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New Study Examines PE's Impact on Hospital Performance

In recent years, private equity investments in the healthcare sector have been on the rise. From 2008 to 2018, the number of private equity healthcare deals in the U.S. soared from 325 deals in 2008 to 788 deals in 2018, totaling more than $100 billion in value.[1] Private equity firms use capital from investors to purchase assets, such as hospitals, with the goal of increasing the value of the asset before selling off the asset, typically within three to seven years, at a profit and returning the profits to the investors.[2] Private equity firms generally look for underperforming yet stable targets, wherein costs can be cut and operational efficiencies can be realized to increase value.[3]

The healthcare sector has become an increasingly attractive target for private equity firms for several reasons. First, the fragmented nature of the healthcare industry provides private equity firms with ample opportunities to acquire and consolidate businesses to increase market power and negotiate higher reimbursement from payors.[4] Second, up to 25% of healthcare costs can be attributed to wasteful spending, largely attributable to administrative complexity.[5] The excess of waste in the healthcare system provides private equity firms with substantial opportunities to increase value through realized operational efficiencies.[6] Finally, revenue streams in the healthcare industry are reliable and represent a large portion of U.S. spending. Historically, demand for healthcare services has remained stable even through economic downturns.[7] Moreover, since the federal government accounts for approximately 40% of total healthcare spending, there is confidence in a secure cash flow for services.[8] Consequently, private equity firms may view healthcare assets as a less risky investment.

However, controversy remains as to whether private equity firms' increased interest in the healthcare industry is beneficial to consumers. Proponents assert that private equity firms have a unique capability to help reduce healthcare costs, improve efficiencies, and provide much needed capital to update IT systems and upgrade facilities.[9] Still, many remain concerned that the very nature of the private equity business model and the substantial pressure placed on providers to increase revenue and decrease costs will result in significant sacrifices in quality.[10]

In an effort to address these concerns, researchers from Harvard's School of Public Health and Medical School published a study in *JAMA Internal Medicine* in August 2020, evaluating the impact of private equity hospital acquisitions on several metrics, including hospital income, profitability, use, and quality.[11] The study revealed that post-acquisition, private-equity-owned hospitals experienced increased annual net income, hospital charges, charge-to-cost ratios, and case mix.[12] Additionally, these hospitals realized some improvement in certain quality metrics.[13]

To evaluate the impact of private equity acquisition on quality in acquired hospitals, the study aggregated the scores for quality-of-care process measures from the *Centers for Medicare & Medicaid Services'* (CMS's) Hospital Compare dataset for three conditions: heart failure, acute myocardial infarction (AMI), and pneumonia.[14] Analysis of these aggregated scores post-acquisition revealed an increase of 3.3 and 2.9 percentage points in the aggregate quality-of-care process scores for AMI and pneumonia, respectively.[15] These increases suggest better care for patients.[16] While this data is seemingly encouraging, other study results raise new concerns surrounding private equity's involvement in healthcare.

Post-acquisition, private-equity-acquired hospitals experienced an average increase of $2.3 million in net income relative to peer hospitals.[17] To explain this increase, the study also reported an increase of $407 in total charge per inpatient day, as well as increases of 0.61 and 0.31 in emergency and total charge-to-cost ratio, respectively.[18] These increases in charges and charge-to-cost ratios have many possible explanations.

First, patients who are commercially-insured provide higher reimbursement to hospitals.[19] As a result, if a hospital is to increase the percentage of commercially-insured patients served, it can increase its average charges, thus resulting in higher net income. As reported in the study, in private-equity-acquired hospitals, the percentage of Medicare patients comprising the total patient population decreased by 0.96% relative to peer hospitals.[20] It is possible that this change in payor mix is the result of strategic tactics to increase the number of commercially-insured patients, a common strategy used by hospitals – even nonprofit hospitals.[21] Hospitals can "*improve*" their payor mix through a variety of strategies, including marketing to commercially-insured patients and prioritizing commercially-insured patients for non-emergent care.[22]

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Another possible explanation for private-equity-acquired hospitals' increase in charges and charge-to-cost ratio is that, post-acquisition, these hospitals are receiving higher diagnosis-related group (DRG) payments on average.[23] According to the study, post-acquisition, private-equity-owned hospitals exhibited an increase of 0.02 in their case mix index relative to peer hospitals (the sum of DRG weights for all Medicare discharges divided by the number of Medicare discharges), suggesting that post-acquisition, these hospitals saw sicker patients.[24] However, the study's authors also assert that the case mix increase could be indicative of changes in coding practices.[25] The study explains that the increase in case mix index could be the result of more complete coding if the hospital was previously assigning a code with too low of a DRG weight to represent the actual complexity of the procedure or diagnosis performed or diagnosed.[26] Alternatively, the authors suggest that the appearance of sicker patients could be the result of upcoding, a type of fraud in which the code submitted by the provider for billing is for a more serious and expensive diagnosis or procedure than was actually diagnosed or performed.[27]

In response to their findings, the study's authors call for further government oversight of the practices of private-equity acquired hospitals, asserting that "*[a]lthough further research is needed, our findings suggest that policy makers should consider monitoring or thoughtful oversight of changes in care delivery and billing practices in hospitals acquired by private equity firms to ensure proper stewardship of societal resources and the prioritization of patient interests*."[28]

These concerns are likely to be amplified both during and after the COVID-19 pandemic. The *American Hospital Association* (AHA) has projected that hospitals will lose a total of $323 billion in 2020 as a result of the pandemic.[29] The revenue losses being experienced by hospitals makes them more vulnerable to private equity acquisition, which in turn may garner increased concern and scrutiny regarding their post-acquisition practices.[30]

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