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Mergers And Acquisitions

Research: What Happens When Private Equity Firms Buy Hospitals?

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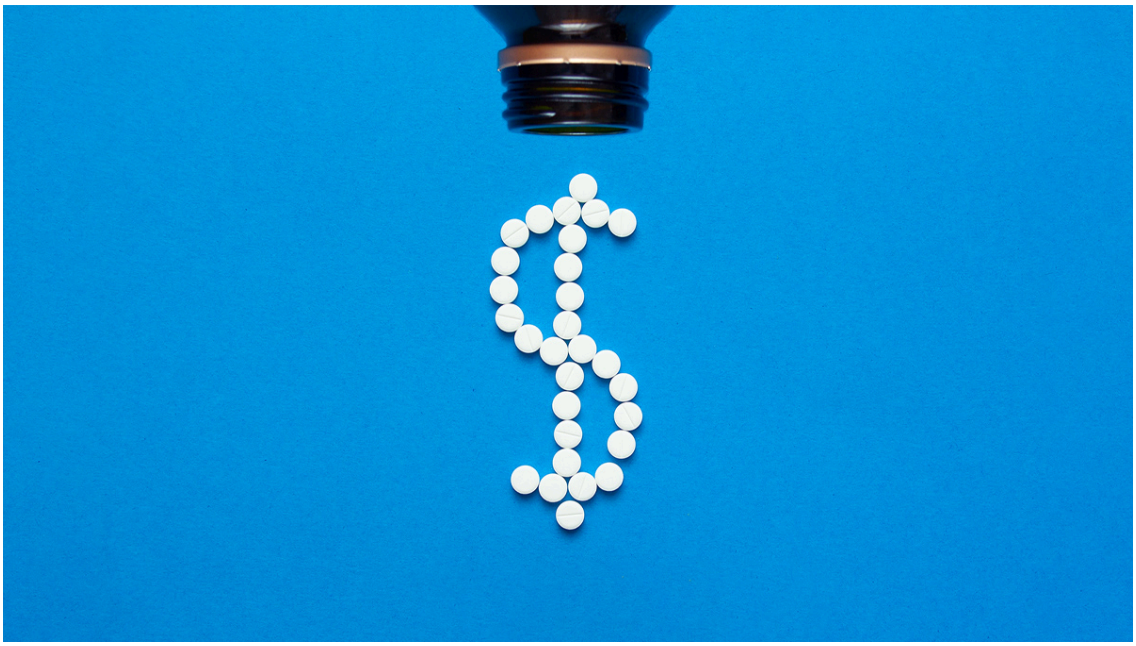

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Summary. The topic of private equity firms acquiring hospitals and health systems in the United States has sparked a fierce debate for years about whether the deals were good or bad for communities they serve. A study of 45 leveraged buyouts produced some... **more**

In the decades leading up to the Covid-19 pandemic, acquisitions of hospitals and health systems by private equity firms soared, sparking debate about how the growing influence of PE in U.S. health care would affect costs, quality, and access. Supporters of

PE cite its established track record of creating value for companies and investors across a variety of industries by improving operations, promoting an innovative culture, providing access to capital to support infrastructure improvements like IT systems and new facilities, leveraging economies of scale, and adopting managerial best practices. Critics point out the downsides of PE's focus on maximizing returns such as surprising patients with costly bills, scaling back nursing staff, and avoiding low-margin service lines primarily used by vulnerable populations. Critics also question whether PE funds' relatively short life cycle of seven to 10 years might have negative implications for the entities they acquire and, as a result, for the communities and patients those entities serve.

Our study of 42 leveraged buyouts of hospitals by PE firms from 2003 to 2017 suggests that these competing views do not fully characterize the reality of these acquisitions. Instead of framing PE's influence in health care as simply "good" or "bad," we believe that future policy discussions around PE should do the following:

- Make recommendations specific to each provider community (e.g., nursing homes, physician practices, hospitals) because the issues — potential benefits, risks, and what's inciting investments — raised by PE acquisitions may vary considerably across them.
- Focus on strategies aimed at aligning economic incentives, penalties, and oversight (e.g., antitrust regulation, public disclosure requirements, and monitoring of fraud and abuse in claims coding practices) so that PE's capital resources and management expertise can be redirected to maximizing benefits for patients (e.g., expanding access to care, increasing care quality, and improving the patient experience).

In this article, we provide an overview of the existing research on the effects of PE ownership of U.S. hospitals and health systems. Specifically, we highlight the key changes in health systems after they've been acquired by PE firms with respect to their financial health, staffing levels, care quality, and availability of service lines. We conclude by calling attention to the key issues that should shape future policy deliberations on PE in health care.

The Impact on Hospitals' Finances and Operations

PE's influence in the hospital industry has become substantial. According to the most recent publicly available data, 11% of inpatient admissions in 2017 were to a facility that had experienced PE ownership at some point.

When we looked at the 42 leveraged buyouts of hospitals by PE firms, several clear patterns emerged. First, relative to their non-acquired counterparts, acquired hospitals were concentrated in the southern United States and tended to be slightly larger, had higher margins, and were in more populated areas.

Second, despite headlines calling attention to bankruptcies in PE-acquired hospitals, the data does not support a narrative of widespread financial instability after the hospitals were acquired by PE firms. In another study, after controlling for differences in hospital characteristics, geographic variation, and temporal trends, we found that hospitals actually improved their financial performance after being acquired by a PE firm. Specifically, when compared with similar hospitals in the same hospital referral region, PE hospitals increased their operating margins by nearly two percentage points, an improvement that came from both

cutting operating costs and boosting revenues. On the cost side, hospitals acquired by PE funds decreased staffing (both overall and specifically for nurses) but also found other ways to become more efficient, amplifying the gains they could reap from staffing changes alone.

To increase revenues, PE-acquired hospitals appeared to make several changes, including shifting their focus from outpatient care to more-lucrative inpatient care services. PE-acquired hospitals also made several operational changes. Compared to their non-acquired counterparts, they were quicker to adopt profitable and more-technology-intensive service lines such as cardiac catheterization, advanced imaging, and robotic surgery. Notably, we did not find any evidence of significant reductions in the most unprofitable service lines.

Despite extensive academic work on PE in health care, several critical questions remain unanswered. Arguably the most urgent open question is whether the standard PE roll-up strategy, perhaps best exemplified by Steward Health's acquisition of multi-state provider IASIS Healthcare in 2017, causes significant changes in health care costs and quality. With little regulatory oversight of the effects of hospital mergers across different health care markets and the scant research on them so far, these questions loom large.

In addition, it remains unclear whether PE acquisitions of hospitals cause them to vertically integrate by purchasing private physician practices as a strategy for increasing patient referrals and maximizing profits. Finally, we still don't know whether PE acquisitions push hospitals into otherwise avoidable or premature closures. In recent years, high-profile reports of rural and community hospital closures in the wake of recent PE ownership suggest they may accelerate insolvency, although these hospital

groups typically struggle financially whether or not they are owned by PE firms and are located in areas characterized by declining populations, opposition to Medicaid expansion, health care staffing shortages, and growing rural poverty — factors unrelated to PE activity.

The Effect on Clinical Outcomes

In several studies, the acquisition of a hospital by a PE firm did not lead to worse clinical outcomes for Medicare patients admitted for acute non-surgical illnesses such as pneumonia and strokes. This result holds at both the patient- and population-level as well as across a range of quality measures, such as 30-day mortality, hospital readmission, and prolonged length of stay.

Importantly, we found no evidence that PE-acquired hospitals engaged in upcoding or cherry-picking healthier patients to make their outcomes look better without actually improving quality. Studies of elective surgical conditions that include treatments such as hip and knee replacements and scheduled hysterectomies are largely consistent with these results, as are findings from studies that used aggregated data on process measures and overall quality scores. There is one exception: Patients admitted to PE-acquired hospitals for heart attacks were found to receive *better* quality care in terms of lower all-cause mortality within 30 days of admission. A major limitation of these studies, however, is that they only examine Medicare claims data, so it remains unclear whether the results would carry over to an under-65 patient group covered by a different payer, and future work should explore this issue.

Policy Implications

Given our findings, we believe that the following principles should guide future assessments of the risks and benefits of PE in

the hospital sector and any ensuing policy action at the federal and state level.

Loopholes should be examined.

Loopholes in payment policies that create opportunities for profit maximization, at the expense of patient welfare, should be the primary focus of regulatory scrutiny. The United States has a market-based approach to paying for care and uses a blend of private and government-financed health coverage that reimburses at different rates rather than the type of universal coverage adopted by many other wealthy nations. The current approach in the United States causes high levels of administrative waste, limited information on price and quality, workforce shortages, and growing consolidation among insurers and hospitals.

Such inefficiencies create opportunities for PE investors, but these incentives are *not unique* to PE, as many of the business strategies they use to profit from health care's bloat and waste are indistinguishable from those of major non-profit health systems seeking to maximize their own margins. In recent months, we have witnessed alarming reports of a large, non-profit hospital manipulating and pressuring poor patients for financial gain even when they were eligible for free care and another that exploited a loophole in the 340b drug-pricing program in which the government reimburses hospitals that serve poor communities by allowing them to mark up certain pharmaceuticals.

As some have suggested, PE strategies in the hospital sector could be used to identify payment loopholes like surprise billing or perverse incentives that may adversely impact the affordability and quality of care. For instance, Medicare's reimbursements for drugs is currently higher for those administered by physicians in their offices, which are covered by Part B, than for the same drugs

prescribed under Part D. Regulators and policymakers should address such underlying issues and not target any one entity or class of investors given that other firms not owned by PE could behave the same way.

Community needs should be prioritized.

All hospitals have a "social contract" with their communities (i.e., to deliver high-quality, equitable, and timely care), a relationship that should take precedence over a PE fund's goal of maximizing stakeholder returns. To that end, PE-acquired hospitals should be required to have manageable debt obligations to ensure that they can provide adequate care to the communities they serve. Other examples of needed policies include increasing the transparency and public reporting of deal terms when a PE fund is in the process of acquiring a hospital and disposing of it. State and federal requirements that PE firms provide advance disclosure of hospital acquisitions would also allow stakeholders to adequately evaluate and provide feedback on such proposed deals. All of these changes would significantly improve the ability of researchers and policymakers to monitor the impact of PE on hospital-based care.

Physician autonomy should be protected.

State laws prevent non-physicians from controlling medical practices (known as the corporate practice of medicine doctrine), but these laws vary considerably by state and do not currently account for the myriad ways in which PE firms exert control over the decision-making and practice patterns of physicians. We propose that ethical guidance, employment law, and regulatory oversight should be updated to better safeguard physician autonomy, reduce conflicts of interest, and ensure that high-quality, patient-centered care is always the top priority.

Antitrust policy should be strengthened.

The Department of Justice and Federal Trade Commission (FTC) under the Biden administration have shown a keen interest in strengthening antitrust enforcement as a means of curbing PE's influence. Traditionally, protecting patients from harm was the primary objective, but the current approach and definition of harm should be updated to account for 1) inequities in access to care and 2) the anti-competitive effects on and responses of non-acquired hospitals in a market following a PE acquisition (e.g., Do non-acquired hospitals in a hospital market alter health care prices or limit care access in the wake of a PE firm's entry into the market?). Consideration should also be given to reducing the current $101 million threshold for the size of deals subject to the FTC's requirement that parties report their intended deals to it and give it a chance to review them before finalizing them. Our reasoning: Some deals below the $101 million level might still harm market competition.

Our research on the net effects of PE activity in the hospital sector paints a mixed picture of its effects. Any policy reforms should therefore be guided by the available evidence specific to a particular sector and the principle that protecting patients from harm should always be the top priority.

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