

## Current Industry Trends Affect Hospital Valuations

The following article, “Current Industry Trends Affect Hospital Valuations,” by PYA Senior Manager Robert Mundy appears in *Valuation Strategies*, March/April, Copyright 2013 Thomson Reuters/RIA.

The challenges that hospitals face today in the wake of healthcare reform and a difficult economy have an influence on their value, and appraisers must properly reflect these factors in valuation opinions.

The difficult current economic climate is riddled with change and uncertainty, and the hospital industry is not immune to the effects. In fact hospitals face an unprecedented series of challenges, including poor economic conditions, increasing competition, and greater reporting requirements. On top of these issues, the healthcare reform law looms, with a great deal of perplexity regarding its ultimate effect on hospital operations. This environment makes it difficult for an appraiser to assess the value of a hospital. Before confronting these uncertainties, the appraiser must gain an understanding of the hospital industry as a whole including its main value drivers.

The major focus of this article is on general acute-care hospitals. Other types of hospitals in the marketplace (e.g., long-term acute-care hospitals, rehabilitation hospitals, critical-access hospitals, psychiatric hospitals, and specialty surgical hospitals) often have significant differences, such as different reimbursement methodologies and volume drivers.

### Overview of the Hospital Industry

According to the American Hospital Association (AHA), there were 5,795 registered hospitals in the U.S. in 2009, with the overwhelming majority—5,008—composed of community hospitals. Of these community hospitals, 58% were nonprofit, 20% were for-profit, and 22% were state and local government community hospitals.<sup>1</sup>

The hospital industry is complex and highly regulated. Various laws and regulations, such as the Stark Law on physician self-referral and the federal Anti-Kickback Statute, govern and define fair market value for the healthcare industry. In addition, other federal laws, such as the False Claims Act and the Section 501(c)(3) anti-inurement rules, commonly apply to healthcare valuations. While the discussion of these laws is outside the scope of this article, an appraiser should possess a thorough understanding of them before undertaking a hospital valuation assignment.

### Hospital Value Drivers

Various characteristics affect the value of a hospital. These value drivers should be thoroughly examined and taken into consideration in order to ensure a sound valuation opinion for a hospital.

**Location, Location, Location.** As with the real estate industry, the location of a hospital is a primary value driver. The location has a substantial influence on all of its operations, from inpatient admissions to payer mix and its workforce. A hospital located in an affluent area more than likely has a high percentage of commercial insurance patients, which could enhance its profitability. A hospital located near an interstate or major highway tends to have higher patient volumes than a hospital in a less desirable location. Also, a hospital in a rural area could have a hard time attracting and retaining physicians.

**Age and Appearance of the Facility.** While a book should not be judged by its cover, a shiny, new exterior does help attract new readers. In the same manner, a new, modernized facility attracts more patient volume than an out-of-date facility. Hospitals need to continually reinvest in their facilities and

equipment to provide the most up-to-date technologies. Capital investment also plays an integral role in maintaining and increasing a hospital's physician network. Physicians favor a modernized, technologically-current hospital, so capital investment should be a key concern for hospital administrators.

**Medical Staff Composition.** Physicians are the lifeblood of hospitals. A hospital cannot successfully operate without developing relationships with the physicians in its community. An appraiser should, therefore, gain an understanding of the hospital's medical staff composition, including both employed and privileged physicians. In particular, an appraiser should make inquiries of hospital management regarding any recent changes or anticipated changes to the hospital's medical staff.

An emerging trend in hospital/physician relations is the employment of physicians by hospitals. According to surveys reported by the Medical Group Management Association (MGMA), 68% of the respondent physician practices were hospital-owned in 2010,<sup>2</sup> compared to only 26% in 2005.<sup>3</sup> From the physician's perspective, numerous factors are driving this trend, including declining physician reimbursement, increasing costs of providing care, and poor economic conditions. An appraiser needs to understand the hospital's physician alignment strategy and how it intends to implement this strategy.

**Competition.** As with any other business, the value of a hospital is greatly affected by the competitiveness of the market in which it operates. Historically, a hospital's only real competition has been other hospitals in its market area. However, other competitors, such as physician-owned hospitals and ambulatory surgery centers, have increasingly captured surgical volumes by pulling physicians away from hospitals. Community hospitals received a reprieve in the recent healthcare reform package, which placed a ban on any new physician-owned hospitals, and limited the growth potential of existing physician-owned hospitals. Still, many hospitals face fierce competition, and an appraiser must recognize the various competitive risk factors when valuing a hospital.

**Community Demographics.** Another factor that has an effect on a hospital's value is the demographics of the community in which it operates. A hospital operating in an area with a high percentage of people over age 65 tends to be in higher demand. The demographics of a community also drives a hospital's payer mix and, therefore, its profitability. For instance, a hospital operating in a lower socio-economic area tends to have higher levels of Medicaid or uninsured patients.

**Contracting Strength.** The relative contracting strength of a hospital also affects its value. The dynamics of the local commercial insurance market affects the negotiated reimbursement amounts for a hospital. A hospital with a large market share in a community can potentially garner higher reimbursement amounts from commercial payers. Conversely, when a single commercial insurer dominates a market, hospitals have a harder time negotiating higher rates.

**Level of Community Support.** The level of community support is important for a hospital, especially a community hospital. Many community hospitals are taxpayer-owned or taxpayer-supported, so capital projects are often funded through taxpayer dollars. If a hospital has a reputation for providing substandard service, then taxpayers will probably be less inclined to increase funding to the hospital. Thus, the location, age, and appearance of the facility; the medical staff composition; local or other competition; community demographics; the hospital's contracting strength; and the level of community support are all factors affecting a hospital's volumes, profitability, and, ultimately, its value. An appraiser needs to gain a thorough understanding of these characteristics in order to value a hospital properly.

## Challenges Facing Hospitals

Current economic conditions mixed with impending healthcare reform presents a new economic landscape in which hospitals must conduct business. Hospitals are currently facing unprecedented challenges from an operational standpoint. Various factors, both internal and external, are forcing hospitals to change how they do business. These challenges must be successfully navigated in order for hospitals to continue growth. An appraiser needs to understand the hospital management's perspective on how it is addressing these factors.

**Poor Economic Conditions.** The recent economic downturn has had a negative effect on almost every industry, and the hospital industry is no exception. For many years, the healthcare industry has been viewed as "recession-proof," but these poor economic times have proven otherwise.

A major problem facing the hospital industry is the high percentage of uninsured Americans. The latest recession has only exacerbated this problem, because the majority of Americans receive their health insurance benefits through their employer. As the unemployment figures have risen, the number of uninsured has also increased. According to The Kaiser Commission on Medicaid and the Uninsured, the number of non-elderly uninsured in the U.S. was 43.4 million in 2007, and this number increased to 49.1 million in 2010.<sup>4</sup> As a result, hospitals have experienced increases in uncompensated and charity care. According to a March/April 2010 survey of hospital leaders conducted by the AHA, 87% of hospitals saw an increase in bad debt and charity care as a percent of total gross revenue.<sup>5</sup>

Along with increasing bad debt expense, hospitals are also experiencing flat-to-negative admissions growth, fueled particularly by patients delaying medical care. With the decline in the economy, many patients—even those with health insurance coverage—are foregoing costly or elective surgical procedures, putting even more strain on hospital profitability. According to this same AHA survey, 72% of the hospitals surveyed reported depressed numbers of elective procedures, and 70% of the surveyed hospitals reported depressed overall patient volumes.

Another effect of the declining economy on hospitals has been restricted access to capital sources. According to the AHA survey, 44% of hospitals reported reduced access to capital and 67% have not started or continued capital projects. As previously mentioned, hospitals need to continuously invest in their capital infrastructure in order to maintain high quality facilities and equipment; however, the poor economy has forced many hospitals to delay capital projects.

**More Competitive Landscape.** Hospitals have continued to see an increased level of competition for services. Ambulatory surgery centers (ASCs) are relatively new competition for hospitals. ASCs provide outpatient surgical services to patients who do not require hospitalization and for whom the expected duration of service does not exceed 24 hours after admission. Since 1982 when Medicare began to make payments for surgical procedures provided in an ASC, the number of ASC facilities has increased dramatically. At the end of 1983, only 239 ASCs were Medicare-certified; by 1998, that number had increased tenfold—to over 2,300. In 2010, the number of Medicare-certified ASCs was 5,316.<sup>6</sup> Advancements in medical technology have made it possible for doctors to perform complex surgical procedures in an ASC setting, operations that had traditionally required hospitalization. This has led to a shift of surgical volumes from the hospital setting to ASCs, and therefore to decreased inpatient volumes for hospitals.

Value-based purchasing or pay-for-performance programs make up yet another arena of competition. Currently, the majority of payers reimburse under a traditional fee-for-service (FFS) model. Under this

model, third-party payers agree to pay a negotiated rate for medical services regardless of the patient outcome or quality of the service provided. Many payers are migrating toward value-based purchasing. Under value-based purchasing, a portion of the negotiated FFS rate is adjusted based on certain quality metrics. In this scenario, hospitals are benchmarked against their peers to determine if they fall above or below the quality measurements. The reimbursement amounts paid to the hospitals would be either lowered or raised depending on how the hospital compares to the benchmarks. In this way, hospitals are now competing for third-party reimbursement dollars.

**Physician Shortages.** A growing problem that hospitals face is a shortage of medical service providers. According to a June 2010 study by The Association of American Medical Colleges, the U.S. faces a predicted shortage of 130,600 physicians across all specialties by 2025. Of this projected number, 65,800 are anticipated to be primary care physicians.<sup>7</sup> These shortages drive up physician salaries and particularly affect small, rural hospitals that already have difficulty attracting physicians to their communities.

**Increased Reporting Requirements.** The new value-based purchasing requirements have increased the administrative and reporting burden on hospitals. In order to accurately report meaningful quality data to outside payers, hospitals must appropriately track and document patient outcomes. In many cases, this requires additional provider documentation to capture previously untracked data, which leads to increased administrative costs.

Another increase to the administrative burden of hospitals is the conversion from ICD-9 to ICD-10. International Classification of Diseases (ICD) is the coding system healthcare providers use to submit claims to payers for reimbursement. While most of the modernized countries around the world converted to ICD-10 long ago (and ICD-11 is due by 2015), the U.S. still uses ICD-9, which is over 30 years old. The conversion from ICD-9 to ICD-10 (“10” stands for 10th Revision) represents a seismic shift for the U.S. healthcare system. ICD-10 is not merely an addition of new diagnosis codes to the previous ICD-9 system—it is a totally new methodology of identifying and coding medical diagnoses that requires substantial infrastructure investments by hospitals, from new IT software to training for medical providers, billers, and coders. Although the implementation deadline for ICD-10 has been postponed to October 2014, hospitals need to begin laying the groundwork for this change, as it will require a significant investment in infrastructure.

## **Healthcare Reform**

The Patient Protection and Affordable Care Act (PPACA), signed into law on 3/23/2010, will bring widespread changes to the U.S. healthcare system and have a profound influence on the hospital industry. In the midst of the many challenges that hospitals are facing, the healthcare reform law presents even more uncertainty for hospitals. And since the majority of the PPACA was upheld as constitutional by the Supreme Court, hospitals need to be prepared for the effects of the legislation.

The primary goals of the healthcare reform law are threefold:

1. Increase access to healthcare services.
2. Improve the quality of healthcare services.
3. Reduce the overall costs of providing healthcare services.

The following are some of the major healthcare reform law initiatives that will affect hospitals:

**Increase Access to Healthcare Services.** Two of the major healthcare reform provisions that are intended to increase access to healthcare services are the individual insurance mandate and the expansion of the Medicaid program.

**Individual Insurance Mandate.** The individual insurance mandate included in the PPACA is the most hotly-contested piece of the legislation. Under this provision, Americans will be required to purchase healthcare insurance by 2014. A tax penalty will be assessed on those individuals that do not purchase healthcare insurance by that date. As previously mentioned, a major problem facing hospitals is the increasing level of bad debt and charity care brought about by an increasing number of uninsured Americans. This provision will potentially reduce the number of uninsured in the U.S., thereby improving the profitability of hospitals by reducing bad debt and charity-care expenses.

**Expansion of Medicaid.** Medicaid eligibility was expanded under the law to cover individuals up to 133% of the poverty level.<sup>8</sup> Originally states were mandated by the PPACA to begin this new coverage starting in 2014, and those that did not provide such coverage would be at risk of losing all federal Medicaid funding. However, this particular provision was struck down by the Supreme Court, allowing states to opt out of the Medicaid expansion. Coverage issues will most likely remain hotly contested between the states and the federal government, as many states are already experiencing budget shortfalls, and Medicaid expansion will only exacerbate these deficits.

### **Improving the Quality of Patient Care.**

**Value-Based Purchasing.** PPACA expanded Medicare's value-based purchasing program. Beginning in 2013, a percentage of Medicare's payments to hospitals are tied to performance under certain quality measures. The base payments to hospitals are either increased or decreased depending on whether a hospital attains certain quality benchmarks—a perfect incentive for hospitals to improve the quality of care provided to patients.

**Hospital-Acquired Conditions.** PPACA reduces Medicare payments to hospitals related to hospital-acquired conditions and preventable readmissions. "Hospital-acquired conditions" refers to conditions acquired by patients during a hospital stay. In 2015, Medicare payments will be reduced by 1% for hospital-acquired conditions.<sup>9</sup> This is intended to encourage hospitals to strengthen their infection control programs. Also, beginning in 2013, Medicare is reducing payments to hospitals whose readmission rate is higher than expected. The largest potential reductions would be 1% in 2013, 2% in 2014, and 3% in 2015 and beyond.<sup>10</sup>

**Reducing Healthcare System Costs.** The hospital market basket is a fixed-weight index, used to determine price changes for a mix of hospital goods and services (similar to the Consumer Price Index). The hospital market basket is used by the Centers for Medicare and Medicaid Services to determine changes to the fee schedules for hospital inpatient and outpatient services.

**Reductions in the Hospital Market Basket.** PPACA included automatic cuts to the hospital market basket. The market basket was reduced by 0.25% in 2010 and 2011; 0.1% in 2012 and 2013; 0.3% in 2014; 0.2% in 2015 and 2016; and 0.75% for 2017 through 2019.<sup>11</sup> Hospitals thus should be preparing to operate at reduced levels of reimbursement from Medicare.

**Disproportionate Share Hospital Payment Reductions.** Disproportionate share hospital (DSH) payments are made under the Medicare and Medicaid programs to hospitals that serve a high percentage of low-income or indigent patients. These payments are made to compensate hospitals for the losses that the hospitals incur by serving these populations. In 2014, Medicare DSH payments will be reduced by 75%.<sup>12</sup>

These cuts coincide with the individual insurance mandate—the theory being that because the number of uninsured should decline due to the individual insurance mandate, hospitals will be providing less uncompensated care and will therefore require fewer subsidies through the DSH program.

## Conclusion

Hospitals, like other industries, are subject to the economic environment around them. The challenges and uncertainty that hospitals face today affect their value, and appraisers must properly reflect these factors in valuation opinions.

While the ultimate resolution of the healthcare reform debate is not entirely certain, the hospital industry will clearly experience change in some form or fashion. Change provides opportunities for improvement. Like many other businesses in America, hospitals need to focus on cutting costs—and doing more with fewer resources. Hospitals can potentially emerge as lean operating entities, with greater focus on patient outcomes and quality care. When the economy recovers, hospitals should then be better positioned for future growth and profitability.

<sup>1</sup> American Hospital Association, *AHA Hospital Statistics 2011 Edition* (Health Forum, LLC, 2010).

<sup>2</sup> Medical Group Management Association, *Physician Compensation and Production Survey: 2011 Report Based on 2010 Data* (Glacier Publishing Services, Inc., 2011).

<sup>3</sup> Medical Group Management Association, *Physician Compensation and Production Survey: 2006 Report Based on 2005 Data* (Heggie Enterprises, Inc., 2006).

<sup>4</sup> The Kaiser Commission on Medicaid and the Uninsured, “The Uninsured: A Primer” (The Henry J. Kaiser Family Foundation, 2011).

<sup>5</sup> American Hospital Association, “Hospitals Continue to Feel Lingering Effects of the Economic Recession,” [www.aha.org/content/00-10/10juneeconimpact.pdf](http://www.aha.org/content/00-10/10juneeconimpact.pdf).

<sup>6</sup> Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program, June 2011*, <http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf>.

<sup>7</sup> Association of American Medical Colleges, “The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025,” June 2010, [https://www.aamc.org/download/158076/data/updated\\_projections\\_through\\_2025.pdf](https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf).

<sup>8</sup> Main and Starry, *The Effect of Health Care Reform on Hospitals: A Summary Overview* (Pillsbury Winthrop Shaw Pittman LLP, 2010), <http://www.pillsburylaw.com/siteFiles/Publications/2C9547A6BFCBB37D8366EA2272190123.pdf>.

<sup>9</sup> Association of American Medical Colleges, “Selected Medicare Hospital Quality Provisions Under the ACA,” [https://www.aamc.org/advocacy/medicare/153882/selected\\_medicare\\_hospital\\_quality\\_provisions\\_under\\_the\\_aca.html](https://www.aamc.org/advocacy/medicare/153882/selected_medicare_hospital_quality_provisions_under_the_aca.html).

<sup>10</sup> *Id.* [www.aamc.org/advocacy/medicare/153882/selected\\_medicare\\_hospital\\_quality\\_provisions\\_under\\_the\\_aca.html](http://www.aamc.org/advocacy/medicare/153882/selected_medicare_hospital_quality_provisions_under_the_aca.html).

<sup>11</sup> See Note 8, *supra*.

<sup>12</sup> *Id.*

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