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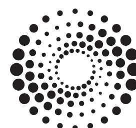

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Private equity firms: Could they help save your hospital?

Although hospital mergers and acquisitions have been slow in recent years, investment in one sector of the hospital industry has been picking up: capital infusions by private equity firms into not-for-profit (NFP) hospitals and hospital systems. The common goal of these transactions is to earn above-average profits for the equity investors while maintaining the charitable missions and long-term survivability of the hospitals.

The question is: Are these contradictory aims? And can private equity firms provide relief to financially stressed hospitals?

The current situation

Community hospitals are caught between rising costs and the need for investment capital on the one hand, and declining reimbursements on the other. The proportion of NFP hospitals is hovering between 25% and 30%, and uncompensated care (that is, charity care and bad debt) in NFP hospitals increased from $3.9 billion in 1980 to $39.1 billion in 2009, according to the American Hospital Association. Credit rating services, such as Moody's and Fitch Ratings, have continued their negative outlooks for the NFP hospital sector into 2011.

Reimbursement rates for Medicare and Medicaid patients are below the cost of caring for such patients. Medicaid reimbursements are falling even further as states struggle to close their budget gaps.

In addition, payments from commercial insurers are likely to drop as they act to carry out health care reform mandates, such as equalizing premium rates, justifying premium increases and covering pre-existing conditions. These circumstances are aggravated by weaker revenues from falling inpatient utilization, a continuing decline in employer-sponsored health insurance and new restrictions under health care reform.

Hospitals have responded to these pressures by drastically cutting costs, converting variable-rate debt to fixed-rate instruments and short-term bank loans, and, in the most dire cases, filing for bankruptcy. This comes at a time when additional capital is needed to invest in clinical technologies, such as electronic health records (EHR) and computerized order entry systems, enhanced efficiency measures, and infrastructure expansion to accommodate formerly uninsured patients.

> ***The goal of bringing in a private equity firm is to make the hospital profitable enough to stand on its own.***

What private equity firms offer

Private equity firms use their own capital or capital raised from investors to invest in nonpublic, often poorly performing companies. They turn the companies around and then sell them either to other companies or to the public via an initial public offering.

In the case of health care, the firms provide their financial support through a separate entity that serves as the vehicle for acquiring hospitals. That entity presumably

has the expertise to identify and then successfully manage the acquired hospitals. Private equity firms can help hospitals by providing:

- Substantial amounts of capital,
- A top-notch management team,
- Purchase systems and technology required to be competitive, improve the revenue cycle, introduce process improvements, and launch appropriate new service or product lines.

In other words, the goal of bringing in a private equity firm is to make the hospital profitable enough to stand on its own.

Before an NFP hospital can be acquired by a for-profit (FP) entity, however, it must be converted to FP status. This usually requires the approval of the state attorney general and some assurance that the sale will ultimately serve the hospital's charitable mission.

Great expectations

Such arrangements might make you ask: How can a private equity firm earn profits on a financially distressed community hospital?

For the risk they take, the firms demand higher rates of return than can be found in traditional stock market investments. In addition to drawing their management fees, private equity firms keep a share of the proceeds when the hospital is sold. Much can be accomplished with a large capital injection and an expert management team. It's also worth noting that private equity investments typically are committed for a 10-year period.

Another common question a hospital might ask is: How can profit-driven ownership be good for a community-oriented, charitable hospital? Before allowing the FP conversion and ensuing sale to go through, public officials and hospital trustees must elicit promises about future policies.

For example, some deals might guarantee that the equity investors will uphold the hospital's charity care mission and economic commitment to their communities. In one case, the acquiring firm pledged not to lay off any employees, sell the hospital or take it public for at least three years. In another, the deal included a 10-year commitment to maintain the hospital's charity care policy and keep its facilities open.

In addition, health care reform law requires all hospitals, NFP or FP, to evaluate their communities' needs every three years and make plans for meeting them.

Almost limitless

A year-end 2010 Pepperdine University poll of private equity executives found that 11% of them plan to invest in the health care industry (excluding pharmaceutical, biotech, and medical devices manufacturers). This is up from 4.8% last summer.

The parameters of the investment deals that can be negotiated with private equity firms are almost limitless. For some hospitals, it may be the most attractive survival strategy. Talk to your financial advisor to determine whether this strategy could benefit your hospital. ☐

Names to know: Active private equity firms

If your hospital could use an infusion of cash, don't rule out approaching a private equity firm. (See main article.) Here's a list of some of the more active hospital-focused firms, along with the entities that make the investments.

Private equity firm	Investment entity
Blackstone Group	Vanguard Health Systems
CCMP Capital Advisors	LHP Hospital Group
Cerberus Capital Management	Steward Health Care System
Oak Hill Capital Partners	Ascension Health Care Network
TPG Capital	IASIS Healthcare
Warburg Pincus	RegionalCare Hospital Partners

In the last year, the Caritas Christi hospital system in Boston was purchased for $900 million, and the Detroit Medical Center was acquired for $1.5 billion. The initial public offering of the Hospital Corporation of America, backed by private equity, raised $3.8 billion.

Several private equity firms bought a majority stake in St. Joseph Medical Center in Houston after its previous owner filed for bankruptcy. Ascension Health Care Network, the largest Catholic not-for-profit health system in the United States, formed a joint venture with a private equity firm to purchase Catholic hospitals to keep them from turning to for-profit investors.

How to succeed under CMS's hospital VBP program

It used to be called "pay-for-performance." Now CMS describes it as "value-based purchasing" (VBP). It represents the new paradigm for payment to hospitals initially, and for nearly all health care providers eventually.

Beginning in fiscal year (FY) 2013, per-discharge payments from base operating diagnosis-related groups (DRGs) to participating hospitals will be reduced by 1%. The reduction will gradually increase to 2% by 2017. Hospitals then will have an opportunity to earn back those payment reductions — and more — through CMS's VBP program. This redistribution of hospital DRG payments will amount to almost $850 million in the program's first year.

Determining payments

The VBP program will determine the size of each hospital's incentive payments by comparing accomplishments made during the baseline period (July 1, 2009, to March 31, 2010) to the first period for which hospital quality performance will be judged — July 1, 2011, to March 31, 2012.

In the first year, CMS will measure your hospital's performance in both clinical process of care and patient experience of care. It will compute two measures of that performance: 1) the hospital's absolute *achievement* during the performance period, and 2) the hospital's *improvement* or consistency in meeting quality targets and benchmarks in both domains.

Initially, the VBP program will use 13 performance measures across those two domains. Twelve are concerned with the clinical process of care and include measures such as:

- How quickly do physicians perform percutaneous coronary interventions to open blocked blood vessels on heart attack patients?
- How often do surgery patients receive treatments to prevent blood clots from forming in the 24-hour period before and after surgery?
- How often do hospital staff provide heart failure patients with appropriate discharge instructions on new medications and treatment procedures to manage their symptoms at home?

You can find the full list of clinical process of care measures here: http://www.healthcare.gov/news/fact sheets/valuebasedpurchasing04292011b.html

Focusing on patient care

The 13th measure deals with patient experience of care and is covered by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. It asks patients how satisfied they were with hospital stay features such as:

- How well doctors and nurses communicated with them,
- How responsive hospital staff were to their needs,
- How well caregivers managed their pain,
- How well caregivers explained their medications to them,
- How clean and quiet the hospital was, and
- How well caregivers explained the discharge instructions.

New metrics and entire domains will be added in the future. For instance, in FY 2014, CMS intends to add eight measures of Hospital Acquired Conditions (HAC), as well as five outcome-based measures.

Preparing for current and future VBP criteria

In order to flourish under CMS's new value-based purchasing (VBP) program (see main article), your hospital must anticipate the standards against which it will be measured and take the necessary steps to enhance its performance in those areas. CMS gives ample advance notice of the metrics, so make sure you launch your own initiatives to focus attention on those measures. Doing so will involve gathering the same data that CMS will be looking at in order to track performance. To learn more about CMS's initiatives and hospital VBP, check out http://www.cms.gov/hospitalqualityinits.

Getting extra credit

For each metric within the clinical process of care domain, a hospital will receive points based on the higher of an achievement score or an improvement score. Achievement points are possible only if your hospital exceeds the established achievement performance standard, which is the 50th percentile of all hospitals' performance during the performance period. Hospitals can boost their achievement scores by performing at higher levels, up to an achievement "ceiling" — that is, the mean of the top 10% of all hospitals' performance nationally during the baseline period.

In the patient experience of care domain, CMS also will calculate both an achievement score and an improvement score, and then take the higher of the two scores. In addition, hospitals may receive up to 20 extra "consistency" points that recognize and reward consistent achievement among the HCAHPS components.

Next, CMS will calculate an overall VBP score by combining the two domain scores and applying a weight of 70% to the clinical process of care domain and a 30% weight to the patient experience of care domain. This highlights CMS's growing emphasis on the quality of patient experiences.

Reaping the reward

Hospitals that meet or exceed VBP program performance standards will receive an increase in their base operating DRG payments. The amount of that increase will be determined by multiplying the base operating DRG payment amount for a particular discharge by the value-based incentive payment percentage for the hospital for that fiscal year.

CMS plans to post each hospital's estimated performance scores and value-based incentive payment adjustment amount for FY 2013 on its website for quality improvement matters, QualityNet (qualitynet.org), at least 60 days before Oct. 1, 2012.

Base operating DRG will be reduced by 1% beginning Oct. 1, 2012. CMS will notify each hospital of the amount of its value-based incentive payment adjustment on Nov. 1, 2012. Your hospital will have 30 days to review and submit corrected information. VBP incentive payments will begin Jan. 1, 2013, with retroactive adjustments for any FY 2013 discharges paid before that date.

Looking ahead

CMS has solicited comments on a structure and procedure whereby hospitals might appeal its decisions under the VBP program, but no process has yet been proposed. In addition, Congress is considering legislation that would extend VBP to ambulatory surgery centers. Stay tuned. ◻

Economic credentialing: Part 2

When HMOs were morphing into MCOs more than 20 years ago, there was a strong movement to accept onto provider panels only physicians who could practice cost-efficient medicine. This meant those who used a minimum of resources without compromising quality. Such "economic credentialing" provoked vigorous debate and several lawsuits.

The disputes eventually subsided, but the enactment of the Patient Protection and Affordable Care Act (PPACA) last year has brought economic credentialing back to the forefront.

Incentives for ACOs

The resurfacing of economic credentialing stems from one of the most significant features of PPACA: the Medicare Shared Savings Program (MSSP). The

program will offer incentives to enhance care quality, improve clinical outcomes and increase the value of services delivered through the development of Accountable Care Organizations (ACOs). These new entities will combine providers and suppliers, who will work together to manage and coordinate the care delivered to a defined set of Medicare beneficiaries.

The purpose of an ACO is to shift the risk of excessive resource usage from payors to providers, holding an integrated team of clinicians ultimately responsible for patient care. In the words of PPACA itself, an ACO is "accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it." In return for accepting that added responsibility, the ACO participants share in the savings they achieve.

Qualifying for savings

To qualify for shared savings, an ACO must meet certain quality performance standards and keep expenditures for its assigned Medicare beneficiaries below a specified level. The earned savings are distributed to the ACO as a whole, which in turn disburses them among its participants.

Every participant must perform at top efficiency if the ACO is to qualify for the shared savings and maximize the amount it receives. The clinicians, particularly primary care physicians, play a key role in determining how many resources are consumed — for instance, how many specialist referrals are made, how many diagnostic tests are called for and whether hospitalization is prescribed.

Hospital ACOs

A well-managed ACO is likely to use fewer hospital inpatient and outpatient services. To offset those revenue losses and share in the MSSP savings, many hospitals are creating or controlling their own ACOs. Because the key to maximizing shared savings is to minimize expenditures, hospital owners of ACOs will seek physician participants who will:

- Avoid using unnecessary resources,
- Minimize using unreimbursed resources,
- Emphasize practices that produce savings, and
- Favor the hospital owner when hospitalization is necessary.

This focus on proficiency in cost control begins to sound like the second coming of economic credentialing. If that's true, the same controversy and legal questions of 20 years ago will likely surface again.

Economic credentialing issues

Here is where the issues stand now:

- The AMA opposes conflict-of-interest policies that limit medical staff membership or clinical privileges based on a physician's ownership interest in another hospital.
- The American Academy of Family Physicians (AAFP) opposes the use of criteria such as cost per case or resource utilization as the sole basis for terminating or excluding membership in health care organizations.
- Although a recent state supreme court case allowed an injunction against a hospital's "loyalty" policy on the grounds that it tortiously interfered with the physicians' business expectations with their patients, most court decisions have supported the right of a hospital to "decide not to affiliate with physicians who are directly competing with the hospital."

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These economic credentialing issues could be a major hurdle to the formation of ACOs. Eventually, formal guidance will be needed from the government — either through CMS rulemaking or a Congressional statutory enactment.

Until formal guidance becomes available, the Joint Commission (JC) offers a useful model for startup

ACOs. In its Ongoing Professional Practice Evaluation (OPPE), the JC mandates that hospitals and health systems credential their physicians on the basis of "professional practice trends that impact quality of care and patient safety."

This requirement encompasses utilization review of requests for tests and procedures, length of stay patterns and use of consultants. It can be fairly said that the OPPE combines quality and economic elements in a way that's likely to satisfy the AMA and the AAFP. This analysis of ACO options is based on the arguments and legal principles that apply to conventional hospital medical staff credentialing.

Keeping credentialing separate

Even when an ACO is owned or controlled by a hospital, it doesn't have to rely on that hospital's credentialing processes. In fact, ACOs may be allowed greater credentialing freedom, taking into account economic factors frowned upon in hospitals alone. Keeping the two processes separate could be the best way to avoid the practices of one creating legal liability for the other. ☐

10 capital financing strategies for turbulent times

The capital financing environment for hospitals has become quite volatile and unpredictable. Hospitals and health systems have had to contend with limited capital access, fewer options, higher costs, more restrictive terms and less flexibility than in previous years. As the volatility and unexpected events are likely to continue for the foreseeable future, here are 10 strategies that can help keep your hospital afloat:

1. Encourage your corporate boards and executive teams to do everything possible to maintain as strong a credit rating as possible.
2. Practice enterprise risk management across your organization. Doing so entails an integrated strategic assessment of organizational risks measured from a financial perspective — including strategic, operational and capital structure.

3. Develop an inclusive capital strategy that encompasses assets, liabilities and their relationships with each other. Clearly decide on the organization's preference for or aversion to risk, and pinpoint metrics that accurately track assumed risks.
4. Choose a diverse mix of debt instruments to minimize risk and volatility. Don't rule out informed use of derivatives or swaps. Diversification can extend to banks, loan repayment terms and cash/reserve fund balances.
5. Examine existing banking relationships in anticipation of the near-term need to renew existing lines of credit or seek new capital loans. It's never too early to begin the renewal or application process.
6. Incorporate leasing options into the hospital's capital financing strategy. Evaluate current leases and consider leasing for appropriate future projects, balancing them against other funding alternatives.
7. Purge nonproducing, noncore assets from the hospital's existing portfolio of businesses.
8. Pursue partnership options with other hospitals and health care players. Early movers in consolidating markets will have a competitive advantage.
9. Consider a capital injection or a full acquisition by a private equity firm if your situation looks truly dire. (See "Private equity firms: Could they help save your hospital?" on page 2.)
10. Project how the evolving national health care reform plan may affect your hospital's financial operations and strategic initiatives.

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