D., William and Wright, Ph.D., Adam. Characterizing the Health Information Workforce: Analysis from the HIMSS Analytics Database. April 17, 2008.

[10] The Road to Meaningful Use: What it Takes to Implement Electronic Health Record Systems in Hospitals. Trendwatch, American Hospital Association, April 2010.

[11] Knickehm, Mark and Ficery, Kristin. Secrets of Success on the EMR Journey to Meaningful Use: Leading Hospital CIOs Reveal Key Lessons Learned. Accenture (2011).

[12] Sataline, Suzanne. Cash-Poor Governments Ditching Public Hospitals. *The Wall Street Journal*, Aug. 29, 2010.

[13] Pruitt, A.D. Nursing Home Stocks Ailing—Some Analysts Say Investors Fears Are Overdone, Citing Healthy Balance Sheets. *The Wall Street Journal*, Nov. 16, 2011.

[14] Holleman, Joey. Larger State Medicaid Cuts May Lead to Layoffs. The State, May 15, 2011.

[15] Gershman, Jacob. Cuomo in Medicaid Deal. *The Wall Street Journal*. Feb. 25, 2011.

[16] Arnold, Scott. TennCare Budget Hearing Explores $343 Million Cut. NewsChannel 5 WTVF-TV Nashville, Tenn. (Accessed Jan. 18, 2012 at http://www.newschannel5.com/story/16140188/tenncares-budget-future); Wadhwani, Anita. TennCare Funding Problem Persists Despite Overhaul. *The Tennessean*, Jan. 4, 2012.

[17] Community Hospital 100 Survey: Community Hospitals-Financial Health and New Initiatives. Anthelio Healthcare Solutions Inc. Community Hospital 100 Executive Management Conference, Oct. 23-25, 2011.

[18] Dealing with the Self-Pay Dilemma; Front-end focus key to managing financing challenges. Healthcare Registration, Nov. 1, 2011.

[19] Id.

[20] Id.

[21] Hospital Revenues in Critical Condition; Downgrades May Follow. Moody's Investors Services. Aug. 10, 2011.

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the amount written off of as uncompensated care 10 years earlier.[22]

In response to these revenue pressures, many community-based stand-alone hospitals across the United States have implemented significant cost-cutting measures just to allow them to continue operations, including shutting down less profitable facilities and implementing significant layoffs. For example, the Southern New Hampshire Medical Center in Nashua, N.H., laid off 6 percent of its workforce and shut down a medical unit that held 60 percent of the city's beds for inpatient psychiatric cases.[23] The Christus Santa Rosa medical facility in San Antonio, Texas, laid off 80 employees.[24] Catholic Medical Center in Manchester, N.H., laid off 110 employees.[25] MultiCare System in Tacoma, Wash., laid off 350 employees.[26] Richmond University Medical Center in Staten Island, N.Y., laid of 60 workers, in addition to the 55 employees laid off in 2008 to deal with a $6 million budget shortfall brought on by significant Medicare and Medicaid cuts.[27] Providence Hospitals in South Carolina laid of 35 employees with more layoffs expected.[28] Promise Regional Medical Center in Hutchinson, Kan., laid off 49 employees.[29] Boston Medical Center laid off 119 employees.[30] Nearly 40 community cancer clinics throughout the United States have closed since January 2010.[31]

Cost and Revenue Pressures Leading to Increased Distressed M&A Activity

Experiencing declining revenue plus the expected increased costs of implementing EMR systems (and the Act's other initiatives) and with limited access to capital, many stand-alone hospitals have realized they may not be able to survive on their own. Faced with the prospect of continuing financial distress, these stand-alone hospitals, in some cases, are proactively seeking to merge with, and in other cases have become targets of consolidation of, larger hospitals or hospital networks.

In considering their options, many stand-alone hospitals have found that consolidating with a larger hospital or hospital network is the best way to alleviate the financial pressures they face and allow them to continue to operate. Merging with a larger hospital or network allows stand-alone hospitals to spread fixed costs over a larger patient base and expand patient access to services, thereby better managing costs and improving patient care.

Since 2009, the vast majority of hospital mergers have involved stand-alone hospitals. In 2009 alone, 85 percent of hospital mergers involved stand-alone hospitals.[32] Hospital merger activity has had a significant effect on the number of remaining stand-alone, community hospitals. Indeed, the number of community hospitals not part of a hospital system has fallen from 2,167 in 2007 to 2,044 by 2010.[33] This merger trend shows no signs of abating any time soon. In 2011, hospital mergers increased by 12 percent from 2010.[34] Further, already in the first months of 2012, large hospital systems, like HCA, Community Health Systems, Prime Healthcare Services and Steward Health Care System, have announced that they have acquired or intend to acquire in the coming months stand-alone hospitals located in Kansas, Pennsylvania, Illinois, and Rhode Island.[35]

Despite the Act's objective of lowering health care costs, at least over the next few years, stand-alone hospitals face increasing costs to institute and expand EMRs, as well as the Act's other initiatives. At the same time, reduced hospital reimbursement rates from Medicare and Medicaid and an increasing number of patients who are not paying for or are altogether forgoing care put pressure on stand-alone hospital revenues. Faced with higher costs and lower revenues, stand-alone hospitals in many instances are struggling to survive as independent operators. To alleviate these financial pressures and continue serving their patients, stand-alone hospitals have been consolidating with larger hospitals and hospital networks. Given the cost and revenue pressures that stand-alone hospitals can expect to continue to experience over the foreseeable future, this trend of merger activity is only likely to continue.

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[22] Dealing with the Self-Pay Dilemma; Front-end focus key to managing financing challenges. Healthcare Registration, Nov. 1, 2011.

[23] Meighan, Patrick. Budget Cuts Will Have Far-Reaching Impact on State's Hospitals. *Nashua Telegraph*, Nov. 28, 2011.

[24] Danner, Patrick. Christus Cutting 80 Jobs. San Antonio Express News, Sept. 21, 2011.

[25] Marchocki, Kathryn. CMC Joins Layoff Parade. The Union Leader, Aug. 19, 2011.

[26] Chueng, Karen. Hiring and Firing: Hospitals Face Economic Changes. *Fierce Healthcare*, July 14, 2011.

[27] Id.

[28] Holleman, Joey. Larger State Medicaid Cuts May Lead to Layoffs. The State, May 15, 2011.

[29] Staff Reduction, Program Adjustments Announced at Promises Regional. *The Hutchison News*, March 22, 2011.

[30] Donnelly, Julie M. Boston Medical Center Cuts Staff. *Boston Business Journal*, Sept. 13, 2010.

[31] Chase, Julie. Community Cancer Clinic Closings on the Rise. PR Newswire, July 14, 2010.

[32] Id.

[33] Barr, Paul. Dealing them in; Annual M&A report shows industry changes drive another year of growth. *Modern Healthcare*. Jan. 30, 2012.

[34] Health Care M&A Spending Rise 11% in 2011. Irving Levin Associates Inc. Press Release. Jan. 25, 2012.

[35] *See, e.g.*, Community Health Systems Announces Acquisition of Blue Island Illinois Hospital. NewsBites. March 2, 2012; Prime Healthcare Services Acquires Roxborough Memorial Hospital from Solis Healthcare. PR Newswire. Feb. 22, 2012; Steward Backs Bill to Lift 3-Year Wait on RI Hospital Purchases. Newstex Web Blogs. Feb. 8, 2012; HCA Completes Acquisition of Galichia Heart Hospital. GlobalData Financial Deals Tracker. Feb. 2, 2012.