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HEALTH CARE CONSOLIDATION:

Which way is up, and why are we going there?

Health care providers are looking to scale—in a variety of forms—to meet evolving market demands and regulatory pressures

By RONALD A. WIRTZ
Editor

To many, it's a four-letter word—spelled with 13 letters. It comes eventually to any big industry, whether farming, auto-making or banking. It's often feared, at least until one becomes familiar with it, or its alternative. But like it or hate it, it's probably coming to your health care provider in one of many shape-shifting forms. The word comes laden with emotion, denoting a loss of independence, with small-town businesses getting gobbled up by a faceless corporation. It should almost come with its own dramatic background music.

Consolidation. The combining of two or more previously separate businesses is in full force among health care providers, with large numbers of mergers and acquisitions as providers seek both horizontal breadth and vertical integration to offer the most care services to the most people.

Earlier this decade, Medcenter One, based in Bismarck, N.D., started considering partners for its 228-bed hospital, a college of nursing and seven primary clinics and care facilities serving western and central North Dakota communities like Dickinson and Jamestown. After kicking the tires on possible suitors, in 2012 the organization merged with Sanford Health of Sioux Falls, S.D., but not without some controversy, said Craig Lambrecht, president of Medcenter One at the time, and now president of the newly formed Sanford Bismarck.

"People were scared to death" because there was a lot of uncertainty about potential layoffs and the autonomy of local providers, said Lambrecht. "Once we engaged [employees and the community], that fear dissipated."

For health care providers, consolidation is simply a logical business reaction to a multitude of economic and policy pressures that require new strategies for providers to remain viable given prevailing, even conflicting, policies for manag-

More on health care consolidation ...

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One of the Minneapolis Fed’s congressionally mandated responsibilities is to gather information on the Ninth District economy. The *fedgazette* is published quarterly to share that information with the district, which includes Montana, North and South Dakota, Minnesota, northwestern Wisconsin and the Upper Peninsula of Michigan.

The Quick Take

While it’s not a new phenomenon, consolidation among health care providers appears to be growing in activity and expanding in form. Traditional mergers and acquisitions are expanding health care organizations to offer more services to a broader market. But consolidation has also morphed into many different structural and legal forms that stop short of traditional mergers and acquisitions but achieve strategic objectives for both organizations.

Consolidation, in its many shapes, sizes and arrangements, appears to be accelerating as health care organizations look to achieve greater scale to address a dizzying array of market and government pressures. Reimbursement policies, technology, regulations, capital needs, shifts in patient care and other factors have combined to create a state of flux in health care that is making organizational independence more and more difficult.



Consolidation from page 1

ing costs and getting paid for the care provided.

But this isn’t your father’s consolidation, so to speak. While there are plenty of traditional mergers and acquisitions among providers, consolidation is fundamentally about a relationship between two entities for the economic benefit of both.

As the complexity of health care increases, so do the number of legal arrangements between providers—partnerships, affiliations, joint ventures and other agreements. These “consolidation lite” arrangements offer smaller shifts in control while giving each party better competitive footing in a grueling health care market.

The many shapes, sizes and arrangements of consolidation activity today stem from a dizzying array of drivers. Most can be boiled down to the chase for greater efficiencies and leverage made possible by economies of scale and pursued for the sake of addressing steadily rising health care costs.

But the desire for scale is itself driven by a host of market and regulatory pressures within a dauntingly complex U.S. health care system. Reimbursement policies, technology, government regulations, capital needs, shifts in patient care and other factors have combined to create a state of flux in health care that is making it harder for organizations to remain independent.

The business of consolidation

Evidence of consolidation among health care providers is all around. Since 2008, there has been an increase nationwide in the number of mergers and acquisitions among hospitals, according to industry consultant Irving Levin Associates (see Chart 1). As a result, more hospitals than ever are part of a health care system rather than operating independently, according to the American Hospital Association (see Chart 2).

Much of this consolidation is horizon-

tal in nature; providers are seeking to either enter or expand in a given market by acquiring similar providers. In Minnesota, the number of private hospitals that remained unaffiliated with another health care organization fell 26 percent (from 62 to 46) from 2003 to 2013, according to data from the Health Economics Program with the Minnesota Department of Health. The total number of unique private health care systems in the state fell by a similar percentage (see Chart 3).

But consolidation also travels vertically as health care providers acquire other providers to expand available care services and build larger and broader internal referral loops so that patients don’t have to seek care elsewhere.

One of the biggest vertical consolidation trends deals with hospital-based health care systems buying up previously independent physician groups. Historically, most primary and even many specialty care physicians have been employed independently and given special admit-

ting and treatment privileges at hospitals. That’s changing, as more hospital-centric health care systems add so-called hospital outpatient departments (HOPDs) that look and act much like traditional physician-owned clinics. An Accenture report this year noted that “the era of the independent physician that many adults grew up with is swiftly coming to an end.” In 2000, 57 percent of physicians practiced independently, outside a larger health care system. In 2013, that number had fallen to 37 percent, and Accenture projects a further fall to 33 percent by next year. (See “Loss of independent physicians” on page 3 for more discussion of this trend.)

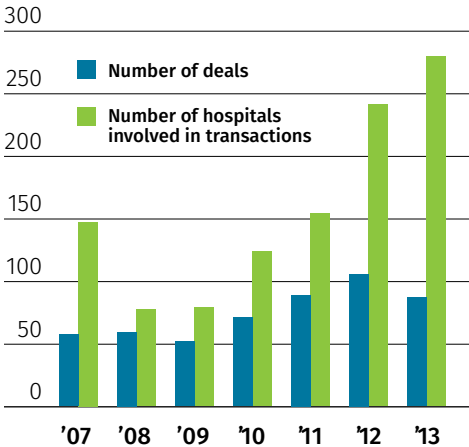
Though there are no official data on the matter, that trend appears to be present in Ninth District states. In Montana, there has been a “tidal wave” of physicians leaving private practice to become hospital and/or health care system employees, according to Carter Beck, president of the Montana Medical Association. In Minnesota, physician groups were a hot target for health care systems, “but that game is pretty much done,” with many available groups already getting snapped up, said Mary Brainerd, CEO of HealthPartners. (Full disclosure: Brainerd is the former chair of the board of directors for the Federal Reserve Bank of Minneapolis.)

Specialists are also targets for vertical consolidation and integration. According to a national survey by the American College of Cardiology, the share of cardiovascular practices that are owned by physicians dropped from 59 percent to 36 percent from 2007 to 2012. Hospital ownership of these groups rose from 11 percent to 35 percent over this period (remaining ownership is with universities, government and health management organizations).

Different parts of the Ninth District

Announced U.S. hospital mergers and acquisitions

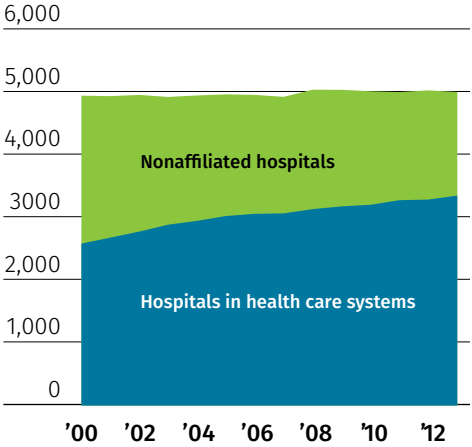
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Source: American Hospital Association and Irving Levin Associates, Inc., *The Health Care Acquisition Report*, 2014

More U.S. hospitals are part of a health care system

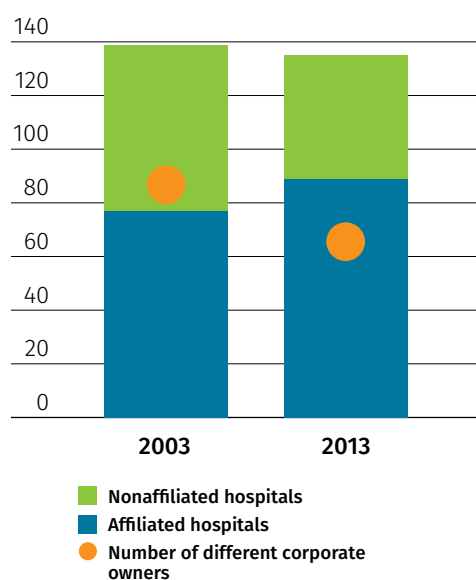
2



Source: American Hospital Association

Fewer independent private hospitals in Minnesota

3



Source: Minnesota Department of Health, Health Economics Program



HORIZONTAL CONSOLIDATION

garners the most attention—especially when it comes to mergers and acquisitions. This happens when a large provider, like a hospital, acquires smaller independent hospitals or when a large integrated provider merges with another health system. The goal here is to enter new regional markets or expand in existing ones. In Minnesota, the number of independent hospitals has fallen by about one-quarter since 2003.

appear to be at different stages of consolidation. Minnesota's health care sector is viewed by many as already quite integrated, said Matthew Anderson, senior vice president for policy and strategy with the Minnesota Hospital Association (MHA), who responded at length via email. While there is still consolidation activity in the state, "the rate or frequency of

those transactions has not been as feverish over the past five years as in other areas in the country."

Given its smaller population and expansive geography, horizontal consolidation among hospitals "has not taken hold in Montana yet. However, there are a number of larger hospitals that have begun conversations" in hopes of

expanding their markets and reducing costs, said Dick Brown, president of the Montana Hospital Association. There has been recent activity too. Earlier this year, Benefis Health System (Great Falls, Mont.) paid just \$500,000 for Teton Medical Center (Choteau, Mont.), which included a 10-bed critical access hospital, clinic and 36-bed long-term care facility.

Activity in North Dakota has reportedly been heating up. "I think North Dakota has been isolated from consolidation for a lot of years," said Jerry Jurena, president of the North Dakota Hospital Association (NDHA). The state has an independent streak, and health care

Continued on page 4

Loss of independent physicians: Follow the money

The downward trend among independent physician groups seems innocuous in the broader context of health care consolidation. But certain reimbursement policies have facilitated the shift.

For physician-partners at an independent clinic, income is directly related to a clinic's net income, all of which is paid out to partners, said Mike Foley, administrator and chief operating officer at the Apple Valley (Minn.) Medical Center, which operates a joint venture with Allina Health in the Twin Cities. AVMC runs primary and urgent care centers—employing its own doctors—along with some miscellaneous operations, according to Foley, while Allina runs "everything else."

Contrast that with the flow of money in larger health care systems, where an increasing number of doctors are employed in hospital outpatient departments (HOPDs). Here, doctors are typically paid market-rate salaries on the basis of being able to generate "downstream revenue"—patient referrals to other more expensive and more profitable care services within the same health care system—rather than their ability to generate net income for the HOPD, Foley said.

As such, HOPDs are used as a loss leader similar to those used in retail, where a grocer will sell soda at a low price—even at a loss—to get shoppers in the door on the expectation that they will also pick up a few higher-margin products. According to the Medicare Payment Advisory Committee (MedPAC), hospital outpatient margins have consistently been in the red—negative 10 percent or worse—for about a decade.

There is also a reimbursement quirk that compounds the salary matter: The negative margins exist despite the fact that Medicare pays HOPDs more for certain services than it does for similar services at a traditional clinic in the belief that HOPDs are part of hospitals, which offer more comprehensive services and have higher carrying costs than a physician's office and thus are due higher reimbursement.



In a report this spring to Congress, MedPAC pointed out that Medicare usually pays more for services in HOPDs "even when those services are also safely performed in physician offices." For example, Medicare pays an outpatient facility \$492 for a Level II echocardiogram compared with \$228 in a freestanding physician's office. "This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to HOPDs without changing their location or patient mix." In 2013, echocardiograms billed from HOPDs increased 7 percent, while those from physicians' offices declined 8 percent. This increases Medicare spending for taxpayers and cost-sharing beneficiaries, MedPAC pointed out, with no known change in patient care.

For its part, the American Hospital Association commissioned a study this year by KNG Health Consulting to look at patient populations. It found that HOPD differentials were warranted because their patient base was more likely to be uninsured or on Medicaid (which does not pay a higher differential), have more severe chronic conditions and have higher prior utilization of hospitals and emergency departments, all of which increased overall treatment and operating costs.

Whatever the case, doctor-owners at independent clinics converted to HOPDs stand to see a nice payout for their ownership stake in a clinic and a salary bump of as much as 30 percent, according to Foley. While doctors in an HOPD lose much of their previous autonomy, "there is also a certain amount of stress in running your own business" that is relieved by the transition.

Foley himself recently had to tamp down rumors of AVMC being fully acquired by Allina. "I think there is logic to the rumor," he said. "It's just not true."

—Ronald A. Wirtz

Consolidation from page 3

organizations traditionally respected each other's territorial lines.

That changed around 2009, Jurena said, pointing to two events. The first was the merger of MeritCare in Fargo—the state's largest health care system at the time—with Sanford Health. The resulting entity has become one of the nation's largest nonprofit, integrated rural health care systems.

The other factor? "They discovered how to get oil out of the ground at a good price," said Jurena. The oil boom and the subsequent crush of workers coming to the state "brought a whole new clientele" for health care organizations, "who started to see market potential that they wanted to be involved with."

When Medcenter One started considering a marriage partner for its sizable operations, "we looked at all the options, and the best option was to go with Sanford," said Lambrecht. At the time, Sanford had little presence in western North Dakota, and the company pledged to invest \$200 million over the coming decade to improve Medcenter facilities and services. This saved some medical services at locations in smaller communities that might otherwise have gone away, because "we could not have afforded them," Lambrecht said.

In 2014, Sanford built a new \$30 million clinic in Dickinson, six times the size of the previous facility, giving patients there better access to primary and specialty care closer to home.

"That's why the merger was so attractive," said Lambrecht. "It allowed us to be relevant."

Smaller, one-off acquisitions tend to reinforce regional markets. Sanford Health grew its Minnesota presence from nine hospitals to 15 from 2003 to 2013, acquiring smaller facilities in the western part of the state in places like Alexandria, Bagley, Thief River Falls and Wheaton. In 2004, Benedictine Health System and St. Mary's Duluth Clinic Health System merged their seven Minnesota hospitals to eventually form Essentia Health, based in Duluth. By 2013, Essentia had grown to 12 in-state hospitals, mostly by acquiring facilities in rural northeastern communities like Aurora, Deer River and Virginia.

Not every merger involves a major health care system. In some cases, mergers happen between smaller organizations in the same regional market looking to become stronger by joining forces.

In rural northwestern Wisconsin, NorthWoods Community Health Center and The Lakes Community Health Center merged in 2013 to become NorthLakes CHC. "They were both small CHCs with minimal patient base," said Lisa Olson, director of policy and programs for the Wisconsin Primary Health Care Association, an organization supporting CHCs

statewide. "They decided it made the best sense to leverage their strengths and merge ... to attract and maintain [qualified health plan] contracts as well as leadership staff." Turnover of executive and clinical staff was high at both organizations, said Olson.

As a result of the merger, "NorthLakes is more efficient than the two separate entities were," and the five northern Wisconsin locations offer greater access to a broad array of services, including medical, dental, chiropractic, behavioral health, and occupational and speech therapy. "They now have the largest seal-a-smile program in the state" to provide tooth sealants to kids in schools, said Olson.

Missing a lot of detail

But this overview of health care consolidation leaves out a lot of detail and activity. Unfortunately, measuring the full scope of provider consolidation over time is difficult because the health care sector is so large, at 17 percent of the economy, yet government tracks virtually none of the consolidation activity (though Minnesota offers a few modest exceptions). Private sources fill some of the void, but they typically offer limited insights on a state or regional level.

Hospitals and major health care systems receive the lion's share of attention in news accounts and other analysis regarding consolidation—not surprising given their size and common status as large employers. But the provider market has exploded outside of hospitals, thanks to growing markets for different care services and settings—many of them still comparatively small, private entities. In Minnesota alone, the number of advanced diagnostic imaging providers roughly tripled between 2003 to 2013—to more than 80—and the total number of unique facilities more than quadrupled, to 272, according to data from the Minnesota Department of Health. The large majority are not owned by major

health care systems—at least not yet, as they seem likely to face many of the same consolidation pressures that hospitals and physician groups face.

So getting a good picture of the state of consolidation is more art than data science. This is especially the case because there is also an undercurrent of other transactions that are bringing more providers together in formal, but less comprehensive ways, leveraging some of the benefits of consolidation without the ownership shift that occurs in a merger or acquisition. These transactions vary in the depth and breadth of legal integration among the parties involved, ranging from management contracts to joint ventures and long-term leases.

Getting any measure of this type of consolidation—everything below mergers and acquisitions—is nearly impossible. Activity encompasses a multitude of legal forms and agreements and no one, public or private, is tracking these transactions, partly because they are privately negotiated and partly because some transactions are mundane—like a management agreement that gives a smaller hospital access to group purchasing through a larger health care system. But sources say

this grayer area of consolidation and integration is the most active (see "Beyond mergers and acquisitions" on page 9 for examples and more discussion).

"We're seeing huge creativity in the market in this regard ... and a lot of interdependent relationships" are developing as a result, said Terry Hill, senior adviser at the National Rural Health Resource Center in Duluth, Minn. He attributed this growth partly to the complexity and imperfections of the health care sector, which creates incentives for experimentation. But this activity is also occurring because of "the difficulties in merging [health care organizational] cultures as much as anything," said Hill.

Keith Anderson is a partner in the health care practice at the law offices of DrinkerBiddle and consults for major health care systems nationwide. "I'd describe strategic transactions today as frenetic ... and they've really accelerated" over the past half-dozen years or so, said Anderson. "We see a lot of creative models" in the types of transactions that bring providers together. In many of these, providers "are not looking to merge or sell off assets. They are picking teams" to compete in a variety of areas—recruitment, contracts, IT systems and value-based care models, to name a few.

Driving for change

The forces behind the many forms of consolidation are both simple and exceedingly complex. At its core, consolidation is a market reaction, a structural response by providers that see larger size and broader reach as a competitive advantage, bringing efficiencies that flow through to the bottom line and, ideally, to patients.

In the case of health care, providers are pursuing scale for numerous reasons, but most of them have some relationship to rising costs.

Although health care cost increases have slowed in recent years, costs have



GRAB BAG 1 OF CONSOLIDATION DRIVERS

ICD-10

Starting in October, the health care world is transitioning to ICD-10.

The International Classification of Diseases, or ICD, contains standardized codes for medical conditions and procedures used for diagnosis and billing that have not been updated in more than 35 years.

It replaces ICD-9, and the changeover will replace the current 14,000-code system with 69,000 codes. A survey by the Physicians Foundation found that 50 percent of physicians believed implementation of ICD-10 "will cause severe administrative problems" in their practices. Given the expansion, its implementation will be simpler for providers who have automated, centralized record keeping, where fewer people have to learn the complexities of the new system.

GRAB BAG 2 OF CONSOLIDATION DRIVERS

Consolidation of health benefit and other health services companies

Health benefit and other health services companies are consolidating to gain the same efficiencies of scale as other sectors in health care.

This year, for example, Catamaran Corp. was acquired for \$12.8 billion by OptumRX, a unit of health insurance giant UnitedHealth Group of the Twin Cities. This consolidation will combine the third and fourth largest pharmacy-benefit businesses, increasing economies of scale and negotiating leverage with drug companies and providers.

consistently been well above inflation in the rest of the economy (see Chart 4). It's not hard to connect the dots: Spending for Medicare and Medicaid programs has been rising rapidly, and health insurance costs for employers have increased much faster than wages and other benefits since 2006 (see Chart 5).

"As employers and government payers continue to look for ways to reduce health care spending, their efforts will put further pressure on health care providers to reduce costs and increase risk management," said Scott Duke, president of the South Dakota Association of Healthcare Organizations.

But "rising cost" is itself rather obtuse. It springs from a multitude of other sources, and unbundling some of these factors offers a better picture of the more direct drivers behind consolidation.

(Editor's note: For a better sense of the many disparate factors driving provider consolidation, see a wide range of examples in the "Grab Bag" boxes sprinkled throughout the text that demonstrate the scope of forces affecting providers.)

For example, human labor makes up 60 percent to 70 percent of costs at a hospital, according to Jurena, from NDHA, "and there is not enough go around,"

especially for high-skill positions. A hospital administrator in Bismarck told Jurena that if 200 nurses showed up tomorrow, "he could hire all of them." A Fargo hospital administrator put the number at 100 nurses.

Minnesota job vacancies in the health care and social services sector more than tripled over a five-year period, reaching 18,000 in 2014, according to biennial surveys by the Minnesota Department of Employment and Economic Development.

Tight labor markets tend to push up wages. In Minnesota and North Dakota, average weekly wages for hospital workers have risen 18 percent (inflation-adjusted) since 2010, according to the Quarterly Census of Wages and Employment. Such circumstances—high vacancy rates in the face of rising wages—make consolidation more attractive, as providers look for efficiencies that can reduce labor need, especially in administrative and other nonmedical positions.

Build it and they will ... charge you for it

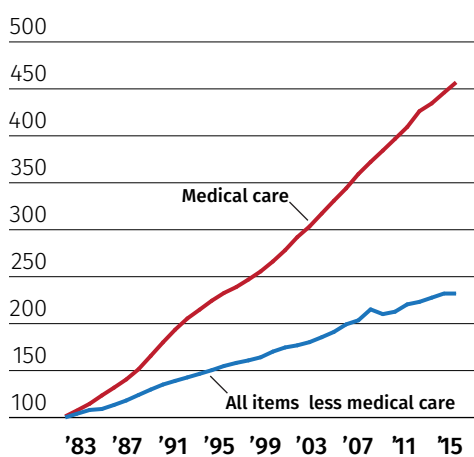
Capital costs are also a powerful driver of consolidation in health care. Kelby

VERTICAL CONSOLIDATION is done to expand the care services available to patients. This is often referred to as a "cradle to grave" model, and includes the acquisition of providers to build larger and broader internal referral networks. This way, patients don't need to seek care anywhere else. There are no hard measures, but vertical consolidation appears to be quite strong currently as providers react to the Affordable Care Act and other forces seeking greater care integration.



Chasing health care inflation ... and losing

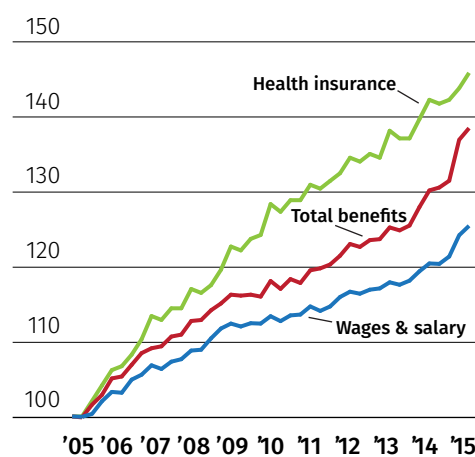
Consumer price index, all urban consumers (1983 = 100)



Source: Bureau of Labor Statistics

U.S. employee compensation costs

(2005 = 100)



Source: Bureau of Labor Statistics

Krabbenhoft, president and CEO of Sanford Health, called health care "one of the most capital-intensive industries in America." Small hospitals and other providers often struggle to keep up, and as a result "have been amalgamating for some time."

Capital needs run the gamut, from facilities to advanced medical equipment to the electronic health records that keep track of all those doctor visits. Many rural

facilities, for example, are "Hill-Burton hospitals," named after the federal law in 1946 that gave grants and loans to mostly rural hospitals to grow and modernize over the coming decades. Many have not been updated over the years, "and patients expect more modern buildings, equipment, all the bells and whistles" that come with health care services today, said

Continued on page 6

GRAB BAG 3 OF CONSOLIDATION DRIVERS

Lower reimbursements for uncompensated care

Nonprofit hospitals are required to provide care for the poor as a condition of their nonprofit status, much of which goes down in the books as uncompensated care. But hospitals get some of that back through so-called bad debt reimbursements from Medicare.

In 2012, federal legislation reduced Medicare bad-debt reimbursement for noncritical access hospitals from 70 percent to 65 percent. Critical access hospitals—which by definition are small

and rurally based—saw bad debt write-offs cut from 100 percent to 65 percent (phased in over three years and now fully implemented).

The loss of these write-offs puts more financial pressure on many small community hospitals already operating on thin margins.

ACCOUNTABLE CARE ORGANIZATIONS:

The shift from volume to value

Accountable care organizations (ACOs) are an example of new reimbursement models that replace the fee-for-service model with a so-called patient-centric model that emphasizes service value rather than service volume.

ACOs were first introduced with the Affordable Care Act as a means to improve care quality and reduce the costs of Medicare. A voluntary ACO program began in early 2012 that allowed providers and suppliers to coordinate care for their Medicare population. ACOs received upfront lump sums and modest monthly payments from the federal government for each Medicare beneficiary. ACOs that managed to lower growth in Medicare costs, while meeting certain standards of care and patient outcomes, then shared in the accrued Medicare cost savings. Minnesota-based providers Essentia, HealthPartners, Fairview and Allina Health Systems all have ACOs.

According to the Centers for Medicare and Medicaid Services (CMS), 103 ACOs held Medicare spending \$926 million below their targets in 2014, earning performance payments of more than \$423 million; the balance represents net savings to the Medicare trust fund.

Call it a good start, with a long way to go. Only 30 percent of all participating ACOs earned any cash bonus, according to CMS. While net savings to Medicare were \$500 million, total Medicare spending in 2014 was more than \$500 billion.

Within the health care industry, there is considerable disagreement over the staying power of ACOs and other similar value-based care models. A 2014 survey by the Physicians Foundation found “dubious acceptance” among physicians of the shift from volume to value. A Deloitte survey last year found that physicians anticipate

value-based payment models equaling about half of their total compensation a decade from now, but “they are reluctant to participate, preferring the status quo, and are concerned about the consequences of financial risk.”

Jerry Jurena, president of the North Dakota Hospital Association, has seen previous initiatives promising to finally get a handle on rising costs, like health maintenance organizations of the 1990s. “Is this another fad or process in how we pay for health care? I don’t know,” he said. “I’m for trying things, but I’m skeptical it will work.”

Mike Foley, administrator and chief operating officer of the Apple Valley (Minn.) Medical Center, said the jury was still out on ACOs. “I don’t think anyone has figured out how to work that yet” on a sustainable basis, he said. Many providers are involved in ACOs, “but I haven’t heard anyone saying, ‘Eureka, we’ve figured it out.’”

Others said that Medicare’s involvement was a game changer. “There’s no question that’s what all systems are preparing for,” said Terry Hill, senior adviser for the National Rural Health Resource Center, located in Duluth, Minn. “It’s a done deal; everybody knows it.”

Mary Brainerd, president and CEO of HealthPartners, said a lot of vertical integration is occurring under the belief that “Medicare is looking for something different ... and that powerful message is driving behavior.”

Kelby Krabbenhoft, president and CEO of Sanford Health, agreed. “When Medicare will give X number of dollars to take care of a population and the risk is yours ... when that happens, the debate [about ACOs] is over. It’s such a big payer.”

—Ronald A. Wirtz

GRAB BAG

OF CONSOLIDATION DRIVERS

Federal sequestration

When Congress gets a cold, doctors and hospitals sneeze.

The Budget Control Act of 2011 created automatic budget cuts in future federal spending, dubbed sequestration. Included was a 2 percent cut in Medicare reimbursement from 2013 through 2022, and later extended through 2024.

In September, the American Hospital Association estimated that sequestration had cost hospitals \$58 billion in lost reimbursements.

Compounding the matter: Because sequestration cuts are considered temporary, recommendations for annual Medicare reimbursement rate changes do not take sequestration effects into account.

Consolidation from page 5

Michael Topchik, senior vice president at iVantage, a health care analytics firm.

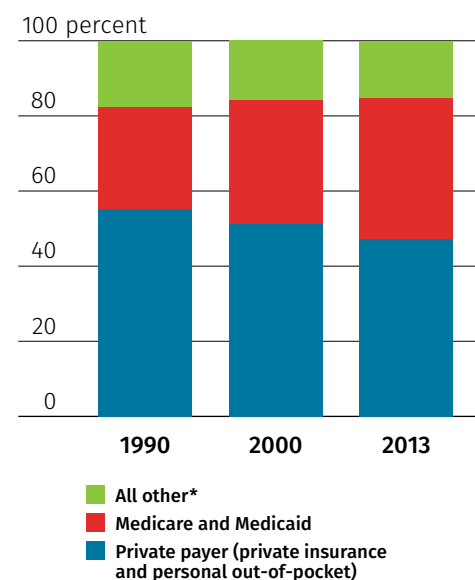
Upgrading such facilities often becomes prohibitively expensive, given razor thin operating margins common in the industry. Many hospitals “have been happy to get by on 1 to 2 percent” net income margins, said Krabbenhoft, but that’s why they have outdated facilities and equipment. The industry target now is 4 to 5 percent, Krabbenhoft said, because “no matter how hard you try, you can’t get by on 1 to 2 percent margins.”

In 2013, 27 percent of Minnesota hospitals had bottom-line margins of 2 percent or less, according to financial data from the Health Economics Program with the state Health Department. Another 9 percent of hospitals cleared that bar only because of other income from nonhospital operations.

But modernizing outdated facilities is just one of the many capital mouths to feed at every health care organization—small or large, rural or urban. New technology, for example, promises increased consumer demand but comes at a steep price. “It’s not that they just need a new emergency room or a new roof,” said Krabbenhoft. “Now they need technology for care, and it’s so, so expensive.”

Cardiac ultrasound scanning systems cost an average of \$158,000 in June, almost 12 percent more than a year ear-

Share of national health care expenditures



*Includes Children's Health Insurance Program, Department of Defense, and Department of Veterans Affairs, as well as other private and public health care expenditures, including workers' compensation, Indian Health Service, vocational rehabilitation and school health

Source: Centers for Medicare & Medicaid Services

lier, according to the ECRI Institute, a nonprofit medical research and technology assessment organization that tracks equipment purchasing and pricing. But that's a pittance compared with the price of other big-ticket items like MRI machines (\$1.5 million) or PET/CT scanners (\$1.9 million). Average prices for the 10 most popular capital items rose by 7 percent in June compared with a year earlier, according to ECRI.

Still, even these costs can pale compared with those associated with federal mandates for electronic health records (EHR), systems that keep track of medical histories and provide access for any authorized user, including patients.

To insure “interoperability” among providers, EHR requires entirely new information technology systems, and

GRAB BAG

OF CONSOLIDATION DRIVERS

The continued shift away from inpatient visits

Hospitals nationwide are facing a long-term trend of stagnant or lower volumes of acute care admissions—historically the bread and butter of hospital revenue. This creates incentives to look for—and acquire—other growing care services. In Minnesota, inpatient admissions at the state's hospitals were down 4 percent from 2010 to 2013, according to the Minnesota Department of Health. Certain facilities are feeling a much greater pinch. At the state's 78 critical access hospitals, acute care admissions and total patient days were both down more than 12 percent over the same period.



There is also consolidation activity that stops short of a traditional merger or acquisition, but still achieves strategic objectives for both entities.

CONSOLIDATION LITE can take many forms.

For example, it can help multiple providers affiliate for a particular objective—like contract negotiation with insurers. Or a management agreement can allow a large health system to give small providers access to their expanse of resources. These types of transactions aren't new, but they are increasing, thanks to expanding market and regulatory pressures.



In 2013, 27 percent of Minnesota hospitals had bottom-line margins of 2 percent or less, according to financial data from the Health Economics Program with the state Health Department. Another 9 percent of hospitals cleared that bar only because of other income from nonhospital operations.

hardware and software costs can quickly run into the millions—often with additional zeroes. “It’s an expensive ordeal, and there is no reimbursement for that,” said Jurena.

Krabbenhoft said that Sanford has spent more than \$1 billion across its network of facilities for seamless record keeping and sharing. With the Medcenter One merger, Sanford has spent \$30 million to \$40 million “just getting rid of a hodge-podge of IT systems.”

And expense aside, few small providers have the technical know-how to properly manage such systems.

Matthew Anderson, from MHA, said the challenge of installing and maintaining an EHR system that meets federal requirements “appears to be perhaps the most significant factor” among many pushing consolidation.

As a federal mandate, EHR is part and parcel of growing costs for regulatory compliance. Health care organizations are required to gather truckloads of data on patients, fill out binders of paperwork and jump through other operational hoops to be reimbursed and to meet patient safety and other requirements. A 2014 survey of about 20,000

doctors by the Physicians Foundation found that doctors spend 20 percent of their time on nonclinical paperwork, and that doesn’t consider the compliance efforts of other workers.

A study by PricewaterhouseCoopers and the American Hospital Association found that on average, every hour of patient care provided entails 30 minutes of paperwork. Administrative work benefits from economies of scale, making consolidation an attractive option.

Beck, from the Montana Medical Association, said “exploding” regulatory compliance costs stemming from the Affordable Care Act and other government regulation have “significantly driven the vertical integration ... forcing doctors out of private practice.”

Bill collector

On the other side of the financial ledger, reimbursements play a big role in consolidation, particularly those from the country’s largest health insurance plans, Medicare and Medicaid, the federal health care programs for the elderly and poor, respectively. The populations

Affordable Care Act

The Affordable Care Act is widely cited for accelerating consolidation due to a variety of regulatory and other mandated changes.

But possibly the broadest impact might come from the acceleration of Medicaid enrollments, which have increased 23 percent since 2010 (pre-ACA). Enrollments have grown the most in states that broadened their eligibility as part of the ACA. In North Dakota, Medicaid rolls have grown 27 percent; in Minnesota, 16 percent.

Higher enrollments put added pressure to tighten allowable costs and reduce reimbursement rates to keep costs from rising too quickly. This further exacerbates the reimbursement imbalance that providers must manage between public versus private insurance payers (see cover article for more details).

of both programs have been rising, and their combined share of national health care expenditures has grown steadily, from 27 percent in 1990 to 38 percent in 2013 (see Chart 6).

The federal government sets the prices that providers receive for patient care from Medicare and Medicaid—for providers, there’s no negotiating prices. With rising enrollments, the federal government has attempted to control expenditures by tightening the allowable costs that providers can claim for reimbursement—so much so that the operating margin (payments minus cost) for the average Medicare and Medicaid patient has been in the red for a decade and a half. Providers currently receive about 90 cents for every dollar of service provided to these patients (see Chart 7 on page 8).

“We haven’t figured out how to care for the patient and get paid for it,” said Jurena, who has worked in the sector since 1975. “So everybody is struggling because you don’t have a model that works.”

To keep the doors open, providers have increased what they charge a shrinking base of patients with private insurance. Consolidation helps providers on both ends: It offers centralized expertise in dealing with regulation and paperwork associated with Medicare and Medicaid reimbursements, as well as federal regulation in general, making these patients comparatively less expensive. In the private-payer market, consolidation also expands networks and limits competition, helping to maintain pricing leverage with health insurance companies and the employer plans they sponsor,

GRAB BAG 7 OF CONSOLIDATION DRIVERS

Consolidation of device makers

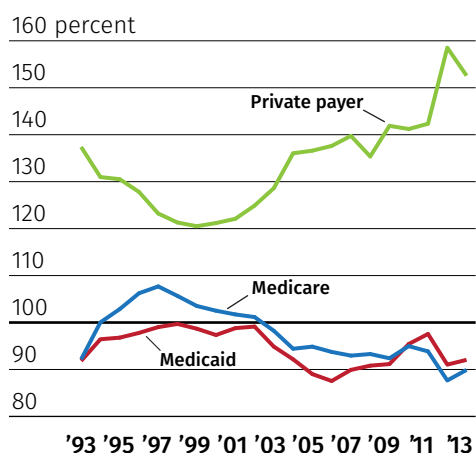
Minnesota is home to some of the largest medical device makers. The bigger they are, the more leverage they have on pricing, and 2015 was a busy year.

Twin Cities-based Medtronic alone closed four deals this year worth a total of \$1 billion; St. Jude Medical acquired heart-device firm Thoratec for \$3.4 billion; Boston Scientific acquired Minnetonka-based AMS, a maker of men's health devices, for \$1.6 billion.

Consolidation from page 7

Aggregate U.S. hospital payment-to-cost ratios

By payment source



Source: Avalere Health analysis of American Hospital Association annual survey data, 2013, for community hospitals

which have much higher profit margins.

The Accenture report attributed much of the decline of independent physicians to reimbursement pressures. A national survey by the American College of Cardiology attributed the drop in physician-owned cardiovascular practices to Medicare reimbursements that are higher for hospitals than for clinics.

The tensions of this fee-for-service reimbursement model is the impetus for a fundamental change in how care is provided and paid for, something several sources said represented a shift from “volume to value.”

“You’re seeing a compelling and dramatic shift in the very nature of how health care is financed,” said Krabbenhoft, of Sanford. This includes a shift to value- and risk-based contracting, where providers

are paid upfront fees to manage the health of an enrolled population and rewarded or penalized depending on whether they

meet certain health metrics and cut care costs for patients. (An example of this reimbursement model is accountable care organizations, or ACOs. See sidebar on page 6 for more discussion.)

The good news is that many sources see a fundamental, positive shift toward smarter health care spending. For example, if Medicare wants to hypothetically pay a significant, one-time fee to care for a patient for a year, and the provider gets to keep any savings but also bears the risk of overspending for care, “you start to think differently than if you get paid every time someone visits the hospital,” said Brainerd, from HealthPartners.

Under such a model, said one source, primary care becomes a driver of provider revenue by keeping patients out of the emergency room and off the surgery table; these expensive services become a net cost to the provider rather than a profit center, as they are in the current model.

But part and parcel with this shift toward value-based care, at least at this stage of development, is that it requires large patient populations to properly

distribute and manage risk, and integrated networks offering a full continuum of care to better track and manage the health of a covered patient population. “You need analytics. You need financial heft to accept the risks” inherent in this care model, said Brainerd.

A pleasure to meet you, consolidation.

Build your own models

What consolidation hasn’t done yet is provide a clear view of the future of health care, or even whether it has been net positive for patients in terms of access, care quality and costs.

Sources widely agreed that little progress had been made on cost. “As is readily apparent to anyone, consolidation is not resulting in better pricing for consumers,” said Beck, from Montana.

Anderson, from MHA, was a little more sanguine about the overall effects of provider consolidation. “Studies generally show that the quality of care as a whole continues to improve across the country [and] that the rate of cost growth ... has been more stable and lower than it has been in decades.”

But he acknowledged that “whether consolidation is necessary to achieve these results—or if similar outcomes can be achieved through other efforts of independent organizations—remains debatable. ... Consolidation seems like a more clear, direct and intentional means to create the kind of alignment and coordination that produce better outcomes at lower costs. But there is not definitive proof that [consolidation] is the only way that providers can accomplish these goals,” Anderson said.

For the time being, it will be consolidation’s game to lose, as no sources believed a reversal of consolidation was likely in the near term. Foley, from Apple Valley Medical Center, said there

will always be anecdotes “of two doctors leaving Mayo to start up their own practice, but ... I think all big [health care system] corporations are looking to capture market share through mergers and acquisitions or alignment strategies. It’s all about the cost. Follow the money.”

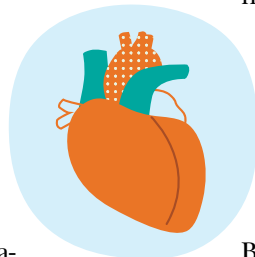
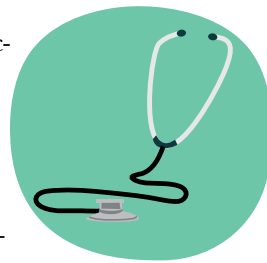
Where the health care market currently lies along the full arc of consolidation is anyone’s guess. In many ways, health care is a constantly rejuvenating industry with new products and services developed to treat both rare and common afflictions that keep us kicking longer, giving birth to new markets and firms.

Health care is also still a regional market almost everywhere. That’s why every state has a small-to-large cadre of unique providers. Multiplied by 50 states, health care is still far from consolidated compared with many industries.

Keith Anderson, from DrinkerBiddle, said health care is not maturing as quickly as other industries like manufacturing, where consolidation typically leads to fewer business models. Anderson said that until fairly recently, health care has been “more of a cottage industry,” with providers at each level of care often not far removed from their local-owner roots.

“I think we’re a long way away” from the point at which consolidation starts to taper off, Anderson said. “But I think we have the seeds” of the models that will survive into the future.

Pointing to the likes of Mayo Clinic and Cleveland Clinic, highly reputable health care systems, “the common seed is that they employ physicians,” said Anderson. “This allows you to design a care model where the physician and hospital have the same stake in the outcome. They are bound together.” ■



GRAB BAG 8 OF CONSOLIDATION DRIVERS

Well-intended but unintended reimbursement effects

The federal 340B program requires drug manufacturers to provide significant discounts for outpatient drugs purchased by eligible providers—most of them hospitals—serving poor and other underserved populations.

Medicare drug reimbursements, however, are the same regardless of participation. So for 340B providers, drug manufacturers’ discounts flow through to the bottom line and give hospitals an incentive to acquire certain physician practices that prescribe 340B-eligible drugs.

Drugs for cancer treatment receive as much as a 50 percent discount, making cancer treatment “very profitable for hospitals with 340B discounts,” according to a 2014 analysis by the Community Oncology Alliance. From 2008 to mid-2014, almost 700 oncology practices have been acquired by other providers, including 70 in Ninth District states. Over the past two years, COA found, 75 percent of oncology practices were acquired by hospitals with 340B drug discount pricing.

MEDICAID



BEYOND MERGERS AND ACQUISITIONS: When providers marry but don't live together

More than a thousand miles separate Mayo Clinic in Rochester, Minn., and Livingston HealthCare, in Livingston, Mont., and possibly as much virtual distance lies between their organizational size, structure and complexity.

The Mayo Clinic owns 70 hospitals in a handful of states, employs more than 50,000 people and has a worldwide reputation. Livingston HealthCare (LHC) has many facilities, but they are all concentrated in its small namesake city. With about 300 workers, it's the biggest employer in rural Park County.

But both Mayo and LHC demonstrate the changing business models of health care providers today that often create interdependent relationships while stopping short of acquisition or merger.

More than a decade ago, LHC made a decision that changed the trajectory of health care in the rural southern part of the state when it decided to partner with the Billings Clinic, now Montana's largest health care organization. In 2002, LHC "was in grave risk of going under," according to Bren Lowe, CEO of LHC for the past three years. So it entered a management contract with the Billings Clinic, which gave LHC access to group purchasing and other management expertise to help the organization survive.

Since then, the relationship with the Billings Clinic "has been more of an evolution," according to Lowe. More agreements were made between the two that gave the Billings Clinic greater say in operations and other matters—but no direct ownership—in exchange for expertise that LHC needed, including an advanced medical records systems developed by Billings, which LHC subleased "at far below the market cost" of such a system if LHC had tried to buy it on its own, Lowe said.

This relationship paid its biggest community dividend when LHC sought financing for a new facility to consolidate 15 "fragmented" offices sprinkled around town and expand the combined space. "We were facing issues," said Lowe. The hospital was 60 years old, and many services were in cramped spaces. Operating rooms were one-half to one-third the size of the norm today. "We made them work ... [but] we were patching things together," said Lowe. "We could not expand services to the community without additional space."

Unable to commercially finance the cost of a proposed \$43.5 million facility, LHC applied for a \$40 million loan through a rural health program with the U.S. Department of Agriculture (USDA). The program had never financed a loan this large, Lowe said, and "Billings' involvement was one of the things that made it possible." The project manager, from the Billings Clinic, had experience with both large projects and small rural ones, handling all phases from planning to construction.

"That went a long way toward our approval," said Lowe, adding that the USDA "would not have been comfortable without it." This month, LHC is scheduled to move into a new 115,000-square-foot facility that is 50 percent larger than the original space.

Such arrangements are not new in health care, but they are not often talked about in the arena of health care con-



Mayo's eTumor Board members consult with providers onscreen about an oncology case through the subscriber-based Mayo Clinic Care Network.

solidation. Yet these relationships are accomplishing many of the same objectives of a merger or acquisition.

These transactions "have a strategic driver," said Keith Anderson, a partner in the health care practice of the law firm DrinkerBiddle. Anderson has outlined a continuum of strategic transaction models that vary in the degree of integration involved between parties, from management agreements (low integration) to asset sales (high integration). The trick, said Anderson, "is to identify the driver and then dip into the tool kit to achieve the organization's objective with the least cost and administrative overhang and the best likelihood of success."

Matthew Anderson, vice president of the Minnesota Hospital Association (and no relation to Keith), agreed that there is "a wide variety of agreements" between providers today "that make it very difficult to define what level of interaction constitutes a consolidation of organizations versus a collaboration between organizations."

He pointed to Wilderness Health, a coalition of nine regional health care providers formed last year to improve quality care and patient outcomes in northern Minnesota, as an example of "achieving greater alignment and coordination of care while remaining independent," with each hospital having a director on the Wilderness board of directors.

Other arrangements, said MHA's Anderson, involve "multiple providers coming together to create a joint venture for a particular service that would otherwise be unaffordable or duplicative if each organization tried to build it independently." One example is LifeLink III, a medical air-transport company, owned and operated by a consortium of nine health care organizations. Minnesota's strong co-op culture has helped these kinds of joint ventures develop in the state's health care system, he added.

The full extent of such "consolidation lite" transactions among providers is difficult to determine. For one, they are not exactly new. Kelby Krabbenhoft, CEO of Sanford Health, believes health care has always had an "undercurrent" of different operational models. "They get people to the table" and help build trust to "then take the next step," he said. Sometimes that next step never

happens; Sanford has had a management agreement with a provider in Perham, Minn., for 25 years, he said. There are also downsides to such arms-length arrangements because partners "tend to only like the good days, and you can leave the marriage," he said.

Another side of Mayo

But many sources believe these arrangements are increasing rapidly as providers react to growing reimbursement, regulatory and other pressures (see cover article).

The Mayo Clinic offers a great example of a major health care system developing an entirely new strategy toward integration with other providers that stops well short of the conventional acquisition strategy.

Over the previous two decades, Mayo Clinic "had acquired a number of hospitals throughout the Midwest" and today has a presence in 70 communities in a multistate region, according to Jeff Bolton, Mayo chief administrative officer. But in the past five years or so, he said, "we've moved away from an active M&A strategy."

While other health care systems, insurance companies and other sectors of the care industry have been getting bigger, "we didn't think that would benefit patients," said Bolton. It's not for lack of interested parties, he added. "We could have tripled our size" given the number of providers that wanted to be connected with Mayo, he said. "We felt at our current size we were at an optimal level," and additional M&A "could jeopardize the culture of the organization."

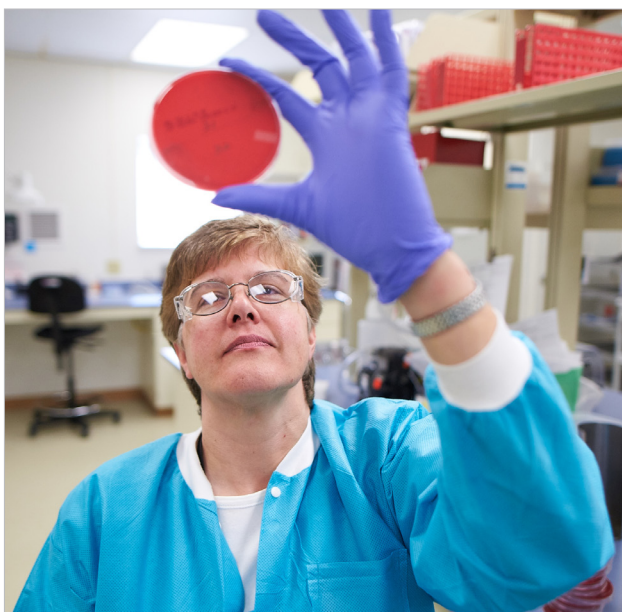
In place of major new acquisitions, Mayo decided it wanted to help health care providers offer patients "the same level of care" no matter where they were, and without patients having to travel to a Mayo facility. So it "invested heavily in knowledge"—medical research and best practices, technology, administration and other areas of expertise, according to Bolton.

The organization is now exporting that know-how as a subscription-based affiliation to providers interested in the Mayo model that do not want to give up their local independence and identity. Dubbed the Mayo Clinic Care Network, the affiliation lets providers collaborate with Mayo through channels such as "e-consults" that offer access to Mayo specialists via phone or online meetings. At eTumor board conferences, for example, affiliated doctors can describe complex cancer cases and solicit treatment advice from a multidisciplinary panel of Mayo specialists.

The new affiliation strategy started in 2011 and currently has 30 subscribers—including five in the Ninth District—spread across 20 states and Puerto Rico, and extending outside the country to Mexico and Singapore.

As with an acquisition, a lot of time goes into matchmaking, Bolton said. "There is the same due diligence [with this affiliation] as in an acquisition," he said, because Mayo wants to ensure that the two organizations "are like-minded."

—Ronald A. Wirtz



Help wanted for workforce housing

Housing development for workers lags job growth in some district communities

By PHIL DAVIES
Senior Writer

Newport Laboratories belongs to a new breed of employer in Worthington, a city of 13,000 in southwestern Minnesota known primarily for pork processing. Newport, a locally founded firm that was acquired in 2012 by a French animal health care firm, performs diagnostic testing and manufactures veterinary vaccines. The company, one of several animal health firms in the Worthington area, employs veterinarians, researchers, lab technicians and other professionals, many of them recent college graduates.

Newport is the type of new-economy employer that small communities everywhere covet. But companies looking to move to or expand in Worthington run into a problem: a dearth of new local housing.

"In this community, we've got a great school system and other amenities,

but housing opportunities—whether that's good rental opportunities, quality entry-level housing—there's a gap there," said Dan Greve, Newport's business operations director. Almost all of Worthington's housing stock is decades old; city records show that over the past five years, fewer than 30 new homes and only eight apartment units have been built in town.

"If a recruit feels they don't have an opportunity for suitable housing, that may deter them from choosing to come to work for Newport," Greve said.

As the regional economy continues to expand, communities across the Ninth District are seeing increased hiring. But it appears that in some non-metropolitan areas, not enough new housing is being built for wage earners—lower-income workers such as food prep workers, nursing aides and teachers as well as professionals like those employed at Newport Labs.

As a rule, markets are efficient hous-

ing providers; when demand for shelter increases, driving up home prices and rents, builders and investors respond with sticks and bricks. But in some communities, market frictions appear to be hampering the development of workforce housing, in some cases frustrating firms' expansion efforts and forcing workers to commute long distances from other communities with more housing choices.

Reasonably priced older housing is often available in these communities, but most units are smaller, well-worn homes unavailable for rent. Meanwhile, persistent

Although pork processing is the chief industry in Worthington, Minn., the city is also home to animal vaccine manufacturers, environmental services firms and other high-tech employers. Clockwise from top left: Darrin Pater of Bioverse; Lynette Demuth of Newport Labs; Danielle McKeown of Grazix Animal Health Inc.; Braden Wathen of Bioverse Inc.; Angie Cunningham of Newport Labs; (group of 5, left to right): Paige Schultz, Lori Peterson, Stephanie Olson, Cheryl Schuett and Cassie Nelson (seated) of Purnet Inc.

low rents and home values have discouraged developers from building new housing in Worthington and other cities such as Roseau and Thief River Falls, Minn.,

What is workforce housing?

There is no standard definition of workforce housing. To some it means low-income housing—shelter for workers in low-wage production or service jobs who otherwise couldn't afford to live in town. To others the term includes workers from households with more moderate incomes up to 115 percent of the statewide or area median. For the purposes of this article, workforce housing is any housing that suits the budgets and preferences of workers in a given community, from blue collar to professional—but excludes special-use housing like seasonal, student and senior units.



Reasonably priced housing is available in Worthington, but most units are older homes unavailable for rent. The few new apartments and townhomes in the city, such as the Rising Sun Estates Townhomes (below, right) have received government subsidies to help cover construction costs.



PHOTOS BY DAVID BOWMAN

Madison, S.D., and Great Falls, Mont. Rising construction costs—including the cost of complying with new building regulations—and stricter lending standards have also played a role in dampening development in the face of rising demand.

Some employers, civic leaders and policymakers see public subsidies for developers as a way to provide more housing for workers. Developers in the district have received property tax breaks and grants meant to encourage housing development, and last spring the Minnesota Legislature created a grant program to help cover the cost of workforce rental projects.

However, there's evidence that obstacles to workforce housing development can be overcome, given time for strengthening market signals to spur builders to address gaps in local housing supply. For example, Mitchell, S.D., has seen a jump in apartment construction since a 2012 housing study showed that rising incomes would support higher rents.

Have job, will travel for housing

Since the end of the Great Recession, private industry employment has grown about 6 percent in Minnesota, South Da-

kota and Wisconsin combined (see July 2015 *fedgazette*). Job growth has occurred not just in metro areas such as the Twin Cities, Fargo-Moorhead and Sioux Falls, but also in small- to medium-sized cities in the district. From 2009 to 2014, employment in Mitchell increased 9 percent to about 13,000, according to the U.S. Bureau of Labor Statistics (BLS). In Roseau County in northwestern Minnesota, which includes the city of Roseau, employment rose 8 percent over the same period.

Yet in some smaller communities experiencing a jobs rebound there is little housing being built for newly hired workers. Particularly scarce is new rental housing—apartments, duplexes, townhomes—suitable for lower- to middle-income workers whose paychecks won't cover a home mortgage or higher-earning new hires who don't want to commit to a home purchase.

New government-subsidized housing has been built in these places, but often such development is reserved at least in part for households earning 60 percent or less of median area income—too low for many wage earners.

A scarcity of new, market-rate housing in growing communities is a burden for

both employers and workers. In Roseau, snowmobile and all-terrain vehicle maker Polaris Industries and other firms, many of them suppliers to Polaris, have struggled to hire and retain workers, partly because of a housing crunch.

Big fish in a small labor pool, employers such as Polaris must hire workers from outside the area, "but that's where they run into the housing issue," said Todd Peterson, the city's community development director. "I can recruit people, but where do I put them when they get here? There's not available housing for them."

For the past two years, Polaris has leased a former group home 40 miles from Roseau to house workers from Mexico who are bused daily to its Roseau plant. Other Polaris workers recruited from elsewhere in Minnesota and other parts of the country by a temporary-labor contractor bunk in hotel rooms. The company has said that roughly half of new hires in Roseau quit within a month because they can't find suitable permanent housing. Virtually no rental units have been developed without subsidies; and with only about a half-dozen homes being built each year, Peterson said, "we're not putting a huge

dent in the availability of housing." Lay-offs during the recession reduced housing demand, but the hiring spurt since then has renewed pressure on the housing supply.

Worthington has seen less job growth than Roseau; employment in surrounding Nobles County grew just 1 percent between 2011 and 2014, according to the BLS. But local sources said they believe that employment would be higher if more workforce housing were available in the area.

JBS USA Pork is the main employer in town with 2,200 workers involved in the slaughtering and processing of hogs into pork products. Human Resources Director Len Bakken said the company could ramp up production and hire an additional 100 to 200 workers over the next two years—if they had somewhere to live within reasonable driving distance. About 200 employees commute more than an hour each way from Sioux Falls. "That's probably our major drawback right now," Bakken said. "We've definitely got a lot more room to expand in this facility, but we don't have enough housing to bring in more workers."

Based on projected population and



Multifamily housing in Worthington built with government aid: Rising Sun Estates Townhomes; bottom: Nobles Square Apartments



Market circumstances have converged in these communities to prevent, or at least slow, the matching of housing supply to demand. Some of these factors have been decades in the making; others have come into play more recently.

Workforce housing from page 11

job growth, a 2013 housing study estimated local demand for approximately 500 new housing units, including at least 300 rental and senior housing units, over the next seven years. But the city has seen little of any type of residential construction in recent years. In a two-year span through 2014, city per-

mits were issued for only six new single-family homes in Worthington. And despite vacancy rates that have hovered near zero for at least a decade, no apartments have been built in the city without subsidy since 2006.

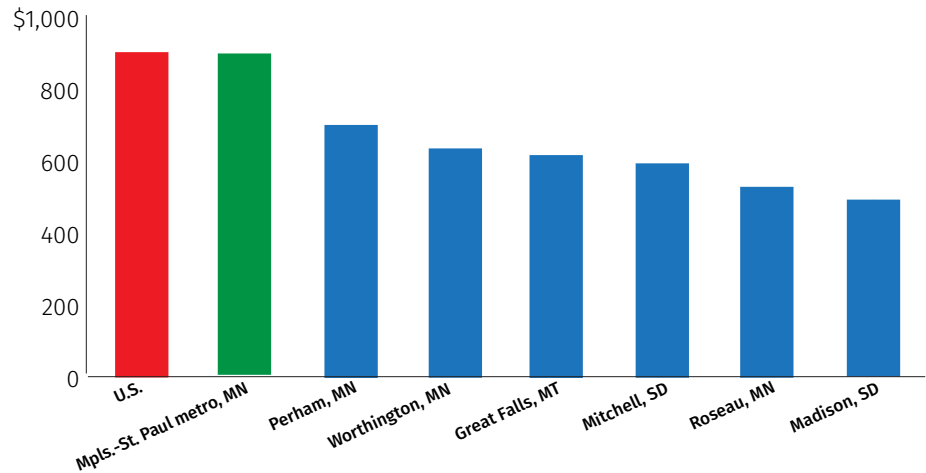
Greve of Newport Labs said new hires often end up buying an older home—entry-level houses are available for \$175,000

or less—but he believes they’d prefer to rent a new apartment or townhome with up-to-date amenities and finishes while they weigh their housing options.

Other district communities where the supply of workforce housing appears to lag demand include Thief River Falls and Perham, Minn.; Mitchell and Madison, S.D., and Great Falls, Mont. In Thief River Falls, which has seen strong job growth since the recession, electronic-component distributor Digi-Key said last year that more than 1,100 of its employees commuted from other communities in northwestern Minnesota, including some over 60 miles away.

Low rents in some nonmetro communities

Median monthly rent* 2009-13



* All renter-occupied housing units
Source: U.S.Census, American Community Survey 5-year estimates

Cheap digs, but a downside

Market circumstances have converged in these communities to prevent, or at least slow, the matching of housing supply to demand. Some of these factors have been decades in the making; others have come into play more recently.

One element stagnant housing markets have in common is persistent low rents and home values. For much of the past 50 years, economic growth has lagged in many smaller communities in the district, resulting in low rents and

home appraisals relative to more populous, faster-growing areas. Low housing costs are a boon for lower-income households, but they can impede housing development because builders and investors carefully consider prevailing rents and home sales prices before deciding whether to build. Low rental rates and home appraisals reduce expected revenues and return on investment, discouraging housing development.

Low rents are prevalent across wide swaths of Minnesota and South Dakota. Census five-year estimates for 2009-13 show that rent levels in selected non-metro cities with rising employment were well below the median for the Twin Cities and the country as a whole (see Chart 1). Prices of existing homes also tend to be low in low-rent markets. According to the Minnesota Association of Realtors, the 2014 median home sales price in Roseau County was \$97,000—just over half of the statewide figure.

To some degree, low rents and home values are commensurate with modest local wages; Noble County’s average wage was 69 percent of the statewide average in 2014, according to the BLS. But a recent analysis by the Greater Minnesota Housing Fund (GMHF), a Twin Cities nonprofit that finances lower-income housing, indicated that rents in some northern Minnesota cities are “artificially low.”

In Roseau and Thief River Falls, for example, the study estimated that households earning the median income could afford to pay nearly twice the median market rent, based on the federal benchmark that shelter costs should not consume more than 30 percent of household income.

Why are rents persistently low in some communities with high demand for rental housing? One explanation is that these communities have two distinct, qualitatively different housing markets: existing housing and new housing. Many existing apartment units and single-family homes available for rent were built decades ago and are in need of repair and updating; they may truly not be worth more than the current rent paid. The presence of housing subsidized through federal low-income housing tax credits, USDA Rural Development loans and other government programs—and often earmarked for low-income residents—also lowers overall rents.

“It’s great to have affordable housing available,” said Amy Long, program and loan officer for GMHF, “but if that housing makes up a significant percentage of that community’s available rental, then the average rents are going to reflect that.” The Worthington housing



JBS USA Pork in Worthington could increase production and hire an additional 100 to 200 workers over the next two years—if they had somewhere to live within reasonable driving distance. About 200 employees commute more than an hour each way from Sioux Falls.



PHOTOS BY DAVID BOWMAN

study found that properties renting for below-market rates accounted for about 20 percent of the 1,650 occupied rental units in the city.

There's also a market for new rental housing—energy-efficient units with modern amenities and styling—that command higher rents. As GMHF's analysis indicated, many residents of rural communities, including in all likelihood newcomers filling openings at firms such as Polaris or Digi-Key, could afford such rents. But it appears that depressed rents for existing housing are adversely affecting the construction of new apartments and other types of rental units.

A similar dynamic has restricted the construction of new single-family housing in some communities.

Raising the roof on costs

Over the past decade, low overall rents and home values have collided with two national trends in the housing industry to further hinder the development of workforce housing in many communities: escalating construction costs and more stringent lending practices.

Rising residential construction costs have made it harder for developers to provide workforce housing at a price local markets—even segments with incomes at or above the area median—are expected to bear. Land is cheap in rural areas compared with metro areas, but prices of labor and materials in outlying

areas are roughly equal to larger cities with higher rents and home sales prices.

Revived demand for housing has driven up prices of construction materials nationwide; producer price indexes compiled by the BLS show that rising prices of lumber, cement, drywall and other materials have outpaced wholesale and consumer over the past five years (see Chart 2).

Scant data exist on material cost trends in the district, but multiple sources indicated that higher labor costs were driving increases in construction costs. The North Dakota oil boom has drawn construction workers from neighboring states such as Minnesota and South Dakota, although some workers have returned home since last fall's drop in oil prices and drilling activity. Also, during the recession and slow recovery, the region's building trades lost thousands of workers to other industries.

"Now that people want to build something, there aren't as many skilled laborers around," and contractors can command higher pay, said Herb Tousley, director of real estate programs in the College of Business at the University of St. Thomas in St. Paul, Minn. Indeed, in Minnesota wages for residential construction workers increased 11 percent from 2011 to 2014 (adjusted for inflation), according to the BLS; South Dakota housing construction workers saw a 6 percent pay hike over that period.

Several sources also cited building

and land use regulation as a factor in higher construction costs. Successive revisions to state building codes have raised standards for energy efficiency and safety in residential construction; in Minnesota, for example, code changes over the past six years have mandated stronger load-bearing walls and better insulated walls and windows. Elevated costs due to new regulations are difficult to quantify, but the Builders Association of Minnesota has estimated that changes this year

Left: Mastaki Makofi drives daily from South Dakota to work at JBS Pork; top: parking sign at JBS Pork; bottom: Interstate Highway 90 looking west—the main commuting route to Sioux Falls.

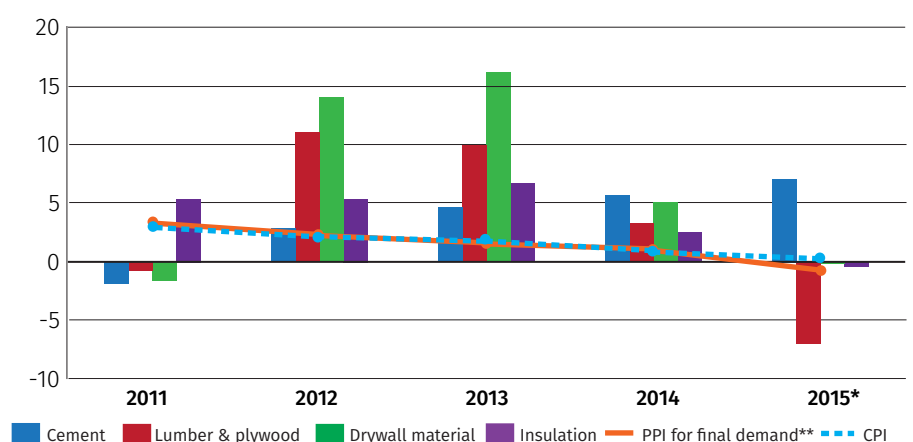
to state energy-efficiency codes added over \$10,000 to the construction cost of an average single-family home.

Housing developers in rural areas also face financing constraints. Stung by losses during the housing crash, community banks "are being more

Continued on page 14

Construction prices outpace wholesale and consumer prices

Percent change from a year earlier



*Percent change from June 2014 to June 2015

**Change in selling prices received by domestic producers for goods, services and construction sold to final demand
Source: Consumer Price Index (CPI), and Producer Price Index (PPI), Bureau of Labor Statistics. Data compiled by Associated General Contractors of America



Workforce housing from page 13

conservative in how they're underwriting loans," Tousley said. Today banks pay closer attention to loan-to-value ratios than before the housing crash, often limiting loans to 60 percent to 75 percent of a project's projected value in nonmetro areas where traditionally the limit was about 80 percent of value. Together with low housing appraisals (which reduce valuation) and high construction costs, this increases the amount of equity developers must bring to the table.

Some communities in the district, such as Roseau and Worthington, carry the additional burden of being dominated by a single employer. Both developers and bankers may think twice about building housing in such communities for fear that layoffs in an economic downturn will leave housing units empty and loans unpaid.

Stuck on the drawing board

The consequence of these market conditions for some district communities is that housing development has been slow and halting, seemingly out of step with increased demand from workers.

Multifamily rental development is the most efficient way to provide workforce housing because many units can be built on a small plot of land and the upfront costs and credit requirements for tenants are lower than for homeowners. But all too often, apartment and townhome projects never get off the drawing board because developers lack confidence in the market or have trouble securing financing.

In Worthington, hardly anyone comes to First State Bank Southwest seeking loans to build apartments, said Mark Vis, a loan officer with the bank. Last year, two local builders proposed a 24-unit apartment complex in town, Vis said. But after multiple meetings with bank and local government officials, the developers backed out of the \$2 million project, citing concern that rental income wouldn't cover the construction cost.

"The risk of building the project and trying to get a high enough rent to break even, let alone make a profit—they just couldn't get it to pencil out," Vis said. "They got a little gun shy, and that seems

to happen a lot in Worthington."

The few apartments and townhomes that have gone up in the city and other communities with low prevailing rents have been heavily subsidized to close the gap between anticipated rental income and construction costs.

For example, Parkland Place, a new 30-unit apartment building in Roseau, cost \$3.3 million to build—\$1 million more than its appraised value based on market rents. To defray construction costs, local developer Darrin Smedsmo received \$460,000 from the city and a \$325,000 grant from the state Department of Employment and Economic Development (DEED).

A second, long-delayed apartment complex in Roseau that broke ground in July received \$5.8 million in public subsidies, including \$3 million in tax-exempt city revenue bonds and \$634,000 in federal low-income housing tax credits. The use of the tax credits, which will be purchased by Polaris, requires 40 percent of the units to be set aside for low-income tenants.

In Madison, a city of 7,000 near Sioux Falls, \$375,000 in tax increment financing sweetened the deal for the developer of 14 townhomes completed last summer. Local developer and real estate agent Brenda Thompson said the project wouldn't have been feasible without the TIF—an arrangement in which expected property taxes from the development are used to cover infrastructure and other costs. "It was barely doable with the TIF," Thompson said.

Another TIF-financed townhome development was built in Madison last year. "I'm not aware of any other new construction," Thompson said. "Part of it is that rents in Madison are not high enough to justify new construction, so the TIF is necessary to help keep those rents down to a level that folks can afford," she said.

Some market-rate single-family housing is being built in low-rent communities, but prices are beyond the means of many workers. In Roseau, the minimum price for a new single-family home is about \$180,000, given construction costs and local land use and building standards. Even though average wages in Roseau County are about 85 percent of the state average, "that's still out of reach for a lot of the folks that we see being recruited by employers, at least initially," said Peterson, the community development director.

Similarly, in Mitchell, where average wages are lower than in Roseau, few new homes are priced below \$175,000. Lot prices, infrastructure and other development costs are high in the city, said Bryan Hisel, executive director of the Mitchell Area Development Corp. At the same time, for more expensive homes, bargain prices for existing houses deter construction because costs often outstrip the house's appraised value, limiting the

amount banks are willing to lend.

"We are having a mismatch between appraisals and construction costs," Hisel said. "The valuation of older homes is holding back the construction of new, because today's construction costs are much higher."

Reviving housing markets

Frictions or impediments in housing markets aren't necessarily permanent; economic theory states that even in areas with long-standing low housing values, increased demand for homes and apartments should eventually raise prices and attract interest from builders and investors.

The case study for market adaptation in the district is western North Dakota; early in the boom, developers and lenders didn't want to take a chance on building new housing for workers in the Bakken oilfields and oil-related industries, leery of an oil bust. In communities such as Williston and Watford City, rents skyrocketed and firms housed their workers in motels (see "No room at the inn," April 2012 *fedgazette*).

But in time, confidence grew in sustained demand for housing, and houses, townhomes and apartments started going up in large quantities, although housing costs remain high in the region. "If you go up there, you see that they're building stuff all over the place," and construction has slackened only slightly since the drop in oil prices, Tousley noted.

Such a confidence boost was the key to a recent surge of apartment construction in Mitchell. In the wake of the recession, population growth and increased hiring by firms such as truck-trailer manufacturer Trail King Industries drove rental vacancy rates down to 1 percent, yet rents remained low and few new units were built. The development landscape changed after a 2012 housing study commissioned by the city found that local incomes had risen sufficiently to support rents that would make new apartment construction worthwhile.

"The study helped us break through the market psychology that higher rental rates were not possible to cover current construction costs," Hisel said. Over the past two years, more than 300 apartment units have been built in the city by local developers and others, such as Stencil Homes of Sioux Falls, based elsewhere in South Dakota.

Also, in Great Falls, a 2014 market study found an "extremely tight supply" of rental housing with very low vacancy—but paradoxically modest rents. As of last summer, vacancies were still scarce in the city, but recent job growth has triggered rising rents and a spate of new apartment construction in the city.

However, policymakers in some district states are unwilling to wait for housing markets to adjust on their

own. In response to the difficulties encountered by Worthington, Roseau and other communities in building workforce housing, lawmakers have enacted or proposed more public subsidies intended to overcome barriers to development.

In Minnesota, the 2015 Legislature created a \$5.4 million state grant program intended to help communities outside the Twin Cities metro area develop market-rate workforce housing to support job growth. The \$325,000 DEED grant for the Parkland Place apartments in Roseau came from a pilot project for this initiative, which requires a 50 percent match of nonstate funds.

This year, Montana legislators rejected a proposal for a workforce housing fund similar to North Dakota's Housing Incentive Fund, which has spurred moderately priced housing development in the Bakken region. The bill would have awarded an income tax credit to contributors to a pool of money set aside to help pay for streets, sewer lines and other housing infrastructure.

Affordable housing organizations have also proposed leveraging public funds to jump-start stagnant housing markets. GMHF, which receives support from private foundations as well as the federal government, has launched a pilot program that would reduce the financial risks for developers of apartment projects in Minnesota. The organization would guarantee construction loans from private banks and offer additional debt financing in hopes of stimulating market-rate development that would, in time, raise prevailing rents and lead to more apartments being built.

"We believe that if there are new developments that occur in areas with demand for housing, those can help strengthen the market for future development," said Robyn Bipes, director of programs and lending for GMHF. **f**



Amy Long, program and loan officer for the Greater Minnesota Housing Fund, talks about Workforce 2.0, the organization's pilot program to spur housing development in rural Minnesota.

<https://youtu.be/o0lwxAZNh18>

For more on rural housing, see article by Jacob Wascalus on efforts to preserve affordable rental housing in greater Minnesota, in the October *Community Dividend*.

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CHANGE SERVICE REQUESTED



Health care consolidation
October 2015

Number of hospital
beds per 1,000
persons, 2013

- 1.7 to 2.0
- 2.1 to 2.5
- 2.6 to 3.5
- 3.6 to 5.6

United States: 2.5

Source: American Hospital
Association

