BANKING & FINANCE
INTERNATIONAL

Hospital Consolidation: Vicious Cycle

What the urban shift means for healthcare as demographic changes continue to impact rural communities.

Banking & Finance International, Spring 2015

Despite what news accounts may lead you to believe, the biggest healthcare story of our generation may be one rooted in demographics, not new legislation. As the lifestyle requirements of patients and doctors have transformed to favor urban markets, rural hospitals are struggling to stay profitable. Desperate to survive, they are cutting care and closing or - increasingly - consolidating.

The implications of this are wide-reaching, and not just for the 12 million Americans employed in the healthcare sector. The ability of a hospital or system to actualize itself is directly correlated to the quality of care it is able to provide. Failing rural hospitals can't provide the same care that more efficiently run systems can, which is driving patients away from their communities and amplifying the problem in a cycle that's been spinning for years. This further validates physicians' decisions to align with larger regional systems.

As a result, we've seen a heightened level of consolidation since 2010, and now more than two-thirds of hospitals are part of a larger health system. So why is this happening?

The Urban Shift

My grandfather grew up in a small town, went to Havana Medical School in Cuba, then migrated to the United States and entered into private practice to serve as a healthcare leader in his small community. My father, like his father and grandfather, went to medical school and established a small-town private practice dedicated to the welfare of his community. But when I went to medical school, I opted not to return to my hometown - and I wasn't alone.

Beginning in the 1970s, newly minted physicians increasingly moved to urban areas instead of returning to the towns in which they were raised. They wanted the intellectual challenges, job opportunities and social life afforded by cities, just like millions of other Americans who have taken part in the urban shift.

Many of these physicians sought to avoid the complexities of staffing an office or managing increasingly complex insurance regulations and landed, instead, in urban hospitals as employees. This is a fundamental change in employment status: Although 70 percent of physicians in my father's generation were self-employed, today more than 70 percent are employed by hospitals.

This simple but perfectly timed shift in sentiment happened concurrently with several other key factors: various renditions of reimbursement reform driven by the federal government, increasing focus on population health and value-based funding allocations, and advancing technology that shifted care from long hospital stays to outpatient settings.

And while all of these factors have positive implications, they've also contributed to failing rural hospitals.

Aging Populations, Aging Facilities

Most doctors employed in tertiary markets are part of the generation that returned home following medical school. This means many are now retiring or close to retiring without a younger physician to replace his or her role. In fact, rural doctors are often paid more because it has become so hard to lure these high-value potential hospital employees away from primary markets.

But physicians aren't the only ones undergoing change. Rural populations are disproportionately aging and, like their physicians, aren't being replenished with younger, healthier individuals. Since the older population relies more on government care, tertiary hospitals are getting fewer high-paying commercial patients. This situation has been exacerbated by new Medicaid eligibility requirements that have increased enrollment in rural states and by increasing government scrutiny of inpatient care reimbursement.

Additionally, the proliferation of high-deductible plans has made potential patients question the value of addressing their health needs, especially as the economy struggles to recuperate in rural America.

These circumstances have resulted in dwindling liquidity and lack of capital to maintain and update facilities and equipment, as well as the ability to recruit and fund the start-up costs of physician practices. A consequential effect is that the first on the list to go are specialists, whose high-tech equipment and specialized knowledge are costly and serve a narrow population. Physical facilities suffer and now are as aged as the populations they serve, a consequence of years of delays in maintenance and new construction.

Another serious problem resides with electronic medical records. The papers within manila portfolios look archaic in an era of Apple Pay and Google Glass. While having a digital system would expand the care capacity of each employee, the cost of technology and time required to implement such a system is an insurmountable task for many healthcare facilities already on the brink of bankruptcy.

What Hospitals Should Do

None of this comes as a surprise to rural hospital executives. For the second consecutive year, all three of the major ratings agencies have had negative outlooks for the nonprofit hospital sector. In 2014, nonprofit hospital margins fell more than 3 percent in an industry where margins are already slim.

They mask this knowledge with short-lived improvements. The second- and third-quarter 2014 increase in admissions at large nonprofit hospital systems was simply a short-lived behavioral result of the Affordable Care Act and changes in Medicaid.

Adding insult to injury, larger systems have the deep pockets to hire sophisticated marketing teams to advertise their state-of-the-art facilities and services. Large regional multispecialty physicians groups pose further competitive threats to the small community hospital world, cannibalizing patient volumes with tactics that drive out-migration from the local community hospitals to the physician groups' care centers.

Tertiary hospitals are pursuing partners now, while they still have negotiation leverage. Many for-profit operators are also looking for joint ventures and acquisition targets to consolidate volumes. If they see a good opportunity, more likely than not they'll be willing to strike a deal. If, however, a hospital waits until it is in the throes of bankruptcy, it is unlikely to have much voice at the negotiating table, further perpetuating a cycle that offers little upside to rural America.

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