# Physician Hospitals After the PPACA

## Life Goes On and New Strategies Emerge

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The Patient Protection and Affordable Care Act of 2010 ("PPACA") was signed into law on March 23, 2010. The period since enactment has been a time of soul searching for 285 existing physician owned hospitals ("POHs"). Our work at VMG Health, providing valuation and transaction advisory services to the POH industry, affords us the opportunity to analyze the financial condition and observe the strategic response of a large sample of POHs post PPACA.

Our observations confirm that POH leaders are busy assessing their future, weighing their options, and mulling strategic opportunities with the ultimate goal of preserving and enhancing shareholder value. Although POH management's skill in navigating these challenges will become clearer in years down the road, evidence displayed thus far has shown that the industry will respond with skill and ingenuity to pursue creative paths to improve financial performance and enhance shareholder return.

Each POH's exposure to the growth and physician ownership restrictions promulgated by the PPACA is unique. The characteristics of each POH will determine the level of risk exposure to these restrictions and generally dictate the appropriate strategic response. In the post PPACA environment, existing POHs can be considered to fall within three separate and distinct classifications based on their unique attributes. These include those operating in a "Business as Usual" manner, those reaching a "Fork in the Road", and those that are "In Need of Restructuring". The attributes of each POH category are summarized in the table below:

| Hospital Classification | Hospital Attributes |
|---|---|
| Business as Usual | Strong economics; zero capacity constraints; optimal physician ownership |
| Fork in the Road | Some capacity and growth constraints |
| In Need of Restructuring | Poor economics; physician ownership and/or capacity concerns |

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### Business as Usual

The lowest risk category of POH are those with minimal or manageable physical capacity constraints and those that operate at what can be considered optimal levels of aggregate physician ownership. "Business as Usual" POHs have no short-term or long-term plans for facility expansion and have levels of aggregate physician ownership that were set at the highest level for their respective structure prior to March 23, 2010. These POHs have thus far been unaffected by growth and ownership restrictions.

Other obstacles – including a slow economic recovery, commercial reimbursement challenges, state regulations, and a scarcity of available physician recruits – are still prevalent and will continue to challenge POH leadership. Despite these headwinds, financial performance for "Business as Usual" POHs continues to be strong as these hospitals benefit from strong patient satisfaction, physician loyalty and operational efficiency.

### A Fork in the Road

A second class of POHs are those with capacity constraints that make them susceptible to the growth restrictions imposed by the PPACA. Without restrictions, these POHs would have increased physical capacity to facilitate growth. Hospitals falling within this classification were granted a reprieve thanks to clarifications provided by CMS in the 2011 Hospital Outpatient Prospective Payment System ("HOPPS") final rule. The 2011 HOPPS final rule included a significant relaxation of growth restrictions as compared to the original language contained in the PPACA. POHs still may not increase the number of patient beds, operating rooms ("ORs") and procedure rooms

("PRs") from the March 23, 2010 baseline. The HOPPS final rule clarifies, however, that this restriction refers to the **aggregate** number of ORs, PRs and patient beds and does not impose restrictions regarding the manner in which a POH deploys its total number of patient beds, ORs or PRs. Therefore, a POH may reduce or increase the number of **either** beds, ORs or PRs as long as the aggregate number of beds, ORs and PRs does not increase. This represents a significant departure from the original language in the PPACA which restricted growth for all categories, not in aggregate and results in improved flexibility and strategic opportunity for "Fork in the Road" POHs.

"Fork in the Road" POHs now have several strategic options for expansion. The most apparent of these strategies is to simply allocate physical resources in the most efficient manner possible. For example, if your POH has excess capacity in its patient beds but is bursting at the seams with respect to its OR space, hospital leadership may choose to de-license several patient beds and construct additional ORs. Similarly, if a PR lies dormant for several days each week, the POH may select to shut down that PR and construct an OR.

Another expansion option is to pursue increased capacity through acquisition. An example of this option is illustrated below:

**Fact Pattern:**

- Hospital XYZ is a 32-bed, 100% physician owned hospital
- Service Line Offerings – multi-specialty surgery, endoscopy & diagnostic imaging
- Physical Layout – 50,000 sf; 6 ORs; 2 PRs; 32 patient beds
- OR capacity – very limited due to the hospital's focus on outpatient surgical procedures
- Patient bed capacity – considerable capacity, the hospital's average daily census is approximately 10 (<30% occupancy)

At first blush, Hospital XYZ could be considered at high risk in that future growth would be limited given OR capacity constraints. However, because of the relaxed growth restrictions, Hospital XYZ now has several options. Forward thinking management at XYZ has identified and initiated discussions with a three OR ASC in the market regarding the acquisition of the ASC by Hospital XYZ. The two entities agree to execute the acquisition in a debt-free transaction whereby the ASC is acquired in exchange for an ownership share in Hospital XYZ. To remain compliant with the PPACA, Hospital XYZ de-licenses three of its patient beds such that the aggregate level of ORs, PRs and patient beds remains unchanged. Furthermore, aggregate physician ownership does not change as the Hospital's existing owners are diluted slightly in the acquisition of the ASC.

**The benefits of the acquisition strategy described above include:**

- **Win / Win for Hospital and ASC** – Hospital accomplishes its objective of greater OR capacity and new physician recruitment; ASC's owners monetize their asset and obtain equity in an established hospital entity;
- **Immediate Reimbursement Arbitrage** – Volume performed at the ASC will enjoy higher reimbursement levels assuming the ASC can be qualified as an outpatient department of Hospital XYZ;
- **More Lucrative use of Capacity** – In swapping three under-utilized patient beds for three ORs, Hospital XYZ has now shifted its limited capacity to more lucrative ORs;
- **Greater Efficiencies** – Hospital management has the flexibility to shift certain specialties / procedures to one location to maximize staff, supply and space efficiencies;
- **Access to adjacent markets** – To qualify for provider based status, the acquired ASC would need to be located within 35 miles of Hospital XYZ. Depending on the proximity of the ASC, this acquisition could allow the Hospital gain a foothold in an adjacent patient/physician market.

As illustrated in the example, the "Fork in the Road" category of POHs have significant flexibility to pursue growth under the revised restrictions.

## In Need of Restructuring

A third class of POHs include those with limited capacity in all ORs, patient beds and PRs; hospitals with less than optimal aggregate physician ownership; and those that continue to underperform despite management's best efforts to "right the ship". For these POHs, a partial or complete sale or major restructuring may be in order. Potential partners in a restructure include acute care hospitals and national hospital management / operating companies. Partnering with an acute care hospital may yield certain synergies and capacity expansion may exist in cooperation with the main campus. In addition, the combined entity may have the ability to leverage more favorable managed care rates.

Other creative strategies are emerging in the face of the PPACA restrictions. One such strategy that is currently being implemented in several instances throughout the country is joining several POHs to become part of a public offering and thus exempting the POH from the restrictions of the PPACA. The pursuit of such innovative strategies will continue to ensure POHs have options and flexibility in today's competitive market.

## Summary

Simply stated, the value of POHs are dependent upon two primary inputs - expected *future cash flow* and the *risk* of reaching and sustaining those expected cash flows. These inputs, and thus POH value, are dependent on the specific attributes of each POH and their susceptibility to the restrictions in the PPACA. Following PPACA enactment, a common reaction to the growth and ownership restrictions was that such restrictions would serve to destroy the value and viability of the POH model due to restrained future cash flows and elevated risk. As we've explored in this article, a broad array of strategic options exist for POHs (regardless of the POH category) which enhance potential future cash flow and lower the risk of sustaining positive operational performance. ✚

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