



# Private Equity Buyouts in Healthcare: Who Wins, Who Loses?

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## ABSTRACT

Private equity firms have become major players in the healthcare industry. How has this happened and what are the results? What is private equity's 'value proposition' to the industry and to the American people -- at a time when healthcare is under constant pressure to cut costs and prices? How can PE firms use their classic leveraged buyout model to 'save healthcare' while delivering 'outsized returns' to investors? In this paper, we bring together a wide range of sources and empirical evidence to answer these questions. Given the complexity of the sector, we focus on four segments where private equity firms have been particularly active: hospitals, outpatient care (urgent care and ambulatory surgery centers), physician staffing and emergency

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room services (surprise medical billing), and revenue cycle management (medical debt collecting). In each of these segments, private equity has taken the lead in consolidating small providers, loading them with debt, and rolling them up into large powerhouses with substantial market power before exiting with handsome returns.

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Private equity firms have become major players in the healthcare industry. In 2018 alone, PE investments in healthcare reached 855 deals and \$100 billion in capital invested -- an historic high. Why has private equity accelerated its investments in healthcare in recent years? How can private equity use its classic business model of a leveraged buyout in healthcare – in which it buys out a company using high levels of debt that are loaded on the company? How can PE firms deliver their promised ‘outsized returns’ to investors on the backs of sick patients?

Interest in private equity’s role in healthcare exploded in the summer of 2019. Investigations revealed that two large private equity firms, with a 30 percent share of the market for outsourced emergency room doctors, were at the heart of the surprise medical billing crisis. Patients who thought their insurance would cover their ER visit found instead that, in outsourced ER rooms, doctors could charge out-of-network rates, leaving patients with huge medical bills. Congressional debate over legislation to curb these abuses was ongoing in 2020 even as private equity firms poured millions to lobby Congress to adopt watered-down legislation that would not substantially alter out-of-network rates.<sup>1</sup>

Private equity’s role in this sector is of particular concern at a time when healthcare prices have continued to rise. In 2018, Americans spent \$3.65 trillion on healthcare – 4.6 percent more than in 2017 – and the growth was due to higher prices, not more visits to doctors or hospitals. A disproportionate share of rising prices was due to higher prices paid by private insurers – up from a 2 percent annual increase in 2012 to a 6.7 percent increase in 2018. By contrast, rates increased in 2018 by 3.7 percent for Medicare and just 2 percent for Medicaid.<sup>2</sup> Why -- at a time when the industry has experienced years of consolidation and outsourcing of services to improve scale efficiencies and reduce costs – are healthcare prices still rising sharply?

These questions make private equity’s role in healthcare a timely policy issue as the country hotly debates the future financial model of the industry. At 17.9 percent of the US Gross Domestic Product in 2019 – projected to be 19.4 percent of GDP by 2027<sup>3</sup> -- the sector is central

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<sup>1</sup> Eileen Appelbaum and Rosemary Batt. 2019. “Private Equity Tries to Protect Another Profit Center.” *The American Prospect*. September 9. <https://prospect.org/article/private-equity-tries-protect-another-profit-center>. Eileen Appelbaum and Rosemary Batt. 2019. “Private Equity and Surprise Medical Billing: How Investor-owned Physician Practices Are Driving up Healthcare Costs.” Institute for New Economic Thinking. September 4. <https://www.ineteconomics.org/perspectives/blog/private-equity-and-surprise-medical-billing>

<sup>2</sup> Caitlin Owens. 2019. “Health care spending grew again in 2018 thanks to higher prices.” *Axios-Vitals*. December 6. <https://www.axios.com/health-care-spending-united-states-2018-prices-cb32009a-5e10-4ed1-a487-56143398bb04.html>

<sup>3</sup> Centers for Medicare & Medicaid Services. National Health Expenditure Data. CMS.gov NHE Fact Sheet; projected NHE 2018-2027.

to the health of the US economy and the jobs of millions of Americans. In this context, what is private equity's 'value proposition' to the industry and to the American people -- at a time when healthcare is under constant pressure to cut costs and prices? What attention should be paid to regulating unregulated financial actors such as private equity firms as they penetrate healthcare markets for services that are so central to people's ability to live healthy lives?

Private equity investments in healthcare are not new, but they have accelerated since 2010. They have played a central role in the restructuring of the healthcare industry – a leading force in mergers, acquisitions, and the consolidation of providers in order to gain market power in local, regional, and national markets. They began investing in healthcare by buying up provider organizations in certain segments -- nursing homes and hospitals -- and rolling them up into large for-profit chains in the 1990s and 2000s.<sup>4</sup> In the last decade, they have led mergers and acquisitions (M&As) in fast growing and niche market segments -- physician staffing firms that buy up specialty practices, such as emergency medicine, radiology, and anesthesiology; then into urgent care, ambulatory surgery, and revenue cycle management. More recently, they have been buying up a wide range of primary and physician specialties in outpatient settings – dermatology, dentistry, ophthalmology, gastroenterology, and orthopedics – as well as home healthcare.

Many healthcare policy makers and professionals have begun to take note -- with a lively debate emerging in medical journals such as the *Journal of the American Medical Association (JAMA)*, *Health Affairs (HA)*, *the Journal of Health Economics (JHE)*, and *Medical Economics (ME)* -- as well as on the websites of all the major medical specialty associations.<sup>5</sup>

There is much heat but little light regarding what the actual private equity model consists of, under what conditions it can offer benefits, and under what conditions it cannot or does not. Private equity firms and their advocates argue that they have much to offer to help curb costs, improve efficiencies, and infuse capital into a sector where many hospitals are failing and the need is great to finance new technologies, upgrade facilities, and consolidate fragmented markets. On-going financial pressures and heightened contestation over reimbursements by the government and third-party payers have led some providers to view private equity buyouts of

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<sup>4</sup> In this study, we use the term healthcare industry and sector interchangeably. We refer to industry segments as more narrowly defined markets (e.g. hospitals, outpatient care) and we refer to 'sub-segments' as specialized niches within the segments (e.g. urgent care or ambulatory surgery within the outpatient segment.)

<sup>5</sup> Suhas Gondi and Zirui Song. 2019. "Potential Implications of Private Equity Investments in Health Care Delivery" *JAMA*. 321 (11):1047-1048. February 28.; Annabelle Fowler, David Grabowski, Robert Gambrel, Haiden Huskamp, and David Stevenson. 2019. "Corporate Investors Increased Common Ownership in Hospitals and the Postacute Care and Hospice Sectors." *Health Affairs* 36 (9): 1547–1555; Todd Shryock. 2019. "Private Equity in Healthcare," *Medical Economics* 96(22). November 12. <https://www.medicaleconomics.com/news/private-equity-healthcare>

their practices as a welcome relief – they were trained to be doctors and healthcare professionals, not business people; they want to focus on their craft and their deep commitment to serving patients -- not doing paperwork.

Some medical professionals caution, however, about losing control of decision-making and professional autonomy. Critics argue that the classic private equity business model -- of extracting value in a short time frame in order to meet interest payments on the high levels of debt typical of private equity buyouts and to deliver ‘outsized returns’ to investors -- is rarely consistent with building a sustainable healthcare system for high quality patient care. The focus on generating cash flow and exiting the investment in a five-year window puts pressure on doctors to increase volumes of patients seen per day, to overprescribe diagnostic tests or perform unnecessary procedures, or to save on costs by using shoddier but less costly supplies and devices. These are important and contentious issues, which need evidence-based research to inform industry players and policy makers.

The private equity industry, however, lacks transparency and accountability because it is largely unregulated under state or federal law. While many states require that doctor practices must be doctor-owned and come under the jurisdiction of state health regulators, private equity firms have found a way to get around this. They describe their role as a management services organization (MSO) that has bought up all the financial assets of the physician practice, but has placed leadership of medical practice in the hands of a chief medical officer who is a physician and a partner in the practice. The document governing the relationship between the MSO and the physician group typically provides that the management services organization can fire and replace the chief medical officer, giving the MSO de facto influence over requirements for revenue generating and cost saving goals for individual doctors.

In this study, we bring together a wide range of sources and empirical evidence to help shed light on these issues. We review the classic private equity business model, its application to different segments of the health care industry, and the outcomes of its activities where data is available. We focus on three research questions. First, what are the trends in private equity investment in health care, and in which segments have PE firms focused their investment activity? Second, what are private equity’s business models and exit strategies in these segments? To what extent are PE firms able to use the classic leveraged buyout (LBO) model in healthcare – a sector characterized by many small service providers? How prevalent is the strategy of rolling-up small firms into larger platform companies that have greater negotiating power vis-a-vis insurance companies, medical supply companies, and local healthcare systems? Third, what are the implications of private equity ownership and control of these services for patients and for healthcare delivery? Given the complexity of the sector, we focus on four segments where private equity firms have been particularly active: hospitals, outpatient care (urgent care and ambulatory surgery centers), physician staffing and emergency room services, and revenue cycle

management (bill collecting). In each of these segments, private equity has spurred consolidation, raising the possibility, as Nobel Prize winning economist Joseph Stiglitz put it recently, that their goal is to “take advantage of others through market power, through individual vulnerabilities, and through inside or unequal information.”<sup>6</sup>

### **The Classic Private Equity Business Model**

When an investment fund sponsored by a private equity firm buys an established, profitable company, it uses the company’s assets as collateral for debt (or leverage) used to acquire the company — typically financing 70 percent of the purchase price with this debt, less in smaller companies with fewer assets. In this leveraged buyout model, the 30 percent equity stake is provided by the PE investment fund. The acquired company — not the PE fund that buys it or the PE firm that sponsors it — is responsible for repaying this debt. The PE fund consists of the general partner (a committee of partners and principals of the PE firm) and limited partner investors (pension funds, endowments, sovereign wealth funds, wealthy individuals). Limited partners typically provide 98 percent of the equity in the PE fund and the PE firm, via the general partner, provides 2 percent (though a few PE firms provide as much as 10 percent).

Principals in the PE firm typically take seats on the board of directors of the acquired company (referred to as a “portfolio company”), but in any case, they appoint the company’s board of directors. The PE firm typically works with the CEO of the acquired company to come up with a 100-day plan for how it will meet performance goals set by the PE firm. This often results in companies acquired by private equity squeezing workers — cutting hours, reducing compensation, or even firing workers. Those CEOs who either can’t or won’t meet the PE firm’s expectations are quickly replaced with a CEO willing to follow the PE firm’s strategy. PE firms typically have a cadre of executives they can turn to -- whose loyalty is to the PE firm that hires them and not to the company they have been hired to manage.

It is typical for the PE firm to enter into a Management Services Agreement (MSA) with the acquired portfolio company that requires the company to make annual “monitoring fee” payments directly to the PE firm (not the PE fund) and to pay all transactions costs associated with the acquisition of other companies, including time spent by PE firm partners working on the transaction. In 2018, 58.0 percent of private equity firms required their portfolio companies to

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<sup>6</sup> Joseph Stiglitz. 2019. “It’s Time for Congress to Do Something about the Economic Mess That Private-Equity Giants Have Created,” *Business Insider*. December 7. <https://www.businessinsider.com/joseph-stiglitz-private-equity-impact-us-economy-jobs-wages-2019-12>

pay monitoring fees; 85.8 percent required payment of transactions fees.<sup>7</sup> These are not transactions between independent parties, one representing the interests of the PE firm and the other representing those of the portfolio company. The portfolio company really has no choice but to agree to pay monitoring and/or transaction fees, whose purpose appears to be to generate income for the PE firm that owns it.

The private equity owners also have other actions they can require the portfolio company to take that may enrich the PE firm and its investors. The board of directors may require the portfolio company to engage in a dividend recapitalization — i.e., to issue bonds (of low grade or junk status given that the company already carries substantial debt and use the proceeds to pay a dividend to its shareholders -- that is, to the PE firm (via the General Partner) and to the firm's limited partner investors. It may also require the company to sell off assets, such as real estate. Proceeds of these sales must be used to repay any loans for which the asset was used as collateral. Typically, the asset is sold for more than these loans, with the difference going to investors in the PE fund or, sometimes, just to the PE firm. The portfolio company now has to lease the real estate (or other assets) that it previously owned (referred to as a 'sale leaseback'), and is saddled with rent payments. In all of these ways, the private equity firm transfers resources of the portfolio company to itself. As a result, the portfolio company may lack resources to respond to business cycle fluctuations, changes in customer preferences, or the introduction of major new technologies.

The high debt placed on the portfolio company at the time of purchase boosts the profit the PE fund makes when it successfully exits this investment – ideally three to five years after making the acquisition. The PE firm via the general partner receives 20 percent of any gain, despite having contributed only 2 percent of the equity. In the case in which the acquisition is financed with 70 percent debt, the PE firm has very little of its own funds at risk, just 0.6 percent of the purchase price ( $.02 \times .30 = .006$ ).

The PE model contrasts sharply with how publicly traded companies operate. Shareholders in publicly traded companies expect them to be going concerns that create shareholder value for the foreseeable future. CEOs of these companies are hired by independent boards and typically have a substantial history of related management experience and success. None of the actions just described are available to a publicly traded company. Public shareholders would flee a company that loaded itself with debt equal to 70 percent of its enterprise value – or one that issued junk bonds to pay dividends. The parent firm cannot charge departments or subsidiaries fees for monitoring their activities and can't require departments or subsidiaries to bear the costs of acquisitions the firm makes. The firm may engage in sale-leaseback transactions, but the

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<sup>7</sup> PitchBook. 2018. "2018 Annual Global PE Deal Multiples," p. 3.  
[https://files.pitchbook.com/website/files/pdf/PitchBook\\_2018\\_Annual\\_Global\\_PE\\_Deal\\_Multiples.pdf](https://files.pitchbook.com/website/files/pdf/PitchBook_2018_Annual_Global_PE_Deal_Multiples.pdf)

proceeds of such sales are typically used for investments in improving the company's operations or other business needs — unlike the PE case, in which the portfolio company does *not* receive the proceeds of the sale nor does it have those funds available to improve its performance. PE firms also are required to submit very minimal information to the Securities and Exchange Commission (SEC), allowing them to operate with little transparency or accountability — in contrast to the very detailed reporting requirements of publicly-traded companies.

These differences between PE-owned and publicly-traded companies lead to substantial differences in their operations and incentive structures. The low-risk/high-reward nature of the PE business model for the PE firm is a classic case of moral hazard. It results, as is typical in such cases, in excessive risk-taking by the PE firm, using other people's money — often to the detriment of the portfolio company, its managers, workers, creditors, suppliers, and customers. Portfolio companies face a high-risk environment as a result of the risks taken on their behalf by the PE firm.

Before buying a portfolio company, the PE firm, as noted above, works with the CEO to create a 100-day strategic plan to operate the company with a positive cash flow despite the heavy debt burden created by the leveraged buyout; but this plan may be based on overly optimistic assumptions about the industry, the state of the economy, the direction of prices, or other conditions necessary to operate a highly leveraged company at a profit. PE firms rarely have expertise in the industries in which they operate. An economic downturn, a new innovative competitor, or the introduction of a disruptive technology may upset plans for repayment of debt. High debt loads leveraged on acquired companies, together with the lack of responsibility for repayment of this debt by either the PE fund or the PE firm, may leave the private equity owners indifferent to any individual portfolio company's inability to make scheduled payments on its debt. The threat of financial distress or bankruptcy looms large in such circumstances.

The opaqueness of the operations of private equity firms — abetted by the lack of transparency in their famously private business dealings — provides opportunities for self-dealing that are utilized by some private equity firms to profit even as their portfolio companies spiral into bankruptcy. Examples of such actions in cases of bankruptcy are well documented in bankruptcy proceedings.<sup>8</sup> Indeed, a looming threat of bankruptcy may lead the PE firm to mine the assets of the failing company to extract value at the expense of creditors or to violate firewalls and engage in unfair competitive practices in the markets in which the company operates.

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<sup>8</sup> See detailed discussion of the bankruptcy of the Mervyn's department store chain in Appelbaum and Batt (2014), *Private Equity at Work: When Wall Street Manages Main Street*. See also analysis of bankruptcies of private equity-owned supermarket chains between 2015 and 2018 in Batt and Appelbaum (2018) "Private Equity Pillage: Grocery Stores and Workers at Risk," *The American Prospect*. October 26. <https://prospect.org/article/private-equity-pillage-grocery-stores-and-workers-risk>



The excessive use of debt is at the heart of private equity's promise to deliver outsized returns. While leverage (the percent of debt used in a transaction) declined during and in the immediate aftermath of the 2008-2009 financial crisis, it soon began rising to high levels again. In response, the Federal Reserve Board, the Federal Deposit Insurance Corporation, and Office of the Comptroller of the Currency issued guidance to banks in March 2013 covering transactions characterized by a borrower with a high degree of financial leverage.<sup>9</sup> In light of the problems that resulted from tremendous growth in the volume of leveraged lending prior to the 2008 financial crisis, the guidelines noted:

“Generally, a leverage level after planned asset sales (that is, the amount of debt that must be serviced from operating cash flow) in excess of 6X Total Debt/EBITDA [earnings before interest, taxes, depreciation, and amortization] raises concerns for most Industries.”<sup>10</sup>

Initially, this effort by regulators to tamp down on bank financing for takeovers with high levels of debt put a crimp in private equity's ability to over-leverage companies acquired for PE fund portfolios.<sup>11</sup> PE firms responded by establishing affiliates to make loans that exceeded the 6X earning guidance given to banks by the regulators,<sup>12</sup> and the bank regulators themselves soon walked the guidance back. The current administration has made it clear that the guidelines were suggestions, not rules, and would not be enforced.

The result has been a return to the use of risky levels of leverage.<sup>13</sup> Figure 1.1 shows the changing levels of debt/EBITDA used in US private equity leveraged buyouts between 2003 and 2019. As can be seen, debt/EBITDA levels were relatively low in the early 2000s, but increased sharply during the bubble years leading up to the financial crisis in 2007, when about 20 percent of buyouts had debt levels (leverage) that were 6-7X EBIDTA and 40 percent had debt

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<sup>9</sup> Board of Governors of the Federal Reserve System, Federal Deposit Insurance Corporation, Office of the Comptroller of the Currency. 2013. “Interagency Guidance On Leveraged Lending.” March 21. <https://www.federalreserve.gov/supervisionreg/srletters/sr1303a1.pdf>

<sup>10</sup> Ibid, p 7.

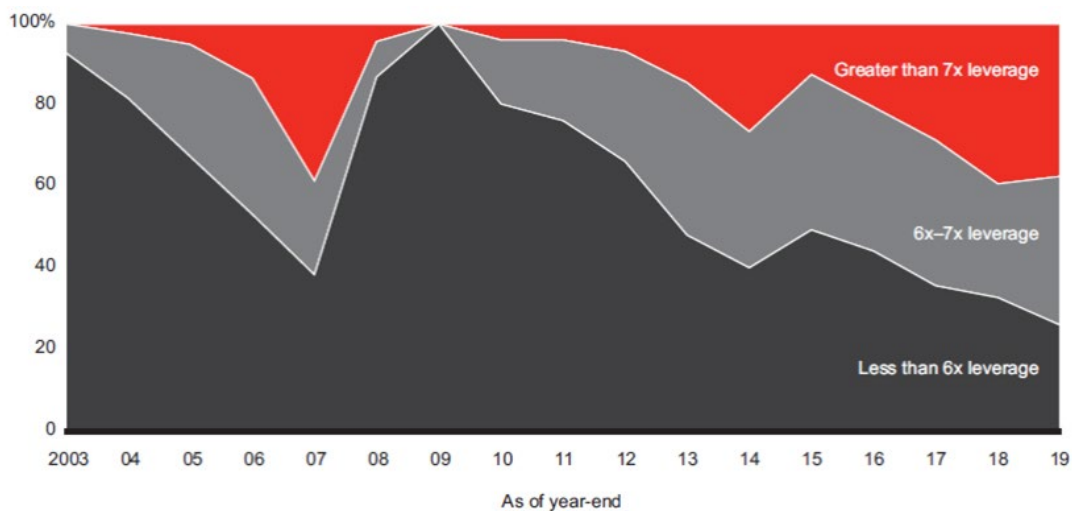
<sup>11</sup> Gillian Tan. 2015. “Buyout Firms Feel Pinch From Lending Crackdown,” *Wall Street Journal*. March 25. <https://www.wsj.com/articles/buyout-shops-feel-pinch-from-lending-crackdown-1427304125>; Lauren Tara LaCapra, Greg Roumeliotis and Michelle Sierra. 2014. “Banks Deny KKR Buyout Loan amid Regulatory Crackdown.” *Reuters*. May 29. <http://www.reuters.com/article/2014/05/29/us-kkr-loan-idUSKBN0E92BS20140529?feedType=RSS&feedName=businessNews>

<sup>12</sup> Miriam Gottfried and Rachel Louise Ensign. 2018. “The New Business Banker: A Private Equity Firm.” *Wall Street Journal*. August 12. <https://www.wsj.com/articles/the-new-business-banker-a-private-equity-firm-1534075200>.

<sup>13</sup> PitchBook. 2019. “2018 Annual US PE Breakdown,” p. 4. <https://pitchbook.com/news/reports/2018-annual-us-pe-breakdown>

(leverage) equal to 7X EBITDA or more. The use of leverage then plummeted during and after the crisis, when the share of deals with debt equal to 6X EBITDA did not exceed 25 percent. By 2014, however, the use of leverage had rebounded to close to 2007 levels. Since then, debt levels have grown substantially: by 2019, 75 percent of all leveraged loans had debt multiples higher than 6X EBITDA and about 40 percent had levels of 7X EBITDA or higher. In their 2020 Global 2020 Private Equity Report, Bain & Company note that, “The true leverage of many deals may be even greater, as banks commonly allow borrowers to calculate multiples based on projected earnings instead of actual results.”<sup>14</sup>

**FIGURE 1.1:  
Share of US Leveraged Buyout Market, By Leverage Level: 2003-2019**



Source: Thomson LPC

Source: Bain & Company: Global 2020 Private Equity Report, Figure 1.5.

Intense competition from corporate buyers and other PE firms have continually pushed asset valuations higher in recent years; and in 2019, the total purchase price for US LBOs averaged 11.5X EBITDA. Fully 55 percent of all LBOs had a multiple higher than 11X EBITDA.<sup>15</sup>

PE funds are willing to overpay for acquisitions because they face the prospect of having to return dry powder that is not spent in the first half of a PE fund’s life (in the first five or six years following the launch of the fund) to the LP investors in the fund, along with the management fees collected on those capital commitments. This is something PE firms prefer to avoid, even if it means paying a price to acquire a company that is not justified by the portfolio company’s earnings. At the end of 2019, US private equity firms sat on almost \$800 billion dry powder

<sup>14</sup> Bain & Company. 2020. “Global 2020 Private Equity Report,” p. 6. <https://www.bain.com/insights/topics/global-private-equity-report/>

<sup>15</sup> Ibid. p. 7

across all funds,<sup>16</sup> while at the same time, US PE fundraising has averaged over \$200 billion annually since 2013.<sup>17</sup>

A change in demand patterns or a slowdown in the economy can threaten the viability of companies burdened with too-high debt levels. During the 2008–09 financial crisis, highly leveraged companies experienced a disproportionate share of bankruptcies.<sup>18</sup> More recently, new competitors such as Wal-Mart and Amazon have led to heightened competition in the retail and grocery sectors, causing disruption and changes in consumer demand. Notably, however, it was disproportionately private equity owned companies, such as Toys ‘R Us, Payless ShoeSource, and Shopko, which went bankrupt. In the last 10 years, retail companies owned by private equity and hedge funds destroyed 1.3 million jobs in stores and suppliers at the same time that the industry added 1 million new jobs.<sup>19</sup> In the grocery sector, seven major chains owned by private equity went bankrupt between 2015 and 2018, while no publicly-traded chains did so.<sup>20</sup>

### **Buy and Build: Private Equity’s Strategy for Building Powerhouse Companies**

The high prices paid for portfolio companies not only put these companies at risk in case of an economic downturn, they also undermine the ability of PE funds to exit investments in these companies at a profit. The median PE fund in vintages since 2005 has not beaten the stock market, according to recent academic reports.<sup>21</sup> PE firms have responded with a “buy and build” strategy that consists of horizontal mergers between the original portfolio company — now referred to as the “platform company” — and its smaller rivals, which can be acquired at prices far less than 10X EBITDA. This dilutes the overall purchase price of the expanded company, facilitating a profitable exit.

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<sup>16</sup> Mirium Gotfried 2019. “Private-Equity Cash Piles Up as Takeover Targets Get Pricier. Buyout activity in the U.S. is down sharply even as firms’ unspent cash allocated for North American deals hits record \$771.5 billion.” *Wall Street Journal*. Dec. 1. <https://www.wsj.com/articles/private-equity-cash-piles-up-as-takeover-targets-get-pricier-11575208800>

<sup>17</sup> PitchBook 2019. Q3 2019 US PE Breakdown, p 13. <https://pitchbook.com/news/reports/3q-2019-us-pe-breakdown>

<sup>18</sup> Edith Hotchkiss, David C. Smith and Per J. Strömberg. 2012. “Private Equity and the Resolution of Financial Distress.” Working Paper. [www.law.uchicago.edu/files/files/Stromberg.pdf](http://www.law.uchicago.edu/files/files/Stromberg.pdf).

<sup>19</sup> Jim Baker, Maggie Corser, and Eli Vitulli. 2019. “Private Equity: How Wall Street Firms are Pillaging American Retail.” Washington, D.C. July. <https://populardemocracy.org/sites/default/files/Pirate%20Equity%20How%20Wall%20Street%20Firms%20are%20Pillaging%20American%20Retail%20July%202019%20FINAL%20UPDATED%207-23-2019.pdf>.

<sup>20</sup> Eileen Appelbaum and Rosemary Batt. 2018. Op. cit. at endnote 9.

<sup>21</sup> Eileen Appelbaum and Rosemary Batt. 2019. “Are Lower Private Equity Returns the New Normal?” in M. Wright, K. Amess, N. Bacon, and D. Siegel, eds., *The Routledge Companion to Management Buyouts*. London: Routledge.

The growing use of add-ons by PE firms is evident in data provided by PitchBook. Overall, PE add-ons as a proportion of all buyout activity across all segments grew substantially over the last decade – from 56.5% of buyouts in 2009 to an estimated 68% in 2019.<sup>22</sup> PitchBook reports that:

“Nearly 30.0 percent of PE-backed companies now undertake at least one add-on acquisition, compared to less than 20.0 percent that did so in the early 2000s...More than 25.0 percent of add-ons are now being acquired by platforms with at least five total add-on deals.”<sup>23</sup>

Small acquisitions that are less expensive than large buyouts enable the PE firm to “blend down” the aggregate acquisition multiple and enable it to exit at a higher profit when the expanded company is sold or taken public. A growth strategy of acquiring and adding on other companies to the original portfolio company is more lucrative than investing in the original company and taking the time to allow it to grow organically. PE investors are impatient and plan to exit their investments in 3 to 5 years.

One new private equity firm, for example, completed 20 add-ons across just two platforms shortly after the firm was founded. The firm describes its strategy as pursuing healthy acquisitions in “highly-fragmented, niche markets” and utilizing the platform’s “unlimited potential to expand into hundreds of smaller, local territories...through multiple add-on acquisitions.”<sup>24</sup>

PitchBook’s researchers also found that PE funds that complete more add-ons generate better cash-on-cash returns, have higher internal rates of return (IRR), and have a disproportionate share (36.3 percent) of top-quartile funds. “PitchBook research on the effects of add-on investing on fund performance show a clear trend of outperformance by firms that used a higher rate of add-ons.”<sup>25</sup>

While the popular justification for private equity’s buy and build strategy is that it ‘blends down’ the price of expensive acquisitions, and this is certainly true, it is also true that this strategy is an effective way to consolidate ownership and market power on a national scale without coming under scrutiny by antitrust agencies – a strategy that can contribute to ‘outperformance’ by

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<sup>22</sup> PitchBook. 2019. Q3 2019 US PE Breakdown. <https://pitchbook.com/news/reports/3q-2019-us-pe-breakdown>

<sup>23</sup> PitchBook. 2018. “Analyst Note, Additive Dealmaking Part II: An analysis of add-ons effect on fund performance,” Q3. [https://files.pitchbook.com/website/files/pdf/PitchBook\\_3Q\\_2018\\_Analyst\\_Note\\_Additive\\_Dealmaking\\_Part\\_II.pdf](https://files.pitchbook.com/website/files/pdf/PitchBook_3Q_2018_Analyst_Note_Additive_Dealmaking_Part_II.pdf).

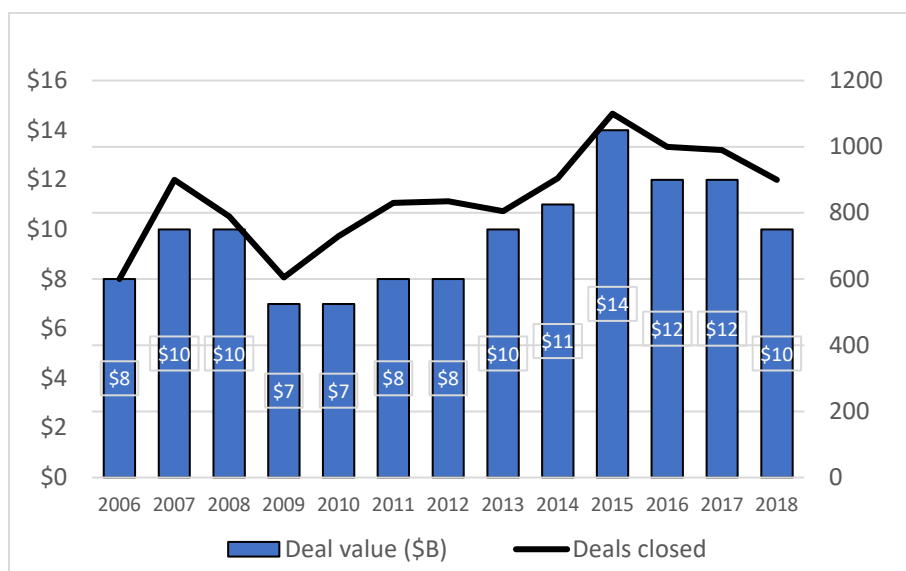
<sup>24</sup> Ibid., p. 2.

<sup>25</sup> PitchBook. 2019. “2018 Annual US PE Breakdown,” p. 5. <https://pitchbook.com/news/reports/2018-annual-us-pe-breakdown>

increasing the PE firm’s ability to charge higher rates. The threshold below which companies do not need to provide the Federal Trade Commission with a premerger report was established at \$50 million in 1976. It is indexed to the growth of GDP and on February 28, 2018, it was \$84.3 million.<sup>26</sup>

A recent report by Abacus Finance, using PitchBook data, examines the annual number of add-ons by PE firms of companies with enterprise values below \$50 million in every year from 2006 to 2018. The number peaked in 2015 at over 1,100; it has declined since but remains robust. As can be seen in **Figure 1.2**, PE-owned companies have added on thousands of companies to their platforms in what is referred to as the sub-\$50 million segment of the lower middle market (LMM).<sup>27</sup>

**FIGURE 1.2**  
**Add-on Activity in US Lower Middle Market Across All Industries**



Source and notes: Adapted from Abacus Finance (2019).

These acquisitions, while too small individually to come to the attention of the Federal Trade Commission (the antitrust agency with jurisdiction in health care), may greatly expand the size

<sup>26</sup> Federal Trade Commission. 2018. “HSR Threshold Adjustments and Reportability Requirements for 2018.” Washington, DC: Federal Trade Commission. <https://www.ftc.gov/news-events/blogs/competition-matters/2018/02/hsr-threshold-adjustments-reportability-2018>.

<sup>27</sup> Abacus Finance. 2019. “Breaking Down PE’s Push into the Lower Middle Market, A Review of Key Dynamics in the Lower Middle Market,” 1Q. [http://static1.l.sqspcdn.com/static/f/915290/28080234/1550194988397/Abacus\\_Finance\\_Breaking\\_Down\\_PE\\_Push\\_Into\\_Lower\\_Middle\\_Market.pdf?token=pHZsnq2FC3oxUlyfeq0F7h0IvJs%3D](http://static1.l.sqspcdn.com/static/f/915290/28080234/1550194988397/Abacus_Finance_Breaking_Down_PE_Push_Into_Lower_Middle_Market.pdf?token=pHZsnq2FC3oxUlyfeq0F7h0IvJs%3D)

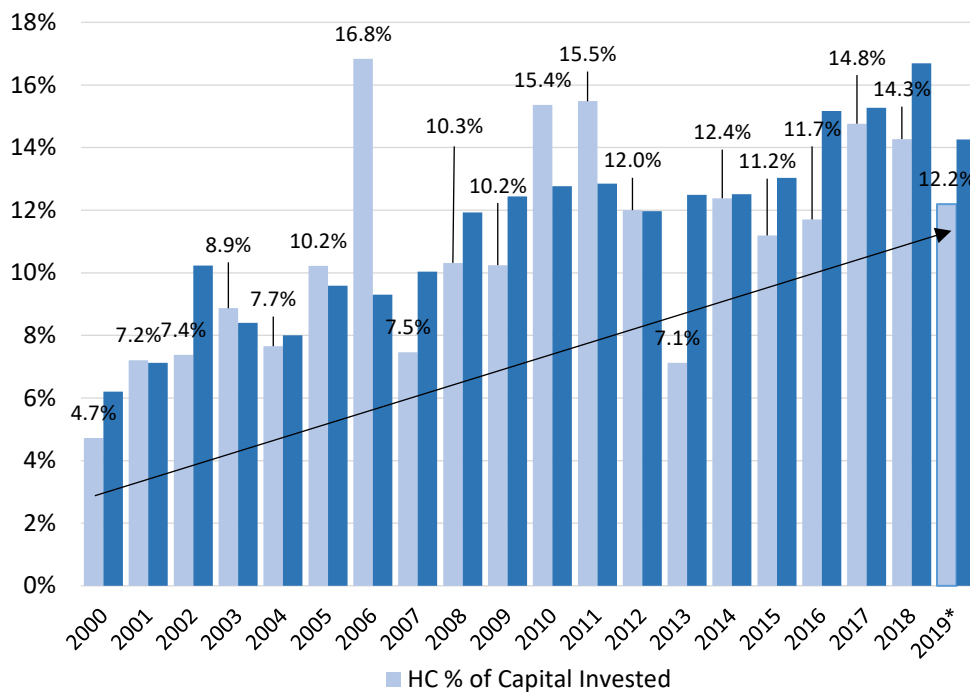
of the original platform company and its dominance in a product line or national or regional markets.

As we discuss more fully in below, the healthcare industry is especially conducive to the buy-and-build strategy. The industry is characterized by fragmented market segments and changing technology, providing opportunities for platform companies to scoop up smaller companies, scale up, and dominate certain health care market segments.

### Trends in Private Equity Investment in Health Care

Private equity investments in the healthcare sector have increased dramatically in the past 2 decades. Private equity firms have shifted capital investments away from other sectors – primarily consumer products -- into healthcare. If we examine PE *leveraged buyout* activity alone, the percent of US private equity capital invested in healthcare more than doubled -- from under 5 percent of the total in 2000 to 14 percent in 2018 (Figure 2.1).

**FIGURE 2.1**  
**Percent of US Private Equity LBO Activity in the Healthcare Sector: 2000-2019**



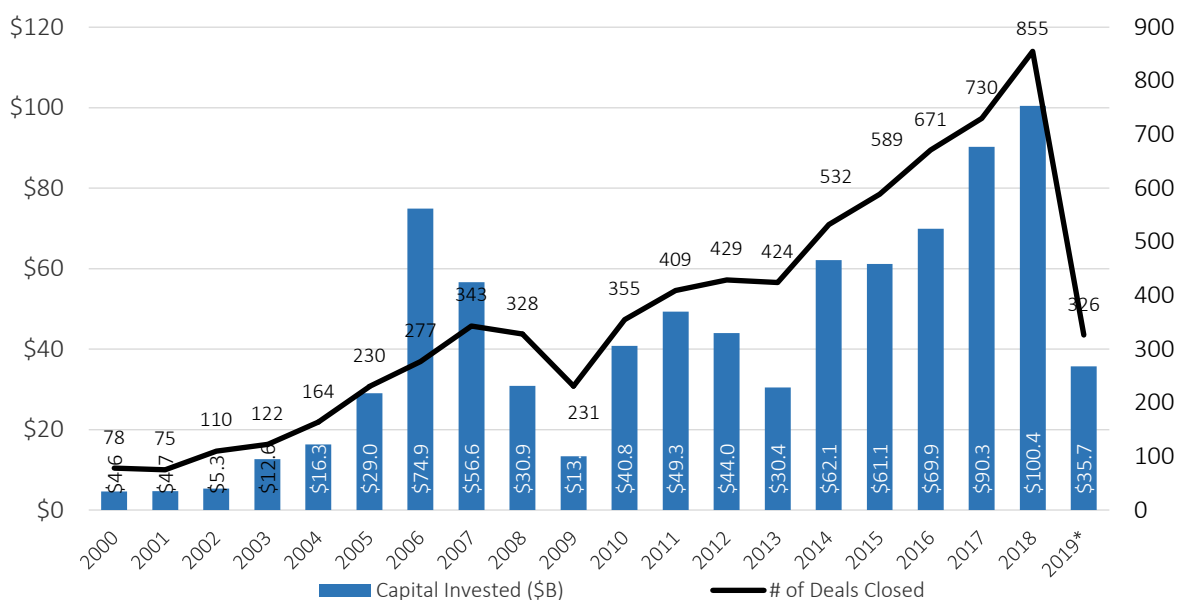
\*Source: PitchBook data, as of October, 2019.

If we consider *all types* of healthcare deals (LBOs, add-ons, growth investments, secondary buyouts) PE capital invested in healthcare grew from less than \$5 billion per year in 2000 to \$100 billion in 2018 – a 20-fold increase. The number of deals each year increased from 78 in

2000 to 855 in 2018 – a 10-fold increase (Figure 2.2). Cumulative PE investments in the healthcare sector in this two-decade period totaled \$833 billion dollars and involved almost 7,300 deals.

Investments have also accelerated over time. The overwhelming majority of PE investments in healthcare – 70 percent – have occurred since 2010. Moreover, in 2018, PE healthcare transactions reached their highest in history -- at 855 deals and \$100 billion in capital investments, up 43 percent over 2016.

**FIGURE 2.2**  
**Private Equity Deal Flow in Healthcare: Capital Invested and Deal Count: 2000-2019**



\*Source: PitchBook data, as of October, 2019

This level of private equity activity is likely to continue, according to an expert in healthcare financial advisory services, Greg Kooneman: "Back in the early 1990s, there were only a handful of private equity firms actively seeking healthcare services investments. But fast forward to 2019, and just about every one of the 4,000 private equity firms has an interest in healthcare services. Healthcare is approaching 20 percent of the gross domestic product and given the fragmented nature of many verticals, it is a very attractive market."<sup>28</sup> There is tremendous demand among private equity investors for quality healthcare service companies, particularly given the high level of ‘dry powder’ and new capital that is available.

<sup>28</sup> *Becker's Hospital Review*. 2019. "Private Equity in the Healthcare Space: Transaction Trends & Lessons Learned." April 26. <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/private-equity-in-the-healthcare-space-transaction-trends-lessons-learned.html>

Despite the high level of regulatory complexity in healthcare, private equity interest in the sector is strong due to its fragmented nature and opportunities to consolidate businesses and resell them at a large profit to strategic buyers - buyers such as hospitals and insurance companies, with a long-term interest in the acquisition as a complement to on-going operations. In addition, third party payment systems provide a secure cash flow. The federal government controls roughly 40 percent of total healthcare spending, and Medicaid, Medicare, and other government programs are anticipated to rise at 5.4 percent annually through 2026, even though the government has pursued efforts to reduce the rate of growth in these programs. Government solutions are likely to provide further incentives for consolidation in the industry.<sup>29</sup>

The growth of private equity interest in the sector is also evident from a PE industry association—the Healthcare Private Equity Association (HCPEA) -- formed specifically to advance investments in the sector, provide professional development, hold conferences and networking events, and educate members on current industry and regulatory issues. Members include a wide range of small to large private equity firms, including major PE firms such as Bain, Blackstone, Clayton Dubilier & Rice, KKR, TPG, Thomas H. Lee Partners, Welsh, Carson, Anderson, & Stowe, and Warburg Pincus. According to its website, in 2019 the association's 74 members had over \$2 trillion in assets under management (AUM) involving some 1,500 healthcare businesses. At its founding with 40 members in 2010, it reported \$200 billion in revenue in 500 companies with roughly 750,000 employees.<sup>30</sup>

Some private equity firms have specialized in the healthcare sector for a considerable time and tend to be small boutique firms that offer a combination of financing, financial advising, and operational consulting. Because they are small and tend to buy out small enterprises, they have opportunities to undertake operational strategies to help portfolio companies grow and may not be able to leverage as much debt on their portfolio companies.

While a large *number of deals* are undertaken by these smaller companies, *most of the capital invested* in healthcare has come from large or mega-fund private equity firms with primarily financial expertise and little expertise in the healthcare industry – although they increasingly recognize the need to add former healthcare executives to their organizations. Large PE firms that have invested heavily in healthcare include Bain Capital, Blackstone, KKR, and Welsh, Carson, Anderson, & Stowe.

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<sup>29</sup> The Keckley Report. 2019. <https://www.paulkeckley.com/the-keckley-report/2019/4/22/private-equity-is-re-shaping-us-healthcare>. April 22.

<sup>30</sup> Healthcare Private Equity Association. 2019. <https://www.hcpea.org/current-member-firms>.

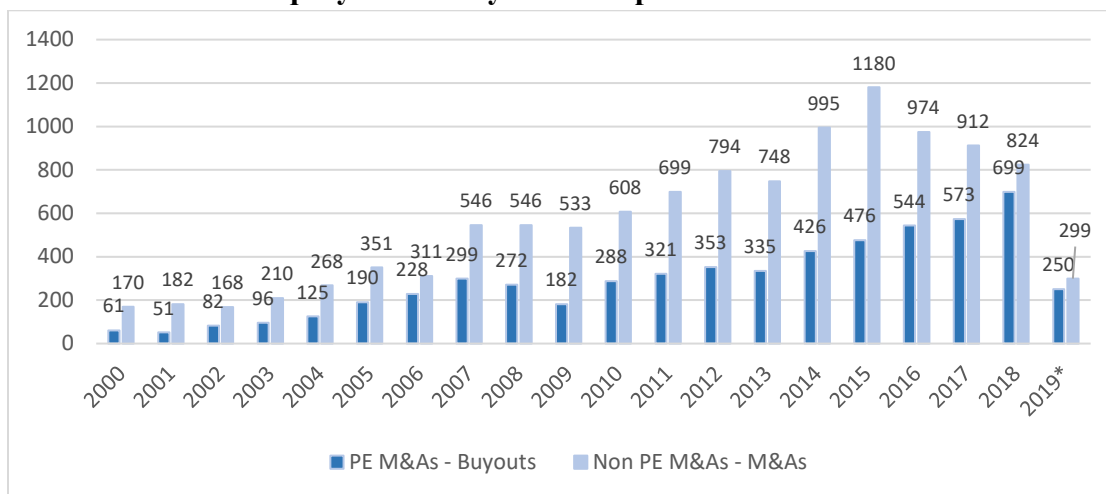


## Private Equity Firms Driving Mergers, Acquisitions, and Industry Consolidation

More importantly, private equity investments in healthcare are driving changes in the structure of the industry. It is well known that consolidation in the healthcare industry has exploded in the last decade in response to financial pressures, decreases in government funding, and new technologies that allow for the virtual integration of hospitals, outpatient clinics, physician practices, and other specialty units.<sup>31</sup> M&A activity in healthcare is among the highest of any sector in the economy. This has led many analysts to worry about the growth of monopoly power in certain segments, and some recent studies have shown that it has led to higher healthcare costs for patients in certain consolidated markets.<sup>32</sup> Less known is that private equity firms are driving a substantial portion of this M&A activity – and their activity relative to other players has grown substantially in the last 20 years, as shown in Figure 2.3.

**FIGURE 2.3**

**Number of Private Equity M&A Buyouts Compared to Non-PE M&As: 2000- 2019**



\*Source: PitchBook data, as of October, 2019.

Between 2000 and 2019, the number of private equity M&A buyouts in healthcare each year grew at a much faster rate than non-PE related M&A buyouts -- a 12-fold increase for PE related buyouts compared to only a 3-fold increase for non-PE M&As. While non-PE buyouts still dominate, by 2018 private equity firms had substantially closed the gap and represented fully 45 percent of all mergers and acquisitions in healthcare.

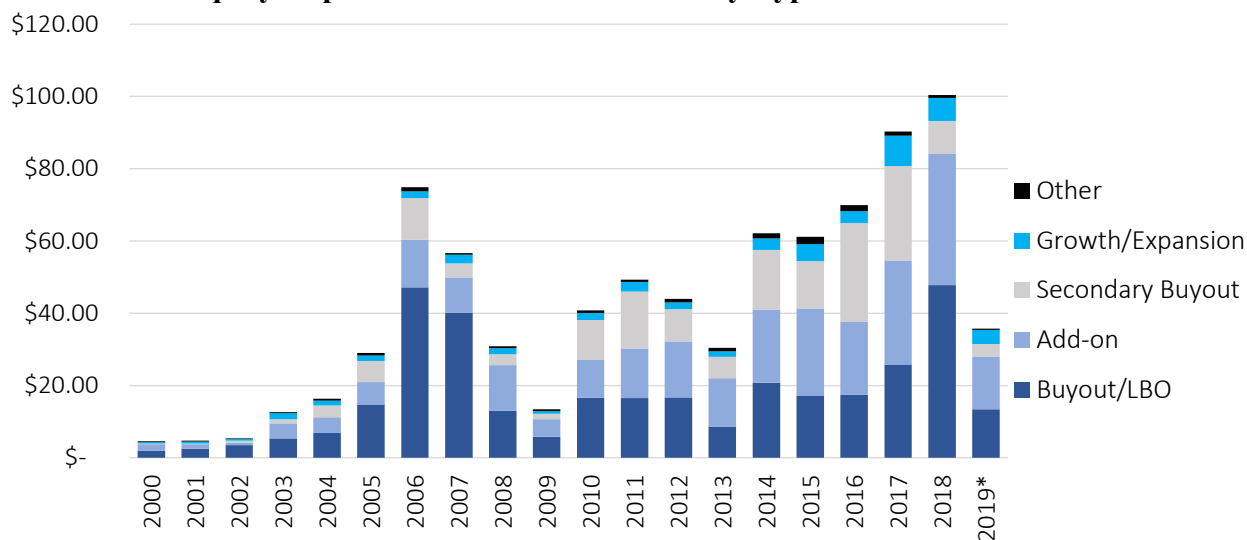
<sup>31</sup> Eileen Appelbaum and Rosemary Batt. 2017. “Organizational Restructuring in U.S. Healthcare Systems: Implications for Jobs, Wages, and Inequality” (Washington, DC: Center for Economic and Policy Research, September). <http://cepr.net/publications/reports/organizational-restructuring-in-us-healthcare-systems>

<sup>32</sup> Zack Cooper, Stuart Craig, Martin Gaynor, and John Van Reenen. 2015. “The Price ain’t Right? Hospital Prices and Health Spending on the Privately Insured.” Cambridge, MA: NBER Working Paper 21815. December. <https://www.nber.org/papers/w21815>.

As noted above, add-ons are a key strategy for private equity investments in general – and it has become a particularly important way for PE firms to consolidate operations in healthcare. Consistent with this observation, the median deal size of PE leveraged-buyouts in healthcare is in the range of \$60-70 million. The figures for non-PE M&As are similar. The average size is twice that for PE deals (in the range of \$120 - \$140 million in recent years), while that for non-PE related deals is larger -- in the range of \$215 - \$230 million. These deal sizes are very small when compared to the mega \$500 million to several billion dollar deals that mark much of private equity activity more generally.

Add-ons as a proportion of PE buyout activity have grown over time, as shown in Figure 6. In earlier periods, private equity firms were more likely to buy out single organizations, such as large hospital chains, but as they found it difficult to make money and exit these investments in their preferred time frame add-ons have grown in popularity. This strategy allows PE firms to gain market power in a particular healthcare segment or sub-segment, as we illustrate below in the case of private equity ownership of physician staffing firms in which Envision Health, owned by KKR, and TeamHealth, owned by Blackstone together supply 30 percent of the market for outsourced physicians, especially doctors employed in outsourced emergency rooms.

**FIGURE 2.4**  
**Private Equity Capital Invested in Healthcare by Type of Investment: 2000-2019**



\*Source: PitchBook data, as of October, 2019.

Between 2013 and 2019, capital invested in add-ons equaled 35 percent of all PE investments in healthcare, compared to leveraged buyouts at 34 percent (Figure 2.4).

The next largest category of investments was secondary buyouts (23 percent), which are deals in which a portfolio company owned by one PE firm is acquired in a buyout by another PE firm. These deals can include LBOs or leveraged add-ons. By contrast, in the pre-bubble years of 2000-2005 (and prior to the mega-buyout of Hospital Corporation of America in 2006), LBOs represented 48 percent of PE investments, add-ons 26 percent, and secondary buyouts only 15 percent. The data clearly show the marked changes in PE investment strategies over time.

Comparing the *number of deals* executed by type of investment in recent years, almost three times as many deals were completed as add-ons versus LBOs between 2013 and 2019 (2,035 versus 791).

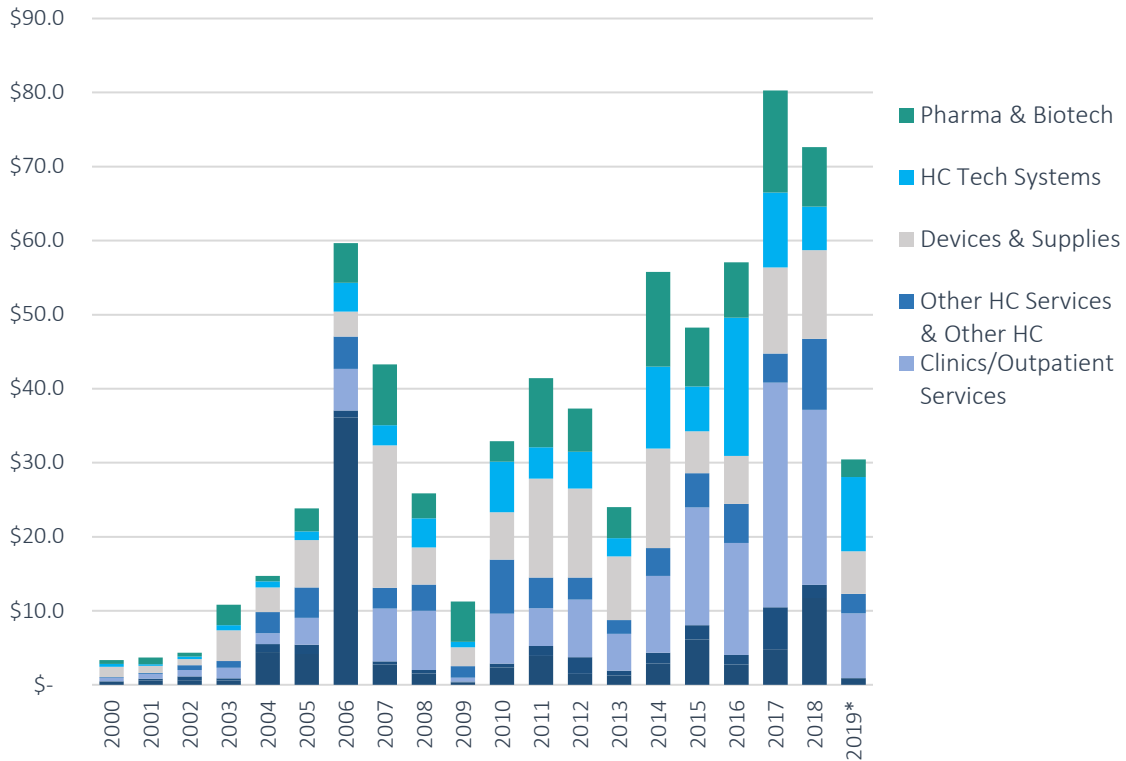
Consistent with this trend, private equity investments have shifted to different market segments – especially from hospitals to clinics and outpatient services. Between 2013 and 2019, 8 percent of PE investments were in hospitals compared to 30 percent in clinics and outpatient services. Note that many of the services listed under ‘other healthcare services’ are also small physician specialty practices. This highly fragmented segment includes over 150 physician specialties and more than 900,000 physicians in the US.<sup>33</sup> With these added in, PE investments in small provider services represented 39 percent of all investments in this period (Figure 2.5). Healthcare technology systems, another major opportunity for the add-on and roll-up strategy, are also a growing and lucrative segment for private equity investment.

Similar to the private equity industry as a whole, PE investments in healthcare have continued to grow despite the rising cost of targeted buyouts. As the number of PE firms competing for the best targets has increased, so has the price. In 2006, total price multiples were 13.7X EBITDA -- including 7.2X debt/EBITDA. This figure was driven largely by the mega-buyout of HCA in that year. In the post-recession period, price multiples were 12.6X EBITDA in 2014; and since 2016, they have returned to the 2006 highpoint. In 2018, the median healthcare deal cost 15.8X EBITDA, including 7X debt/EBITDA – considerably higher than the average of 11.5X EBITDA in the private equity industry as a whole in 2019 (as noted above).

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<sup>33</sup> *Becker's Hospital Review*. 2019. Op. cit., at endnote 29.

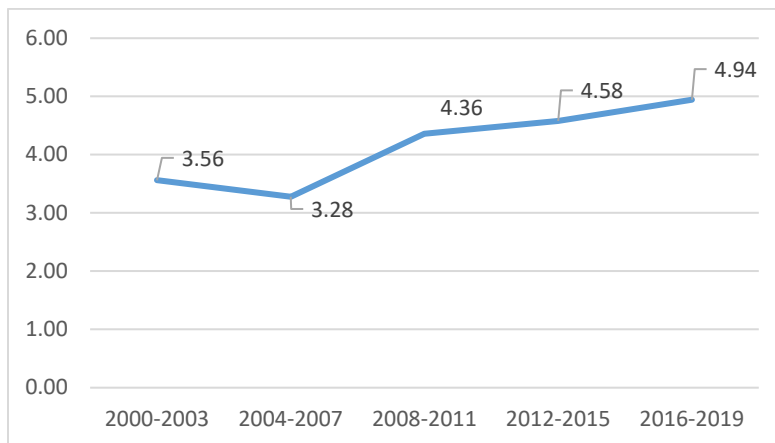
**FIGURE 2.5**  
**Private Equity Capital Invested by Segment: 2000-2019**



\*Source: PitchBook data, as of October, 2019.

As a result, the ability of private equity firms to exit their investments has become more difficult, as is evident in the rise in the median holding time for PE investments (Figure 2.6). While most

**FIGURE 2.6**  
**Exited PE Buyouts Median Hold Time (Years): 2000-2019**



\*Source: PitchBook data, as of October, 2019.

PE firms appear to have exited their investments within their preferred 5-year time frame over the past two decades, that median time to exit has increased from about 3.5 years in the early 2000s to 5 years in the current period. This implies that most recently, about half of exits have taken more than 5 years.

In sum, it is evident from the data that private equity firms have increased their penetration into healthcare, which now accounts for a substantially increased proportion of their overall acquisitions activity. The amount of PE capital flowing into healthcare has risen dramatically, as has the number of deals made each year. Private equity is driving much of the M&A activity in healthcare, fueling consolidation in virtually all segments of the industry. The strategy of acquiring a platform company and then adding-on smaller companies has overtaken large LBOs in number of deals, allowing PE firms to operate under the radar of anti-trust regulators. Investments have shifted from hospitals to outpatient clinics and other specialty services where value-added services offer more lucrative cash flow. The competition for these deals has driven the price of acquisitions sky-high and increased the length of time it takes for PE firms to exit their investments. Despite these challenges, private equity's continued investment in healthcare shows no sign of abating.

### **Destabilizing Local Health Care Markets: Private Equity and Hospital Acquisitions**

In one of the earliest acquisitions of a hospital system by a private equity firm, Forstmann Little & Co. acquired Community Health Systems (CHS) in July 1996 in a leveraged buyout for \$1.63 billion and took it private.<sup>34</sup> Forstmann used CHS as a platform and expanded the health care system by having CHS add-on other health care companies. Unlike traditionally managed hospitals, whose shareholders are committed to its continued operation as a going concern for the foreseeable future, private equity owners plan to exit their investments in companies they acquire in a relatively short period of time. Not surprisingly, CHS' PE owners began the process of selling their interest in CHS just a few years after acquiring it. In 2000, CHS was returned to the public markets via an IPO, but Forstmann continued to hold a majority of the health system's shares. The PE firm did not complete its exit from CHS until 2004.<sup>35</sup> Between March 2000 and June 2017, with Forstmann and other investment firms providing financing, CHS added-on 66 health care companies – making it, for a time, the largest for-profit chain in the U.S. by number of hospitals.<sup>36</sup>

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<sup>34</sup> PitchBook\_CHS\_20151020095002923, Community Health System profile dated 09-Oct-2015, p. 18.

<sup>35</sup> Ibid, p. 14.

<sup>36</sup> PitchBook\_Community\_Health\_Systems\_2019\_03\_19\_17\_03\_36, Community Health Systems Profile dated 19-Mar-2019, p. 4 -8.

While Forstmann was an early PE player in the hospital space, the acquisition in 2006 of Hospital Corporation of America, Inc. (HCA) by a consortium of private equity firms led by Bain Capital Partners was the largest LBO of a hospital chain in terms of revenue. At the time it was acquired, HCA was a for-profit hospital system that included 176 hospitals, 92 out-patient surgery centers, and 41,850 beds.<sup>37</sup> The consortium of PE firms acquired HCA for \$21 billion in a leveraged buyout that took the company private. The PE investors put up \$4.5 billion in equity and funded the remaining 80 percent (approximately \$17 billion) of the purchase price with debt. They also assumed HCA's outstanding debt, resulting in an enterprise value of \$33 billion and total debt of nearly \$29 billion.

With the onset of the financial crisis in 2007, HCA's private equity owners were unable to exit the hospital chain investment in their preferred three to five-year time frame. Instead, they turned to dividend recapitalizations to provide returns to investors. During 2010, HCA paid its private equity owners dividends of \$4.25 billion, which virtually covered their original investment. HCA finally went public on March 9, 2011, raising \$3.79 billion for its private equity owners, even while they retained substantial equity shares in the enterprise. The private equity firms realized extremely high returns on their equity investments. Bain Capital, for example, invested about \$64 million in the 2006 buyout of HCA; and by the time it went public, Bain had received about \$750 million – equal to roughly 10 times its initial investment.<sup>38</sup>

This acquisition of the largest U. S. hospital chain by revenue in a leveraged buyout signaled the important role that private equity would play in hospital M&A activity. HCA's financial success spurred other private equity funds to acquire hospitals in megamergers, an undertaking facilitated by access to low cost debt in the mid-2000s. While PE-owned hospitals accounted for a small fraction of the 5,724 acute care community hospitals in the U.S. in 2011, they were among the largest hospitals and hospital chains operating at that time.

Blackstone Group (with minority participation of other PE firms) acquired two-thirds of management-owned Vanguard Health Care in 2004 for 1.75 billion (post-deal valuation of \$2.65 billion). Approximately \$700 million of this was equity and \$1.05 billion was debt. Vanguard took on additional debt of \$950 million in 2010 to retire debt and to pay its PE owners a dividend. In 2011 Vanguard did a dividend recapitalization, raising \$750 million. Half of this was used to finance a dividend payment to its PE owners. As a result of the dividend recapitalization, Vanguard's debt rose from \$1.97 billion to \$2.73 billion. Vanguard acquired a number of hospitals between 2010 and 2012 including Baptist hospital system, hospitals in Chicago, and the Detroit Medical Center (DMC) hospital system. In late 2011, Vanguard did an

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<sup>37</sup> Levin Associates. 2010. "Largest Hospital Mergers and Acquisitions for the 10-Year Period Ended December 31, 2009 Revealed by DealSearchonline.com." March 31.  
<http://www.levinassociates.com/pr2010/pr1003hospital> (accessed 9-22-2014)

<sup>38</sup> Eileen Appelbaum and Rosemary Batt. 2014. Op. cit. at endnote 9, pp. 227-232.

IPO, selling a fraction of its shares, with most shares remaining in the hands of its PE owners. In 2013 publicly-traded Tenet Healthcare acquired Vanguard for \$1.8 billion, ending its private equity ownership.<sup>39</sup>

This was a financial success for Blackstone. Tenet, however, has struggled to run the hospitals it bought from the PE firm at a profit, while servicing the debt it assumed when it acquired Vanguard and addressing health and safety problems in some Vanguard hospitals. It has since divested several hospitals to cut costs and pay down debt, including all of its Chicago hospitals. Cost cutting was a major focus in 2018 and that continued in 2019.<sup>40</sup>

Tenet has also struggled with serious problems of patient harm and poor safety and cleanliness conditions at DMC that resulted in a federal investigation launched in 2016 and a civil suit alleging a patient's wrongful death in 2014. These problems have roots going back years but were not addressed during DMC's time as a PE-owned hospital system. Problems in DMC's once stellar cardiology unit, according to reports by hospital insiders<sup>41</sup>

“... include difficult-to-meet production goals for heart and vascular procedures, high profit expectations by DMC parent company Tenet Healthcare Inc., layoffs of key staff when profit margins dipped, the creation of Cardio Team One in 2008 that requires 24-7 coverage by cardiologists. ... [O]utcomes over the past five years have declined somewhat and been uneven because of staff cuts, several patient deaths and a growing number of unnecessary or risky procedures conducted by some cardiologists, six DMC doctors and other sources told Crain's.”

Problems at DMC are not limited to cardiology. Reports of dirty surgical instruments and problems with infections led to investigations by the Michigan Department of Licensing and Regulatory Affairs and the Centers for Medicare and Medicaid Services in 2016 and 2017. Their investigations led to citations for DMC for multiple violations of federal and state quality

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<sup>39</sup> PitchBook. 2019. Vanguard Company Profile dated January 15, 2019. PitchBook\_Vanguard\_Health\_Systems\_2019\_05\_02\_20\_06\_44.

<sup>40</sup> Ayla Ellison. 2019. “Tenet Sells 3 Hospitals, Exits Chicago Market,” *Becker's Hospital Review*, January 29. [https://www.beckershospitalreview.com/hospital-transactions-and-valuation/tenet-sells-3-hospitals-exits-chicago-market.html?origin=cfoe&utm\\_source=cfoe](https://www.beckershospitalreview.com/hospital-transactions-and-valuation/tenet-sells-3-hospitals-exits-chicago-market.html?origin=cfoe&utm_source=cfoe); Ayla Ellison. 2019. “Tenet Shrinks Loss to \$5M, Plans \$200M Cost-Cutting Drive,” *Becker's Hospital Review*, February 26. <https://www.beckershospitalreview.com/finance/tenet-shrinks-loss-to-5m-plans-new-200m-cost-cutting-drive.html>

<sup>41</sup> Jay Greene. 2018. “Detroit Medical Center's Cardiology Program Faces Problems,” *Modern Healthcare*. October 7. [http://www.modernhealthcare.com/article/20181007/NEWS/181009921?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=20181007-NEWS-181009921&utm\\_campaign=am](http://www.modernhealthcare.com/article/20181007/NEWS/181009921?utm_source=modernhealthcare&utm_medium=email&utm_content=20181007-NEWS-181009921&utm_campaign=am)

regulations. (DMC has since restructured its sterile processing department and meets standards.)<sup>42</sup> Although Blackstone's exit can be counted as a success for the PE firm and its investors, the same cannot be said for Tenet.

Private equity interest in buying up hospitals surged briefly in the 2009-2011 period in anticipation of increased demand for hospital use under the Affordable Care Act (ACA) of 2010 due to expanded coverage of the uninsured via Medicaid expansion and the growth of insurance exchange markets. And PE firms were emboldened by the success of HCA. PE ownership of hospitals reached its high-water mark in 2011, when 7 of the 12 largest for-profit chains were owned by private equity firms. Cerberus Capital, for example, created the Steward Healthcare System platform in 2010 by converting a group of non-profit Catholic hospitals in Massachusetts to a for-profit chain; and then quickly adding additional hospitals.

Many private equity firms new to the healthcare industry, however, lacked the deep industry expertise needed to manage hospitals and healthcare professionals and did not understand the complexity of the regulatory context. They also failed to anticipate how the political backlash to the ACA would undercut their economic forecasts. Opposition to Medicaid expansion and the failure of many local exchanges undercut projected demand. The windfall of additional revenues from healthcare reform did not materialize. While the uninsured population did decline post-ACA (from 20 percent to 12 percent of Americans between 2010 and 2016), the underinsured (with high deductible plans offered through local exchanges) grew from 16 percent to 22 percent in the same period. Employer plans also shifted to higher deductibles.<sup>43</sup> Moreover, the ACA's ban on discrimination against those with pre-existing conditions or ratings based on health status meant that sicker and more costly patients have made greater use of ER and hospital facilities. These conditions have meant that many patients cannot pay their unexpectedly high bills. Medical debt has thrown many families into financial distress or bankruptcy. While uncompensated hospital costs fell slightly after the ACA, they have rebounded since 2014.<sup>44</sup>

These conditions led private equity firms to sour on investing in hospitals. Many of their investments, as detailed below, failed to achieve profitability, and PE owners have attempted to recoup losses ever since by resorting to other financial engineering strategies in the PE playbook. Ironically, the disappointments of the ACA in the hospital segment created new opportunities for private equity gains in other segments. The high deductibles and co-pays on the most popular

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<sup>42</sup> Ibid.

<sup>43</sup> In sum, 45 percent of Americans were inadequately insured in 2019 – nearly the same as in 2010 – but the composition has shifted. Sara Collins, Herman Bhupal, and Michelle Doty. 2019. “Health Insurance Coverage Eight Years after the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, but More Underinsured. February. Harrisburg, PA: The Commonwealth Fund.

<sup>44</sup> American Hospital Association, 2019. AHA Uncompensated Hospital Care Cost Fact Sheet. January. Chicago, IL: AHA.



insurance policies obtained on the exchanges and the rise in net bad debt created demand for ‘more efficient’ hospital bill collectors – leading to the rapid growth of private equity investments in the outsourced ‘revenue cycle management’ segment, as we discuss below. Other private equity firms moved aggressively into the less complex and potentially more lucrative niches of urgent care and ambulatory surgery centers and specialty physician practices and ER outsourcing – each detailed below.

Table 3.1 shows the major private-equity owned hospital systems as of March 31, 2011. By then, CHS and HCA had been returned to the public markets and are not included in this table. HCA was taken private in 2006 in a \$21 billion mega-buyout by a PE consortium led by KKR, Bain Capital, and Merrill Lynch PE. On March 9, 2011, it exited in a successful IPO, but the three PE partners each retained a 25 percent stake in the company.<sup>45</sup>

Most of the other hospital chains acquired by private equity firms in the 2000s have failed to duplicate Bain’s financial success with HCA. Cost cutting measures to meet debt obligations have been common – including reductions in staff and closing departments that provide low margin services such as obstetrics and gynecology. In the extreme, hospitals have been shuttered and, occasionally, a hospital system has entered bankruptcy. Most recently, long-term care hospital chain New LifeCare Hospitals, which operates 17 facilities in 9 states, filed for bankruptcy protection on May 6, 2019. Owned by a consortium of PE firms led by Blue Mountain Capital, the chain had previously engaged in cost cutting measures and had shut several hospitals.<sup>46</sup>

PE-owned hospital systems have, however, succeeded in providing liquidity to investors via sale-lease backs of hospital real estate and via sales of the heavily leveraged hospital chains to other private equity firms in secondary buyouts. For example, Warburg Pincus acquired RegionalCare Hospital Partners in 2009. It sold the chain, now known as RCCH HealthCare Partners, to Apollo Global Management in 2015, which acquired it in a leveraged buyout. Apollo subsequently acquired Capella Health Care (previously owned by GTCR) in 2016 via an LBO as an add-on to RCCH. Most recently, in 2018, Apollo merged RCCH with LifePoint Health. The merged system operates 84 hospitals across 30 states, mainly in rural communities. Apollo is expected to sell off some of LifePoint’s real estate, as it did with RCCH, to provide quick returns to its investors.<sup>47</sup>

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<sup>45</sup> Appelbaum and Batt. 2014. Op. cit. at endnote 9, p. 229.

<sup>46</sup> Peg Brickley. 2019. “New LifeCare Hospitals Files for Bankruptcy amid Deal Talks,” *Wall Street Journal*. May 7. <https://www.wsj.com/articles/new-lifecare-hospitals-files-for-bankruptcy-amid-deal-talks-11557233127>

<sup>47</sup> PitchBook. 2019. RCCH HealthCare Partners Company Profile dated April 3, 2019. PitchBook\_RCCH\_HealthCare\_Partners\_2019\_05\_02\_18\_24\_04; PitchBook. 2019; Capella Healthcare Company Profile dated December 7, 2018.

**Table 3.1**  
**Major Private Equity Owned Hospital Systems as of March 31, 2011**

<i>Private Equity Firm</i>	<i>Vehicle/ Platform</i>	<i>Hospitals in System</i>
Blackstone Group	Vanguard Health Systems	26 hospitals in Arizona, Illinois, Massachusetts, Michigan and Texas. Includes Arizona Heart Hospital, 10 hospitals of the Detroit Medical Center, Baptist Health System of Texas, and 4 Chicago area hospitals.
CCMP Capital Advisors, Canada Pension Plan Investment Board	LHP Hospital Group	Portneuf Medical Center in Idaho, Texas Health Presbyterian Hospital.
Cerberus Capital Management	Steward Health Care System	Caritas Christi Health Care in eastern Massachusetts (St. Elizabeth’s Med. Ctr., Carney Hospital in Boston; St. Anne’s, Holy Family, Norwood Hospitals and Good Samaritan Med. Ctr. in Boston suburbs). Nashoba Valley Medical Center, Merrimack Valley Hospital, Morton Hospital and Medical Ctr., and Quincy Medical Ctr.
GTCR Golden Rauner	Capella Health Care	River Park, SW Medical Center, Grandview Medical Center, Capital Medical Center – all acquired from HCA.
TPG Capital	Iasis Health Care	17 acute care hospitals in Arizona, Florida, Texas and Utah. Also St. Luke’s Behavioral Health Center; and 2 managed health plans in Phoenix.
Warburg Pincus LLC	RegionalCare Hospital Partners	Regionally focused community hospitals in non-urban markets. Includes Eliza Coffee Memorial Hospital and Shoals Hospital in Alabama, Ottumwa Regional Health Center in Iowa, and Clinton Memorial Hospital in Ohio.
Welsh, Carson, Anderson & Stowe	Ardent Health Care	Lovelace Health System (6 hospitals in Albuquerque, New Mexico) and Hillcrest Health Care System (10 hospitals in Oklahoma).

Source: Adapted from Advisen (2011); includes additional information from authors’ analysis of American Hospital Association micro data.<sup>48</sup>

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PitchBook\_Capella\_Healthcare\_2019\_05\_02\_19\_49\_21; Alia Paavola. 2018. “Private equity firm to buy LifePoint Health for \$5.6B,” *Becker’s Hospital Review*. July 23. <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/private-equity-firm-to-buy-lifepoint-health-for-5-6b.html>; Tara Bannow. 2018. “LifePoint Assets Could go into REIT Following Merger,” *Modern Healthcare*. July 23. [http://www.modernhealthcare.com/article/20180723/NEWS/180729972?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=20180723-NEWS-180729972&utm\\_campaign=am](http://www.modernhealthcare.com/article/20180723/NEWS/180729972?utm_source=modernhealthcare&utm_medium=email&utm_content=20180723-NEWS-180729972&utm_campaign=am)

<sup>48</sup> Advisen Ltd. 2011. “Private Equity and Hospitals,” Bermuda-domiciled: *OneBeacon Professional Insurance*, May. [https://www.advisen.com/downloads/topical\\_report\\_private\\_equity\\_hospitals.pdf](https://www.advisen.com/downloads/topical_report_private_equity_hospitals.pdf)

But it is, perhaps, the saga of CHS, Steward Health Care System, and IASIS Health Care that most vividly illustrates what has become of the hospitals acquired by private equity in the 2000s – and what that has meant for the stability of health care markets and the community’s access to acute care services.

### **CHS, Steward, and Iasis: A Cautionary Tale**

CHS, Steward, and Iasis provide remarkable illustrations of how the private equity business model – of growing through add-ons in leveraged buyouts – undermines the stability of local healthcare systems. The strategy is designed to allow the PE-owned system to grow rapidly, build a national powerhouse, and launch an IPO in its preferred five-year window. PE-owned hospital systems can cobble together significant market power by acquiring a series of small acquisitions, many of which escape regulatory oversight because they fall below the Hart-Scott-Rodino (HSR) deal size threshold -- \$84 million in 2018 -- that triggers antitrust review. Leveraged buyouts of larger hospitals also generally escape serious antitrust scrutiny, in this case because the hospitals tend to be located in geographically dispersed health markets and do not serve the same patients or compete in the same healthcare markets.

In this way, heavily indebted Community Health Systems (CHS) became the largest for-profit hospital chain in the U.S. by number of hospitals; and financially struggling Steward hospital chain, owned by Cerberus, became the largest private hospital system in the U.S. in terms of both number of hospitals and revenue. CHS is now frantically selling off hospitals to pay down debt and avoid default, while Steward bought some of the CHS hospitals as well the TPG-owned IASIS hospital chain.

Despite the fact that they do not compete for patients in the same healthcare markets, PE-owned health systems nevertheless have the potential to disrupt local markets as their PE owners struggle with high debt loads and as they turn to financial engineering strategies to provide returns to investors, whether the hospitals are profitable or not. These strategies include selling hospital real estate to a real estate investment trust, requiring the hospital to lease-back the property it used to own (in a sale-lease back agreement), and distributing the revenue from the real estate sale to the private equity owners. Also common are dividend recapitalizations, in which the private equity-owned business sells junk bonds in order to pay dividends to its PE owners; and the use of management services agreements (MSAs) that require the hospitals to make large annual payments to the PE firm that owns them.

While the private equity owners of a hospital chain would prefer to avoid bankruptcy, they typically recover their initial equity investments and more regardless of whether or not the hospitals operate at a profit. As a result, they may be less focused on the hospitals’ long-term success. The overhang of leveraged debt – high debt that carries junk bond status – may threaten the ability of PE-owned hospitals to invest in life saving and other new technologies or to

provide high quality care and a full range of acute care health services. Ultimately, the viability of the hospitals maybe threatened. This disrupts the delivery of health care services in local markets, a situation that is especially troubling in the case of rural hospitals where health markets in many states may simultaneously be disrupted, with cascading effects on patients and providers.

There are also well-founded concerns that private equity's takeover of health care companies and their consolidation into powerful national players will lead to higher prices and less choice than patients have now. Prices might become even less transparent than they are currently. As Dr. Barbara McAneny, President of the American Medical Association, noted:<sup>49</sup>

"We have to decide whether the goal of a healthcare system is to increase profits, because PE firms are selecting those parts of healthcare where they can see a profit because their goal is to make profit. The consolidation of various parts of the healthcare industry has been shown to increase prices and decrease choice, and if you're lucky, quality stays about the same."

These concerns are amply illustrated in the intertwined cases of Community Health Systems owned by Forstmann Little; its spin-off of rural hospital operator Quorum; and its interactions with Cerberus-owned Steward Hospital System which acquired TPG-owned IASIS.

### **Community Health Systems**

Community Health Systems, as noted earlier, was one of the first hospital chains to be taken private in a leveraged buyout by private equity firm Forstmann Little & Co. in July 1996. In June 2000, Forstmann returned CHS to the public markets via an IPO, at an offering price of \$14.94.<sup>50</sup> At that time, CHS had \$1.2 billion in long-term liabilities and its debt/equity ratio was an already high 161.2 percent.<sup>51</sup> Forstmann continued to own a majority stake in CHS.

In November 2000, CHS held a secondary sale (2PO) of shares of CHS, with approximately 18 million shares sold -- about 10 million by CHS and about 7.6 million by Forstmann. The company used the proceeds from the secondary offering to pay down debt. Forstmann continued to control just under 55% of CHS after the offering.<sup>52</sup> Between March 2000 and June 2017, CHS added on 66 health care companies. For a time, it was the largest for-profit chain in the U.S.

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<sup>49</sup> Shelby Livingston. 2018. "Surge in Private Equity Deals Causes Some Alarm," *Modern Healthcare*. June 16. <http://www.modernhealthcare.com/article/20180616/NEWS/180619918>

<sup>50</sup> Op cit., PitchBook\_CHS\_20151020095002923 at endnote 35, p. 14, 18.

<sup>51</sup> Ibid, p. 15, 16; In 2000, the typical publicly traded company had debt equal to about 30 percent of its enterprise value, and a debt/equity ratio of 42.9 percent.

<sup>52</sup> Ibid, p. 14

by number of hospitals, before the overhang of debt threatened its viability and it began divesting hospitals in order to pay down debt and avoid default.<sup>53</sup>

Many of the acquired hospitals – especially those in rural areas – fell under the Hart-Scott-Rodino threshold for reporting to the FTC, allowing CHS to grow in size and market power without full scrutiny by antitrust regulators. One measure of CHS’ successful expansion of its footprint is the increase in the price of shares held by Forstmann between 2000 and 2004. On August 12, 2004, CHS filed another secondary offering at a price of \$24.21 per share. As a result of this sale, Forstmann no longer owned any shares of Community Health Systems. CHS did not receive any proceeds from the offering. To the contrary, CHS agreed to purchase just over half of the shares its PE owners were selling. CHS borrowed approximately \$260 million in order to fund this purchase of its own shares from its PE owners.<sup>54</sup>

While the private equity firm no longer owned CHS, Forstmann remained active for a time in financing CHS’ leveraged buyouts of add-on hospitals and other health care organizations.<sup>55</sup> Other investment firms also engaged in debt financing of the hospital chain’s expansion.<sup>56</sup> While CHS was no longer owned by private equity, it continued to operate using the private equity business model, including the use of leveraged buyouts to add-on smaller healthcare companies – many in rural, suburban, or small town locations – and loading CHS with dangerous amounts of debt.

Not all acquisitions by CHS were small. In 2007, CHS acquired hospital system Triad for \$5.1 billion plus the assumption of \$1.7 billion of debt. With this acquisition, CHS nearly doubled its number of hospitals to 130.<sup>57</sup> FTC approval was required, but it does not appear that the FTC raised questions about this merger, despite the number of facilities now controlled by CHS.

By 2013, CHS was the second-largest U.S. hospital chain in the US when it made a bid to take publicly-traded Health Management Associates (HMA) private in a leveraged buyout. HMA – with 15 percent of its stock owned by PE firm Glenview Capital Management – was struggling financially and facing litigation at the time. The offer valued HMA at about \$7.5 billion, including \$3.7 billion in assumed debt. The LBO increased this debt burden by an unspecified

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<sup>53</sup> PitchBook\_Community\_Health\_Systems\_2019\_03\_19\_17\_03\_36, Community Health Systems Profile dated 19-Mar-2019, p. 4 -8.

<sup>54</sup> Op cit., PitchBook\_CHS\_20151020095002923 at endnote 35, p. 14.

<sup>55</sup> Op cit., PitchBook\_Community\_Health\_Systems\_2019\_03\_19\_17\_03\_36 at endnote 54. p. 8.

<sup>56</sup> PitchBook\_CHS\_20151020095002923, Community Health System profile dated 09-Oct-2015, pp. 6-16.

<sup>57</sup> Theo Francis. 2007. “Community Health to Acquire Rival Triad,” *Wall Street Journal*, March 20. <https://www.wsj.com/articles/SB117431682165041442>

amount. HMA operated 71 hospitals with about 11,000 beds, while CHS operated 135 hospitals with about 20,000 beds. The FTC took note of this merger and required CHS to divest a handful of hospitals. When the deal closed, CHS operated 206 hospitals with 31,000 beds in 29 states. While HCA remained the biggest for-profit U.S. hospital chain by revenue, CHS had the largest number of hospitals.<sup>58</sup> By June 2015, about a year after the HMA deal closed, CHS' total long-term liabilities had increased dramatically to \$19.7 billion and its debt/equity ratio had nearly tripled since 2000 to 401.5 percent.<sup>59</sup>

As a condition of approving the merger, the FTC required that CHS divest just 2 hospitals and related facilities in Alabama and South Carolina.<sup>60</sup> This is surprising: The FTC made almost no demands on the heavily indebted hospital chain that had gobbled up so many hospitals in just 8 years. The FTC should have anticipated that the HMA acquisition and additional debt load would introduce unacceptable levels of instability in the health markets served by the merged company's hospitals.

Almost immediately, CHS was unable to meet its debt obligations out of current income, and CHS began divesting facilities to pay down debt and avoid default.<sup>61</sup> Its share price, which had risen to \$65 a share in July 2015 following the merger, fell to \$13.96 in February 2016.

In late 2016, CHS announced it would sell more than 12 of its hospitals; earlier, in April, it did a spinoff of 38 small, mostly rural hospitals into Quorum Health Corp, a newly created public company. In 2017, the hospital chain "made significant progress toward" its goal of selling a group of hospitals with combined revenue of \$2 billion. In 2018, CHS divested 11 hospitals.

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<sup>58</sup> Sharon Pettypiece and Stephanie Armour. 2013. "Community to Buy Health Management for \$3.9 Billion," *Bloomberg*, July 30. <http://www.bloomberg.com/news/2013-07-30/community-to-buy-health-management-for-3-9-billion.html>; Michael J. de la Merced, 2013. "Community Health Agrees to Buy H.M.A. for \$3.6 Billion," *New York Times*, July 30. <https://dealbook.nytimes.com/2013/07/30/h-m-a-to-be-sold-to-community-health-for-3-6-billion/>

<sup>59</sup> PitchBook\_CHS\_20151020095002923, Community Health System profile dated 09-Oct-2015, p. 20, 21.

<sup>60</sup> Federal Trade Commission. 2014. "FTC Requires Community Health Systems, Inc. to Divest Two Hospitals As a Condition of Acquiring Rival Hospital Operator." January 22. <https://www.ftc.gov/news-events/press-releases/2014/01/ftc-requires-community-health-systems-inc-divest-two-hospitals>

<sup>61</sup> Virgil Dickson. 2015. "Community Health Systems to spin off 38 hospitals, shift focus to larger markets." *Modern Healthcare*. August 3. <http://www.modernhealthcare.com/article/20150803/NEWS/150809993>

By October 2019, CHS had sold off 12 hospitals.<sup>62</sup> In 2018 Tennova, part of CHS, said it would cut staff and “reconfigure” health services at three Knoxville area hospitals. CHS also closed two Tennova hospitals; and in Missouri, CHS closed Twin Rivers Regional Medical Center, a 116-bed hospital, leaving local physicians struggling to fill the health care gap.<sup>63</sup> Selling off hospitals is likely to have been disruptive, eliminating services or closing hospitals altogether even more so.

### **Quorum Health Corp.**

The spinoff of 38 rural hospitals into a publicly-traded operating company known as Quorum Health Corp in April 2016, apparently without FTC oversight, simply shifted some of CHS’s debt problems to Quorum – robbing Peter to pay Paul. The spinoff yielded about \$1.2 billion in net proceeds to CHS, which the health care system was able to use to reduce its massive debt.<sup>64</sup> Quorum, however, was loaded with roughly \$1 billion in debt, which it needed to raise and pay off on its own. The debt was ‘speculative grade,’ meaning Quorum was financing its spinoff from CHS with junk bonds.<sup>65</sup> The outcome of the sale of the hospitals to Quorum had an

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<sup>62</sup> Dave Barkholz. 2016. “Troubled Hospital Giant CHS Looking to Sell Business,” *Modern Healthcare*. September 16.

[http://www.modernhealthcare.com/article/20160916/NEWS/160919916?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=20160916Ayla-NEWS-160919916&utm\\_campaign=mh-alert](http://www.modernhealthcare.com/article/20160916/NEWS/160919916?utm_source=modernhealthcare&utm_medium=email&utm_content=20160916Ayla-NEWS-160919916&utm_campaign=mh-alert);

Ayla Ellison. 2019. “CHS to Sell Hospital,” *Becker’s Hospital Review*. April 1.

[https://www.beckershospitalreview.com/hospital-transactions-and-valuation/chs-to-sell-tennessee-hospital-040119.html?origin=cfoe&utm\\_source=cfoe](https://www.beckershospitalreview.com/hospital-transactions-and-valuation/chs-to-sell-tennessee-hospital-040119.html?origin=cfoe&utm_source=cfoe); Ayla Ellison. 2019. “CHS Sees Net Loss

Quadruple; Revenue Sink in First Quarter,” *Becker’s Hospital Review*. May 1.

<https://www.beckershospitalreview.com/finance/chs-sees-net-loss-quadruple-revenue-sink-in-q1.html>;

Ayla Ellison. 2019. “CHS’ Shrinking Hospital Portfolio: 12 Latest Divestitures,” *Becker’s Hospital*

*Review*. October 8. <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/chs-shrinking-hospital-portfolio-12-latest-divestitures-100819.html>

<sup>63</sup> Ayla Ellison. 2018. “CHS Closes Missouri Hospital; Physicians Put Their Money on the Line to Expand Services,” *Becker’s Hospital Review*. July 10.

<https://www.beckershospitalreview.com/finance/chs-closes-missouri-hospital-physicians-put-their-money-on-the-line-to-expand-services.html>;

Ayla Ellison. 2018. “CHS to close 2 hospitals: 3 things to know,” *Becker’s Hospital Review*. December 26. <https://www.beckershospitalreview.com/finance/chs-to-close-2-hospitals-3-things-to-know.html>

<sup>64</sup> Barkholz, Op. cit., at endnote 63.

<sup>65</sup> Melanie Evans. 2016. “What Ugly Financial Markets Mean for Community’s Big Spinoff Plans,” *Modern Healthcare*. February 23.

[http://www.modernhealthcare.com/article/20160223/NEWS/160229962?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=20160223-NEWS-160229962&utm\\_campaign=am](http://www.modernhealthcare.com/article/20160223/NEWS/160229962?utm_source=modernhealthcare&utm_medium=email&utm_content=20160223-NEWS-160229962&utm_campaign=am)

enormous impact on hospital services in rural towns and communities across the Midwest and South.<sup>66</sup> *Modern Healthcare*, a trade publication for the healthcare industry, captured the scale and scope of the sale:<sup>67</sup>

“The facilities picked for Quorum have 3,635 licensed beds across 16 states. Most of them are in cities or counties with 50,000 or fewer residents. In 84% of the markets, the hospital is the sole provider of acute-care hospital services. Illinois is the state with the largest number – nine rural hospitals – to become part of Quorum.”

In its first year of operation, the hospital chain lost \$348 million.<sup>68</sup> Almost immediately after the spinoff from CHS, Quorum began selling off hospitals. In the three years following its spinoff from CHS, Quorum sold or shuttered 11 rural hospitals in health care markets with few to no alternative acute care facilities. The sale of these hospitals yielded \$86.5 million in net proceeds to Quorum, nearly all of which was used to pay down debt, with none going to improve the quality of care. By March 2019, Quorum’s hospital count had fallen to 27, and the rural chain announced its intention to shed another nine.<sup>69</sup> In April 2019, Quorum sold Scenic Mountain Medical Center, a 146-bed hospital in Big Spring, Texas to Steward Health Care System (a health system we examine below), reducing its count to 26 hospitals.<sup>70</sup> Quorum closed Affinity

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<sup>66</sup> Beth Kutscher. 2015a. “Community Health Systems Sees Volume Decline, Adverse Payer Mix,” *Modern Healthcare*. October 21. [http://www.modernhealthcare.com/article/20151021/NEWS/151029974?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=20151021-NEWS-151029974&utm\\_campaign=am](http://www.modernhealthcare.com/article/20151021/NEWS/151029974?utm_source=modernhealthcare&utm_medium=email&utm_content=20151021-NEWS-151029974&utm_campaign=am)

<sup>67</sup> Dickson, 2015, Op. cit. at endnote 62.

<sup>68</sup> Bob Herman. 2017. “KKR Buys into Quorum Health,” *Axios*. March 30. <https://www.axios.com/kkr-buys-into-quorum-health-1513301289-4d701327-514b-4759-acaf-6fb745fba19e.html>

<sup>69</sup> Ayla Ellison. 2019. “Quorum Aims to Shed Up to 9 Hospitals,” *Becker’s Hospital Review*. March 18. <https://www.beckershospitalreview.com/finance/quorum-aims-to-shed-up-to-9-hospitals.html>

<sup>70</sup> Ayla Ellison. 2019. “Quorum Divests Texas Hospital,” *Becker’s Hospital Review*. April 15. [https://www.beckershospitalreview.com/hospital-transactions-and-valuation/quorum-divests-texas-hospital-041519.html?origin=cfoe&utm\\_source=cfoe](https://www.beckershospitalreview.com/hospital-transactions-and-valuation/quorum-divests-texas-hospital-041519.html?origin=cfoe&utm_source=cfoe); Ayla Ellison. 2019. “17 Latest Hospital Mergers and Acquisitions,” *Becker’s Hospital Review*. April 16. [https://www.beckershospitalreview.com/hospital-transactions-and-valuation/17-latest-hospital-mergers-and-acquisitions-041619.html?origin=cfoe&utm\\_source=cfoe](https://www.beckershospitalreview.com/hospital-transactions-and-valuation/17-latest-hospital-mergers-and-acquisitions-041619.html?origin=cfoe&utm_source=cfoe)



Medical Center, a 156-bed hospital in Massillon, Ohio in 2018.<sup>71</sup> The company announced the closing of 314-bed MetroSouth Medical Center in Blue Island, IL in June 2019.<sup>72</sup> In a bid to cut costs and increase revenue, Quorum Health also began outsourcing revenue cycle management services (bill collecting) to R1 RCM to obtain end-to-end revenue cycle management services at Quorum's outpatient centers and 24 hospitals across 14 states. Moody's, however, said this change contributed to its negative outlook for the company because these moves come with high execution risk.<sup>73</sup>

By November, 2019, Quorum's stock was trading at \$.85, having fallen 80 percent in two years. It posted more than \$300 million in combined net losses in 2017 and 2018. Private equity firm KKR sent a letter in early December 2019 proposing to buy out its public shares held by minority owners for \$1 per share – valuing the company at about \$33 million. KKR owns 9 percent of Quorum's common stock and is its largest debt holder.<sup>74</sup> KKR had positioned itself for this takeover in 2017, when it took a 5.6 percent stake in the chain, a deal worth \$11.6 million to Quorum.<sup>75</sup>

In the meantime, CHS (still the second largest for-profit hospital chain in the US), has not achieved financial stability, despite divesting the Quorum hospitals and retiring some of its debt. Following the divestiture, CHS wrote down \$1.43 billion to better reflect the diminished value of hospitals and assets it still held.<sup>76</sup> It ended 2016 with a net loss of \$1.7 billion and announced a sale of eight hospitals to Steward Health Care System and a plan to sell a total of 25 hospitals to trim its debt load and improve its finances.<sup>77</sup> CHS continues to struggle: in August 2019 its

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<sup>71</sup> Ayla Ellison. 2018. "Quorum Health to Close 156-bed Ohio hospital," *Becker's Hospital Review*. January 5. <https://www.beckershospitalreview.com/finance/quorum-health-to-close-156-bed-ohio-hospital.html>

<sup>72</sup> Ayla Ellison. 2019. "Quorum to Close Illinois Hospital if Buyer Isn't Found." *Becker's Hospital Review*. June 12. <https://www.beckershospitalreview.com/finance/quorum-to-close-illinois-hospital-if-buyer-isn-t-found.html>

<sup>73</sup> Tara Bannow. 2019. "Quorum Health Considering Buyout Offer from KKR." *Modern Healthcare*. December 04.

<sup>74</sup> Bannow, Ibid.

<sup>75</sup> Bob Herman. 2017. Op. cit. at endnote 69

<sup>76</sup> Dave Barkholz. 2016. "CHS posts \$1.43 Billion Loss on Massive Write-Down of Assets," *Modern Healthcare*. August 2. <https://www.modernhealthcare.com/article/20160802/NEWS/160809971/chs-posts-1-43-billion-loss-on-massive-write-down-of-assets>

<sup>77</sup> Ayla Ellison. 2017. "CHS Divests 8 Hospitals to Steward, Adds Another to Sale Pipeline," *Becker's Hospital Review*. May 11. <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/chs-divests-8-hospitals-to-steward-adds-another-to-sale-pipeline.html>

shares traded at just \$1.81<sup>78</sup>; In February, 2020, it was trading at between \$4.00 and \$5.00 per share.

The health care system is still selling off hospitals to stave off default on its debt. By the end of 2019, CHS was down to 101 hospitals, more than 80 percent of these in somewhat larger markets with populations of 50,000 or more. The smaller, mainly rural and small-town hospitals have been divested. What has happened to the former CHS hospitals? According to a recent study, most of them are losing money, are bankrupt, or have been closed. Of the 53 hospitals CHS sold off in the three years from 2017 to 2019, only 11 had positive operating margins in their most recently available public reports. Four hospitals have been closed since they were sold; 38 had operating losses and six of these have declared bankruptcy.<sup>79</sup> The usual arguments for the poor performance of these hospitals have been put forward – smaller hospitals don't have the revenue or the payer mix to survive. The effects of the debt burden CHS was carrying and the ways in which it hampered efforts to put the health system's smaller hospitals on a sustainable footing goes unmentioned.

### **Steward Health Care System<sup>80</sup>**

Steward Health Care System, owned by private equity firm Cerberus Capital Management, was an early purchaser of hospitals divested by Community Health Systems. Steward was formed in November 2010 when Cerberus acquired financially troubled Caritas Christi. The CEO at the time, Ralph de la Torre, was a well-respected cardiac surgeon and the previous CEO of Beth Israel Deaconess Medical Center's Cardiovascular Institute. He firmly believed that the survival of Caritas as a community-based hospital system depended on attracting private equity backing. Between 2010 and 2020, Cerberus' aggressive M&A activity turned Steward into the largest private hospital system in the US -- with 37 hospitals (over 7,900 beds), more than 25 urgent care centers, 42 skilled nursing facilities, a network of physician groups, and some 42,000 workers serving 800 communities in the US and Malta.<sup>81</sup>

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<sup>78</sup> Ayla Ellison. 2019. "New Low for CHS Shares: \$1.81," *Becker's Hospital Review*. August 28. <https://www.beckershospitalreview.com/finance/new-low-for-chs-shares-1-81.html>

<sup>79</sup> Tara Bannow. 2020. "Most Former CHS Hospitals Losing Money, Bankrupt Or Closed," *Modern Healthcare*. February 21. [https://www.modernhealthcare.com/providers/most-former-chs-hospitals-losing-money-bankrupt-or-closed?utm\\_source=modern-healthcare-am-friday&utm\\_medium=email&utm\\_campaign=20200220&utm\\_content=article1-headline](https://www.modernhealthcare.com/providers/most-former-chs-hospitals-losing-money-bankrupt-or-closed?utm_source=modern-healthcare-am-friday&utm_medium=email&utm_campaign=20200220&utm_content=article1-headline)

<sup>80</sup> This section draws on the research by Aimee La France, "The Trends and Outcomes of Mergers & Acquisitions in the U.S. Healthcare System," Senior Honors Thesis, ILR School, Cornell University. March, 2020.

<sup>81</sup> <https://www.steward.org/about>

After ten years of private equity leveraged buyouts and sale-leasebacks, however, Steward's financial stability is in ruins: In Massachusetts, Steward is the lowest performing system in the state, putting hospitals and workers at risk. But Cerberus, its PE owner, has more than recovered its investment. In 2010, Caritas Christi was the largest community-based health care system in New England. The system encompassed six acute care hospitals – two in Boston and four in nearby working class suburbs – as well as the Caritas Physician Network, the Catholic Labor College, and an international relief organization Por Crito. It employed 13,000 workers, served more than half a million patients annually, and had 1,552 hospital beds under management prior to the acquisition by Cerberus. Two strong unions represented Caritas employees: the Service Employees International Union (SEIU) and the Massachusetts Nurses Association (MNA). Cerberus acquired the six hospitals and affiliated units of Caritas Christi in a \$420 million leveraged buyout plus assumed debt and pension liabilities of \$475 million that valued the healthcare system at \$895 million.<sup>82</sup> This system became the core of a hospital platform for Cerberus, which expected Steward to grow in, and beyond, Massachusetts via acquisitions of additional community hospitals.

Steward quickly added-on four more acute care community hospitals in 2011 – Nashoba Valley Medical Center and Merrimack Valley Hospital which were acquired from private equity-owned Essent Healthcare Inc., plus Morton Hospital and Medical Center and Quincy Medical Center. In 2012, Steward added New England Sinai Hospital.<sup>83</sup> By 2012, Steward was a \$1.8 billion company, with over 17,000 employees (making it the third largest employer in Massachusetts); it cared for 1.2 million patients annually.<sup>84</sup> According to Steward's CEO, Cerberus planned to refine the Steward approach to making hospitals profitable, expand it to other states, and then sell the expanded Steward system to another hospital system, or exit via an IPO.<sup>85</sup>

Unfortunately, things did not go as planned. As part of its deal to convert non-profit Caritas Christi to for-profit Steward Health Care System, Cerberus was obligated, to invest \$400 million in upgrading the hospitals' infrastructure. Cerberus funded the system's operating losses as well as its infrastructure expenditures and the acquisition of additional hospitals by monetizing some of Steward's assets via sale-lease back deals for its medical office buildings and loading the health care system up with junk bonds and other debt. As the Attorney General stated, "The

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<sup>82</sup> PitchBook\_Steward\_Health\_Care\_System\_20160927145753641, Company Profile dated 8-Sep-2016, p.3

<sup>83</sup> Ibid., p. 9. Deal prices are generally not available, but PitchBook reports that New England Sinai Hospital was acquired for \$28 million, well under the HSR threshold for reporting the acquisition to the FTC. It should be noted that Steward closed failing Quincy Medical Center a few years after acquiring Caritas Christi and, in 2014, merged Merrimack Valley with Holy Family Hospital.

<sup>84</sup> Bruce Mohl. 2012. "Cerberus' Health Care Play," *Commonwealth Magazine*. July 10. <https://commonwealthmagazine.org/health-care/001-cerberuss-health-care-play/>

<sup>85</sup> Ibid.

solvency position of the system declined as debt increased, while operating losses and pension fund charges eroded equity.”<sup>86</sup>

The investment in Steward proved to be a money losing proposition for Cerberus. The system lost money in its first four years of operation. In 2014 it closed Quincy Medical Center. In 2015, it reported its first profit of \$131 million, but this was due to a \$132 million pension settlement. Without the move to a multi-employer pension fund, Steward would have lost \$1 million that year.<sup>87</sup> Steward has refused to submit legally required financial information to the Massachusetts Health Policy Commission and has failed to pay fines for this.<sup>88</sup> In 2015, Cerberus’ hopes that the health care network would expand beyond the state’s borders had not been realized.<sup>89</sup>

Cerberus’ investment in Steward was rescued in September 2016 when Medical Properties Trust Inc. (MPT) agreed to buy all of Steward Health Care’s acute care hospital properties. The real estate investment firm agreed to pay \$1.2 billion for the properties and a further \$50 million for a 5 percent equity stake in the health care system. Steward now must lease back the properties for its hospitals and other facilities, paying rent to MPT. The deal was especially favorable for Steward’s PE owners. It paid back Cerberus’ initial investment in Steward and more, although the total amount the PE firm and its investors reaped has not been revealed. The deal is also expected to pay down all of the company’s more than \$400 million debt and provide a payoff for top executives. Steward also received an undisclosed amount to try once again to revive its failed strategy to acquire hospitals outside of Massachusetts and grow into a national powerhouse.<sup>90</sup>

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<sup>86</sup> Office of the Attorney General, 2015. *Reports on Steward Health Care System*. December 30, p36. [www.mass.gov/ago/docs/healthcare/shcs-report-123015.pdf](http://www.mass.gov/ago/docs/healthcare/shcs-report-123015.pdf)

<sup>87</sup> Priyanka Dayal McCluskey. 2016a. “Steward Health Care Posts First-Ever Profit in 2015,” *Boston Globe*. July 24. <https://www.bostonglobe.com/business/2016/07/24/steward-health-care-stops-bleeding-money/JYKmRaPxdA4ZFhE9sM3fJI/story.html> Steward was locked in a dispute with Massachusetts state officials over what financial information it must disclose. Its 2015 statement was submitted two months late, and with several pieces missing according to the Center for Health Information and Analysis (CHIA), which in 2016 had already levied more than \$43,000 in fines against Steward for violations in 2013, 2014, and 2015.

<sup>88</sup> Priyanka Dayal McCluskey. 2017. “Steward Health Care Fails to Submit Financial Data as it Expands,” *Boston Globe*. September 1. <https://www.bostonglobe.com/business/2017/09/01/amid-expansion-plans-steward-health-care-shows-signs-sharing-financial-data/tS7nwWkw2y8gyNSdCoOII/story.html>

<sup>89</sup> Devin Leonard. 2013. “Private Equity’s Hospitals: A Business Model for the Obamacare Era?” *Bloomberg*. August 29. <https://www.bloomberg.com/news/articles/2013-08-29/private-equitys-hospitals-a-business-model-for-the-obamacare-era>

<sup>90</sup> Priyanka Dayal McCluskey. 2016b. “Steward gets \$1.25 Billion to Fund Expansion, Repay Cerberus,” *Boston Globe*. September 26. <https://www.bostonglobe.com/business/2016/09/26/steward-gets-fund-expansion-repay-cerberus/hgC7sjOqZ1lnH1B1bV991M/story.html>

Steward justifies its sale-leaseback strategy on its homepage, where it boasts its “asset-light” business model: “we lease our hospitals rather than own them, ensuring that our top service and priority is providing great care”.<sup>91</sup>

Within months of receiving the MPT stake, Steward embarked on an aggressive campaign to expand its health care network. In early 2017, expanding beyond Massachusetts for the first time, it acquired eight hospitals, with over 1,800 beds and 7,000 employees in Ohio, Pennsylvania, and Florida from CHS. Steward’s CEO expressed confidence that “there shouldn’t be any large over-arching issues or anti-trust concerns.”<sup>92</sup> The deal for the eight hospitals closed for \$304 million.<sup>93</sup> It does not appear that the FTC saw a need for a detailed review of these acquisitions.

## **IASIS Healthcare**

In May 2017 Steward announced a \$1.9 billion purchase of 18 hospitals in Utah, Arizona, Colorado, Texas, Arkansas, and Louisiana from IASIS Healthcare, owned by private equity firm TPG. IASIS had been created as a healthcare platform company in 1999 by private equity firm JLL Partners through the acquisition of hospitals from Paracelsus Healthcare Corporation and Tenet Healthcare Corporation for \$800 million, with minority participation of Trimaran Capital Partners. The hospital system grew by adding-on hospitals in widely separated health markets in Arizona, Colorado, Louisiana, Texas, and Utah. In 2004, PE firm TPG acquired a majority stake in IASIS via a \$1.5 billion leveraged buyout. In March 2012 IASIS put itself up for sale and expected to be acquired by a corporate buyer for about \$2.4 billion.<sup>94</sup> The sale was later cancelled. Three years later, in early 2015, IASIS filed to go public with plans to trade under the

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<sup>91</sup> <https://www.steward.org/model/business>

<sup>92</sup> Jessica Bartlett. 2017. “Steward to Acquire Eight Hospitals In Three States,” *Boston Business Journal*. February 16, updated February 21. <https://www.bizjournals.com/boston/news/2017/02/16/steward-to-acquire-eight-hospitals-in-three-states.html> The hospitals include three hospitals in Ohio — Northside Medical Center in Youngstown, Trumbull Memorial Hospital in Warren, Hillside Rehabilitation Hospital in Warren, two in Pennsylvania — Sharon Regional Health System in Sharon, Easton Hospital in Easton, and three in Florida — Wuesthoff Medical Center in Melbourne, Wuesthoff Medical Center in Rockledge and Sebastian River Medical Center in Sebastian.

<sup>93</sup> Priyanka Dayal McCluskey. 2017. “Steward Health Care Merges with Tenn. Hospital System,” *Boston Globe*. May 19. <https://www3.bostonglobe.com/business/2017/05/19/steward-health-care-merges-with-tenn-hospital-system/11In2QDBV2xgQylOyk35IP/story.html?arc404=true>

<sup>94</sup> IASIS\_Healthcare\_20121106093215551, PitchBook Company Profile dated November 6, 2012, p. 2, 4, 5, 8.

ticker symbol IAS. This was the healthcare system's second attempt at going public and, like the earlier attempt, it failed.<sup>95</sup> The proposed IPO was unattractive to public market investors.<sup>96</sup>

Failure of the 2012 corporate sale and 2015 IPO may have been due to IASIS' extensive junk bond debt. In 2011 IASIS had sold more than \$450 million in junk bonds rated five steps below investment grade and increased its debt burden from 4.9 to 6.5 times earnings. The proceeds were used for a variety of purposes, but as much as \$230 million was used as a payout to IASIS' PE owners. This was the third payout by IASIS to TPG, and enabled the PE firm to recoup the last of its \$434 million investment in the healthcare system.<sup>97</sup>

The merger, which was subject to regulatory approval by the FTC, created a network of 36 hospitals across 10 states and made Steward the largest private hospital system in the U.S. in both revenue and number of hospitals. The combined system, with 38,000 employees, was expected to generate almost \$8 billion in revenue in its first year of operation.<sup>98</sup> As we noted earlier, revenue did increase in the first year after the merger, but operating losses continued to mount.

The deal closed on September 29, 2017. The size of the deal triggered a review by the FTC, but it was allowed to proceed and no conditions were imposed on either party to the deal. A letter from a major IASIS health insurance subsidiary to one of its regulators informed the regulator that.<sup>99</sup>

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<sup>95</sup> PitchBook\_IASIS\_Healthcare\_2019\_03\_12\_13-50\_45, Company Profile dated March 12, 2019, p.10, 6, 4; IASIS grew in the period from 2000 to 2015 through the acquisition via leveraged buyouts of additional hospitals, p. 17

<sup>96</sup> See IASIS SEC filing of January 30, 2015, Form S-1.  
[https://www.sec.gov/Archives/edgar/data/1073615/000119312515027931/d856463ds1.htm#toc856463\\_1](https://www.sec.gov/Archives/edgar/data/1073615/000119312515027931/d856463ds1.htm#toc856463_1)

<sup>97</sup> Emre Peker and Tim Catts. 2011. "TPG Recoups Iasis Investment With Junk-Backed Dividend: Corporate Finance," *Bloomberg*. April 20. <http://www.bloomberg.com/news/2011-04-20/tpg-recoups-iasis-investment-with-junk-backed-dividend-corporate-finance.html> (last accessed March 2, 2012).

<sup>98</sup> Melanie Evans. 2017. "Steward Health Care to Buy IASIS Healthcare for \$1.9 billion," *Wall Street Journal*. May 19. <https://www.wsj.com/articles/steward-health-care-to-buy-iasis-healthcare-for-1-9-billion-1495199135>; Jessica Bartlett. 2017. "Steward to Acquire 18 Hospitals Through Merger with Tennessee System," *Boston Business Journal*. May 19.  
<https://www.bizjournals.com/boston/news/2017/05/19/steward-to-acquire-18-hospitals-through-merger.html>

<sup>99</sup> Letter dated July 19, 2017 from Health Choice Integrated Care, an IASIS subsidiary, to Ms. Lola Davis, Arizona Health Care Cost Containment System ("AHCCCS"), AHCCCS Operations and Compliance Officer.  
[https://www.azahcccs.gov/Resources/Downloads/HealthChoiceIntegratedCare/HCICResponseToAHCCSLetter\\_07192017.pdf](https://www.azahcccs.gov/Resources/Downloads/HealthChoiceIntegratedCare/HCICResponseToAHCCSLetter_07192017.pdf)

“A U.S. Hart-Scott-Rodino Antitrust Improvements Act of 1976 (“HSR Act”) pre-merger notification was filed for the proposed mergers. The applicable waiting period under the HSR Act must have expired or been terminated in order to proceed with the merger. The request for early termination of the waiting period was granted by the FTC effective June 26, 2017.”

On the day that it closed the deal for the 18 IASIS hospitals, Steward sold the real estate of 11 of them to Medical Properties Trust (MPT) for \$1.4 billion in a sale-lease back deal that returned nearly three-quarters (74 percent) of the purchase price of IASIS to Steward’s PE owners, but burdened the hospitals with rent payments. In addition, MPT invested \$100 million in Steward.<sup>100</sup> Thus, it is likely that Cerberus’ own investment in IASIS was fully or nearly fully covered by the deal with MPT, as was much of the investment of the fund’s limited partner investors.

Medical Properties Trust’s investment is protected in case Steward proves unprofitable or even fails because it owns all of the health care system’s valuable real estate, including the real estate of the former IASIS hospitals. Cerberus’ own investment in Steward, including the acquisition of IASIS, has been fully recovered. While Steward’s PE owners would prefer a successful exit from this investment via an IPO, it no longer has skin in the game and may prefer to focus attention and resources elsewhere. The myth behind Cerberus’s optimistic claims about its successful financial strategy for Steward became clear in September 2019, when the Massachusetts state Center for Health Information and Analysis (CHIA) included Steward’s 2018 financial performance in its annual report. Steward had again failed to submit the required system level audited financial statement data, but CHIA was able to obtain it from publicly available information included in an SEC filing by MPT.

In 2018, Steward was the worst-performing hospital system in the state on every metric. The system had a loss of \$270 million in 2018 and \$322 million in 2017. Revenue was substantially higher in 2018, only due to its acquisition of IASIS.<sup>101</sup> Steward’s operating margin, based on

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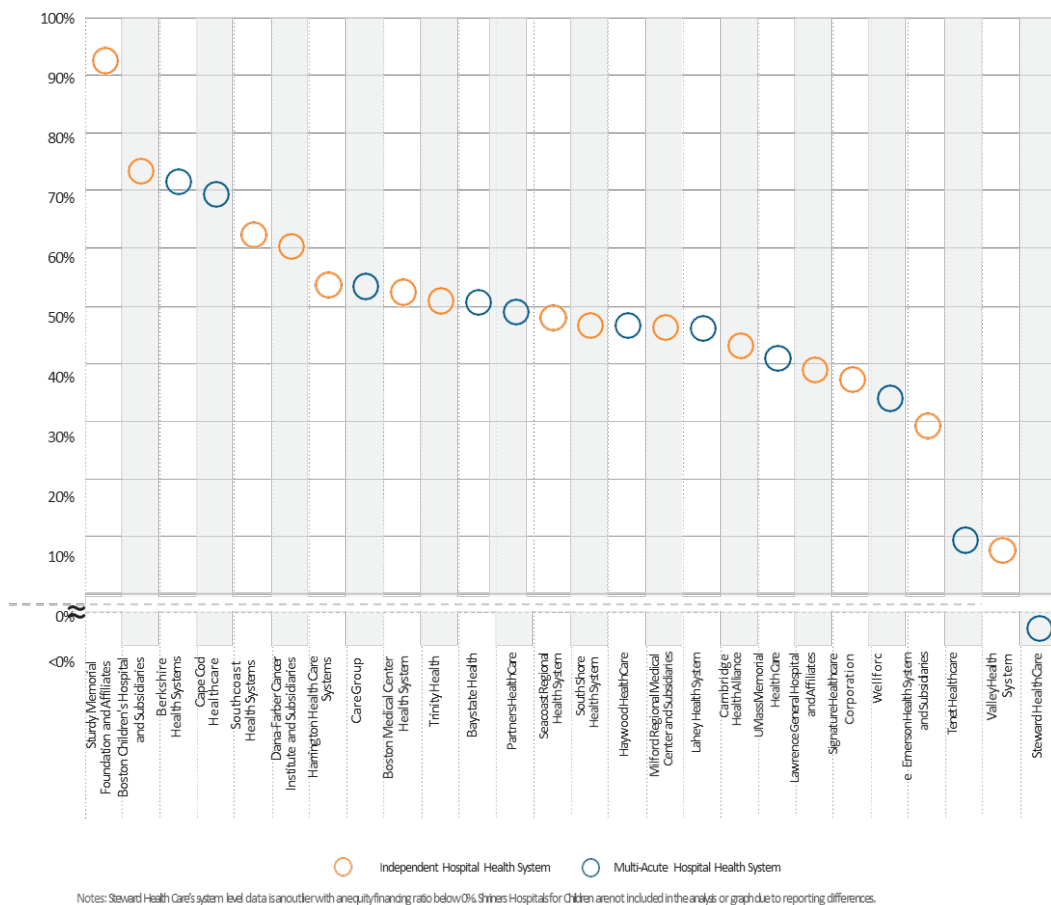
<sup>100</sup> Medical Properties Trust. 2017. “Medical Properties Trust Completes \$1.4 Billion Investment in Eleven IASIS Hospitals Now Operated by Steward Health Care,” *Business Wire*. Sept. 29. [https://www.businesswire.com/news/home/20170929005650/en/Medical-Properties-Trust-Completes-1.4-Billion-Investment/?feedref=JjAwJuNHiyStnCoBq\\_hl-Rc4vIAVcHHkbDcwJimU8QtrlakeQ9hNboBqTAWIjTge3KWq9s9jif-UkBjBsFRyYAbRTSLTcImgyhPlnaBA55M-oupQnbXnhKsYk8RmHF\\_kAy2gZikaX3QWV6xOvgFIA==](https://www.businesswire.com/news/home/20170929005650/en/Medical-Properties-Trust-Completes-1.4-Billion-Investment/?feedref=JjAwJuNHiyStnCoBq_hl-Rc4vIAVcHHkbDcwJimU8QtrlakeQ9hNboBqTAWIjTge3KWq9s9jif-UkBjBsFRyYAbRTSLTcImgyhPlnaBA55M-oupQnbXnhKsYk8RmHF_kAy2gZikaX3QWV6xOvgFIA==)

<sup>101</sup> Alia Paavola. 2019. “Steward Health Care Reports \$592M Loss amid Major 2-Year Expansion Push,” *Becker’s Hospital Review*. September. <https://www.beckershospitalreview.com/finance/steward-health-care-reports-592m-loss-amid-major-expansion-push.html>

patient care and related activities was -4.2 percent. Its overall margin, including both operating and non-operating activities (typically acquisitions, divestitures, other financial activities) was -4.1 percent. Its current ratio (a measure of liquidity), was under 1 -- indicating that its current liabilities cannot be met with current assets.

It was the only Massachusetts hospital system with a negative financing ratio, as shown in Figure 3.1.<sup>102</sup>

**Figure 3.1:**  
**FY 2018 Equity Financing Ratio by Health System, State of Massachusetts**  
 FY 2018 Equity Financing Ratio by Health System



Source: Center for Health Information and Analysis. 2019. Massachusetts Acute Hospital and Health System Financial Performance, FY 2018, September.

<sup>102</sup> Center for Health Information and Analysis. 2019. Massachusetts Acute Hospital and Health System Financial Performance, FY 2018, September. <http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2018-annual-report/Acute-Hospital-Health-System-Financial-Performance-Report-FY2018.pdf>



Its equity financing ratio, a measure of solvency, was equally worrying. High values on this measure indicate a health system with little or no long-term debt, low values indicate a health system is highly leveraged. Steward's long-term debt exceeded the value of its assets by \$1.21 billion and its equity financing ratio was -37.6 percent.

### **What Does the Future Hold?**

The high returns HCA generated for Bain Capital and its other private equity owners inspired copycat buyouts of hospital systems by more PE firms. But operating a hospital system at a profit is challenging in any case, and even more so when the system has been loaded with debt and resources have been extracted through dividends paid to PE fund investors and monitoring fees paid to the PE firm. Hospitals owned (or formerly owned) by private equity as well as the patients and communities that rely on them have suffered as service lines were eliminated, hospitals were shuttered, and resources to invest in quality care were extracted. Hospitals in rural areas and small towns are especially endangered and some have closed, leaving residents without a nearby facility in case of an emergency. Hospitals still in private equity hands have been stripped of their real estate to provide a generous return to their PE owners even as operating income falters. Hospital systems that were returned to the public market via an IPO are now selling or closing hospitals to repay or reduce debt and stave off bankruptcy.

It's not much of a leap from selling off hospital real estate to salvage a failing private equity deal to acquiring a hospital as a pure real estate play – buying it for the value of the land it occupies. That appears to be the case in Paladin's leveraged buyout of money-losing Hahnemann hospital in Philadelphia.

Hahnemann is an older hospital serving a largely low income population and reliant on Medicaid and Medicare to cover the health care costs of a majority of its patients. In recent years, the area to its south has been extensively redeveloped. The hospital now sits on the northern edge of what is referred to as the Avenue of the Arts – an area replete with theaters, music venues, a major entertainment center, restaurants and the University of the Arts – in what has become a gentrifying neighborhood. In a move more common in retail than health care, the hospital's PE owners quickly separated it into an operating company that provided patient care and a property company that owned the real estate that housed the hospital.

Despite announcements at the time of the buyout that the hospital's PE owners planned to turn it around, little was done to achieve that outcome. The hospital's new owners did not acquire smaller hospitals in suburbs or more affluent sections of Philadelphia to change the payer mix to include a larger share of insurance companies. They did not expand Hahnemann's network of urgent care and other outpatient centers to meet patient's preferences for care that was located closer to home and was cheaper than in-patient services.

Not surprisingly, the hospital continued to lose money. The hospital went bankrupt and closed in the fall 2019. Developers have come forward with proposals to build luxury condos, high end retail, and other establishments that cater to the affluent on the acres of highly desirable real estate that housed the hospital.<sup>103</sup> The concern is that this might become part of the private equity playbook, and PE firms may buy older hospitals in gentrifying neighborhoods for their land, with no intention of turning them around and helping them serve the communities that rely on them.

### **Consolidating Outpatient Services: PE's Role in Fragmented Markets**

As private equity investments in hospitals over the last decade failed to produce sufficient returns to investors, PE firms shifted to investments in outpatient services among other health care niches. Cumulatively, private equity bought out 2,500 clinics and other small healthcare services in the last 20 years for a total of \$158.5 billion. They particularly increased their investments from 2010 on: 81 percent have occurred since then. Of all the acquisitions of outpatient centers in the 2010-2019 period, private equity firms were responsible for 60% the deals. The next largest competitor group was hospitals, which accounted for the overwhelming majority of the remaining deals.<sup>104</sup>

The outpatient segment is an attractive one for private equity firms because they can take advantage of the segment's fragmented market structure and use the buy and build formula to consolidate and flip entities in a low risk, high reward model. The market is growing and has been little affected by economic downturns; and third-party payers guarantee cash flow. As a market intermediary, private equity serves as an aggregator and reseller. PE firms scour the market for good buyout targets, carry out extensive due diligence to identify targets with strong fundamentals, and often take advantage of first mover options because they have lots of dry powder – that is, available capital – on hand.

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<sup>103</sup> Lydia DePillis. 2019. "Rich Investors May Have Let A Hospital Go Bankrupt. Now They Could Profit from the Land," *CNN Business*. July 29. <https://www.cnn.com/2019/07/29/economy/hahnemann-hospital-closing-philadelphia/index.html>

<sup>104</sup> Irving Levin Associates – Quarterly Healthcare Merger & Acquisition Reports; Capital IQ announcements; VMG proprietary research through involvement in the transaction; company press releases (see Corey Palasota. 2019. "End Users and Consolidators: The Next Possible Wave of Transactions in Urgent Care.")  
[https://www.jucm.com/end-users-and-consolidators-the-next-possible-wave-of-transactions-in-urgent-care/?utm\\_campaign=JUCM&utm\\_source=hs\\_email&utm\\_medium=email&utm\\_content=70483229&\\_hsenc=p2ANqtz--WmHC9EJAAW36zLpL91rjnhUjZ1Qx4M\\_Mbl0XghdNADGPiPznychob2LzQQMIsl1XkfIFGjltH83HwSOd\\_M6PqoD-WuQg&\\_hsmi=70483229](https://www.jucm.com/end-users-and-consolidators-the-next-possible-wave-of-transactions-in-urgent-care/?utm_campaign=JUCM&utm_source=hs_email&utm_medium=email&utm_content=70483229&_hsenc=p2ANqtz--WmHC9EJAAW36zLpL91rjnhUjZ1Qx4M_Mbl0XghdNADGPiPznychob2LzQQMIsl1XkfIFGjltH83HwSOd_M6PqoD-WuQg&_hsmi=70483229).

In addition, the buyout opportunities for private equity have increased in recent years as the number of outpatient care centers has expanded rapidly. While the proportion of people employed in outpatient clinics is about 10 percent of those employed in hospitals, their numbers grew at six times the rate of hospitals from 2005 to 2015 (albeit from a very low base), and numbered some 738,000 in 2015.<sup>105</sup> Outpatient growth has accelerated as hospitals have expanded their cost-saving strategies from outsourcing non-core activities (cleaning and food services), to core areas such as medical diagnostics (laboratories, imaging), non-critical care (broken bones, colds, flus), pharmacies, medical specialties (radiology, anesthesiology, surgery), and emergency room services.

Outpatient care includes a wide array of acute and subacute health services. Sub-segments include retail clinics (for common ailments and usually located in supermarkets or pharmacies), urgent or convenient care centers (stand-alone clinics covering more serious nonlife-threatening conditions), specialized clinics (ambulatory surgery, rehabilitation, trauma, burn, neo-natal clinics), and multi-purpose freestanding emergency rooms.

### **Urgent Care and Ambulatory Surgical Centers**

In this section, we focus on the *urgent care* and *ambulatory surgery* sub-segments, where private equity has been particularly active. Private equity firms and investors played a leading role in the design and marketing of these centers and their ability to offer convenient services. They were first movers in buying up, rolling-up, and consolidating small clinics into national chains.

In the urgent care sub-segment, buyout opportunities have been abundant, as this sub-segment grew from 6,100 outlets in 2012 to 8,774 in 2017 – a 44 percent increase in five years -- according to annual surveys conducted by the Urgent Care Association (UCA).<sup>106</sup> Revenue growth has also been considerable – with UCA estimates of \$18 billion in 2018 and expected growth at 5.8 percent annually.<sup>107</sup> This growth is due in part to patient preferences: Patients like their convenient locations, lower wait times than emergency rooms, lower co-pays, and availability when primary care doctors are not available.

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<sup>105</sup> Eileen Appelbaum and Rosemary Batt. 2017. Op. cit. at endnote 32.

<sup>106</sup> Urgent Care Association. 2018. 2018 Benchmarking Report. <https://www.ucaoa.org/Portals/80/pdfs/benchmarking/UCA-BenchmarkSurvey18.pdf?ver=2019-02-18-150322-753>. The Urgent Care Association (UCA) defines urgent care to include centers that offer walk-in care for common illnesses and injuries, nonlife-threatening conditions, and work-related illnesses and injuries.

<sup>107</sup> Bruce Japsen. 2018. “Urgent Care Industry Hits \$18 Billion As Big Players Drive Growth.” *Forbes*. Feb. 28.

<https://www.forbes.com/sites/brucejapsen/2018/02/23/urgent-care-industry-hits-18b-as-big-players-drive-growth/#24ae9cbb4d89>

For private equity, the centers are also attractive due to their low cost and simplified organizational structures. They require limited staffing and low facilities maintenance costs. The typical center is small and staffing patterns are slim, with one physician, one physician assistant or nurse practitioner, one or two medical assistants, one radiological technician, one center manager, and one or two receptionists.<sup>108</sup> The services provided in these centers require a narrower range of skilled staff with less medical expertise, although more social and patient communication skills than those demanded in hospitals. Employees also command lower pay than do hospital employees in similar occupations with similar educational and demographic characteristics. On average, depending on the occupational group, urgent care centers pay roughly 9-12 percent lower hourly wages than do hospitals, except cleaning services (which pays 18 percent lower). Moreover, unionization rates in outpatient are half those of hospitals – 6 percent versus 13.6 percent in 2015.<sup>109</sup>

Private equity firms and other providers first focused on building out urgent care centers in the wealthier suburbs of Sunbelt cities -- to serve patients with private insurance at a time when these states did not allow Medicare and Medicaid reimbursements to cover outpatient costs. They copied the big box strategy of ‘clustering’ in retail zones where they could achieve high volumes of patients with the most attractive demographics and with adequate commercial insurance.<sup>110</sup>

Because of this strategy, the availability of urgent care clinics became highly skewed towards certain states (New York, Florida, Texas, California, Michigan) and particular locations – with 78 percent located in suburban sites in large metropolitan areas. That skewed distribution has not changed, and only 5 percent of urgent care centers are located in small towns and rural areas, where they would provide the greatest benefit to people with little access to good medical care.<sup>111</sup>

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<sup>108</sup> Urgent Care Association. 2017. 2017 Benchmarking Report.

<https://www.ucaoa.org/Portals/80/pdfs/benchmarking/2017BMSurvey.pdf>

<sup>109</sup> John Schmitt, Eileen Appelbaum, and Rosemary Batt. 2018. “Gender Wage Gaps in Health Care Occupations,” Tables 2 and 3 and additional analyses of ACS and CPS ORG data for 2016. Estimated wage penalty for full-time workers based on regression analyses of the CPS (Outgoing Rotation Group 2016 data), which controls for age, education, occupation, state location, part-time status, ethnicity, country of birth, and union status. For union rates see, Eileen Appelbaum and Rosemary Batt. 2017. “Organizational Restructuring in U.S. Healthcare Systems: Implications for Jobs, Wages, and Inequality” (Washington, DC: Center for Economic and Policy Research, September). Table 12b, p 40. <http://cepr.net/publications/reports/organizational-restructuring-in-us-healthcare-systems>

<sup>110</sup> Alan Ayers. 2019. “Rural and Tertiary Markets: The Next Urgent Care Frontier.” December 2. <https://www.jucm.com/rural-and-tertiary-markets-the-next-urgent-care-frontier/>

<sup>111</sup> Urgent Care Association. 2019. Op. cit.; Urgent Care Association. 2018 Benchmarking Report. Alan Ayers. 2019. Ibid.

Two hospital systems owned or engaged with private equity were in the forefront of buying up outpatient clinics and integrating them into their sprawling healthcare systems via mergers and acquisitions: Tenet and HCA.<sup>112</sup>

Tenet (founded as National Medical Enterprises and based in Nevada) was among the first investor owned hospital systems, formed in 1968 and expanded through M&A buyouts in the 1970s – before the leveraged buyout model had been fully articulated. But Tenet’s founders used many of the strategies of later LBOs and private equity investors – particularly in their strategy of growth through mergers and acquisitions (M&As) rather than organic growth. Its private equity-like approach was cemented when it acquired through its acquisition of PE-owned hospital chain, Vanguard. Through a long history of M&As, it became the third largest for-profit healthcare system in the country, with revenues primarily from acute-care and specialized (psychiatric) hospitals. In addition, Tenet has been particularly aggressive in building or acquiring urgent care and ambulatory surgery clinics. As early as 2009 Tenet owned 67 outpatient centers and, in 2010, the health care system spent \$65 million to acquire 24 more. By 2010, about a third of Tenet’s revenue came from outpatient services. By the third quarter of 2014, the number of outpatient centers it operated increased to about 200.<sup>113</sup>

Similar to Tenet, Healthcare Corporation of America (HCA) expanded through hospital buyouts in the 1970s and 1980s and moved in and out of private equity ownership over the next 2 decades. Its most aggressive period of acquisitions occurred during the 2000s after HCA’s private equity buyout by the Bain Capital-led consortium. In this period, it built out a national network of integrated hospitals and outpatient centers, an acquisition strategy that continued even after HCA was returned to the public market, as its former PE owners continued to be majority shareholders. Following implementation of the Affordable Care Act (ACA), HCA acquired more outpatient centers, and by 2015, owned 335 centers under the brands CareNow and Urgent Care Extra. Its most recent deal in 2019 included 24 centers in the Dallas, Texas metro area, where its strategy is to build out a dominant network of outpatient centers.<sup>114</sup>

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<sup>112</sup> Their hospital strategies are discussed in section 3 of this report.

<sup>113</sup> Vince Galloro. 2011. “Growth Strategies: Chains Look beyond Inpatient Side,” *Modern Health Care*. August 29. <http://www.modernhealthcare.com/article/20110829/MAGAZINE/110829989>; Beth Kutscher. 2015b. “Breaking: Tenet Makes Big Ambulatory Play with Deal for Majority United Surgical Partners Stake,” *Modern Health Care*. March 23. [http://www.modernhealthcare.com/article/20150323/NEWS/150329984?utm\\_source=modernhealthcare&utm\\_campaign=mh-alert&utm\\_medium=email&utm\\_content=20150323-NEWS-150329984](http://www.modernhealthcare.com/article/20150323/NEWS/150329984?utm_source=modernhealthcare&utm_campaign=mh-alert&utm_medium=email&utm_content=20150323-NEWS-150329984)

<sup>114</sup> Jo el Stinnet. 2019. “Everything is Bigger in Texas — and Now so is HCA.” *Dallas News*. July 5. <https://www.bizjournals.com/dallas/news/2019/07/05/hca-healthcare-inc-texas.html>

The ambulatory surgery sub-segment of outpatient care is also attractive to private equity as it is a fragmented market with many opportunities to apply the buy and build business model. Independent companies not affiliated with a hospital or health care system account for almost two-thirds (64 percent) of the market. Compared to urgent care, it includes higher margin specialized services and has also experienced considerable growth in recent decades. Similar to the urgent care clinics, freestanding ambulatory surgical centers are overwhelmingly for-profit and urban based -- with 94 percent for-profit and 93 percent located in urban areas. Over half of patients are covered by private insurance, in part because Medicare reimbursement rates are relatively low compared to hospital-based settings.<sup>115</sup> Nonetheless, ambulatory surgical centers have expanded steadily, albeit more slowly than urgent care centers. A 2018 MedPac study estimated there were 4,490 freestanding centers in 2006, 5,105 in 2010, and 5,532 in 2016.<sup>116</sup> In 2011, almost 25 percent of all surgeries were performed in ambulatory clinics and 53 percent in hospitals. Industry analysts expect the segment to generate \$52-55 billion annually by 2025.<sup>117</sup>

As in urgent care, private equity firms also took the lead in building out national chains of ambulatory surgical centers – but not connected to hospital systems. As of 2015, the two largest independent companies were both owned by private equity -- Ambulatory Surgical Centers of America (AmSurg, owned by Kohlberg, Kravis, and Roberts) and United Surgical Partners International (USPI) (owned by Welsh, Carson, Anderson, & Stowe). Each had about 4 percent of the market. AmSurg is a division of EnvisionHealth, which has been identified as a major source of surprise medical billing, as we discuss below. Welsh Carson successfully exited their USPI investment in 2015 in a sale to hospital chain Tenet which, as we noted earlier, had acquired the PE-owned Vanguard hospital chain in 2013. Tenet took a 51 percent interest in USPI and merged its own short-stay surgery and imaging centers into a joint venture with USPI. The deal allowed Tenet to take over USPI and assume full ownership by 2020.<sup>118</sup> By 2019, Tenet operated 475 outpatient centers that provide 10 million patient encounters per year, in addition to its 65 acute care hospitals. The health system ranked No. 172 on the Fortune 500 rankings and has around 110,000 employees.<sup>119</sup>

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<sup>115</sup> MedPac. 2018. “Ambulatory Surgical Center Services,” Report to the Congress: Medicare Payment Policy. Chapter 5. March. [http://www.medpac.gov/docs/default-source/reports/mar18\\_medpac\\_ch5\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch5_sec.pdf?sfvrsn=0); “National Health Statistics Reports. 2017. “Ambulatory Surgery Data from Hospitals and Ambulatory Surgery Centers: United States, 2010.” Number 102, February 28. <https://www.ncbi.nlm.nih.gov/pubmed/28256998>.

<sup>116</sup> MedPac 2018. Ibid. Industry analysts, however, put the number at over 9,000 in 2019.

<sup>117</sup> National Health Statistics Reports. 2017. Op. cit. at endnote 143.

<sup>118</sup> Beth Kutscher. 2015b. Op. cit. at endnote 135.

<sup>119</sup> Tenet Website. 2019. <https://www.tenethealth.com/about/our-story>

Many PE firms continue to invest in the ACS sub-segment, encouraged by the successful sale of USPI and the IPO of PE-backed Deerfield, IL-based Surgical Care Affiliates. Private equity-backed ASC chains include Nashville-based Symbion Healthcare; Brentwood-based Meridian Surgical Partners; Westchester, IL-based Regen Surgical Health; Dallas-based ASD Management; Doylestown, PA-based Physicians Endoscopy; Cincinnati-based Blue Chip Surgical Partners; and Somers, NY-based Merritt Healthcare.<sup>120</sup> As of 2019, the top six ASC chains held a combined 18.8% of total market share and managed 1,300 ASCs, according to an industry market report.<sup>121</sup>

### **Private Equity's Exit Strategies**

Private equity's ability to make 'outsized returns' for its partners and investors depends on successfully exiting the investment in their preferred window of three to five years. To date, it appears they have been able to do this. Table 4.1, for example, lists the major urgent care center chains created by private equity firms between 2010 and 2018, as well as their size and period of PE ownership. They range in size, with the largest owning 100-200 locations. Consistent with the private equity model of buying up, consolidating, and selling-off their portfolio companies in a short time horizon, most PE firms have exited their urgent care investments in a three- to six-year window.

One common exit strategy is to sell to another private equity firm – that is, as a secondary buyout. This allows the PE seller to exit the investment in a relatively short time horizon while allowing the PE buyer to use up some of its dry powder (un-invested capital) that has been piling up and needs to be invested in order for the PE firm to continue to engage in new fundraising. For example, Shore Capital Partners acquired Fast Pace Urgent Care in a leveraged buyout for an undisclosed amount in December, 2012, with some additional financing from Tenth Street Capital and Resolute Partners. Less than four years later, it sold Fast Pace in a secondary buyout to Revelstoke Capital Partners and Yukon Partners in an LBO for an undisclosed amount.<sup>122</sup>

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<sup>120</sup> Scott Becker and Tim Fry. 2014. "Healthcare Private Equity Investment — 5 Areas to Examine in 2014: Hospitals and Health Systems, Pain Management and Anesthesia, Ambulatory Surgery Centers, Urgent Care and Dental Practice Management," *Becker Hospital Review*. January 13. <http://www.beckershospitalreview.com/hospital-management-administration/healthcare-private-equity-investment-5-areas-to-examine-in-2014-hospitals-and-health-systems-pain-management-and-anesthesia-ambulatory-surgery-centers-urgent-care-and-dental-practice-management.html>

<sup>121</sup> Research and Markets. 2019. "United States Ambulatory Surgery Center Market Report." October 25. <https://www.prnewswire.com/news-releases/united-states-ambulatory-surgery-center-market-report-2019-300945571.html>

<sup>122</sup> PitchBook 2019. Fast Pace Urgent Care 2019-12-18-19.

**Table 4.1:  
New PE Urgent Care Chain Investments and their Holding Periods: 2010-2018**

<b>Year</b>	<b>Target</b>	<b>Locations</b>	<b>Buyer</b>	<b>Holding Period</b>
2010	NextCare Urgent Care	75	Enhanced Equity	8.5 years
2010	MedExpress	42	General Atlantic	4.5 years
2010	Urgent Cares of America/FastMed	9	Comvest Partners	4.5 years
2011	MedSpring	4	Summit Partners	3.5 years
2011	WellStreet Urgent Care	12	FFL Partners	Current - 7+ years
2012	Urgent Team	5	SV Life Sciences	5.2 years
2012	MD Now	6	Brockway Moran & Partners	6.3 years
2012	Hometown	25	Ridgemont Equity Partners	2.2 years
2012	Physicians Immediate Care	20	LLR Partners/Wellpoint	Current - 6+ years
2013	PhysiciansOne Urgent Care	14	Pulse Equity	Current - 5+ years
2014	Little Spurs Pediatric Urgent Care	9	Striker Partners	Current - 4+ years
2014	CityMD	8	Summit Partners	3.3 years
2014	GoHealth Urgent Care	17	Texas Pacific Group	Current - 4+ years
2014	Zoom+Care	23	Endevour Capital	4.5 years
2015	Concentra	141	Welsh Anderson Carson Stowe	Current - 3.5+ years
2015	FastMed	14	ABRY Partners	Current - 3.5+ years
2015	CRH Healthcare LLC	10	MSouth Equity Partners	Current - 3+ years
2016	Med First Immediate Care	13	Sverica Capital Management	Current - 2+ years
2016	Fast Pace Urgent Care	14	Revelstoke Capital Partners	Current - 2+ years
2017	Urgent Team	68	Crestline Investors	Current - 1.5+ years
2017	CityMD	216	Warburg Pincus	Current - <1.5+ years
2018	Hulin Health	4	Shore Capital Partners	Current - <1 year
2018	vybe Urgent Care	32	NewSpring Capital	Current - <1 year
2018	MD Now	27	Brentwood Associates	Current - <1 year
<b>Sources:</b> Irving Levin Associates - Quarterly Healthcare Merger & Acquisition Reports; Capital IQ Announcements; VMG proprietary research through involvement in the transaction; company press releases.				

Source: Palasota 2019.<sup>123</sup>

<sup>123</sup> Corey Palasota. 2019. Op. cit. at endnote 107.



Similarly, CityMD is a network of urgent care centers in the NYC metropolitan area. Private equity firm Summit Partners invested \$95 million in the network in 2014 and, three years later, sold it in a secondary LBO to PE firm Warburg Pincus for \$600 million. Shortly thereafter, Warburg Pincus loaded the CityMD with \$344 million in debt (more than half its post-acquisition valuation), in order to finance further network expansion<sup>124</sup>

Other firms have met with resistance when they try to merge or sell to another PE firm in a secondary buyout. For example, NextCare Holdings (backed by PE firm, Enhanced Healthcare Partners) is a national urgent care network of 141 clinics in ten states, which grew from 2007 forward through a series of small acquisitions. FastMed Urgent Care (a 110-clinic network owned by PE firm Abry Partners) attempted to acquire NextCare in 2016, but it failed. It tried again in 2019 and failed again. NextCare went on to add on units through platform expansion and had 251 locations by 2018; but neither PE firm has exited its initial investment.

In the current period, however, PE firms may find it more difficult to exit their investments. According to some industry analysts, the market for urgent care centers has become saturated. This has occurred because strategic actors have increasingly entered the market – given that private equity and other first movers demonstrated the ability to make money in the outpatient segment. Increasingly, these strategic buyers, including hospitals and payers, are bidding up the price of prime acquisition targets, leading to heightened competition for the best target locations. Large insurance providers and hospital systems with deep pockets are anxious to build out networks of primary, specialty, and outpatient centers as feeders to their healthcare ‘ecosystems.’ Table 4.2 provides a list of the major payers and providers that have bought up urgent care networks between 2010 and 2018.

Private equity firms that have engaged in a roll-up strategy are finding it difficult to exit their investments. In 2019, roughly 20 large PE-backed roll-ups in urgent care were nearing the end of their investment cycles and finding it difficult to exit their investments, according to the healthcare M&A advisors, The Braff Group.<sup>125</sup>

Large healthcare payers and providers, however, may also provide private equity firms with their preferred exit strategy – a sale to the strategic buyers. One example from 2010 is Concentra, a network of primary, occupational, urgent care, and medical centers located mainly in onsite

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<sup>124</sup> PitchBook. 2019. PitchBook CitMD 2019-12-19-19.

<sup>125</sup> The Braff Group. 2019. “Crowded Urgent Care Market Suffers Growing Pains.” <https://thebraffgroup.com/wp-content/uploads/2019/06/Crowded-Urgent-Care-Market-Suffers-Growing-Pains.pdf>

**Table 4.2:**  
**Major Payer/Provider Transactions: 2010 – Present**

Year	Target	Locations	Buyer	Notes
2010	Concentra	300+	Humana	4.5 yr. holding period
2012	US HealthWorks	172	Dignity Health	Health system
2014	MedSpring	14	Fresenius	Health system
2014	CareNow	300+	HCA	Health system
2015	MedExpress	87	Optum	Payer
2015	Urgent Care Extra	35	HCA	Health system
2016	CareSpot	32	United Surgical Partners	Health system
2016	Urgent Care Extra	36	Banner Health	Health system
2016	Immediate Clinic Seattle, Inc.	16	MultiCare Health System	Health system
2017	Millennium Healthcare	30	Oschsner Health System	Health system
2018	Zoom+Care	37	PeaceHealth	Health system
<b>Sources:</b> Irving Levin Associates - Quarterly Healthcare Merger & Acquisition Reports; Capital IQ Announcements; VMG proprietary research through involvement in the transaction; company press releases.				

Source: Palasota 2019.<sup>126</sup>

employer clinics. Founded in Texas by private investors in 1978, it grew through acquisitions and was taken private in a leveraged buyout worth \$1.1 billion (and 65 percent debt) in 1999 by Welsh, Carson, Anderson, & Stowe -- a private equity firm focused on healthcare and technology services. The PE firm added new debt worth \$485 million in 2007 to pay debt and pay back its investors, and then launched an expansion into urgent care centers, resulting in a network of over 330 clinics in 40 states.

In 2010, Welsh Carson exited the 10-year investment in a sale to the for-profit health insurance provider, Humana – for a price tag of only \$790 million – 30 percent lower than Welsh Carson’s original 1999 investment. Humana’s strategy was to use the clinics as feeders for its core business, Medicare Advantage. But within five years, Humana flipped Concentra, reporting that it needed to use primary care practices as feeders instead and using the proceeds for its share buyback program. Ironically, Welsh Carson repurchased Concentra in a joint venture with Select Medical Holdings, a chain of 113 long term acute care hospitals, 16 rehabilitation facilities, and

<sup>126</sup> Corey Palasota. 2019. Op. cit. at endnote 107.

1,000 outpatient rehab clinics that Welsh Carson had taken private in a \$1.83 billion LBO in 2005. The PE firm executed an IPO in 2009 while retaining substantial interest in the company. But in June, 2015, Welsh Carson again paid \$1.06 billion for the asset. Using Concentra as a platform to further consolidate its dominant position in the occupational healthcare niche, it acquired US Healthworks, a subsidiary of Dignity Health, in 2017 for \$753 million. (Dignity Health is one of the country's largest for-profit healthcare systems, with 400 healthcare facilities, including hospitals, urgent care, surgery, home health, and primary care centers in 22 states). The US Healthworks purchase, along with other smaller ones, expanded Concentra's footprint to 530 occupational medical and onsite clinics by 2018. Welsh Carson's repurchase of Concentra apparently paid off, as the PE firm was able to flip Concentra in January 2018 for \$1.49 billion to a 'an undisclosed investor' making a strategic acquisition. The transaction was entirely debt financed through a loan from Morgan Chase Bank.<sup>127</sup>

PE firms also have successfully exited their urgent care investments through sale of assets to another different type of strategic buyer – Insurance company-owned subsidiaries such as Optum Care, the health services subsidiary of Minnesota-based insurance provider United Health Group (UHG). UHG became the largest US health insurer in the US through acquisitions of smaller insurers and pharmacy benefits companies since the 1990s. In 2018, it had 49.5 million members, 300,000 employees, a market capitalization of \$225 billion, and was ranked 6<sup>th</sup> in the Fortune 500. UHG formed Optum Care in 2010 as a strategic initiative to establish local networks of low cost primary, specialty, urgent care, and ambulatory surgery centers in key metropolitan areas – with insurance and medical records connected via advanced use of electronic medical records.<sup>128</sup> By 2012, it owned seven local physician and outpatient center

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<sup>127</sup> PitchBook 2019. PitchBook Concentra 2019 12-18-19; PitchBook Welsh, Carson, Anderson, & Stowe 2019-12-18-19; PitchBook Select Medical Holdings 2019-12-18-19; Bob Herman. 2015. "Humana to sell Concentra for \$1 billion." *Modern Healthcare*. March 23 Reuters. 2015. "UPDATE 2-Humana to sell Concentra medical center unit for \$1 billion." Reuters. March 23.

<https://www.modernhealthcare.com/article/20150323/NEWS/150329983/humana-to-sell-concentra-for-1-billion>

Concentra. 2017. "Definitive Agreement to Combine Concentra and U.S. HealthWorks." October 23.

<https://www.concentra.com/resource-center/press-releases/definitive-agreement-to-combine-concentra-and-us-healthworks/>

<sup>128</sup> PitchBook 2019. PitchBook Concentra 2019 12-18-19; PitchBook Welsh, Carson, Anderson, & Stowe 2019-12-18-19; PitchBook Select Medical Holdings 2019-12-18-19; Bob Herman. 2015. "Humana to sell Concentra for \$1 billion." *Modern Healthcare*. March 23.

<https://www.modernhealthcare.com/article/20150323/NEWS/150329983/humana-to-sell-concentra-for-1-billion>; Reuters. 2015. "UPDATE 2-Humana to sell Concentra medical center unit for \$1 billion." *Reuters*. March 23. <https://www.reuters.com/article/humana-welshcarson-ma/update-2-humana-to-sell-concentra-medical-center-unit-for-1-billion-idUSL2N0WP0OL20150323>; Concentra. 2017. "Definitive Agreement to Combine Concentra and U.S. HealthWorks." October 23.

groups; by 2015, it added five more; between 2016 and 2019, it more than doubled its footprint to 26 local and regional medical and outpatient groups with some 45,000 physicians (the largest physician employer in the country). While most acquisitions were small, three were large: the 2015 purchase of MedExpress, a national chain of 250 walk-in centers; the 2017 acquisition of Surgical Care Affiliates, serving 1 million patients annually; and the 2019 acquisition of DaVita Medical Group, with 350 clinics.<sup>129</sup>

Optum's purchase of MedExpress allowed the PE owners to exit their investment at an undisclosed profit. In 2015, MedExpress was owned by Sequoia Capital, Highmark, and General Atlantic -- purchased as part of an add-on strategy, with 'Urgent Care MSO' as the acquiring company. Optum's \$1.5 billion purchase of MedExpress allowed the three firms to exit their LBO acquisition of MedExpress in a three-year window.

In sum, private equity's life cycle of buying and selling in outpatient care mirrors its earlier life cycle in the hospital segment of the industry. Its strategy is to invest in fragmented markets as an early mover, taking advantage of the most promising targets to use as a platform, expand through add-on acquisitions, and consolidate sufficiently to exit the larger network -- either via IPO, sale to a strategic acquirer, or sale to another PE firm in a secondary buyout. Then it moves on to new segments or niches after the 'best targets' in one segment -- the low hanging fruit -- have been swallowed up. Private equity firms play the role of market consolidators with the sole purpose of making money through the buying and selling of healthcare assets. As early movers who cream skim the market for the 'best deals,' private equity firms make money through relatively low risk, high reward transactions. Then they move on.

### **What Does the Future Hold?**

The growth of outpatient services depends importantly on government and private payer reimbursement policies. In the current period, those policies have favored incentives that push hospitals to outsource more services to outpatient settings -- thereby increasing incentives for private equity to move into these markets, but also increasing competition with other healthcare providers and payers. In recent years, both government and private payers have announced a number of changes in reimbursement rules that reduce payments to hospitals, increase reimbursements to outpatient settings, or equalize payments to both. In 2017, for example, the Centers for Medicare & Medicaid (CMS) substantially reduced its drug payments to hospitals in the 340B program that is primarily used for vulnerable populations. In the same set of rule changes, it announced that total knee replacements would be covered in outpatient settings for

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<https://www.concentra.com/resource-center/press-releases/definitive-agreement-to-combine-concentra-and-us-healthworks/>

<sup>129</sup> Optum Care. 2019. <https://www.optumcare.com/about/about/growing-presence.html>; PitchBook. 2019. PitchBook MedExpress Urgent Care 2019-12-18-19.

the first time.<sup>130</sup> The change has spurred private equity interest in buying up orthopedic practices.<sup>131</sup>

In 2017, Anthem Health Insurance also announced two new policies that disadvantage hospitals relative to outpatient clinics: first, it would not cover ER visits in hospitals that it deemed were unnecessary, and second, it would no longer cover MRIs and CT scans at hospital outpatient centers (estimated to cost roughly \$1,000 more than at outpatient facilities).<sup>132</sup> With the decline in Medicare payments over the last decade, hospitals were able to make up for some of the loss via profitable procedures such as imaging (MRIs and CT scans), performed in hospital-based outpatient centers.

Meanwhile, momentum has grown for the adoption of site neutral payments for procedures done by hospital outpatient centers and hospital-owned physicians' groups compared to similar independent facilities. While the 2015 Bipartisan Budget Act included a provision for site-neutral payments for new facilities, it grandfathered in existing hospital-based outpatient centers. Since then, CMS issued a site-neutral plan that would equalize payments -- a plan backed by the Alliance for Site Neutral Payment Reform, a coalition of providers, employers, and payers. The American Hospital Association and its affiliates, however, argue that physicians send sicker patients to hospital outpatient centers, that they treat more complex cases, and that they are open 24/7. An ongoing legal battle between hospitals and the CMS has stalled implementation, as the judge in the case rejected the administration's CMS rule on grounds that it could not unilaterally replace the Congressional directive.<sup>133</sup>

In ambulatory care, conflicts over reimbursement rates have been on-going. The government reimbursement rates for ambulatory surgery centers are lower than for hospital-based outpatient surgeries based on research that shows that ambulatory centers offer lower complexity services.

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<sup>130</sup> Shannon Muchmore, 2017. "CMS Finalizes 340B Drug Program Cut." *HealthcareDive*. Nov. 2, 2017 <https://www.healthcarediver.com/news/cms-finalizes-340b-drug-program-cut/509892/>

<sup>131</sup> Samantha Liss, 2019. "Private Equity Sees Ripe Opportunity in Healthcare This Year." *HealthcareDive*. March 25. <https://www.healthcarediver.com/news/private-equity-sees-ripe-opportunity-in-healthcare-this-year/548831/>

<sup>132</sup> Les Masterson. 2017. "What will be the Fallout From Anthem's New Imaging Policy?" *HealthcareDive*. Sept. 18. <https://www.healthcarediver.com/news/what-will-be-the-fallout-from-anthems-new-imaging-policy/504951/>

<sup>133</sup> Alliance for Site Neutral Payment Reform. <http://www.siteneutral.org/about/>; Shannon Muchmore, 2020. "AHA Files Another Challenge to CMS Site Neutral Payment Policy." *HealthcareDive*. Jan 14. <https://www.healthcarediver.com/news/aha-files-another-challenge-to-cms-site-neutral-payment-policy/570366/>; AHA, 2019. "Study: Hospital Outpatient Clinics Treat Poorer, Sicker Patients than ASCs." April 4. <https://www.aha.org/news/headline/2019-04-04-study-hospital-outpatient-clinics-treat-poorer-sicker-patients-asc>

Average costs are estimated at 17-39 percent lower than hospital-based procedures, depending on the study. Government policy makers also maintain that they lack adequate cost and quality data from ambulatory centers and that reimbursement rates for ACS are adequate, given their continued expansion.<sup>134</sup> In addition, policy makers are concerned about the impact of freestanding ambulatory surgical centers on local healthcare markets. A 2018 MedPac report to the Congress, for examples, expressed concern about the role of ambulatory care centers in local healthcare markets. Several academic studies have shown that the presence of an ASC in a market is associated with a higher volume of outpatient surgical procedures and a higher rate of increase in surgical procedures.<sup>135</sup> Countering these government policies, the Ambulatory Care Center Association has pushed for rate equalization and is currently lobbying for a bill that would equalize payments. That bill, the *Ambulatory Surgical Center Quality and Access Act of 2019* (H.R. 4350/S. 3085), is sponsored by Representatives Devin Nunes (R-CA) and John Larson (D-CT) in the House of Representatives and Senators Mike Crapo (R-ID) and Richard Blumenthal (D-CT) in the US Senate.<sup>136</sup>

### **Surprise Medical Billing, Emergency Services, and Physician Staffing Firms**

Surprise medical billing has become a critical issue facing Americans across the country because of purposeful corporate practices designed to increase profits and reduce costs. As hospitals have outsourced emergency rooms and other specialty care to reduce costs, private investors have bought up specialty physician practices, rolled them into powerful national corporations, and taken over hospital emergency services. The result: large out-of-network surprise bills. The hidden actors: Leading private equity firms looking for ‘outsized’ returns.

Surprise medical billing has made headlines in recent years as patients with health insurance found themselves liable for hundreds or even thousands of dollars in unforeseen medical bills. When patients with urgent medical problems go to an emergency room (ER) or are treated by specialty doctors at a hospital that is in their insurance network, they expect that the services they receive will be ‘in-network’ and covered by their insurance. But often a doctor *not in their insurance network* is under contract with the hospital and actually provides the care. When this happens, patients are stuck with unexpected and sometimes unreasonably high medical bills charged by these ‘out-of-network’ doctors. This typically occurs when the hospital has outsourced the ER or other specialized services to a professional staffing firm or a specialty doctors’ practice. This problem has exploded in recent years because hospitals are increasingly outsourcing these services to cut costs. And more and more patients are faced with surprise

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<sup>134</sup> MedPac. 2018. Ibid.

<sup>135</sup> MedPac. 2019. Ibid.

<sup>136</sup> The Ambulatory Surgery Center Association.

<https://www.ascassociation.org/govtadvocacy/legislativepriorities/asc-quality-and-access>

medical bills -- adding substantially to the already impossible medical debt that working people face.

A study by health researchers at Stanford University examined fees charge to patients with private insurance that were treated by the emergency department of a hospital. They reviewed 13.6 million trips to the ER that occurred over the period 2010 to 2016. About a third (32.3 percent) of these trips in 2010 resulted in a surprise medical bill. But by 2016, that figure had increased to 42.8 percent. That is, more than 4 in 10 trips to the ER led to patients getting surprise medical bills.<sup>137</sup> A recent study found that out-of-network billing by these medical specialists raises physician payments for privately insured patients and raises health care spending by \$40 billion annually.<sup>138</sup>

Hospital outsourcing of emergency, radiology, anesthesiology, and other departments has provided an opening for physician practices to operate these services as independent organizations. Initially, hospitals outsourced these services to small, local doctors' groups. But over the past decade, private equity firms have become major players -- buying out doctors' practices and rolling them up into large corporate physician staffing firms that provide services to outsourced emergency rooms, anesthesiology and radiology departments, and other specialty units.

By 2013, physician staffing firms owned by Blackstone Group and Kohlberg, Kravis Roberts & Co. (KKR) – among the largest PE firms in the country – cornered 30 percent of this market. KKR owns Envision Healthcare (with 69,000 employees) and Blackstone, TeamHealth (with 20,000 employees). And these two companies have been major sources of surprise medical billing.

Another major source of surprise medical billing are emergency air and ground ambulance transport services. The average cost for an air ambulance was over \$36,000 in 2018, and 69

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<sup>137</sup> Eric Sun, Michelle Mello, Jasmin Moshfegh, et al. 2019. "An Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals," American Medical Association. *JAMA Internal Medicine*. August 12.  
[https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2740802?guestaccesskey=9fba6e0c-f029-401a-9675-737db3e67b5d&utm\\_source=for\\_the\\_media&utm\\_medium=referral&utm\\_campaign=ftm\\_links&utm\\_content=tf1&utm\\_term=081219&alert=article](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2740802?guestaccesskey=9fba6e0c-f029-401a-9675-737db3e67b5d&utm_source=for_the_media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tf1&utm_term=081219&alert=article)

<sup>138</sup> Zack Cooper, Hao Nguyen, Nathan Shekita, and Fiona Scott Morton. 2019. "Out-Of-Network Billing and Negotiated Payments for Hospital-Based Physicians," *Health Affairs* 39(1). December 16.  
[https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507?utm\\_source=Newsletter&utm\\_medium=email&utm\\_content=From+Health+Affairs%3A++The+Cost+Of+Out-of-Network+Billing+For+In-Network+Hospital+Care&utm\\_campaign=MEDIA+ADVISORY%3A+Cooper+AOP+12-16-19](https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507?utm_source=Newsletter&utm_medium=email&utm_content=From+Health+Affairs%3A++The+Cost+Of+Out-of-Network+Billing+For+In-Network+Hospital+Care&utm_campaign=MEDIA+ADVISORY%3A+Cooper+AOP+12-16-19)

percent of bills were out-of-network – meaning that insured patients in these cases, were billed directly for the services. Once again, private equity owned companies dominate this sub-segment of healthcare. Two of the three largest ambulance transport companies are owned by private equity firms -- Air Medical Group Holdings (AMGH), owned by KKR, the largest provider of ground services and one of the largest for air transport services; and Air Methods, which reportedly accounts for 30 percent of total air ambulance revenue in the US.

While large surprise medical bills are typically associated with medical emergency situations, the Stanford study found that the likelihood that a patient admitted to an in-network hospital would face a surprise medical bill because they were seen by at least one out-of-network doctor increased from 26.3 percent in 2010 to 42.0 percent in 2016. A particularly egregious instance of this was an assistant surgeon who sent a bill for \$117,000 to a patient who had surgery for herniated discs in his neck. The patient’s own in-network surgeon sent a bill for \$133,000 but accepted a fee of \$6,200 negotiated with the insurance company. The out-of-network assistant surgeon is looking for full payment of his charges. Surprise bills for a few thousand dollars, however, are not uncommon.<sup>139</sup>

### **How Did We Get Here? PE Rolls Up Physician Practices into Large Physician Staffing Firms**

The story begins with “hospitalists” – internal medicine doctors employed by hospitals to care for patients when the admitting physician is not in the hospital, including at night and on weekends. Hospitals traditionally hired these doctors directly or contracted with local physician practices for these services. In 1996, when the term “hospitalist” was coined, there were a few hundred hospitalists in the U.S. By 2002, observers were commenting on the rapid pace of growth in their numbers.<sup>140</sup> At that time, hospitals still mainly contracted with local physician practices, but hospital staffing firms that provided hospitals with nurses, technicians and other clinical staff on long or short-term temporary contracts saw an opportunity to provide doctors on similar contracts, referred to as locum tenens doctors. Hospitalist companies that focused specifically on contracting with hospitals for physician services became more prominent in the late 2000s, sometimes emerging out of hospital staffing firms – as in the case of IPC The Hospitalist Company – as staffing firms merged, retained their hospitalist operations, and divested other hospital staffing functions.

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<sup>139</sup> Elisabeth Rosenthal. 2014. “After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn’t Know,” *New York Times*. September 20. <https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html>;

<sup>140</sup> Mark A. Marinella. 2002. “Hospitalists – Where They Came From, Who They Are, and What They Do,” *Hospital Physician*. May. <https://pdfs.semanticscholar.org/c1a1/4f8e3e2f70489380db025235661b80d84349.pdf>



Despite the emergence of major hospitalist companies during the 2000s, most hospitals hired staff doctors or contracted with small physician practices for such services. In the prevailing fee for service system, however, it proved difficult for hospitals to get insurance companies to pay for hospitalists' services. HMOs and Medicare Advantage plans that relied on capitated payments did not face this problem and provided a growth opportunity for hospitalist companies.

Passage of the Affordable Care Act (ACA) in 2010, with its promise of a move away from fee for service payments to capitated and bundled payment reimbursement models, set off a wave of high-profile mergers among hospitalist companies. These reimbursement models make it much easier for hospitals to pay hospitalists for providing care. Cogent Healthcare ended 2010 by acquiring Endion Hospitalist Systems, then merged with Hospitalists Management Group in 2011 to form Cogent HMG which, later that same year, acquired a major physicians' practice. 2011 saw other major mergers. Eagle Hospital Physicians acquired PrimeDoc and Inpatient Management. IPI acquired 36 practice groups between 2009 and the end of 2011. In total, IPI had 1,200 hospitalists working in 220 local practice groups in 29 markets operating in 365 hospitals and 550 other facilities in 25 states.<sup>141</sup> Continuing announcements by Medicare and Medicaid of bundled payments for additional procedures have led to further acquisitions of doctor's practices by these and similar companies.<sup>142</sup>

While a handful of very large hospitalist companies emerged in the late 2000s, a 2010 survey of 4,613 hospitalist doctors in 412 groups found that a majority worked in small practices, with 40 percent of respondents in groups employing 10 or fewer doctors. One expert noted that there were 34,000 hospitalists practicing in the U.S. in 2011, and that even if all of the hospitalists employed at that time by the largest hospitalist companies – IPC, Cogent HMG, Eagle, and EmCare – were added together, they would account for a small fraction of the total.<sup>143</sup>

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<sup>141</sup> Andis Robeznieks. 2012. "Partnering Up," *Modern Healthcare*. March.  
<http://www.modernhealthcare.com/article/20120331/MAGAZINE/303319963><sup>141</sup> Zack Cooper, Fiona Scott Morton and Nathan Shekita. 2018. "Surprise! Out-of-Network Billing for Emergency Room Services in the U.S." *Yale University Working Paper*. March.  
[https://isps.yale.edu/sites/default/files/publication/2018/03/20180305\\_oon\\_paper2\\_tables\\_appendices.pdf](https://isps.yale.edu/sites/default/files/publication/2018/03/20180305_oon_paper2_tables_appendices.pdf)

<sup>142</sup> Melanie Evans. 2015. "Investors Hope to Profit from Sharing Medicare Bundled Payment Load," *Modern Healthcare*. September 12.  
[http://www.modernhealthcare.com/article/20150912/MAGAZINE/309129963?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=externalURL&utm\\_campaign=am](http://www.modernhealthcare.com/article/20150912/MAGAZINE/309129963?utm_source=modernhealthcare&utm_medium=email&utm_content=externalURL&utm_campaign=am); Phyllis Maguire. 2015. "Going All In for Bundled Payments," *Hospitalist*. August.  
[http://www.todayshospitalist.com/index.php?b=articles\\_read&cnt=2062](http://www.todayshospitalist.com/index.php?b=articles_read&cnt=2062)

<sup>143</sup> Andis Robeznieks, Op. cit., at endnote at 172.

This began to change after 2010 as large hospitalist companies bought up hospitalist practices in ever increasing numbers. These companies then moved on from hospitalists and began buying up practices of specialists employed mainly in hospitals – trauma doctors, anesthesiologists, radiologists, neonatal doctors. Hospitalist companies have since evolved into physician staffing firms, staffing the emergency rooms, anesthesiology departments, radiology and neonatal intensive care units in hospitals across the country.

The growth in the number of board-certified trauma doctors and in the number of hospital emergency rooms paralleled the increase in the number of hospitalists in recent decades. Physician staffing companies, experienced in running hospitalist departments, were quick to see the opportunity presented by the increase in the numbers of trauma doctors and emergency rooms. The business case for hospitals to outsource their emergency departments was straightforward. Emergency rooms are a major point of entry for patients who are admitted to hospitals and, thus, a major conduit for the in-patient hospital stays so important to a hospital's revenue. It is important for hospitals to staff their ERs on a 24/7 basis. A large majority of patients who use an emergency room are not brought there by ambulance and are free to choose which hospital to go for treatment.

An important competitive strategy for hospitals is to assure patients that their ER wait times are reasonable. Outsourcing the management, staffing and billing of emergency room services to a specialty trauma physician practice makes staffing problems easier to resolve. Outsourcing these services also enables the hospital to shift the risk of underpayment for these services from the hospital to the doctors' practice. Hospital emergency rooms cannot turn patients away if they lack adequate insurance coverage or any insurance at all; they must treat all patients. Emergency departments make money on ER visits of patients with commercial insurance, but lose money on those with Medicare or Medicaid, and see very high losses when patients have no insurance.<sup>144</sup>

Hospital outsourcing of emergency departments and anesthesiology departments – and to a lesser extent radiology departments and neonatal intensive care units – has become increasingly common. Outsourcing to local physician practices and smaller providers continues to play an important role. But by 2013 the two largest providers, private-equity owned Envision Healthcare and TeamHealth, had a combined 30 percent of the market for outsourced physicians.<sup>145</sup> The attraction of these specialties to physician staffing firms is also straightforward. Physicians in emergency rooms, in neonatal intensive care units and in radiology or anesthesiology practices do not need to worry that they will lose patients because their prices are too high. Patients can be

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<sup>144</sup> Zack Cooper, Fiona Scott Morton and Nathan Shekita. 2018. "Surprise! Out-of-Network Billing for Emergency Room Services in the U.S.," *Yale University Working Paper*, March. [https://isps.yale.edu/sites/default/files/publication/2018/03/20180305\\_oon\\_paper2\\_tables\\_appendices.pdf](https://isps.yale.edu/sites/default/files/publication/2018/03/20180305_oon_paper2_tables_appendices.pdf)

<sup>145</sup> Andis Robeznieks, Op. cit., at endnote at 172.

billed for these services at rates that far exceed payments for out-of-network services by insurance companies without affecting demand for these physician services.

The pitch to physician practices is that selling the practice to a physician staffing company will relieve them of the burden of managing their offices and dealing with the complexities of billing for their services in a system with separate rules for billing Medicaid, Medicare, commercial insurance providers, self-insured companies and self-pay patients. It will free them up to focus on providing care for their patients – the reason they became doctors in the first place. These promises need to be weighed against the potential loss of autonomy in practicing medicine in a corporate environment as physician practices consider their alternatives.

Hospitals' outsourcing of critical but expensive health services began as a cost cutting measure. But hospitals soon learned that outsourcing their emergency rooms to Envision's EmCare division or to TeamHealth increased revenue as well. Doctors in these practices were more likely to admit patients from the ER to the hospital for treatment. And while hospitals lose money on Medicare patients treated in the emergency room, they make money when these patients are admitted to the hospital. Hospitals also found that doctors in practices owned by these two companies ordered more diagnostic tests, another money maker for the hospitals.<sup>146</sup>

### **Private Equity's Role in Physician Staffing and Emergency Transport Companies**

TeamHealth and Envision are the two largest physician staffing companies in the U.S., and both are owned by private equity firms. The companies describe themselves as management services organizations (MSOs) – providers of healthcare administrative services that contract with hospitals for outsourced physicians in a variety of specialties ranging from hospitalists to emergency medicine. This formulation of their role is important. Early in the 20<sup>th</sup> century, the American Medical Association succeeded in establishing state licensing of doctors and state bans on the practice of medicine by corporations. Over time, doctors' practices were allowed to incorporate, and these regulations were waived for HMOs, hospitals, and educational institutions. But laws in the large majority of states still preclude business corporations from collecting fees, or a share of the fees, paid by patients. They also preclude business corporations from dictating medical practice, including the number of patients to be seen and the amount of time to be spent with each patient.<sup>147</sup>

These state regulations, however, have not been a barrier to the de facto acquisition of physician practices by investment funds sponsored by private equity firms. A recent research letter, published in the Journal of the American Medical Association, examined the acquisition of

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<sup>146</sup> Cooper, Morton and Shekita, Op. cit., at endnote 145.

<sup>147</sup> James Moriarity and Marvin Siegal. 2012. "Survey of State Laws Governing the Corporate Practice of Dentistry," October. [http://moriarty.com/content/documents/ML\\_PDFs/cpmd\\_4.10.12.pdf](http://moriarty.com/content/documents/ML_PDFs/cpmd_4.10.12.pdf)

physician practices by private equity firms during the period from 2013 to 2016. The typical private equity acquisition strategy involves a private-equity owned management services organization that is linked to a physician-owned medical group. This group is the “platform company. The PE firm subsequently “rolls up” additional doctors’ practices and merges them its original platform practice. The study found that 355 doctors’ practices were acquired in that time period with anesthesiology and multispecialty practice the most common (each at 19.4 percent of acquired practices), followed by emergency medicine (12.1 percent), family practice (11.1 percent) and dermatology (9.9 percent). The researchers noted an increase in the acquisition of cardiology, ophthalmology, radiology, and obstetrics/gynecology over this period.<sup>148</sup>

In our investigation of private equity and physician staffing companies, we focus on TeamHealth and Envision. They are not the only PE-owned physician staffing or hospitalist companies, but they are the most prominent. We examine how each of these companies grew to become a national powerhouse. We then discuss the business model of each company and its relationship to surprise medical bills. Outcries by patients hit with fees for medical treatments that are out of all proportion to the actual services provided and, in too many cases, ended in personal bankruptcy have led Congress to consider legislation to protect patients with health insurance from surprise bills. The reaction of the bond market suggests that such measures may severely curtail the profitability of these firms.

## **TeamHealth**

In 1999, private equity firms Cornerstone Equity Investors and Madison Dearborn Partners, with minority participation of Becken Petry O’Keefe and Company, acquired TeamHealth as a platform for a physician staffing company. According to PitchBook, TeamHealth made three acquisitions in its first two years – an anesthesiology practice, a hospitalist company and a health management business. It made no further acquisitions until after it was acquired by the Blackstone Group in 2005 in a leveraged (secondary) buyout. TeamHealth made two more acquisition between 2005 and 2009 – an emergency physician’s group and a hospitalist company.

In 2009, Blackstone Group returned TeamHealth to the public market via an IPO but retained possession of a majority of shares in the newly public company. Passage of the Affordable Care Act in 2010, with its promise of capitated and bundled payments, spurred TeamHealth to go on a buying spree. Between 2010 and 2016, TeamHealth acquired 51 companies, mainly practices of

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<sup>148</sup> Jane M. Zhu, Lynn M. Hua and Daniel Polsky. 2020. “Private Equity Acquisition of Physician Medical Groups Across Specialties, 2013-2016.” February 22.

<https://ldi.upenn.edu/healthpolicysense/private-equity-investment-physician-practices>

emergency doctors and anesthesiologists and a few hospital management companies. One very large exception to this pattern was TeamHealth's 2015 acquisition of IPC Healthcare.<sup>149</sup>

IPC Healthcare was a major hospitalist company. In its early years, it attracted four rounds of venture capital investments beginning in 1998 when it was launched as IPC The Health Company and continuing to 2002. In June 2002, IPC had an IPO and began its life as a publicly-traded company. Between 2002 and 2009, IPC acquired 20 physician practices. Between 2010 and 2015, following passage of the ACA, it acquired 78 more. The companies acquired by IPC were overwhelmingly hospitalist companies with a smattering of doctor's practices in specialties such as geriatrics.<sup>150</sup>

TeamHealth's acquisition of IPC in 2015 raised questions. There was no evident fit between TeamHealth's specialty physician practices and IPC's hospitalist companies. IPC was also in trouble with the Department of Justice which, in June 2014, had filed a civil lawsuit against the company for "knowingly engaging in systematic overbilling" for services billed to Medicare and Medicaid and other government health programs. Ultimately, TeamHealth paid \$60 million plus interest to resolve these allegations.<sup>151</sup> This fueled speculation that TeamHealth, which had rebuffed AmSurg's attempt to acquire it, wanted this very large acquisition in order to protect itself from being taken over. TeamHealth's explanation was that it wanted IPC's expertise in participating in Medicare and Medicaid bundled payments programs.<sup>152</sup>

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<sup>149</sup> PitchBook\_Team\_Health\_Holdings\_2019\_08\_09\_17\_21\_39, TeamHealth Holdings Company Profile dated July 27, 2019.

<sup>150</sup> PitchBook\_IPC\_Healthcare\_2019\_08\_09\_17\_57\_38, IPC Healthcare Company Profile dated July 27, 2019.

<sup>151</sup> U.S. Attorney's Office, Northern District of Illinois. 2014. "U.S. Files Lawsuit against IPC the Hospitalist Company, Alleges Overbilling of Federal Health Insurers for Physician Services," *Department of Justice*. June 17. <https://www.justice.gov/usao-ndil/pr/us-files-lawsuit-against-ipc-hospitalist-company-alleges-overbilling-federal-health>; M.L. McLaren. 2017. "\$11M Whistleblower Award on TeamHealth \$60M Overbilling Medicare & Medicaid at IPC Healthcare," *Whistleblower News Review*. February 27. [https://www.whistleblowergov.org/healthcare-and-pharma.php?article=TeamHealth-pays-60M-on-IPC-Healthcare-Upcoding-Fraud-Whistleblower-Allegations\\_107](https://www.whistleblowergov.org/healthcare-and-pharma.php?article=TeamHealth-pays-60M-on-IPC-Healthcare-Upcoding-Fraud-Whistleblower-Allegations_107)

<sup>152</sup> Jason Carris. 2015. "TeamHealth Announces \$1.6 Billion Acquisition of IPC Healthcare," *The Hospitalist*. August 4. <http://www.the-hospitalist.org/article/teamhealth-announces-1-6-billion-acquisition-of-ipc-healthcare/>; Steven Ross Johnson. 2015. "Why TeamHealth Plans to Pay \$1.6 billion for IPC Healthcare," *Modern Healthcare*, August 4. <http://www.modernhealthcare.com/article/20150804/NEWS/150809978>

In February 2017, Blackstone Group once again took TeamHealth private in a \$6.1 billion leveraged buyout. In 2018, the company employed 20,000 people.<sup>153</sup>

TeamHealth has also been aggressive in suing patients for delinquent payments of their medical bills. In 2019, a particularly egregious case came to light in a *ProPublica* investigation. In 2017, Blackstone acquired Southeastern Emergency Physicians and folded it into TeamHealth. The physician group ran the emergency department for Baptist Memorial Hospital in Tennessee. *ProPublica* found that the Southeastern physician practice filed 4,800 lawsuits suing poor patients for payment in the two years following Blackstone's acquisition of the group in a \$6.1 billion deal.<sup>154</sup> *ProPublica* found that while visits to the emergency room staffed by Southeastern doctors grew 12 percent between 2016 and 2018, the number of Southeastern Emergency Physicians lawsuits grew by 132 percent.

As a nonprofit, Baptist Memorial Hospital is required by law to provide charity care for patients. The hospital's policies are that "insured patients receive a partial discount for bills over \$5,000 for a single visit, regardless of income," while uninsured patients with an income below 200 percent of the federal poverty line are eligible for a 100 percent discount on charges, and discounts scale as income increases.<sup>155</sup> However, while Baptist "prefers" doctors' groups it contracts with follow the charity care policies, a representative declined to say whether they require it in contracts. TeamHealth's policy was to match Baptist's charity care policies if the patient submitted proof of eligibility for a discount. However, service representatives at a TeamHealth billing office were instructed not to mention charity care to patients, and billing statements did not include information on charity care. This is not a problem at just one hospital; TeamHealth has over 16,000 physicians and clinicians, in 3,300 facilities across 47 states.<sup>156</sup> In light of *ProPublica*'s report, TeamHealth dropped all ongoing lawsuits and implemented new policies to no longer sue patients and to offer discounts of up to 100 percent for uninsured patients, with policies states on invoices.

## **Envision Healthcare**

In February 2005, Canadian private equity firm Onex acquired two companies – American Medical Response and EmCare Holdings – and merged them to form Envision Healthcare.

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<sup>153</sup> PitchBook TeamHealth Holdings Company Profile, July 27, 2019.

<sup>154</sup> Wendi C. Thomas, Maya Miller, Beena Raghavendran, and Doris Burke. 2019. "This Doctors Group Is Owned by a Private Equity Firm and Repeatedly Sued the Poor Until We Called Them," *ProPublica*. November 27. <https://www.propublica.org/article/this-doctors-group-is-owned-by-a-private-equity-firm-and-repeatedly-sued-the-poor-until-we-called-them/amp>

<sup>155</sup> *Ibid.*

<sup>156</sup> *Ibid.*

American Medical Response (AMR) was an ambulance and medical transport business. A publicly traded company as of August 1992, it was acquired by ambulance company MedTrans, a subsidiary of Laidlaw International in February 1997. At an undisclosed date between 1997 and 2005, PE firm Peak Capital invested an undisclosed amount in the company. In 2005, AMR was acquired by Onex and became part of Envision.

In the decade from 2007 to 2017, while it was part of Envision Healthcare, AMR acquired 12 ambulance and medical transport businesses and one air ambulance company. In addition to these acquisitions, AMR has seven sister companies – mainly ambulance companies, including several air ambulance businesses. In April 2018, AMR was acquired and merged with air ambulance company, Air Medical Group Holdings (AMGH) owned by PE firms Ardian, Koch Equity Development and Kohlberg Kravis Roberts (KKR) through a \$2.4 billion leveraged buyout. The combination of AMR and AMGH gave the merged companies' PE owners a leading position in emergency and medical transport across a range of transport modalities.<sup>157</sup>

Like AMR, EmCare Holdings was acquired by Laidlaw International in the summer of 1997 and subsequently received an undisclosed amount of investment from PE firm Peak Capital. Emergency physician practices figure prominently among its 10 acquisitions and 17 sister physician staffing and management firms.<sup>158</sup>

Envision Healthcare, formed when PE firm Onex acquired and merged these two companies in February 2005, passed in and out of PE ownership in the ensuing years. In December 2005, Onex returned Envision Healthcare to the public market via an IPO in which it retained a majority of the shares. Subsequent sales of shares left Onex with 31 percent of the company's equity at the time it was taken private. Envision was acquired by Clayton Dubilier & Rice with participation of PE firm Ardian through a \$3.2 billion public-to-private LBO in May 2011. An IPO in 2013 returned Envision Health to the public market. The PE owners retained about two-thirds of the shares of the now-publicly traded company. The PE companies subsequently sold some of the stock. And in September 2017, two hedge funds – Starboard Value and Comex Management – took minority stakes in Envision Healthcare.<sup>159</sup>

Envision Healthcare had bought out AmSurg in December 2016 after its failed attempt to acquire TeamHealth. The deal brought together two seemingly complementary healthcare companies to

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<sup>157</sup> PitchBook\_American\_Medical\_Response\_2019\_8\_10\_13\_21\_18, American Medical Response Company Profile dated July 27, 2019.

<sup>158</sup> PitchBook\_EmCare\_2019\_08\_10\_14\_18\_43, EmCare Company Profile dated July 27, 2019.

<sup>159</sup> PitchBook\_Envision\_Healthcare\_2019\_08\_10\_16\_06\_31, Envision Healthcare Profile dated July 27, 2019; Brooke Sutherland. 2018. "It's the Great Health Care Buyout Shuffle," *Think Advisor*, June 11. <https://www.thinkadvisor.com/2018/06/11/its-the-great-health-care-buyout-shuffle/?slreturn=20190710143530>

form a provider organization with pro forma market capitalization of \$10 billion and an enterprise value including debt of approximately \$15 billion. Adding AmSurg’s large chain of ambulatory surgical centers was supposed to make Envision Healthcare a dominant player across the outsourced medical services landscape – emergency room doctors, hospitalists, outpatient surgery, and ground and air ambulance. But integrating the two health care companies – with a combined 69,300 employees as of December 2017 – proved difficult for publicly traded Envision Healthcare. In October 2018, KKR acquired Envision through a \$9.9 billion public-to-private LBO. A little over \$8 billion of this was new debt. However, KKR contributed \$5.57 billion to the deal, using \$4.43 billion to retire Envision’s prior liabilities and the remainder mainly as equity in the LBO.<sup>160</sup>

### **Making Money in Physician Staffing Services: The Private Equity Business Model**

Private equity firms have been busy buying up physician staffing firms as well as ground and air ambulance companies because these providers have billing power. Patients generally have no choice in selecting these doctors or emergency services, and no say in the price they will be charged. A person having a heart attack is not going to wait for an in-network ambulance and a critically ill patient being airlifted to a specialized facility is in no condition to bargain with the air ambulance company. In less dire situations, a patient may carefully choose a hospital and doctor that is in-network, but may be surprised to learn that out-of-network doctors cared for her or him at the in-network hospital and are able to bill separately for their services. This so-called ‘balance billing’ is the root cause of surprise medical bills that patients often face after a hospital stay.<sup>161</sup>

The design of the private equity business model is geared to driving up the costs of patient care. Private equity funds rely on the classic leveraged buyout model in which they use substantial debt to buyout specialty physician practices as well as ambulance services because debt multiplies returns if the investment is successful. They target companies like emergency medical practices that have a steady and high cash flow so they can manage the cash in order to service the debt and make high enough returns to pay their investors ‘outsized returns’ that exceed the stock market. Moreover, demand for these services is inelastic (not sensitive to price) and large – almost 50 percent of medical care comes from emergency room visits, according to a 2017 national study by the University of Maryland School of Medicine, and demand has steadily increased.<sup>162</sup> PE firms believe they face little or no downside market risk in these buyouts.

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<sup>160</sup> PitchBook Envision Healthcare Profile, Ibid.

<sup>161</sup> Bob Herman. 2018. “Private Equity’s Thirst for Health Care Providers,” *Axios*. July 12. <https://www.axios.com/private-equity-thirst-for-health-care-providers-1528737485-195192d5-db93-4c57-9a28-4b7af191d42e.html>

<sup>162</sup> Jeff Lagasse. 2017. “Nearly Half of Medical Care Comes from Emergency Rooms, Study Shows.”



Private-equity owned physician staffing firms grow by buying up many small specialty practices and ‘rolling them up’ into umbrella organizations that serve healthcare systems across the United States. Each acquisition is too small to warrant attention by anti-trust regulators. However, as these companies grow in scale and scope, they become national powerhouses and the major suppliers of outsourced services, with ever greater market power in their negotiations with both hospitals and insurance companies: hospitals with whom they contract to provide services and insurance companies who are responsible for paying the doctors’ bills.

Envision Healthcare, with 69,300 employees and TeamHealth with 20,000 employees dominate the market for outsourced doctors’ practices. A recent study shows what happened when private equity-owned physician staffing firms took over hospital emergency rooms. A team of Yale University health economists examined what happened when private-equity owned companies EmCare (part of Envision Healthcare) and TeamHealth – the two largest emergency room outsourcing companies – took over the emergency departments at hospitals.<sup>163</sup> What they found is that when EmCare took over the management of emergency departments, it nearly doubled its charges for caring for patients compared to the charges billed by previous physician groups. Envision’s EmCare unit has come under scrutiny for the huge out-of-network surprise medical bills it sends to ER patients. This has been a major source of sometimes huge surprise medical bills. These egregious practices have resulted in a Congressional investigation headed by Missouri Senator Claire McCaskill, lawsuits from shareholders, and court actions involving Envision and UnitedHealth Group, the largest U.S. insurer.<sup>164</sup>

The Yale researchers found that TeamHealth, owned in serial fashion by PE firm Blackstone Group, took a somewhat different tack. It used the threat of sending high out-of-network surprise bills for ER doctors’ services to an insurance company’s covered patients to gain high fees from insurance companies as in-network doctors. In most cases, they noted, TeamHealth emergency physicians would go out-of-network for a few months, then rejoin the network after bargaining

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<https://www.healthcarefinancenews.com/news/nearly-half-medical-care-comes-emergency-rooms-study-shows>.

<sup>163</sup> Zack Cooper, Fiona Scott Morton and Nathan Shekita. 2018. Op. cit. at 175.

<sup>164</sup> Michael J. de la Merced. 2018. “K.K.R. Said to Be Near Deal to Acquire Envision Healthcare,” *New York Times*. June 10. [https://www.nytimes.com/2018/06/10/business/dealbook/kkr-envision-healthcare-deal.html?dlbk=&emc=edit\\_dk\\_20180611&nl=dealbook&nid=70726928\\_dk\\_20180611&te=1](https://www.nytimes.com/2018/06/10/business/dealbook/kkr-envision-healthcare-deal.html?dlbk=&emc=edit_dk_20180611&nl=dealbook&nid=70726928_dk_20180611&te=1);  
Shelby Livingston. 2018. “UnitedHealth Hits Back at Envision over ER Billing Practices,” *Modern Healthcare*. March 20. [http://www.modernhealthcare.com/article/20180320/NEWS/180329992SenatorClaireMcCaskill's letter to Envision can be found here](http://www.modernhealthcare.com/article/20180320/NEWS/180329992SenatorClaireMcCaskill's%20letter%20to%20Envision%20can%20be%20found%20here)  
<https://www.hsgac.senate.gov/imo/media/doc/2017-09-20%20CMC%20Ltr%20to%20EmCare%20re%20Pricing.pdf>

for in-network payment rates that were 68 percent higher than in-network rates received by the previous ER doctors.<sup>165</sup> This avoids the situation where a patient gets stuck with a large, surprise medical bill for the services of emergency room doctors, but it raises premium costs for everyone.

In both cases, private equity ownership of physician staffing firms that supply doctors when hospitals outsource emergency room and other physician services raises healthcare costs.

### **Air Ambulance Services**

High charges for ambulance services, where patients cannot choose their provider, are likely to be high. In the case of air ambulances, a study by researchers at Johns Hopkins University found charges were likely to be – as they put it – sky high. The study found that air ambulance charges had risen substantially over 2012 to 2016, and in 2016 these charges ranged from 4 times higher than what Medicare paid for this service to more than 9 times higher. Some of the largest providers had among the highest charges.<sup>166</sup>

KKR’s 2018 acquisition of ambulance company American Medical Resources (AMR) from Envision for \$2.4 billion and the merger of AMR with KKR-owned air ambulance company Air Medical Group Holdings (AMGH) noted earlier, combined the largest provider of ground ambulance services in the U.S. with a leading operator of medical helicopters. The merger of AMGH’s helicopter business with the ground ambulance company may provide opportunities for it to substitute its more expensive medical helicopters for short trips previously done by AMR’s ambulances.<sup>167</sup>

KKR is not the only private-equity firm to own an air ambulance company. Medical helicopter company Air Methods, with nearly 500 helicopters, succumbed to pressure from a hedge fund investor and allowed itself to be acquired in a \$2.5 billion leveraged buyout by private equity firm American Securities. The argument of the hedge fund’s CEO is telling. Activist hedge fund Voce Capital Management, concerned about the bad publicity surrounding predatory charges by air ambulance companies, wanted Air Methods to agree to be taken private by a PE firm in order to keep information about its billing practices out of the hands of the public. According to the hedge fund, Air Methods big price hikes created economic and political risks for the company. Going private would shield its financial documents from patients and insurers. The hedge fund

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<sup>165</sup> Zack Cooper, Fiona Scott Morton, and Nathan Shekita. 2018. Op. cit. at endnote 175

<sup>166</sup> Ga Bai, Arjun Chanmugam, Valerie Y. Suslow, and Gerard F. Anderson. 2019. “Air Ambulances with Sky-High Charges,” Washington, D.C.: Johns Hopkins University, July 10.

<sup>167</sup> Carl O’Donnell. 2017. “Exclusive: Buyout Firm KKR in Lead to Acquire Envision’s Ambulance Unit – Sources,” *Reuters*. July 14. <http://www.reuters.com/article/us-envision-healthcare-m-a-kkr-idUSKBN19X309>

was right to be concerned about Air Methods predatory billing practices. The average bill for being transported in one of its medical helicopters was \$17,262 in 2009 and had risen to \$40,766 in 2014. Air methods calculates that it accounts for nearly 30 percent of total air ambulance revenue in the U.S. And its profit increased sevenfold over the 2004 to 2014 period.<sup>168</sup>

Air Methods is not alone. A 2019 study by the Government Accountability Office (GAO) found that the average cost of an air ambulance is over \$36,000. Of the air transport companies that the GAO studied, 69 percent were out-of-network for the patient, meaning insured patients in these cases ended up being billed for most of the charge.<sup>169</sup>

## Running into Headwinds

Physician staffing firms and air ambulance companies have been highly lucrative investments for private equity firms. But they are running into headwinds as patients turn to facilities other than hospitals for treatment and as their exorbitant fees, which have even bankrupted some patients, have attracted the attention of Congress.

A recent report from rating agency Standard and Poor's notes that physician staffing firms face a softening demand for the doctors they supply and a more precarious financial situation than in the past. An increasing number of patients are covered by government programs like Medicare and Medicaid that block balance billing, and policy decisions that have weakened the Affordable Care Act have increased the number of uninsured. The increase in outpatient care facilities and the emergence of competition from retail healthcare backed by third-party investors have meant a decline in emergency department volumes, making companies that staff emergency departments vulnerable. The decline in in-patient stays in hospitals has reduced the number of outsourced hospitalists, radiologists, and anesthesiologists that hospitals require. New, more sophisticated artificial intelligence applications have improved hospitals' ability to use predictive analytics to ensure appropriate staffing levels which reduces their reliance on staffing firms. Some hospitals have invested in interns, local residency programs, and staff development to

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<sup>168</sup> Bob Herman. 2017. "Air Methods Bought Out for \$2.5 Billion," *Axios*. March 14. <https://www.axios.com/air-methods-bought-out-for-25-billion-1513300942-29d45472-f787-4c79-9eea-7f38ae92a371.html>; Peter Eavis. 2015. "Air Ambulances Offer a Lifeline and Then a Sky-High Bill," *New York Times*. May 5. [https://www.nytimes.com/2015/05/06/business/rescued-by-an-air-ambulance-but-stunned-at-the-sky-high-bill.html?\\_r=0](https://www.nytimes.com/2015/05/06/business/rescued-by-an-air-ambulance-but-stunned-at-the-sky-high-bill.html?_r=0)

<sup>169</sup> United States Government Accountability Office. 2019. "Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk," *GAO*. March. <https://www.gao.gov/assets/700/697684.pdf>

reduce demand for doctors from staffing agencies.<sup>170</sup> Public outcry over surprise medical bills has made it more difficult for physician staffing firms to increase prices to offset falling volumes.

### **Eliminating Surprise Medical Bills**

One solution to the surprise medical billing problem is for hospitals themselves to simply require all attending physicians in their hospitals to remain in-network – receiving payment from the insurance companies with whom the hospital has contracted. This is a common approach for hospitals in managed care networks, according to John Cascell, Senior Vice President of Managed Care at Memorial Care Health System in Fountain Valley, California. But it has fallen into disuse as major physician staffing companies have moved doctors out-of-network to make more money.<sup>171</sup>

Individual solutions are at best stop gap measures as no individual hospital can solve the pervasive problem of surprise medical billing on its own. Twenty-five states have passed legislation that partially protects patients from surprise billing. But this has proven inadequate as the majority of employees who receive insurance from self-insured employer plans that are not covered by state law, as noted earlier.<sup>172</sup> More than three-quarters of Americans want the *federal government* to take action and protect them: 84 percent of Democrats, 78 percent of Independents, and 71 percent of Republicans support federal legislation to protect patients.<sup>173</sup>

The debate over surprise medical bills has been framed by PE-owned physician practices as doctors who only want to be paid for their life-saving services and insurance companies that don't want to pay them fairly. Viewed that way, it's a debate that insurance companies are sure to lose. But these are not the true protagonists. Private equity firms are buying up specialty doctors' practices at an alarming rate because surprise medical bills allow them to extract high

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<sup>170</sup> Alex Kacik. 2019a. "Healthcare Staffing Agencies' Outlook Softens as Providers Control Costs," *Modern Healthcare*. June 17. [https://www.modernhealthcare.com/operations/healthcare-staffing-agencies-outlook-softens-providers-control-costs?utm\\_source=modern-healthcare-am&utm\\_medium=email&utm\\_campaign=20190617&utm\\_content=article2-readmore](https://www.modernhealthcare.com/operations/healthcare-staffing-agencies-outlook-softens-providers-control-costs?utm_source=modern-healthcare-am&utm_medium=email&utm_campaign=20190617&utm_content=article2-readmore)

<sup>171</sup> Tara Bannow. 2019. "Hospitals' Solution to Surprise Out-Of-Network Bills: Make Physicians Go In-Network." *Modern Healthcare*. January 12. [https://www.modernhealthcare.com/article/20190112/TRANSFORMATION04/190119990?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=20190112-TRANSFORMATION04-190119990&utm\\_campaign=am](https://www.modernhealthcare.com/article/20190112/TRANSFORMATION04/190119990?utm_source=modernhealthcare&utm_medium=email&utm_content=20190112-TRANSFORMATION04-190119990&utm_campaign=am)

<sup>172</sup> Michael Ollove. 2019. "Surprise Medical Billing: Some States Ahead of Feds," *PEW Stateline Article*. April 5. <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/04/05/surprise-medical-billing-some-states-ahead-of-feds>

<sup>173</sup> Emmarie Huetteman. 2019. "Legislation to End Surprise Medical Bills Has High Public Support — In Both Parties." *Kaiser Health News*. September 12. <https://khn.org/news/legislation-to-end-surprise-medical-bills-has-high-public-support-in-both-parties/>

payments for medical care from patients and/or insurance companies. It's private equity whose interests are opposed to those of insurance companies. And insurance companies which, in defending themselves against exorbitant payments to these doctors, are also acting to hold down healthcare costs and health insurance premiums for consumers.

In 2019, at the beginning of the summer, Congress appeared poised to act to protect consumers from surprise medical bills. A surprising number of proposals to shield patients from surprise medical bills have been put forward, some from unexpected places. They ban surprise medical bills in situations where the patient was unable to choose their provider and hold insured patients financially harmless for charges for out-of-network physician services in hospitals and outpatient facilities. Democratic Senator Maggie Hassan and Republican Senator Bill Cassidy were the first to introduce bipartisan legislation to stop surprise bills. Stronger bills were subsequently introduced in the Senate and the House. Early in the summer, Senate HELP committee Chair Lamar Alexander and Ranking Member Patty Murray introduced the Lower Health Care Costs Act (S. 1895), a strong bill to rein in doctor and air ambulance surprise bills – the only bill to address air ambulance charges. This bill passed out of the Senate Health, Education, Labor and Pensions Committee, and could be taken up by the full Senate. In May, the House Energy and Commerce Committee took up the bipartisan No Surprises Act (H.R. 3630), introduced by committee Chair Frank Pallone Jr. and Ranking Member Greg Walden. The chances of legislation to protect insured patients from high out-of-pocket costs from out-of-network doctors and air ambulances passing in 2019 looked good.

Congress and the public agree that insured patients need to be protected from surprise medical bills; even the White House announced that it wants legislation to protect consumers from these medical bills.<sup>174</sup> Two solutions, both of which take surprise charges to patients out of the equation, dominate current debates. Employers, patient advocates, and insurance companies favor paying out-of-network doctors a rate ‘benchmarked’ to rates negotiated with in-network doctors –for example, the median in-network payment for this service or, alternatively, 125 percent of the Medicare payment. This approach restricts how high an out-of-network doctor’s fee can go, restrains the growth of healthcare costs, and limits payouts that insurers can be made to pay. It is supported by insurance companies, employers, researchers at the USC-Brookings Schaeffer Initiative for Health Policy, and advocacy groups such as Families USA, which have

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<sup>174</sup> Kelly Gooch. 2019. “Senate Committee Tackles Surprise Medical Bills. 5 Takeaways,” *Becker’s Hospital Review*. June 20. [https://www.beckershospitalreview.com/finance/senate-committee-tackles-surprise-medical-bills-5-takeaways.html?origin=rcme&utm\\_source=rcme](https://www.beckershospitalreview.com/finance/senate-committee-tackles-surprise-medical-bills-5-takeaways.html?origin=rcme&utm_source=rcme); Caitlin Owens. 2019. “White House Wades into Surprise Billing Debate,” *Vitals*. May 10. [https://www.axios.com/newsletters/axios-vitals-c58a199c-7176-4073-8970-f590b1d2ccb9.html?utm\\_source=newsletter&utm\\_medium=email&utm\\_campaign=newsletter\\_axiosvitals&stream=top](https://www.axios.com/newsletters/axios-vitals-c58a199c-7176-4073-8970-f590b1d2ccb9.html?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top)

been vocal on the surprise billing issue on behalf of consumers.<sup>175</sup> Major insurance companies and associations have formed the Coalition against Surprise Medical Billing, which includes the American Benefits Council, America's Health Insurance Plans, America's Physician Groups, Blue Cross and Blue Shield, and the ERISA Industry Committee to lobby for benchmarking out-of-network doctors' charges.<sup>176</sup>

Not surprisingly, this solution is opposed by specialist physician practices, whose professional associations back the 'Out of the Middle' coalition,<sup>177</sup> and by large physician staffing companies that want to continue to charge prices higher than the in-network fees to patients that require critical health services. These companies, some backed by private equity firms, are lobbying intensively for a second option that would require insurance companies to pay out-of-network providers a negotiated benchmarked fee, but also allow those doctors to seek a higher fee via an arbitration process -- in the belief that most settlements would ensure higher physician pay and higher company revenues and profits.<sup>178</sup> The campaign by Physicians for Fair Coverage, a private-equity backed group lobbying on behalf of large physician staffing firms (Table 5.1), launched a \$1.2 million national ad campaign in July to push for this second approach.<sup>179</sup>

Their argument is that insurance companies have created the problem of surprise medical bills by "forcing emergency room doctors, radiologists, anesthesiologists and other providers out of their networks."<sup>180</sup> But the reality is that hospitals are outsourcing ERs, anesthesiology and radiology departments, and specialized care units to cut costs; and large physician staffing firms have positioned themselves to supply doctors to fill these positions or take over these units altogether. Under the second option, individual patients would no longer receive surprise medical bills, but arbitration awards would mean higher health care costs and would drive up premiums, deductibles, and co-pays for everyone.

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<sup>175</sup> Susannah Luthi. 2019a. "Providers Notch Wins in House Surprise Billing Legislation," *Modern Healthcare*. July 17. <https://www.modernhealthcare.com/politics-policy/providers-notch-wins-house-surprise-billing-legislation>

<sup>176</sup> The Advisory Board. 2019. "Why a New Coalition is Spending Millions to Target 'Surprise' Medical Bills." June 12. <https://www.advisory.com/daily-briefing/2019/06/12/coalition>

<sup>177</sup> Out of the Middle. <https://www.outofthemiddle.org/>

<sup>178</sup> Bob Herman. 2019. "Doctors Flood Congress with Lobbyists on Surprise Medical Bills," *Axios*. August 20. <https://www.axios.com/surprise-medical-billing-lobbying-congress-74f40358-998b-42ac-bdc6-1733ccac3c19.html>

<sup>179</sup> Physicians for Fair Coverage website. <https://www.endtheinsurancegap.org/about-us>; Rachel Bluth. 2019. "Doctors Argue Plans to Remedy Surprise Medical Bills Will 'Shred' the Safety Net." August 7. <https://khn.org/news/doctors-argue-plans-to-remedy-surprise-medical-bills-will-shred-the-safety-net/>

<sup>180</sup> Website of Physicians for Fair Coverage. 2019. <https://www.endtheinsurancegap.org/state>.

**Table 5.1**  
**Who is behind “Physicians for Fair Coverage”?<sup>181</sup>**

<b>Organizational Affiliation of Board Members</b>	<b>Private Investment Fund Backing (Equity or Debt)</b>
Apollo MD is an emergency medical services company offering ER and other services to 3.9 million patients. <sup>182</sup>	ValorBridge Partners and others (PE firm)
Radiology Partners is the largest radiology practice in the US, with 1,400 radiologists providing services to over 1,000 hospitals and other facilities. <sup>183</sup>	New Enterprise Associations (VC firm); Carlyle Group (PE firm)
Schumacher Clinical Partners (SPC Health) was created when several firms were merged to create one of the largest hospitalist and physician management companies in the US. It serves 8 million patients and 400 hospitals in 30 states. <sup>184</sup>	Onex (PE firm)
US Acute Care Solutions was formed when an emergency medical staffing and management group was acquired as a platform for further buyouts; by 2019, it had grown to serve 6 million patients in 220 sites in 20 states. <sup>185</sup>	Welsh, Carson, Anderson & Stowe (PE firm)
U.S. Anesthesia Partners (USAP), Inc. was created as a platform by Welsh, Carson, Anderson, & Stowe for rolling up anesthesiology practices; it bought out at least 17 practices between 2012-2018 and USAP now employs 3,500 professionals in 8 states. <sup>186</sup>	HarbourVest Partners (PE firm) bought out USAP in 2016 in LBO; Welsh, Carson, Anderson & Stowe retained a minority stake and held two seats on the Board of Directors as of October, 2019. <sup>187</sup>
US Radiology Specialists includes 30 wholly owned anesthesiology and imaging centers and 50 jointly owned centers in the US. <sup>188</sup>	Welsh, Carson, Anderson & Stowe (PE firm)
Vituity (formerly CEP America) provides facilities with ER services, post-acute inpatient, anesthesiology, psychiatry, and neurology services. <sup>189</sup>	Physician owned

The lobbying campaign bore fruit. In July, Representatives Raul Ruiz and Phil Roe introduced a bipartisan amendment to the House bill to allow arbitration. Pallone and Walden accepted the

<sup>181</sup> All of the information in this chart comes from PitchBook (accessed on August 28, 2019) *except* the name of the Venture Capital firm that backs Radiology Partners. It comes from Susannah Luthi. 2019b. “Physician, Hospital Groups Gear Up for Fight on Surprise Medical Bills.” <https://www.modernhealthcare.com/politics-policy/physician-hospital-groups-gear-up-fight-surprise-medical-bills>

<sup>182</sup> ApolloMD is an emergency medical services company offering ER, anesthesiology, radiology, intensivist, and hospitalist services to 3.9 million patients, according to its website.

amendment because it allowed arbitration only in special cases, and required the arbitrator to use negotiated rates, not provider charges, when deciding on disputes over payment.<sup>190</sup>

KKR-owned Envision and Blackstone-owned TeamHealth were not satisfied with the private-equity backed lobbying efforts that resulted in provisions for arbitration over disputed fees for out-of-network doctors in the Pallone-Walden bill. In late July, as the value of debt on PE-owned staffing firms and air ambulance companies continued to fall, a mystery group called Doctor Patient Unity launched a \$28 million ad campaign aimed at keeping any legislation to protect patients from surprise medical bills from passing. The ads targeted the home districts of 13 vulnerable Republican and Democratic Senators up for re-election. They oppose any limits on what doctors can charge and accuse insurance companies of not wanting to pay their fair share of doctors' fees. Congressional staff expressed concern that the big sums being spent to kill surprise billing legislation would intimidate legislators who might fear that even greater sums would be spent to defeat them if they supported any of the bills under consideration. By late August/early

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<https://apolloomd.com/emergency-medicine-management/>; PitchBook. 2019. It completed a leveraged buyout of Cornerstone Medical Center out of bankruptcy in 2016 with PE backing from ValorBridge Partners. PitchBook. 2019. ApolloMD\_2019\_09\_01\_15\_27\_33 dated September 1, 2019.

<sup>183</sup> Radiology Partners, backed by a consortium of private equity firms and investment banks, is the largest radiology practice in the US., with 1,400 radiologists providing services to over 1,000 hospitals, clinics, and imaging centers in 21 states, according to its website

<https://www.radpartners.com/>; PitchBook. 2019. Radiology\_Partners\_2019\_09\_01\_19\_14\_55\_25.

<sup>184</sup> SPC Health was bought out by Onex PE firm in 2015 and merged with physician management groups, Hospital Physician Partners and ECI Healthcare Partners. This created one of the largest hospitalist and physician management companies in the US. It serves 8 million patients and 400 hospitals in 30 states, according to its website <https://www.scp-health.com/providers/who-we-are/history>; PitchBook. 2019. Schumarcher\_Clinical\_Partners\_2019\_09\_01\_14\_57\_39 dated September 1, 2019.

<sup>185</sup> In 2015 Welsh, Carson, Anderson & Stowe bought out an Ohio-based emergency medical staffing and management group and formed US Acute Care Solutions (USACS) as a platform for further development. By 2019, it had grown to serve 6 million patients in 220 sites in 20 states, according to its website <https://www.usacs.com/history> (accessed September 1, 2019); PitchBook. 2019. US\_Acute\_Care\_Solutions\_2019\_09\_01\_15\_16\_48 dated September 1, 2019.

<sup>186</sup> PitchBook Profile, U.S. Anesthesia Partners, February 26, 2020.

<sup>187</sup> Ibid.

<sup>188</sup> U.S. Radiology Specialists, founded as a platform in 2018 by Welsh, Carson, Anderson & Stowe, includes 30 wholly owned anesthesiology and imaging centers and 50 jointly owned centers in the US. <https://www.usradiology.com/>; PitchBook 2019. US Radiology\_Specialists\_2019\_09\_01\_2019\_01\_04\_30\_21 dated September 1, 2019.

<sup>189</sup> Vituity provides ER services, post-acute inpatient, anesthesiology, psychiatry, and neurology services <https://www.vituity.com/services/>

<sup>190</sup> Susannah Luthi. 2019a. Op. cit. at endnote 206.



September, it became known that private equity owned the two major physician staffing firms behind surprise medical bills and bipartisan legislation in both houses of Congress posed a threat to private equity's business model. In mid-September, a representative for Doctor Patient Unity finally revealed what many observers suspected – that Envision Healthcare and TeamHealth were behind the campaign.<sup>191</sup>

Shortly after it became known that KKR and Blackstone were behind the dark money campaign to defeat legislation to protect patients from surprise bills, the House Energy and Commerce Committee launched an investigation into the business practices of the third-party medical providers backed by the three private equity firms. In a 6-page letter, Pallone and Walden demanded that the PE-owned firms provide past and current financial information about their investments in physician staffing and emergency transportation companies. The committee requested revenue information and information about the negotiating process with insurance companies.<sup>192</sup>

All this talk of reining in charges by out-of-network physicians has taken a financial toll on physician staffing agencies. Private-equity owned companies do not have public shareholders or stock market prices that can be observed, and they are not required to make public information about their finances. However, leveraged buyouts result in lots of debt, much of it subject to public disclosure. These loans have fallen in value as proposals to protect patients from surprise bills has made lenders concerned about whether the debt can be repaid. KKR's 2018 leveraged buyout of Envision, for example, was financed in part by a \$5.4 billion loan due in 2025. According to the financial times, it "slid from almost 97 cents on the dollar at the start of May to just 87.8 cents on the dollar" in late July as talk of reining in charges for Envision's services heated up (See Figure 5.1).

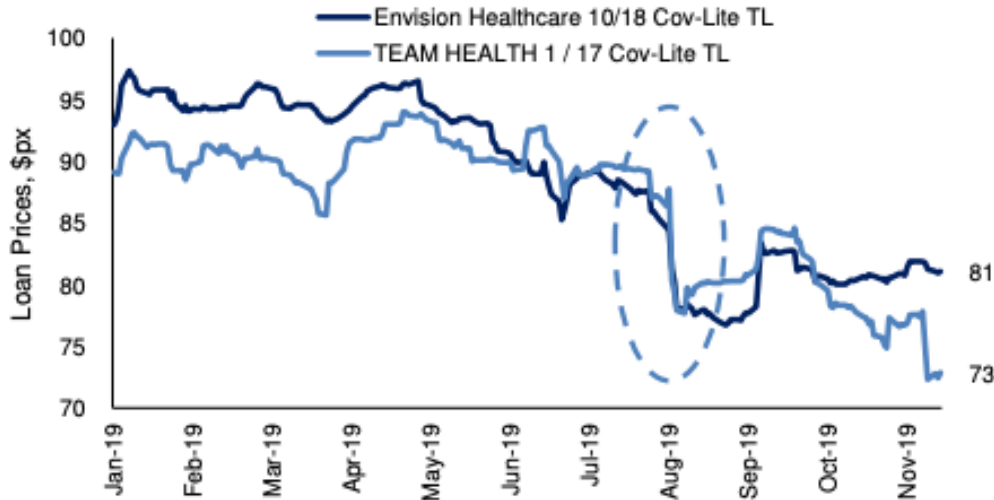
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<sup>191</sup> Alex Ruoff. 2019. "Mystery Group Puts \$1.3 million in Ads on Surprise Health Bills (2), *Bloomberg Government*. August 26. <https://about.bgov.com/news/mystery-group-puts-13-million-into-ads-on-surprise-health-bills/>; Susannah Luthi. 2019c. "Surprise Medical Billing Legislation Threatened by Provider Lobbying," *Modern Healthcare*. August 26. <https://www.modernhealthcare.com/government/surprise-medical-billing-legislation-threatened-provider-lobbying>; Margot Sanger-Katz, Julie Creswell and Reed Abelson, "Mystery Solved: Private-Equity-Backed Firms are behind Ad Blitz on 'Surprise Billing,'" *New York Times*. September 13. <https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html>

<sup>192</sup> Samantha Liss. 2019. "Congress Probes Private Equity Firms Financing Surprise Billing Fight," *Healthcare Deep Dive*. September 17. <https://www.healthcaredive.com/news/congress-probes-private-equity-firms-financing-surprise-billing-fight/563014/>

**Figure 5.1**  
**Price Declines of Envision and TeamHealth Facilities: January-November, 2019**

Figure 121: Price declines of Envision and Team Health facilities



Source: Markit

Source: Deutsche Bank CLO Research and Markit

The slide in the value of Envision’s debt continued even after the arbitration provision was added to the House No Surprises Act. By the end of August, Envision’s debt was trading at 77.3 cents on the dollar. It has since recovered somewhat to about 81 cents on the dollar. TeamHealth, which relies on higher negotiated insurance payments to its in-network doctors, initially experienced a much smaller decline in the price of its \$2.7 billion loan due in 2024. But it also saw its debt decline and, by November, it was trading at 73 cents on the dollar, well below 80 cents on the dollar threshold and deep in distressed debt territory (see figure below). Private-equity owned air ambulance companies Air Methods and Air Medical also saw the price of their loans fall.<sup>193</sup>

<sup>193</sup> Joe RENNISON and Hannah Kuchler. 2019. “US Healthcare Provider Loans Tumble as Politicians Target Patient Billing,” *Financial Times*. July 29. [https://www.ft.com/content/c2c1d7de-ace4-11e9-8030-530adfa879c2?accessToken=zwAAAWxKRHxQkdPCwdferuQR6dOAMFMK36h5wg.MEQCIGDWarB-MEw9e8yOwtBDEQUM4A\\_Hr7S\\_QAz3CeY6yA6IAiBUF1n-48RBLve7HNx28ZEeZuEARS5FmamD2O7x3dcmUg&sharetype=gif?token=80a384b9-7d9b-4023-a08e-ecbdc70d8b3e](https://www.ft.com/content/c2c1d7de-ace4-11e9-8030-530adfa879c2?accessToken=zwAAAWxKRHxQkdPCwdferuQR6dOAMFMK36h5wg.MEQCIGDWarB-MEw9e8yOwtBDEQUM4A_Hr7S_QAz3CeY6yA6IAiBUF1n-48RBLve7HNx28ZEeZuEARS5FmamD2O7x3dcmUg&sharetype=gif?token=80a384b9-7d9b-4023-a08e-ecbdc70d8b3e); Joe RENNISON. 2019. “Prices Tumble for Debt Backing KKR’s \$9.9 billion Envision buyout,” *Financial Times*. August 29. <https://www.ft.com/content/286210f4-c911-11e9-a1f4-3669401ba76f>

The legislative fight over how to limit surprise medical bills is far from over. Agreement on a bipartisan bill by Senator Lamar Alexander and Congressman Frank Pallone in December nearly made it into the omnibus continuing resolution that averted a shut down. It was stymied when Massachusetts Congressman Richard Neal, Chair of the House Ways and Means Committee, offered a last-minute alternative to the Pallone and Walden bill in the House. The Neal bill protects consumers from surprise medical bills but requires disputes between providers and insurance companies to be resolved through arbitration. This, of course, is what the PE-owned staffing firms and the doctors' practices they own lobbied for. The failure of the Democratic leadership in the Senate to support the Alexander-Murray bill and of Nancy Pelosi and the House Democratic leadership to step in with a decision to support the Alexander-Pallone bill meant a delay in legislation to rein in surprise medical bills until the next session of Congress when the Pallone and Neal bills could be reconciled. In his September 2019 fund raising report, Neal reported receipt of \$29,000 from Blackstone, owner of TeamHealth.<sup>194</sup>

In the winter 2020 legislative session, Congress again began work to pass legislation to protect patients from surprise medical bills. But the disputes that emerged in the previous session of Congress remained unresolved. On February 7, two House committees – Energy and Commerce, chaired by Frank Pallone and Ways and Means, chaired by Richard Neal – released their proposals to rein in surprise billing. The Senate Education and Labor Committee, chaired by Lamar Alexander, also released its proposal that day. The Ways and Means Committee's proposal calls for arbitration when insurers and out-of-network providers fail to agree on a payment for a procedure. This approach protects the profits of the physician staffing firms and raises health care costs and premiums for everyone. The Energy and Commerce Committee proposal blends a benchmark rate and arbitration. It allows arbitration in some limited circumstances when providers and insurers can't agree, and requires the arbitrator to start from a benchmark rate and not the payment requested by the provider. The Education and Labor Committee's proposal also blends a benchmark rate and arbitration, but it has more generous arbitration provisions than the Energy and Commerce Committee proposal. However, it falls far

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<sup>194</sup> Richard E. Neal Top Contributors 2019-2020. September 30, 2019.

<https://www.opensecrets.org/members-of-congress/summary?cid=N00000153>; Margot Sanger-Katz. 2019. "Ban on Surprise Medical Bills May Pass After All," *New York Times*. December 6. <https://www.nytimes.com/2019/12/08/upshot/deal-surprise-medical-bills.html>; Rachel Cohrs. 2019. "House Committee Springs New Surprise Billing Proposal, Calls for Delay," *Modern Healthcare*. December 11. <https://www.nytimes.com/2019/12/08/upshot/deal-surprise-medical-bills.html>; [Current version of Richard Neal's surprise billing proposal can be found at https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/SURPRIS\\_EBILL-WM\\_07\\_xml.pdf](https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/SURPRIS_EBILL-WM_07_xml.pdf); Rachel Cohrs. 2020. "House Committee Advances Provider-Friendly Surprise Billing Fix," *Modern Healthcare*, February 12. [https://www.modernhealthcare.com/politics-policy/house-committee-advances-provider-friendly-surprise-billing-fix?utm\\_source=modern-healthcare-am-thursday&utm\\_medium=email&utm\\_campaign=20200212&utm\\_content=article2-readmore](https://www.modernhealthcare.com/politics-policy/house-committee-advances-provider-friendly-surprise-billing-fix?utm_source=modern-healthcare-am-thursday&utm_medium=email&utm_campaign=20200212&utm_content=article2-readmore)

short of the Ways and Means Committee’s proposal in this respect. Chances of a compromise bill emerging in the 2020 winter session of Congress did not look good as of this writing (mid-February 2020), and relief for insured patients from unexpected medical bills did not appear to be on the horizon.<sup>195</sup>

A successful effort to benchmark payments to out-of-network doctors is an existential threat to private-equity owned physician staffing firms that depend on exorbitant fees charged to patients in order to repay their debts and to yield high returns for the PE firm’s limited partner investors. It did not pass in the current Congress, but will be addressed again in the next.

### **Collecting Medical Debt: Private Equity and Revenue Cycle Management**

Revenue cycle management – aka bill collecting – has also become a lucrative niche for private equity firms. Private equity firms have bought up small revenue cycle management companies and rolled them up into large national enterprises. The timing is impeccable. At a time when private equity owned firms are driving up the costs of medical care via surprise medical billing, they are simultaneously hounding patients to pay their bills even as they often face insurmountable medical debt.

Hospital demand for outsourced bill collecting has increased in recent years due in part to increased deductibles in health insurance plans, which shift more costs to patients. Families, already living paycheck to paycheck, fall behind in medical bills, and medical debt is a major contributor to almost 60 percent of personal bankruptcies. As a result, hospital uncompensated care and unreimbursed care has grown at about 3 percent annually since 2015. Hospital demand has skyrocketed for outsourced RCM providers with more efficient and updated IT systems and automated billing systems.

Enter private equity. The rapid and expected ongoing growth in demand for outsourced bill collectors makes the RCM sub-segment very attractive to private equity. It also dovetails with private equity’s existing (and growing) investments in health IT, as extending IT innovations to the RCM segment is relatively straightforward. Private equity’s involvement in bill collecting, however, has earlier roots dating to the 2000s, when two private equity owned hospital systems took the lead: Parallon, a subsidiary at HCA, and Conifer Health Solutions at Tenet Healthcare. More recently, PE firms have used the buy and build strategy to acquire a series of small RCM companies and roll them into national chains providing ‘one-stop shopping’ for a range of RCM

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<sup>195</sup> Rachel Cohrs. 2020. “House Committee Advances Provider-Friendly Surprise Billing Fix,” *Modern Healthcare*. February 12. [https://www.modernhealthcare.com/politics-policy/house-committee-advances-provider-friendly-surprise-billing-fix?utm\\_source=modern-healthcare-am-thursday&utm\\_medium=email&utm\\_campaign=20200212&utm\\_content=article2-readmore](https://www.modernhealthcare.com/politics-policy/house-committee-advances-provider-friendly-surprise-billing-fix?utm_source=modern-healthcare-am-thursday&utm_medium=email&utm_campaign=20200212&utm_content=article2-readmore)

activities. PE firms currently active in this segment include Blackstone, The Gores Group, Thomas H. Partners, Vista Equity, Waud Capital Partners, and Warburg Pincus, among others.

### How Did We Get Here?

The Affordable Care Act enabled millions of people without employer-sponsored health insurance to gain health insurance coverage via federal and state-run exchanges. However, the most popular options selected by individuals and families are low cost, high-deductible plans with significant copays that require patients to pay part of their medical costs.<sup>196</sup> Workers with employer-sponsored health insurance also face significant out-of-pocket costs. The 2008-2009 financial crisis pushed more employers to offer high deductible plans in order to save on health costs. In the decade since, the rising cost of health care and increases in commercial health insurance premiums have led employers to shift more of the burden of health care costs onto employees via insurance plans with high deductibles and copays.

As a result, the share of privately insured people under 65 enrolled in high deductible plans rose from 25.3 percent to 43.7 percent between 2010 and 2017.<sup>197</sup> While these plans have lower premiums, individuals in high deductible plans typically pay the first \$1,300 or more of the covered services.<sup>198</sup> The average deductible for a worker with single coverage is \$1,655 in 2019, a number that has tripled over the past decade.<sup>199</sup> For many families, these out-of-pocket medical expenses are simply unaffordable, and medical debt remains an important contributor to personal bankruptcies. A study of bankruptcy filers from 2013 to 2016 found that 58.5 percent of the debtors cited a medical expense as a contributor to their bankruptcy. This is almost the same as the 57.1 percent of debtors in 2007 who reported that a medical expense contributed to their bankruptcy – an indication that the ACA did not reduce the burden of medical debt despite greatly reducing the number of people without health insurance.<sup>200</sup>

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<sup>196</sup> John Tozzi and Zachary Tracer. 2018. "Sky-High Deductibles Broke the U.S. Health Insurance System," *Bloomberg*. June 26. <https://www.bloomberg.com/news/features/2018-06-26/sky-high-deductibles-broke-the-u-s-health-insurance-system>

<sup>197</sup> Robin A. Cohen, Emily P. Zammitti, and Michael E. Martinez. 2018. "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2017," *National Center for Health Statistics*. May. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf>

<sup>198</sup> Ibid.

<sup>199</sup> Alex Kacik. 2019b. "Hospitals' Uncompensated Care Continues to Rise," *Modern Healthcare*. November 21. [https://www.modernhealthcare.com/operations/hospitals-uncompensated-care-continues-rise?utm\\_source=modern-healthcare-am-friday&utm\\_medium=email&utm\\_campaign=20191121&utm\\_content=article6-headline](https://www.modernhealthcare.com/operations/hospitals-uncompensated-care-continues-rise?utm_source=modern-healthcare-am-friday&utm_medium=email&utm_campaign=20191121&utm_content=article6-headline)

<sup>200</sup> David U. Himmelstein, Robert M. Lawless, Deborah Thorne, Pamela Foohey and Steffie Woolhandler. 2019. "Medical Bankruptcy: Still Common Despite the Affordable Care Act," *American Journal of Public Health*. March.

While an increasing share of patients face unaffordable deductibles, healthcare providers and hospitals are increasingly reliant on patient payments to cover charges for care. Patient payments are a growing share of health system revenue, with patient balances after insurance rising from 8 percent to 12.2 percent of the total bill from 2012 to 2017. Patient balances jumped in the same period from an average of \$467 to \$781 for commercially insured patients, and from \$144 to \$314 for Medicare beneficiaries.<sup>201</sup>

Some patients owe thousands of dollars following a hospital stay. Hospital's uncompensated care and unreimbursed costs have risen since 2015, and they are currently growing at 3 percent annually,<sup>202</sup> indicating hospitals are taking on more costs as patients struggle to pay. The shifting of health care costs to patients and the increasing reliance of hospitals on payments by patients for revenue has led health providers to seek out new strategies for securing these payments. Outsourcing revenue cycle management is an increasingly popular strategy to decrease providers' bad debt and maximize their revenue.

Revenue cycle management (RCM) companies argue that revenue cycle outsourcing has wide-reaching advantages for hospitals, as they are able to offer services and software that addresses the requirements of newer payment models as well as new regulations in the wake of the Affordable Care Act. RCM companies claim to offer expertise and access to competitive technologies that health providers may not have the capital or training to implement on their own.<sup>203</sup> The RCM systems hospitals used around the time of the ACA implementation were reported to be nearly a decade old, and in need of updating to support new payment models.<sup>204</sup> The newer systems that RCM companies make available may enhance cash flow.<sup>205</sup> They may also enable providers to use RCM data for predictive analysis of demand for their services as well as to supply price estimates to patients prior to care. Advance notice of the cost of care can reduce a provider's bad debt by improving patients' knowledge and ability to pay. However, a

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<sup>201</sup> Alex Kacik. 2018. "Growing Bad-Debt Problem Illustrates Broken Billing System," *Modern Healthcare*. June 27. <https://www.modernhealthcare.com/article/20180627/NEWS/180629916/growing-bad-debt-problem-illustrates-broken-billing-system>

<sup>202</sup> Alex Kacik. 2019a. Op. cit. at endnote 230

<sup>203</sup> Megan Caurso. 2019. "More providers outsourcing all of their revenue cycle," *Modern Healthcare*. September 14. <https://www.modernhealthcare.com/revenue-cycle/more-providers-outsourcing-all-their-revenue-cycle>

<sup>204</sup> Scott Becker et al. 2014. "The Top Areas in Healthcare for Private Equity Investment in 2014," *McGuireWoods*. February. <https://www.mcguirewoods.com/client-resources/Alerts/2014/2/Top-Areas-Healthcare-Private-Equity-Investment-2014>

<sup>205</sup> Srinivas Kadepalli. 2019. "Should You Outsource Your Revenue Cycle Management?" *Invensis*. October 18. <https://www.invensis.net/blog/healthcare/rm-outsourcing/>

lot of infrastructure is needed to collect the necessary data for these functions<sup>206</sup> and outsourcing RCM services may be cost effective for providers.

### **Private Equity Opportunities in Revenue Cycle Management** <sup>207</sup>

Many aspects of revenue cycle management make it appealing to private equity firms, particularly the rapid growth in hospital demand, which jumped 86 percent between 2015 and 2018. The percent of hospitals implementing full RCM outsourcing projects grew from 11 to 18 percent between 2015 and 2018.<sup>208</sup> The global RCM outsourcing market is expected to increase from \$11.7 billion to \$23 billion between 2017 and 2023.<sup>209</sup>

RCM is also a technology-driven approach to managing bill collection – one that represents an extension of IT capabilities that many PE owned companies already have or want to pursue.<sup>210</sup> Moreover, the healthcare IT sub-segment is attractive because it is less directly affected by regulatory and reimbursement risks compared to other sub-segments.<sup>211</sup> Private equity firms have found extensive opportunities for mergers and acquisitions in the RCM market dominated by hundreds of small companies; and an important strategy is to expand the number of RCM capabilities offered on a single platform.<sup>212</sup>

### **Early Private Equity Movers in RCM**

Early on, for-profit health care systems – especially HCA and Tenet -- developed revenue cycle management subsidiaries: Parallon at HCA and Conifer Health Solutions at Tenet Healthcare

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<sup>206</sup> Alex Kacik. 2018. Op. cit. at endnote 232

<sup>207</sup> We thank Andrea Beaty for exceptional contributions to the research and writing of this section.

<sup>208</sup> Jacqueline LaPointe. 2018a. "80% of Hospitals Vetting Full Revenue Cycle Management Outsourcing," *Revcycle Intelligence*. May 14. <https://revcycleintelligence.com/news/80-of-hospitals-vetting-full-revenue-cycle-management-outsourcing>

<sup>209</sup> The Market Reports. 2018. "Global Healthcare RCM Outsourcing Market by Manufacturers, Countries, Type and Application, Forecast to 2023." July. <https://www.themarketreports.com/report/global-healthcare-rcm-outsourcing-market-by-manufacturers-countries-type-and-application-forecast-to-2023>

<sup>210</sup> Loyale Healthcare. 2019. "Private Equity Investments and the Drive for Innovation in Healthcare." September 5. <https://markets.businessinsider.com/news/stocks/private-equity-investments-and-the-drive-for-innovation-in-healthcare-industry-analysis-by-loyale-healthcare-1028500970>

<sup>211</sup> Kara Murphy and Nirad Jain. 2018. "Global Healthcare Private Equity and Corporate M&A Report 2018," *Bain & Company*. April 18. <https://www.bain.com/insights/global-healthcare-private-equity-and-corporate-ma-report-2018/>

<sup>212</sup> Crowe. 2018. "Considering Revenue Cycle Outsourcing? Look (Here) Before You Leap." August. <https://www.crowe.com/-/media/Crowe/LLP/folio-pdf-hidden/Benchmarking-Report-Q2-HC-19006-012A.ashx?la=en-US&hash=01900EF19DAD890CF6B3A0543EDC71FCA038EA60>

Corp.<sup>213</sup> Until March, 2011, HCA was owned by a consortium of private equity firms led by Bain Capital, and thereafter, the three primary PE firms continued to own 25 percent each in HCA and were substantially involved in its strategic decisions. Both Parallon and Conifer have continued to be the leading players in the RCM sub-segment. By 2015, Conifer operated in 40 states serving roughly 800 hospitals, physician practices, and other health care customers. Parallon is the largest RCM company, with 16,500 full time employees and 3,926 contracts. Not-for-profit health care systems contract with these and other RCM companies to collect unpaid hospital bills. Catholic Health Initiatives, for example, contracted for RCM services with Conifer Health Solutions, in which it also invested, holding a minority percent stake in 2015.<sup>214</sup>

Other major PE firms have established RCM platforms to acquire additional RCM companies as add-ons.<sup>215</sup> This includes Blackstone Group's Emdeon Inc., The Gores Group's Meridian Medical Management, Thomas H. Lee Partners' Intermedix Corporation, Vista Equity Partners' Greenway Medical Technologies, Inc. and Waud Capital Partners' Adreima Inc. Thoma Bravo took a majority stake in MedeAnalytics, a provider of cloud-based revenue cycle and clinical analytics to establish its platform in this space.<sup>216</sup>

Table 6.1 identifies the leading private equity firms that have established platform RCM companies and the growth of those platform companies via add-ons in the period up to and through 2015. Table 6.2 lists the major RCM companies owned by private equity.

Private equity firms were responsible for seven of the 22 deals – one-third -- of RCM companies in 2015 and 2016. This included Warburg Pincus's acquisition of DocuTAP, Inc., a company

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<sup>213</sup> Beth Kutscher. 2015c. "Hospitals Turn to Friendlier Tools to Collect Unpaid Bills," *Modern Healthcare*. May 16.  
<https://www.modernhealthcare.com/article/20150516/MAGAZINE/305169974/hospitals-turn-to-friendlier-tools-to-collect-unpaid-bills>

<sup>214</sup> Melanie Evans. 2016. "Behind Pamplona's Bid to Build a Revenue Cycle Giant," *Modern Healthcare*. Jan. 23.  
[http://www.modernhealthcare.com/article/20160123/MAGAZINE/301239981?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=20160123-MAGAZINE-301239981&utm\\_campaign=am](http://www.modernhealthcare.com/article/20160123/MAGAZINE/301239981?utm_source=modernhealthcare&utm_medium=email&utm_content=20160123-MAGAZINE-301239981&utm_campaign=am)

<sup>215</sup> BDO Capital Advisors. 2015. "BDO Capital Healthcare Newsletter: Q1 2015 Healthcare RCM M&A Review and Outlook." Q1. <http://bdocap.com/publications/BDOCapitalNewsletter-HealthcareRCM-Q12015.pdf>

<sup>216</sup> Nirad Jain, Vikram Kapur, Franz-Robert Klingan, Kara Murphy, Tim Van Biesen and Joshua Weisbrod. 2016. "Global Healthcare and Private Equity and Corporate M&A Report 2016", *Bain*. April 20. [http://www.bain.com/publications/articles/global-healthcare-private-equity-and-corporate-ma-report-2016.aspx?utm\\_source=healthcare-april-2016&utm\\_medium=Newsletter&utm\\_campaign=global-healthcare-private-equity-and-corporate-ma-report-2016](http://www.bain.com/publications/articles/global-healthcare-private-equity-and-corporate-ma-report-2016.aspx?utm_source=healthcare-april-2016&utm_medium=Newsletter&utm_campaign=global-healthcare-private-equity-and-corporate-ma-report-2016)



**Table 6.1:  
Select Active Healthcare RCM Financial Sponsors**

<b>Financial Sponsor</b>	<b>Inv. Date</b>	<b>Platform Investment(s)</b>	<b>Select Corporate Acquisitions</b>
Audax Group, Inc.	Dec-08	United Recovery Systems	<ul style="list-style-type: none"> <li>• Array Services Group, Inc. (Apr-14)</li> <li>• Financial Health Strategies, Inc. (Jan-14)</li> <li>• Enterprise Recovery Systems, Inc. (Mar-12)</li> <li>• Aid Associates, Inc. (Nov-11)</li> </ul>
Bolder Capital, LLC	Sep-12	Bolder Healthcare Solutions LLC	<ul style="list-style-type: none"> <li>• PPM Information Solutions, Inc. (Nov-14)</li> <li>• MedFin Billing Services, Inc. (Apr-14)</li> </ul>
Praesidian Capital	Jan-13	Etransmedia Technology, Inc	<ul style="list-style-type: none"> <li>• DoctorsXL, LLC (Jan-15)</li> <li>• Medigistics, Inc. (Jan-14)</li> </ul>
Serent Capital	Jun-11	Cardon Outreach	<ul style="list-style-type: none"> <li>• VIA Health, LLC (Jan-14)</li> <li>• Outreach Services Inc. (Jan-12)</li> </ul>
The Blackstone Group L.P.	Aug-11	Emdeon Inc.	<ul style="list-style-type: none"> <li>• AdminSource Communications, Inc. (Dec-14)</li> <li>• Change Healthcare Corporation (Nov-14)</li> <li>• Capario, Inc. (Jun-14)</li> <li>• Goold Health Systems, Inc. (Jun 13)</li> <li>• TC3 Health, Inc. (May-12)</li> </ul>
The Gores Group	Mar-13	Meridian Medical Management	<ul style="list-style-type: none"> <li>• Origin Healthcare Solutions LLC (Dec-14)</li> </ul>
Thomas H. Lee Partners, L.P.	Jul-10	Intermedix Corp.	<ul style="list-style-type: none"> <li>• T-System, Inc., Medical Billing Business (Jun-14)</li> <li>• Anesthesia Revenue Management Inc. (Dec-12)</li> <li>• Practice Support Resources, LLC (Dec-12)</li> <li>• Comprehensive Medical Billing Solutions, Inc. (Aug-11)</li> </ul>
Thompson Street Capital Partners	Jan-15, Jul-12	Infinity Behavioral Health Services, Inc.; Receivables Management Partners, LLC	<ul style="list-style-type: none"> <li>• Seeking add-on acquisitions</li> </ul>
Vista Equity Partners	Sep-13	Greenway Medical Technologies, Inc.	<ul style="list-style-type: none"> <li>• PeopleLYNK (Feb-14)</li> </ul>
Waud Capital Partners, LLC	Sep-08	Adreima, Inc	<ul style="list-style-type: none"> <li>• HealthCPA, LLC (Jan-15)</li> <li>• M. Leco &amp; Associates, Inc. (Mar-14)</li> <li>• Optimum Outcomes, Inc. (Aug-13)</li> <li>• National Healthcare Review, Inc. (Jan-13)</li> <li>• Accounts Receivables Management and Data Services (Jan-12)</li> </ul>

Source: S&P Capital IQ

Source: BDO Capital Advisors 2015<sup>217</sup>

<sup>217</sup> : BDO Capital Advisors 2015 <http://bdocap.com/publications/BDOCapitalNewsletter-HealthcareRCM-Q12015.pdf>

**Table 6.2:  
Major Private Equity-Owned Companies Offering RCM Outsourcing Services**

Company	PE Firm	Year acquired	Mergers/ Acquisitions
Availity	Francisco Partners, Pettybrook Partners	Oct. 2017	Fore Support Services: Apr 2017
Change / Emdeon	The Blackstone Group	Nov. 2011	Altegra Health: Aug 2015; McKesson: Mar 2017; Docufill: Nov 2017; PokitDok: Dec 2018; Connect America: Sept 2019
Navigant	Veritas Capital	Oct. 2019	
nThrive / Precyse	Pamplona	June 2015	MedAssets: Jan 2016; Equation: Jun 2016; Adreima: Dec 2016; e4e: Mar 2017
RI RCM	Towerbrook	Feb. 2016	Intermedix, Feb 2018
Xtend / Navient	WestView	Apr. 2014	Elipse: Aug 2017
Virence Health	Veritas Capital	July 2018	GE Healthcare: Jul 2018; athenahealth: Nov 2018
Waystar Health	Bain Capital; EQT	July 2016 Sep. 2019	ZirMed: Nov 2017
Epic Systems	Martis Capital	Jan. 2014	
MedHost	LMS, Primus	Sep. 2007	MedHost(Texas): Feb 2010
Revint Solutions	Eir Partners; New Mountain Capital	Oct. 2017 Dec. 2017	VHC: Oct 2017; Health Check: Nov 2017; IMA Consulting: Dec 2017; Naveos: Feb 2018; CloudMed Solutions: Jun 2018; AcuStream: Jun 2018; Payment Partners: Apr 2019; Washington & West: Sept 2019
AdvantEdge	Founders Equity; ORIX; Headway	Nov 2006 Mar 2013 July 2018	Frank Hill Associates: Mar 2013; Professional Management: Apr 2018

Source: PitchBook<sup>218</sup>, Crunchbase<sup>219</sup> & *Health Care M&A News*, November 2019<sup>220</sup>

<sup>218</sup> See: PitchBook. 2019. Availity Profile dated December 16, 2019, Change Healthcare Profile dated December 16, 2019, Navigant Profile dated December 16, 2019, nThrive Profile dated December 16, 2019, Xtend Profile dated December 16, 2019, GE Healthcare (Virence) Profile dated December 16, 2019, Waystar Profile dated December 16, 2019, Epic Systems Profile dated December 16, 2019, MedHost Profile dated December 16, 2019, Revint Solutions Profile dated December 16, 2019, and AdvantEdge Profile dated December 16, 2019.

<sup>219</sup> Crunchbase. 2019. “Eir Partners” <https://www.crunchbase.com/organization/eir-partners#section-overview> and Crunchbase. 2019 “Pamplona Capital Management.” [https://www.crunchbase.com/organization/pamplona-capital-management/acquisitions/acquisitions\\_list#section-acquisitions](https://www.crunchbase.com/organization/pamplona-capital-management/acquisitions/acquisitions_list#section-acquisitions)

<sup>220</sup> Irving Levin Associates. 2019. “Health Care M&A News”. November, p. 10.

that provides both RCM and electronic medical record services to more than 1,300 urgent and primary care clinics across the US.<sup>221</sup> In addition, some private equity firms invested in companies that provide the technology to manage billing and collections. In March of 2016, for example, private equity firm Riverside Partners made a major investment in Bottom Line Systems, a provider of revenue cycle management technology.<sup>222</sup>

Private equity firm Pamplona Capital Management became a national powerhouse in the RCM market through its strategic acquisitions of companies. But its aggressive use of leveraged debt to fund these purchases weakened its RCM company (now rebranded as nThrive) and led Moody's to downgrade nThrive's rating from stable to negative in late 2018 and downgrade its rating again a year later. Pamplona Capital purchased MedAssets for \$2.7 billion in 2016. Pamplona combined MedAssets RCM business with Precyse, its own RCM subsidiary to create the first large, free-standing PE-owned RCM company. At the time, Precyse had a staff of 1,400.<sup>223</sup> Acquiring MedAssets' RCM business, which was estimated to serve 2,700 health care providers and manage over \$450 billion in gross patient revenue, greatly expanded Pamplona's market presence and power.<sup>224</sup> Pamplona had begun its self-proclaimed efforts to create a national RCM powerhouse.<sup>225</sup>

Precyse was a firm with expertise in "documenting medical treatment for insurers" while MedAssets focused on bill collection from patients.<sup>226</sup> Pamplona executives claimed hospital executives were experiencing "fatigue" from their multiple contracts with smaller RCM shops that each provided a "slice of what's needed." They observed that hospitals were experiencing trouble filling vacancies in billing and collection departments. Pamplona saw the opportunity to create a 'one stop shop' for outsourced RCM services.<sup>227</sup> In addition, Pamplona had the

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<sup>221</sup> Lisa Phillips. 2016. "PE Firms Target Revenue Cycle Management," *Levin & Associates*. May 5. [http://healthcare.levinassociates.com/2016/05/pe-firms-target-revenue-cycle-management/?utm\\_source=magnetmail&utm\\_medium=email](http://healthcare.levinassociates.com/2016/05/pe-firms-target-revenue-cycle-management/?utm_source=magnetmail&utm_medium=email)

<sup>222</sup> Stephanie Rogan. 2016. "Riverside Makes Major Investment in Bottom Line Systems," *PEHub*. March 17. <https://www.pehub.com/2016/03/riverside-makes-majority-investment-in-bottom-line-systems/>

<sup>223</sup> Vizient. 2014. "MedAssets to be Acquired by Pamplona Capital Management for \$2.7 Billion." November 2. <https://newsroom.vizientinc.com/press-release/legacy/medassets-be-acquired-pamplona-capital-management-27-billion>

<sup>224</sup> Adam Rubenfire. 2016. "MedAssets-Precyse gets new name: nThrive," *Modern Healthcare*. June 27. <https://www.modernhealthcare.com/article/20160627/NEWS/160629938/medassets-precyse-gets-new-name-nthrive>

<sup>225</sup> Melanie Evans. 2016.

<sup>226</sup> Ibid.

<sup>227</sup> Ibid.

advantage that, unlike Parallon and Conifer and similar RCM companies that were housed within medical systems, Pamplona's RCM company provided an independent alternative so hospital systems would not need to contract for RCM services from their competitors.

Pamplona first turned to integrating MedAssets and Precyse operations, a difficult and expensive process for the complex technological details involved in their services. The combined company took the MedAssets name. Thereafter, Pamplona quickly expanded by acquiring additional companies. It also began to make equity investments in other successful RCM companies so as to "accelerate growth without disrupting corporate culture".<sup>228</sup>

In January 2016, MedAssets invested in Patientco Holdings, which "develops technology to collect money owed by patients."<sup>229</sup> In June 2016, MedAssets acquired Equation, a "clinical healthcare analytics" company, and a month later, rebranded its RCM company as nThrive.<sup>230</sup> In November 2016, nThrive acquired Adreima, which was focused on RCM services to help patients "find coverage and meet their financial obligations".<sup>231</sup> At the time, Adreima provided service to 450 hospitals.<sup>232</sup> In October 2018, nThrive proposed a merger with Athenahealth, but it failed.<sup>233</sup> Pamplona also planned to invest in information technology over a 10-year period, a timeline longer than that of the typical PE portfolio company. The longer timeline is intended to give Pamplona more time to acquire new clients and to attract hospital executives that may be waiting for a clear leader to emerge before contracting for RCM services.<sup>234</sup> The risk to providers from investing in the wrong RCM company is high, as implementation of RCM services in hospitals is disruptive and can upend business practices, making switching RCM providers difficult and expensive.

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<sup>228</sup> Ibid.

<sup>229</sup> Ibid.

<sup>230</sup> Iris Dorbian. 2016. "Pamplona-backed MedAssets-Precyse acquires Equation," *PEHub*. June 1. <https://www.pehub.com/2016/06/pamplona-backed-medassets-precyse-acquires-equation/>

<sup>231</sup> nThrive. 2016. "nThrive™ Signs Agreement to Acquire Independent Revenue Cycle Services Organization." November 17. <https://www.prnewswire.com/news-releases/nthrive-signs-agreement-to-acquire-independent-revenue-cycle-services-organization-300365048.html>

<sup>232</sup> Triple Tree. 2016. "Adreima Has Been Acquired By nThrive," December. <https://www.triple-tree.com/investment-banking/transactions/adreima-has-been-acquired-by-nthrive/>

<sup>233</sup> Heather Landi. 2019. "Veritas Capital closes acquisition of Athenahealth, says combined company will have 'transformational impact'," *FierceHealthcare*, February 11. <https://www.fiercehealthcare.com/tech/veritas-capital-closes-acquisition-athenahealth-says-combined-company-will-have>

<sup>234</sup> Melanie Evans. 2016. Op. cit. at endnote 257.

Despite nThrive's aggressive consolidation of major RCM companies and its strong market position as a provider of RCM software and outsourced RCM services, the company faces serious financial challenges as a result of its high use of leverage. In November 2018, Moody's changed nThrive's financial rating to negative from stable, citing its very high leverage and weak cash flow. As Moody's noted: "Leverage as of September 2018 was approximately 8.5X EBITDA excluding restructuring charges and pro forma for cost initiatives (but well over 10X before those adjustments) and free cash flow was negative for the last twelve months." Moody's expected nThrive to have steady revenue growth and pointed out that the ratings could be upgraded if the company generated high single digit organic revenue growth and debt settled at 6X EBITDA.

In reviewing the company's financial performance a year later, in November 2019, Moody's further downgraded its ratings. The downgrade, according to Moody's, reflects the continuing difficulty nThrive experienced in reducing leverage and generating free cash flow in the face of declining revenue and financial strategies that involved further use of leverage. Contradicting the RCM sector's positive public pronouncements, Moody's attributed the negative free cash flow and declining revenue to "softness in in back-office services with large clients opting to insource more of their collections and claims processes." In September 2019, Moody's estimated nThrive's adjusted leverage at 10.3X EBITDA excluding restructuring charges and pro forma for cost initiatives.<sup>235</sup>

According to Irvin Levin Associates, RCM companies are a popular investment target. Waystar, which was formed by Bain in 2017 through the merger of two leading RCM companies – Navicare and ZirMed – was purchased in July 2019 by PE firm EQT and the Canada Pension Plan Investment Board for \$2.7 billion. Waystar serves more than 450,000 providers, 750 health systems, and 5,000 insurance companies.<sup>236</sup>

Despite the efforts to create a dominant one-stop-shop RCM company, the current market remains relatively fragmented. In *Modern Healthcare's* self-reported study of the 20 leading RCM companies, nThrive was ranked second with 3,048 full time employees and 1,565 total

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<sup>235</sup> Moody's Investors Service. 2018. "Rating Action: Moody's Changes nThrive's Outlook to Negative, Affirms B3 Rating." November 29. [https://www.moodys.com/research/Moodys-changes-nThrives-outlook-to-negative-affirms-B3-rating--PR\\_392333](https://www.moodys.com/research/Moodys-changes-nThrives-outlook-to-negative-affirms-B3-rating--PR_392333); Moody's Investors Service. 2018. "Rating Action: Moody's Downgrades nThrive's Corporate Family Rating to Caa1, Outlook is Negative." November 25. [https://www.moodys.com/research/Moodys-downgrades-nThrives-corporate-family-rating-to-Caa1-outlook-is--PR\\_413876](https://www.moodys.com/research/Moodys-downgrades-nThrives-corporate-family-rating-to-Caa1-outlook-is--PR_413876)

<sup>236</sup> Irving Levin Associates. 2019. "Health Care M&A News". November, p. 10.

contracts.<sup>237</sup> They are second to Parallon, which boasts 16,500 full time employees and 3,926 contracts. This compares with just 100 to 1,500 contracts for the 18 other companies on the list. However, health providers continue to use more than one vendor for front, middle, and back-end RCM services.<sup>238</sup> In 2017, just 13 percent of providers used an end to end RCM service, and 60 percent chose vendors for each area separately.<sup>239</sup> However, 40 percent of providers responded that an end to end strategy is the most effective. A separate study in 2018 found that 69 percent of healthcare organizations used more than one vendor for RCM.<sup>240</sup> This suggests that while PE firms have not yet succeeded with the ‘one stop shop’ strategy, the demand for it is high – as hospitals and other providers find multiple vendors difficult to manage and would prefer to work with fewer vendors.<sup>241</sup>

### **Provider Experiences with RCM Companies**

The research evidence to date suggests that hospitals are dissatisfied with their experience with RCM companies. The studies of objective financial outcomes are somewhat more mixed. The most recent research shows only modest differences in collection rates between outsourced and in-house RCM functions, but much longer collection cycle times. These studies do not include data on the relative costs of keeping RCM in-house versus outsourcing it.

The private equity business model – high use of debt to acquire companies and high returns for PE investors in a relatively short period of time – puts pressure on providers to increase payments for RCM services, and this may result in higher costs for patients. It also may lead PE-owned RCM companies to invest less in the quality and safety of their products and services<sup>242</sup> -- or in the technology development that is a key aspect of RCM performance. This could negatively affect innovation in the sector. Health providers are also concerned that if private

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<sup>237</sup> *Modern Healthcare*. 2019. "Largest Revenue-Cycle Management Firms, 2019." September 14. <https://www.modernhealthcare.com/data-lists/40437/largest-revenue-cycle-management-firms-2019-pdf-excel-full-results>

<sup>238</sup> Cognizant. 2019. "Revenue Cycle Management: Market Dynamics & Opportunities in a Changing Healthcare Ecosystem". <https://www.cognizant.com/whitepapers/revenue-cycle-management-market-dynamics-and-opportunities-codex4462.pdf>

<sup>239</sup> Reaction Data. 2017. "Hottest Trends in Revenue Cycle Management". <https://www.reactiondata.com/report/revenue-cycle-management-trends/?download>

<sup>240</sup> Jacqueline LaPointe. 2018b. "69% of Hospitals Use Multiple Vendors for Revenue Cycle Management," *Revcycle Intelligence*. May 16. <https://revcycleintelligence.com/news/69-of-hospitals-use-multiple-vendors-for-revenue-cycle-management>

<sup>241</sup> Cognizant. 2019. Op. cit. at endnote 274.

<sup>242</sup> Alex Kacik. 2019c. "Private equity infuses healthcare with \$63B investment," *Modern Healthcare*. April 18. <https://www.modernhealthcare.com/finance/private-equity-infuses-healthcare-63b-investment>

equity succeeds in consolidating the currently fragmented market, the decreased competition would lead to higher prices. RCM outsourcing also introduces the potential for misaligned interests between the company and provider, and for the RCM company to misrepresent the hospital's brand.

RCM companies argue that outsourcing RCM improves patient care - claiming that when providers focus less on the revenue cycle, they can dedicate more attention and resources to patient care. They claim that patient satisfaction increases when RCM is outsourced because the RCM company is better able than the provider to administer accommodations patients want, such as a 24/7 customer service and other consumer-focused operations.<sup>243</sup>

A 2019 study of providers, however, finds the opposite -- high levels of provider dissatisfaction. One third of health providers stated that they would not purchase their vendor's RCM outsourcing services again.<sup>244</sup> Many of the top RCM companies, including those owned by private equity, are experiencing declines in satisfaction rates, with health providers calling various RCM companies "slow to work," and accusing them of utilizing a "cookie-cutter approach". Pamplona-owned nThrive saw a 13-point decrease in satisfaction from 2017 to 2019, with health providers complaining that the RCM company experiences "few consequences" if they underperform. Notably, Veritas-owned Navigant received a top score in the study, satisfying its core customer base of smaller providers with less than 500 beds.

Recent research provides mixed evidence that hospitals benefit financially from outsourcing the RCM function. A 2018 study, for example, found that compared to hospitals that outsourced RCM, those that kept the function in-house had only a slightly lower rate of patient payments at point-of-service: 16.45 percent compared to 19.68 percent.<sup>245</sup> Payment recovery rates after insurance collection were also only slightly lower -- 36.73 percent for in-house compared with 38.72 percent for outsourced RCM. However, the cycle for outsourced RCM took much longer than the insourced RCM cycle -- 109.4 days versus 76.3 days. In addition, hospitals with outsourced RCMs have higher initial denial rates and higher denial write-offs. The difference between outsourced RCM's 10 percent initial denial rate compared with 9.09 percent initial denial rate for insourced RCMs translates in \$22.7 million in lost revenue for the average 400-bed hospital for hospitals that outsource RCM. A higher initial denial rate means the hospital must fund additional efforts to secure those payments. This study does not include comparative

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<sup>243</sup> Michelle Schmidt. 2016. "The link between Patient Satisfaction and RCM Outsourcing," *The Midland Group*. February 8. <https://www.midlandgroup.com/blog/the-link-between-patient-satisfaction-and-rcm-outsourcing/>

<sup>244</sup> Jacqueline LaPointe. 2019b. "Third of Providers Regret Revenue Cycle Outsourcing Purchase," *Intelligence*. June 26. <https://revcycleintelligence.com/news/third-of-providers-regret-revenue-cycle-outsourcing-purchase>

<sup>245</sup> Crowe. 2018. Op. cit. at endnote 213.

data on how much it costs hospitals to run their own RCM department versus contracting out – the latter may be much higher.

### **Patient Experiences with RCM Companies**

Revenue cycle management companies, especially those owned by private equity firms, are often aggressive in their pursuit of patient payments for medical bills, as this statement by the managing counsel at Parallon Business Solutions, HCA’s revenue cycle management subsidiary, makes clear: “We find it makes no sense to dial someone 50 or 60 times,” she said, but added that the first 20 to 30 calls are “highly effective.”<sup>246</sup> Complaints to the Federal Communications Commission (FCC) about these aggressive tactics have increased: between 2010 and 2014, for example, the government reported a dramatic 560 percent increase in the number of lawsuits claiming violations of the Telephone Consumer Protection Act (TCPA) by RCM and other bill collections companies. This led state and federal regulators to increase their scrutiny of RCM companies, and in December 2014 the Consumer Financial Protection Board (CFPB) held a public hearing to address the “unnecessary and frustrating challenges” faced by people who have a medical bill.<sup>247</sup> Notably, RCMs report any problems they have in collecting payments from patients to credit reporting agencies; and the resulting bad marks on a person’s credit report may continue long after the overdue bills have been paid.

In August 2015, the FCC ruled that the decades-old Telephone Consumer Protection Act (TCPA) applies to calls by bill collectors to cell phones, and not just landlines. In its ruling, the FCC made clear that debt collectors must confirm express consent before autodialing a cellphone. They are allowed one wrong number call to a cell phone. Violations of the TCPA incur substantial financial penalties.<sup>248</sup>

The TCPA is not the only consumer protection law that RCM companies have been accused of violating. Las Vegas-based bill collection company CP Medical, owned by PE firm Capio Partners, is an especially egregious case. Capio Partners describes itself as a business that provides RCM services in health care and health care systems. CP Medical engages in both revenue cycle management and the collection of unpaid medical bills for treatment that occurred years earlier. A 2011 investigative journalism study found that Capio Partners had been sued 15 times in federal court for alleged aggressive collections practices by its portfolio companies that

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<sup>246</sup> Beth Kutscher. 2015d. “Medical Debt Collectors Frustrated by FCC Cellphone Ruling,” *Modern Healthcare*. August 29.  
[http://www.modernhealthcare.com/article/20150829/MAGAZINE/308299969?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=externalURL&utm\\_campaign=am](http://www.modernhealthcare.com/article/20150829/MAGAZINE/308299969?utm_source=modernhealthcare&utm_medium=email&utm_content=externalURL&utm_campaign=am)

<sup>247</sup> Ibid.

<sup>248</sup> Ibid.



violated the Fair Debt Collections Practices Act.<sup>249</sup> It's not just private equity-owned RCM companies that have pursued patients aggressively for payment of medical bills. In Minnesota, revenue cycle management firm Accretive Health agreed to pay a fine of \$2.5 million in 2012 and temporarily cease doing business in the state due to allegations of patient privacy violations and overly aggressive bill collection activities.<sup>250</sup> After facing financial struggle, provider Ascension and PE firm TowerBrook Capital Partners invested in Accretive to save the company in 2015.<sup>251</sup> It is now known as R1 RCM, and is a major supplier of RCM services.

### Charity Care and RCM Companies

Recent headlines on patient lawsuits have thrust hospital's RCM practices and charity care policies into the limelight. *ProPublica* and the *New York Times* have both reported<sup>252</sup> on the practice of non-profit hospitals suing their low-income patients for outstanding payments, and on the consequences for already marginalized people of having their wages garnished, missing work to make court dates, and facing possible jail time if they miss those court dates. One high profile example involves the nonprofit health provider Methodist Le Bonheur Healthcare, which filed over 8,300 lawsuits for unpaid medical bills from 2014 to 2018.<sup>253</sup> The patients involved in these lawsuits were often low-income, and some were Methodist's own employees. After *ProPublica*'s investigation into the case, Methodist erased the debts of 6,500 patients and overhauled its debt collection processes.<sup>254</sup> A study of Virginia hospitals found that fully 36 percent of hospitals used

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<sup>249</sup> Brooke Murphy. 2016. "Debt Collector Files 1,067 Lawsuits against SSM Health Patients." *Becker's Hospital Review*. April 26. <http://www.beckershospitalreview.com/legal-regulatory-issues/debt-collector-files-1-078-lawsuits-against-ssm-health-patients.html>

<sup>250</sup> Beth Kutscher. 2015d. Op. cit. at endnote 282; Melanie Evans. 2012. "Accretive Health to Pay \$2.5 million Settlement," *Modern Healthcare*, July 30. <https://www.modernhealthcare.com/article/20120730/NEWS/307309959/accretive-health-to-pay-2-5-million-settlement>

<sup>251</sup> Dave Barkholz. 2017. "Accretive Health Changes Performance, Then Name to R1," *Modern Healthcare*. January 5. <https://www.modernhealthcare.com/article/20170105/NEWS/170109953/accretive-health-changes-performance-then-name-to-r1>

<sup>252</sup> See Wendi C. Thomas. 2019a. "We Reported on a Nonprofit Hospital System That Sues Poor Patients. It Just Freed Thousands from Debt," *ProPublica*. September 24. <https://www.propublica.org/article/we-reported-on-a-nonprofit-hospital-system-that-sues-poor-patients-it-just-freed-thousands-from-debt>; Sarah Kliff. 2019. "With Medical Bills Skyrocketing, More Hospitals Are Suing for Payment," *The New York Times*. November 8. <https://www.nytimes.com/2019/11/08/us/hospitals-lawsuits-medical-debt.html>

<sup>253</sup> Wendi C. Thomas. 2019b. "The Nonprofit Hospital That Makes Millions, Owns a Collection Agency and Relentlessly Sues the Poor," *ProPublica*. June 27. <https://www.propublica.org/article/methodist-le-bonheur-healthcare-sues-poor-medical-debt>

<sup>254</sup> Wendi C. Thomas. 2019a. Op. cit. at endnote 288.

lawsuits to garnish wages. Of course, the flip side is that nearly two-thirds of hospitals do not engage in this practice.<sup>255</sup>

RCM outsourcing companies, including those owned by private equity firms, market to hospitals and other providers that sue patients for payment of charges for health care and to those that do not go after patients for payment. To hospitals or other providers that sue the RCM companies tout their aggressive bill collection practices, which do not include suing patients, as an alternative that can protect the hospital’s reputation. To those that don’t use aggressive practices to collect hospital charges, they argue that the hospitals are leaving money on the table that their RCM company can collect.

But what do outsourced RCM companies actually do in dealing with low income patients? Provisions in the Affordable Care Act require tax-exempt providers to make their financial assistance policies public and to first determine whether patients are eligible for financial assistance before pursuing “extraordinary collection practices.” To address this, some not-for-profit health care systems have turned to vendors such as CarePayment or ClearBalance to help low-income individuals with high-deductible health insurance plans work out a no-interest, “patient-friendly” repayment scheme. Initially, these payment options were offered to patients *after treatment* and after it was clear what the patient’s responsibility for payment was after taking any insurance company payments into account. ClearBalance claimed to adhere to the

**Table 6.3:  
Private Equity-Owned RCM Companies Offering Medical Payment Financing**

Company	PE Firm	Year acquired
CarePayment	The Cambria Group, Cedar Springs	March 2017
CSI Financial Services (ClearBalance)	Angelo Gordon & Co	Dec 2012
Patientco	Accel-KKR; Pamplona	July 2018; August 2012
AccessOne	Frontier Capital	Jan 2017

Source: PitchBook<sup>256</sup>

<sup>255</sup> Tara Bannow. 2019. "Few Hospitals Aggressively Sue Patients to Pay Bills, and Some Don't Bother at All," *Modern Healthcare*, October 5. [https://www.modernhealthcare.com/revenue-cycle/few-hospitals-aggressively-sue-patients-pay-bills-and-some-dont-bother-all?utm\\_source=modern-healthcare-am-wednesday&utm\\_medium=email&utm\\_campaign=20191008&utm\\_content=article2-headline](https://www.modernhealthcare.com/revenue-cycle/few-hospitals-aggressively-sue-patients-pay-bills-and-some-dont-bother-all?utm_source=modern-healthcare-am-wednesday&utm_medium=email&utm_campaign=20191008&utm_content=article2-headline)

<sup>256</sup> See: PitchBook. 2019. CarePayment Profile dated December 16, 2019, CSI Financial Services (ClearBalance) Profile dated December 16, 2019, Patientco Profile dated December 16, 2019, AccessOne Profile dated December 16, 2019.

Healthcare Financial Management Association's Patient Friendly Billing Practices,<sup>257</sup> the industry standard for ethical RCM practices. But these standards have come under pressure as PE-owned "patient-friendly" vendors see an opportunity to increase payments collected from patients.

ClearBalance and CarePayment are the two largest medical interest-free loan companies. ClearBalance was acquired by Angelo, Gordon & Co, a private equity firm, in December of 2012.<sup>258</sup> CarePayment was purchased by private equity firms Cedar Springs Capital and Crestline Investors in 2017 from PE firm Aequitas Capital Management.<sup>259</sup> ClearBalance's estimated current revenue is \$30 million, while CarePayment's is \$10 million.<sup>260</sup> Two of ClearBalance and CarePayment's major competitors are also linked to private equity. These include AccessOne, which was acquired by Frontier Capital in January 2017, and Patientco, which has two PE investors with minority holdings: Accel-KKR and Pamplona.<sup>261</sup> In addition, AccessOne acquired HealthFirst Financial in May of 2018, a company that also offers patient financing.

While interest-free loans started out as a friendly practice to enable patients to deal with high medical fees, a study of California hospitals suggests that this has changed. Today, hospitals estimate the patient's cost in advance of treatment, taking insurance payments into account, but sometimes without a credit check to see if patient can afford to pay as required by law. In addition, the study found that hospitals may be using price estimates that are higher than what the insurance company would eventually negotiate, resulting in patients overpaying for the services they receive. Patients are given estimates of what they will owe *while in treatment* in hospitals and emergency departments and are offered an interest-free loan to pay for these

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<sup>257</sup> Healthcare Financial Management Association (HFMA). 2019. "Patient Friendly Billing Project". <https://www.hfma.org/patientfriendlybilling/>

<sup>258</sup> PitchBook. 2012. "Angelo Gordon Puts Money into ClearBalance." December 20. <https://pitchbook.com/newsletter/angelo-gordon-puts-money-into-clearbalance>

<sup>259</sup> Kelly Gooch. 2017. "CarePayment Acquired By 2 Firms Amid Growth Period: 5 Things to Know," *Becker's Hospital Review*. March 13. <https://www.beckershospitalreview.com/finance/carepayment-acquired-by-2-firms-amid-growth-period-5-things-to-know.html>; PitchBook. 2019. CarePayment Profile dated December 9, 2019

<sup>260</sup> Owler. 2019a. "CarePayment's Competitors, Revenue, Number of Employees, Funding and Acquisitions". <https://www.owler.com/company/carepayment>; Owler. 2019b "CLEAR BALANCE's Competitors, Revenue, Number of Employees, Funding and Acquisitions." <https://www.owler.com/company/clearbalance>

<sup>261</sup> Kate Leitao. 2018 "RevSpring and Apex Announce Strategic Combination," *RevSpring*. September 1. <https://revspringinc.com/resources/blog/revspring-and-apex-announce-strategic-combination/>; Pitchbook. 2019. Patientco Holdings Profile, dated December 9 2019. <https://pitchbook.com/profiles/company/55032-67>

medical services. If the patient takes the offer, they must pay the lender monthly for the full amount that they have agreed to pay, even if this sum is more than what the patient would have owed after their insurance company negotiated with the hospital. The interest-free credit provider pays the hospital for the patient's bill upfront and collects a designated percentage of the bill as a fee.

Patients may feel pressured to sign up for these loans as they are given the estimates while in treatment in hospitals and emergency departments. Even without interest, patients may be signing on for payments they can't afford. One hospital provider working with ClearBalance reported that loans usually ranged from \$3,000 to \$7,000, but have gone as high as \$13,000. Between 15 and 20 percent of hospital providers are offering such loans. While government funded insurance such as Medicaid stipulates patients can't be required to pay as a condition of treatment, private insurance contracts are not as clear on this point.<sup>262</sup>

Interest-free medical loans, initially offered as a friendly alternative to more aggressive collection practices, deserve more scrutiny by regulators as private equity-owned firms have come to dominate this segment of revenue cycle management. While hospitals may be averting suing patients for medical bills or sending unpaid balances to collection agencies, these companies may still be exploiting patients. Insured patients, pressured for payment right before their appointments or even while in treatment, may be signing up to pay bills in excess of what they would have owed after the usual insurance negotiation. Patients locked into loans for thousands of dollars face a disruptive financial event even if the loans do not explicitly include interest payments.

In sum, as patients face high payment burdens and providers increasingly rely on those payments, private equity firms have seen a money-making opportunity to play a significant role in the new RCM strategies hospitals are adopting to bolster revenue. Private equity is on the forefront of the outsourcing RCM industry, pushing it toward consolidation and enacting new RCM strategies. In recent years, private equity firms have been involved in aggressive billing collection practices, including violating debt collection laws, suing low-income patients, and offering potentially exploitive medical loans. While high growth in the sector coupled with structural changes in the health care industry after passage of the ACA will provide continuing incentives for private equity to operate in this sector for years to come, aggressive billing practices continue to disenfranchise already vulnerable patients. Recent investigations suggest PE owned companies discontinue their most egregious practices once they come to light. Health

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<sup>262</sup> Shefali Luthra. 2018. "Bank Loans Signed in the Hospital Leave Patients Vulnerable," *Los Angeles Times*. February 21. <https://www.latimes.com/business/la-fi-hospital-loans-20180221-story.html>; Donna Rosato. 2018. "Should You Ever Prepay a Hospital Bill?" *Consumer Reports*. April 12. <https://www.consumerreports.org/healthcare-costs/prepay-hospital-bill/>

care stakeholders must continue to track PE involvement, as well as the RCM sector more generally, to protect vulnerable patients from exploitive practices.

### **Conclusion**

This paper documents the ways in which private equity firms have utilized the classic LBO business model and financial engineering strategies in a range of healthcare segments – from hospitals and emergency rooms to bill collection systems. Private equity’s current interest in healthcare is driven by market opportunities to consolidate enterprises in highly fragmented markets. PE firms have been at the forefront of the M&A mania in the healthcare sector, as they take advantage of opportunities to consolidate markets, reduce competition, and increase market power. The number of private equity M&As has grown at four times the rate of non-private equity M&As; and by 2019, private equity represented 45 percent of all M&As in this sector, despite representing only a minority of actors in the industry.

To achieve consolidation, private equity firms supplement the LBO strategy with a buy and build strategy – establishing a ‘platform’ by buying out one enterprise, then adding on and rolling up a series of similar enterprises into a large enough entity to achieve pricing power at the local, regional, or national level. Their goal is to exit the business at a profit through a resale to a strategic buyer (such as a hospital or insurance company), a resale to another private equity firm, (referred to as a secondary buyout), or less frequently, an IPO.

The buy-and-build strategy is an effective way to build market power without coming under antitrust scrutiny because each acquisition is too small to require review by the Federal Trade Commission. The median deal size of PE leveraged buyouts in healthcare is in the range of \$60-70 million – smaller than deals in many other industries.

The private equity model in healthcare is also one of low risk, as third-party government and private insurers guarantee payments. These payments provide a steady cash flow to service the debt. It is one of high returns due to the extensive use of debt. In 2018, the median or typical debt used in a PE healthcare buyout was 7X EBITDA (earnings before interest, taxes, depreciation, and amortization) of the acquired company – about equal to its highpoint in the 2006 bubble year. Notably, the price of target healthcare organizations has risen because other strategic players such as hospitals and payer organizations realize the importance of building out their own vertically integrated inpatient and outpatient healthcare systems. As a result, the price of buyout targets in 2018 increased to an historic high of 15.8X EBITDA – considerably higher than the PE economy-wide average of 11.5X EBITDA in that year. The high prices raise questions about the ability of PE firms to exit these investments and achieve outsized returns for their investors.

To date, this hasn't been a problem. Data show that over the last decade, PE firms have exited their healthcare investments on average in less than five years -- their preferred window. They have done so by moving in and out of different healthcare segments -- targeting the most lucrative segments, cream skimming the 'best targets' in the segment, reselling them, and moving on to the next most attractive market. Private equity firms began buying out hospitals and nursing homes in the 2000s before moving into more lucrative niches post-2010 -- ambulatory surgery, radiology, anesthesiology, emergency room management, neo-natal units, burn clinics, and trauma units, IT health and bill collecting. More recently, they have moved into nonhospital-based physician specialties -- dermatology, dental practice management, case management, ophthalmology, and orthopedics -- as well as behavioral health.

Given private equity's business model and its heightened activity in healthcare, many medical professionals have begun to question whether the PE model is appropriate for physician practices. They are concerned about whether doctors will lose control of decision-making or whether excessive debt and cost pressures will push them to increase patient volumes or undertake unnecessary procedures. Other providers, hospital administrators, community leaders, and healthcare policymakers point to the financial instability of private equity owned hospitals like CHS, Quorum, Iasis, and Steward; the bankruptcy of Hahnemann hospital in Philadelphia; and the surprise medical billing instigated by PE-owned ER staffing firms, Envision Healthcare and TeamHealth, and air transport companies, Air Medical Group Holdings and Air Methods. And they question whether, at a time when millions of Americans face financial distress or bankruptcy in the face of massive medical debt, they should also face aggressive, private equity-owned bill collecting agencies.

Congress is responding to one source of medical debt with specific legislation to curb the practice of surprise medical billing that has been the focus of public outrage. But other private equity practices that raise health care costs continue unimpeded beneath the public radar. Legislation introduced in the Senate and House, intended to curb the worst excesses of the private equity model, will be effective in the healthcare sphere as well.

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