Business Better (Season 3, Episode 13): Health Care Delivery Trends: Understanding Micro-Hospitals

Speakers: Phil Legendy, Bill Rhodes, Kevin Cunningham, and Eric Temmel

Steven Burkhart:

Welcome to Business Better, a podcast designed to help businesses navigate the new normal. I'm your host, Steve Burkhart. After a long career at global consumer products company BIC – where I served as Vice President of Administration, General Counsel, and Secretary – I'm now Special Counsel in the Litigation Department at Ballard Spahr, a law firm with clients across industries and throughout the country.

In today's episode, we discuss the current trend in the health care industry regarding the development of micro-hospitals, especially in certain rural areas. We explain what a micro-hospital is (and is not), the drivers behind the proliferation of micro-hospitals in certain areas of the country, and the various ways they are being financed. Phil Legendy, Of Counsel and Co-Leader of Ballard's Health Care Industry Team, leads the discussion. Phil is joined by Bill Rhodes, a Partner in our Public Finance Group and Leader of the firm's Education Industry Team, Kevin Cunningham, Senior Counsel in the Public Finance Group, and Eric Temmel, an Associate in the Health Care Industry Team. So now let's turn the episode over to Phil.

Phil Legendy:

Welcome to our listeners. I'm Phil Legendy, I'm a Healthcare Lawyer at Ballard Spahr and Co-head of our Healthcare Industry Group. And I'm joined today by my colleagues here at Ballard Spahr, Eric Temmel, Kevin Cunningham and Bill Rhodes. Eric, Kevin, Bill, thank you for being here.

The topic of our discussion is what are called micro-hospitals. These are a creature of state statute that emerged in the mid 2000s and the details of how these hospitals are operated, and even the names, vary a little bit by state. But the general concept is that they offer some combination of acute care, ancillary and retail services in a lower cost and smaller footprint format than a traditional hospital. They're easier and cheaper to build and they're a little bit less stringently regulated. And for that reason, they present some unique opportunities for partnership and innovation.

To kick things off, Eric, let's lay the foundation. How are these micro-hospitals regulated? And how's that different from a traditional hospital?

Eric Temmel:

Sure, thanks, Phil. So these facilities are distinct from a traditional hospital in that they offer a lot of the same sort of inpatient, outpatient or emergency services. But they focus much more on sort of low acuity, minimal invasiveness settings as compared to a larger hospital.

Larger hospitals are strictly regulated under state statute and corresponding regulations, heavily regulated state by state. These micro-hospitals, sort of in contrast, don't tend to have a lot of specific statutes, don't tend to have a lot of specific regulations, but may have some sort of interpretive guidance from relevant state agencies, state departments. So in that way, they're very different from a hospital. They're meant to be much smaller, lower costs. They do, again, offer some of the same services. They may additionally offer some imaging services, lab services, those types of things. Varies by state, whether they're going to offer surgical services, things of that nature.

So in that way, they are somewhat similar to, but much different from not only hospitals, but other facilities, ASCs, urgent care centers, freestanding emergency departments. They're really none of those. As the name I think sort of aptly suggests, they're mini hospitals really. Although it might be somewhat more helpful to conceptualize them as extensions of hospitals or separate campuses of hospitals. But more specifically, when we're talking about the regulations and what these are, it is very specific to each state.

Phil Legendy:

If you take Pennsylvania as an example, maybe give us a sense of what's required in a micro hospital.

Eric Temmel:

Sure, yeah. And so Pennsylvania's a great example, not just because that's where we're sitting, but it also has an interesting framework in that it doesn't have a lot of specific regulations or statutes for these micro-hospitals. It does certainly have a very specific facilities act that outlines what a hospital is and then corresponding regulations that help sort of further determine what is a hospital. But much less so for the micro-hospitals.

We know from state law and state regulation exactly what a hospital is, the general and specialty hospitals that have to offer services that are set forth under these regs and statutes. So any hospital you walk in Pennsylvania is going to have a medical staff, and offer certain medical and nursing services, pharmaceutical services, and certain equipment and treatment rooms that are going to help providers deliver those services. That is a minimal state requirement. You'll find that in any hospital.

Beyond that, I'm sure people are familiar with hospitals, in general. You typically see all sorts of different services like neonatal services, obstetric services, dental, podiatry services, psych services, other behavioral, health services, anesthesia. And then if you get into more specialty hospitals, I mean, burns, coronary care, pulmonary, any sorts of specialty care offered by all these different facilities.

As we stated earlier, these micro-hospitals are not subject exactly to the same statutes or regulations or their own statutes or regulations. But they do operate under the license of one of those standing hospitals. And Pennsylvania now sort of permits these hospitals to offer services in multiple locations. So these become an extension of the hospitals that we just discussed, but they don't offer all of those same services.

Phil Legendy:

Bill, you've worked on several of these projects. Let's talk about the business strategy for a second. Why do people build micro-hospitals? And are there any drawbacks to be aware of?

Bill Rhodes:

Thanks Phil. The reasons or the rationale for building a micro-hospital may be quite varied. Not only by state, but because the regs work differently than another state. But also even within a state, typically a primary goal may be the expansion of a health system service area, particularly their secondary service area, where they presumably face stiffer competition for the same patient base. Because of the cost structure of these facilities, it can help their financial bottom line and make them more financially competitive.

And in an era in which approvals for consolidation, particularly antitrust approvals, have become more and more difficult to obtain, it does provide a lower cost alternative for organic expansion outward from the primary service area into a stronger secondary service area and perhaps even expanding their current secondary service area boundarie, into adjacent areas where the competition has typically provided stronger service in the past.

There's also some defensive use in some of these service areas, it may be a financial need to downscale, say an existing rural community hospital, that can't afford all of the specialists that are required in a full acute care hospital. It also provides, in theory, a steady stream of referrals from patients who are initially brought to a micro-hospital or come into a micro-hospital, but who need a higher level of acuity care. It creates a stronger stream of referrals back to the flagship hospital and, hopefully, captures a greater percentage of the market in these outer service areas and strengthens the referral network.

From a cost point of view, the cost of a micro hospital can be significantly less, sometimes 20% or 25%, maybe, of the cost of a full scale hospital, and also provides a shorter construction period. So when they look at carrying the costs of a new facility, particularly in some of their more outlying areas of the service area, it makes a lot of sense to think about committing far less capital into that area, yet still, hopefully, harvesting a greater number of patients, new patients and referrals, to the flagship.

There are challenges with micro-hospitals. They are not full-blown hospitals, as Eric suggested. They can't handle all medical issues and, in fact, they probably require a significant amount of coordination by management with the flagship facilities or

other facilities within the health system network that have more advanced equipment, more advanced technologies, more specialized doctors. So a micro-hospital is not a simply a scaled down version of a full hospital. But the ability to drive expansion and referrals to the flagship facilities is often a major driver in these.

Phil Legendy:

Now Eric, we hear the business case being able to expand and being able to, perhaps, access rural areas that might find it more difficult to support a full-blown hospital financially. Let's talk about the human element for a second. How does the micro-hospital concept affect access to care?

Eric Temmel:

Yeah, that's a great question. So, as Bill has said, not only are hospitals and health systems and their partners using these to expand their offerings geographically. They're using them as a matter somewhat of necessity, and we see that reflected in some of the regulatory language that we do have. States will afford exceptions to micro-hospitals that have been created out of a rural hospital. If you, for example, seek to keep open a rural hospital, but transition it to a micro-hospital, you might have exceptions from certificate of need requirements or other upfront regulatory barriers.

So it enables rural areas, in particular, to retain at least some form of services, with a huge focus on emergency services. As I said earlier, these are not quite freestanding emergency departments, they're not outpatient emergency departments. Some states have different regulations for those types of entities. But there is a huge focus from the micro-hospital side on the emergency services. So it enables, at least in rural areas, some of these facilities to keep operating. Or it enables health systems to open facilities that'll offer emergency services that may disappear if they don't have these types of micro facilities to offer.

Phil Legendy:

Kevin, I know you've advised on several of these micro-hospital projects. Let's talk about the financing. What are the options to get a project like this financed?

Kevin Cunningham:

Thanks, Phil. When a health system decides that they want to be involved in some way with the construction, development, operation of a micro-hospital, there are three basic ways of financing and participating that I'll talk about.

The first (and simplest) is that the health system simply builds and owns the facility with their own funds. The second is that they build it and own it using revenue bonds that they issue under the health system's own credit, the way they would finance other capital types of projects. And the third is to do the micro-hospital financing as a project financing, in which the health system will likely not be the owner of the facility. They will have other relationships to the facility, but often it'll be financed as a project financing, off balance sheet, and perhaps as a joint venture with another entity.

There are pros and cons to each of these three approaches. The pros of a health system self funding its micro-hospital is that it's very simple. There's no borrowing, there are no financing costs, there's no interest to be paid. And the hospital or health system that is sponsoring the project has total control over the construction and operation, management, et cetera. The cons to self-funding a micro-hospital, very simply, is that it uses cash that the health system might have needed for other projects, possibly for more urgent projects. It reduces the available assets on the balance sheet, it reduces liquidity of the health system. And, in addition, it exposes the health system to all of the risks associated with the costs and potential losses and even failure of the micro-hospital.

The revenue bond financing offers the virtue of relative simplicity. Most health systems have financing structures in place with existing covenants and collateral that secure existing revenue bonds. Typically, they have a master trust indenture structure or something similar in place. There is market familiarity. Investors typically know who the health system is and may own some of the other bonds of that health system. The revenue bonds that are issued to finance a micro-hospital, in this instance, would typically have a rating from a securities rating agency. And because of the fact that the health system is typically a known quantity in the market, the interest costs will be about what they are for any other capital project that a health system might undertake.

This financing also has the advantage of ownership. The health system typically would own and control the construction and management of the facility. And the investors who buy the bonds would rely on the health system's management to make sure the project is built and managed and operated properly. And they would not typically look very closely at the peculiar risks associated with a micro-hospital. Also, these financings can typically be done at lower cost and more quickly than the third option, which is the project finance approach.

The cons for a health system of doing conventional revenue bond financing for a micro-hospital are first, obviously, that it would add debt to the balance sheet of the health system. It might limit the ability of the health system to issue debt for other projects, including potentially higher priority projects. The incurrence of the additional debt could conceivably have an impact on the securities ratings of that health system. And then finally, as with the self-funding option, the health system remains entirely exposed to the risks associated with the ownership and management of that micro-hospital.

Phil Legendy:

So the first two approaches, which are self-funding the micro-hospital, or having the health system issue revenue bonds to pay for it, share some of the similar advantages and disadvantages. What are the pros and cons of the project finance approach?

Kevin Cunningham:

The third approach, the project finance approach, is the most complex. In that case, the health system would in some fashion sponsor or participate in the development of the micro-hospital, but with a view to keeping the debt off the balance sheet of the health system, and minimizing the health system's exposure to the risks associated with the micro-hospital. Typically, a financing like this would be done either with a standalone special purpose entity or some other form of non-recourse financing by the health system or perhaps as a joint venture between the health system and another entity. The pros of this third approach, the project financing approach, are that if they're done correctly, the debt will not go on the balance sheet of the health system. That may preserve debt capacity for other projects. It may preserve the securities ratings of the health system's existing debt.

In the joint venture scenario, the health system may benefit from the participation of a partner that has, perhaps, experience in the design, construction and management of micro hospitals. And it's possible that that joint venture structure could even be part of a larger structure, larger strategy with that joint venture partner or other joint venture partners, including potentially, the development of more than one micro-hospital in that health system's service area.

The negative aspects of the third project financing approach is that the investors are secured primarily by the micro hospital itself and by the revenues of the micro hospital. From the investor's point of view, it is a higher risk transaction. And, therefore, they're going to look much more closely at that facility because they do not have access to the general credit of the health system. It may require that a new financing structure be put into place and developed by the health system for this project. Typically, not just a longer timeframe, but also higher costs of issuance and higher interest rates, because the bonds are likely to be unrated and investors are likely to demand to be compensated for the higher risks associated with the fact that their recourse is just to the micro-hospital and to its revenues. The investor base would typically be institutional for this kind of a financing and not retail. And again, the interest rates are likely to be higher.

Also, the health system that is sponsoring this project is likely to have less control than they're accustomed to having over the construction and management of the facility, because the investors are going to demand a certain level of protections. The investors are going to try to mitigate the risks that are associated with the project. And these risks that investors in a health system revenue bond financing don't normally worry about, but will worry about here, include construction risks, whether the permits and approvals have been obtained, does the builder have the necessary experience, does it have the necessary performance and payment bonds, builders risk insurance, issues such as construction risk; that ordinarily investors don't really worry about in a hospital revenue bond financing.

With respect to management, while the sponsoring health system likely will be involved to some degree, at least, in the management of the facility, the investors are likely to require the ability to replace management if they're not happy with the performance of the micro-hospital. And the investors are likely to require a mortgage and a security interest in the equipment, and possibly a lockbox for the revenues as well. In sum, the health system will have less control over the construction, operation and maintenance of this facility than they would if they owned it outright.

The investors are also likely to be much more focused on defaults and remedies. And in the worst case scenario, they may take over the facility following a default, and they may feel that their best option to be paid is to turn over the management of the micro hospital to a competitor of the original sponsor, which puts potentially a competing health system into the market, a service area of the hospital that originally sponsored the project.

One thing that a health system can do in the context of the project financing to try to mitigate these risks is to make some limited amount of funding available through, for example, a liquidity support arrangement in which they agree in advance to make a fixed amount of cash available to support the operation of the facility, if necessary. And typically the hospital or health system that is sponsoring the micro-hospital will be involved in the planning, design, construction, management and operation of the micro-hospital, including, frequently, the provision of specialty services such as imaging, laboratory services and so forth.

Phil Legendy:

So it's an interesting concept. It has a lot of potential as a scale down and simplified hospital. But as we know, nothing in our world is really simple. So, for folks that are considering exploring the micro-hospital concept, what next steps should they take to explore whether it's something that they can do? Eric, why don't you take the first pass at that from the regulatory perspective?

Eric Temmel:

Sure. So the first step is certainly to check state law. As we've covered, in Pennsylvania, for example, at least, there's not a separate license for a micro-hospital certainly. But these are acute care hospitals or they are campuses of a main licensed hospital that is operated as a micro-hospital. And for those things, we have very specific guidance. I mean, if you want to still comply with the regulations that apply to hospitals as a micro-hospital, we have guidance from the Department of Health in Pennsylvania that tells us exactly what you must do to do that. They're very specific, you must offer emergency services, you need 10 inpatient beds. Again, this is separating these micro-hospitals from some of these other facilities that we know, differ from ASCs, urgent care centers, for example, with this real focus on emergency services plus these inpatient beds.

And you need much more than that. I mean, you need infection rooms, you need 24/7 services offerings, you need proper physical resources to offer services 24/7. Some imaging services, although not necessarily MRIs. So again, sort of scaled down hospitals in that vein. And particularly interestingly, when we're talking about these emergency services, you do need to implement transfer policies for the services that you don't offer. You have to comply with EMTALA, so at the very least, you need to provide screening, stabilization, transfer with which we're familiar from the emergency services contexts under EMTALA. And these are all sort of, I guess, sub regulatory requirements because they're not set forth specifically in statute or regulation. But they are provided by the relevant agency in Pennsylvania.

And beyond that, you have to have specific types of treatment rooms available at this facility. So you have to offer certain obstetrics, pediatrics, trauma and emergency services, as we've sort of covered more specifically. You also need some sort of psychiatric or behavioral health, at least examination rooms so that you can stabilize patients that come in with those types of issues, as well. So there's a huge focus, I think, at the outset, at making sure that in Pennsylvania or whichever state you're in, you're complying with whatever guidance you have that says what services you must offer in order to minimally qualify as a micro-hospital or a mini hospital or a neighborhood hospital, whatever the state may call it.

And then setting aside the services just for a second, I mean, there are also questions of reimbursement, which is more a matter of federal law for which we do have some guidance. And we know that accrediting agencies and CMS will, if you want to get paid as a hospital, require you to at least offer inpatient services, multiple beds and be primarily engaged in the offering of inpatient as opposed to outpatient services.

Now, there's not a very specific definition or guidance as to what it means to be primarily engaged in inpatient services. But that's the type of thing that in conjunction with the state requirements, you want to look at. Because you want to make sure that you're offering sufficient services to be licensed, to continue to operate in your state, but also, to be paid at a higher rate under federal reimbursement requirements.

Phil Legendy:

And Bill, how about from the financing perspective? What can folks do to self-evaluate whether this is something they want to take further?

Bill Rhodes:

Well, Phil, when a health system is going through all of those considerations that Eric just laid out and how to comply with the regs, but also in addition to what's required, what does the service area need? What does this patient population really need in that area? All of those features, services, equipment, they all can get factored into the cost of this facility. And so the first thing, I think, a health system would need to do is make some of the decisions that Eric was talking about, at least preliminarily, in order to get their business objectives sorted out, so that they can then look at the financing alternatives. And typically, as Kevin mentioned, they're going to want to think very carefully about their own debt capacity, competing priorities, and the potential impacts on their credit ratings of doing this deal or financing through a general revenue bond program.

But in our experience, if they go the project finance route, they may have to find a new finance team that they're not typically used to using on their general revenue bonds. It might be a different issuer, it might be a different underwriter or bond counsel. Once they've made some decisions about which structure they may want to pursue financially, if they go to the project finance route, they may need to begin to assemble a team that might be a little different. There may be some overlap with their regular general revenue bond finance team. But, certainly, identifying financial advisors, potentially their bond lawyers and underwriters would be an important first step.

At the same time, there may be some steps that they need to take preliminarily to obtain the best tax-exempt outcome. And because in the project finance space, there is significantly more due diligence by the institutional investors, as Kevin mentioned, regarding real estate risks, and environmental risk, and site or facility risk, that they probably should start to think about feasibility analysis, real estate due diligence, title survey, environmental reviews. All of the basic elements that a lender, whether it's a bank or institutional investors, would expect.

And then another thing that I would be remiss not to remind people is, eventually the construction contracts, the management agreements and other key contracts, operational agreements for a facility like this, if financed on a project finance basis, will all be expected to be collaterally assigned to the trustee as security, so the bond holders could step in and take over the facility upon a default. And those types of collateral assignments may not be something that any of the counterparties, the construction contractors or the management agreement or whatever, would've expected because they don't typically see project finance in the healthcare space. So, broaching those topics and working with the counterparties on the various contracts about what's going to be needed for mortgagee protections and for proper security and collateral, should be a discussion that is undertaken early on in the transaction.

Phil Legendy:

Well, it's an interesting trend and one that's expected to accelerate in the coming years. Eric, Kevin, Bill, thanks for being here today. And thank you to our listeners for taking the time to join us. If you'd like to stay up to date on other healthcare topics, don't forget to check out our blog at www.healthcarereformdashboard.com.

Steven Burkhart:

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