

Capital Formation of Accountable Care Organizations

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Presenter Bio

Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of **HEALTH CAPITAL CONSULTANTS (HCC)**, a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993.

Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on: healthcare valuation consulting and capital formation services; healthcare industry transactions; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting. He is a nationally known speaker on healthcare industry topics, the author of seven books, the latest being *Accountable Care Organizations: Value Metrics and Capital Formation* (Taylor & Francis, 2013) and *Healthcare Valuation* (John Wiley & Sons, 2014).

Mr. Cimasi serves as Vice Chair of the American Health Lawyers Association Accountable Care Organization (ACO) Task Force, and as current Chair of the American Society of Appraisers Healthcare Special Interest Group (ASA HSIG).



Presenter Bio

Todd A. Zigrang, MBA, MHA, FACHE, ASA, is the President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where he focuses on the areas of valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Master of Business Administration from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives, and serves as President of the St. Louis Chapter of the American Society of Appraisers (ASA).



Overview of Presentation

- Overview of ACOs
- Capital Financing of ACOs
- Capital Structure and Budgeting
- The *Great Recession's* Lingering Effects on Capital Formation
- Capital Allocation
- Concluding Remarks



Overview

- The U.S. healthcare delivery system continues to evolve from a *volume-driven reimbursement system* toward an outcome-centered, *value-based reimbursement system*
- Developing a sustainable financial model is vital
 - Will necessitate complex, detailed analyses of the challenges and opportunities involved
 - Requisite capital investment to support the design, development, and implementation of a new Accountable Care Organization (ACO)



Overview

- Participation in federal and commercial ACOs has almost quadrupled since 2012
 - From 4.8% in 2012 to 18.3% in 2014 (as of Spring 2014)
 - The Midwest has the highest concentration of ACO facilities (43% participation)
- Non-ACO participants cite various reasons which deter their move to an ACO model:
 - Concerns related to insufficient patient population
 - Hospital size
 - Perceived value of ACOs, with 52% desiring to see stronger evidence and consistency from successful models



Overview

- Only 20% of healthcare enterprises reported that they will *not* be joining/creating an ACO (as of Spring 2014)
 - Compared to 30% in 2012
- Almost 30% of enterprises reported that new care delivery models (such as ACOs) were their biggest concern over the next 12 months
- 64% cited *reimbursement costs* as their other primary concern



ACO Financing Options

- Capital expenditures play an increasingly important role in the sustainability of healthcare systems
 - Both facilities and equipment are necessary to provide increasingly capital-intensive, technologically driven medical care for enough patients to develop and maintain a viable ACO



Capital Financing of ACOs

Funding Concerns

- Do ACO participants have adequate capital to execute the proposed ACO business plan?
- A sustainable financial model requires robust analyses of the complex *challenges* and *opportunities* necessary to support ACO investment
- Funding will require a strategy that generates start up capital costs, as well as sufficient income to cover operational expenses
- Operational funding can be achieved by increasing efficiency and maximizing reimbursement revenue
- Funding source(s) should be secure and reliable enough to avoid capital shortfalls



Capital Financing of ACOs

- Capital funding sources depend upon:
 - Size and makeup of organization
 - Types of financing
 - Tax posture of the entity
 - Tax shield benefits arising from the use of debt in an enterprise's capital structure incentivizes firms to consider at least partially financing the enterprises through interest-bearing debt
- Adequate capital funding sources are an integral component of a healthcare organization's long-term financial sustainability
 - Sources of capital for healthcare organizations have evolved with the healthcare industry
- Customarily, 50% of a healthcare organization's assets have been financed with equity and the remainder by debt
 - Ratio differs among various types of healthcare delivery entities



Capital Financing of ACOs

Sources of Capital for For-Profit Entities:

- Debt
- Equity
- Internally generated operating surpluses

Sources of Capital for Non-Profit Entities:

- Donations
- Government grants / tax breaks
- Traditional debt
- Investments from non-profit entity
- Tax-Subsidized operating surpluses



Capital Financing of ACOs

Sources of capital for both non-profit and for-profit entities:

- Capital leases
- Bond financing
- Mezzanine lending
- Commercial lending
- Equity
- Sale-leaseback
- Seller “*take back*” financing
- Conduit lending structures, such as *Municipal Backed Bond Issuances*
- Tax increment financing (TIF) programs

May also enter private capital markets through:

- Venture Capital Investors
- Private Equity Investors
- Private Real Estate Investment Trusts (REITs)



“Conversion of HMOs and Hospitals: What’s at Stake?” By Bradford H. Gray, *Health Affairs*, Vol. 16, No. 2, 1997, p. 31. “Financing Issues for Healthcare Providers and Companies” By Deborah Gordon and Lisa Lenderman, Seyfarth Shaw, LLP and MidCap Financial, LLC, American Health Lawyers Association Annual Meeting: Boston, MA, June 27, 2011; “Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations” *Federal Register*, Vol. 76, No. 212 (November 2, 2011), p. 67835. “An Examination of Contemporary Financing Practices and the Global Financial Crisis on Nonprofit Multi-Hospital Health Systems” By Louis J. Stewart and Pamela C. Smith, *Journal of Health Care Finance*, Vol. 37, No. 3, 2011, p. 5.

Capital Structure Decisions

- How an organization plans to finance daily operations
- How it plans to finance growth within the organization
 - Sensitive to market conditions and short- and long-term goals for expansion
- Capital structure is generally comprised of:
 - Short-term debt
 - Long-term debt
 - Common and preferred stocks/equities
- Organizations seek the optimal ratio between debt and equity financing by which to derive the maximum benefit for stakeholders or shareholders

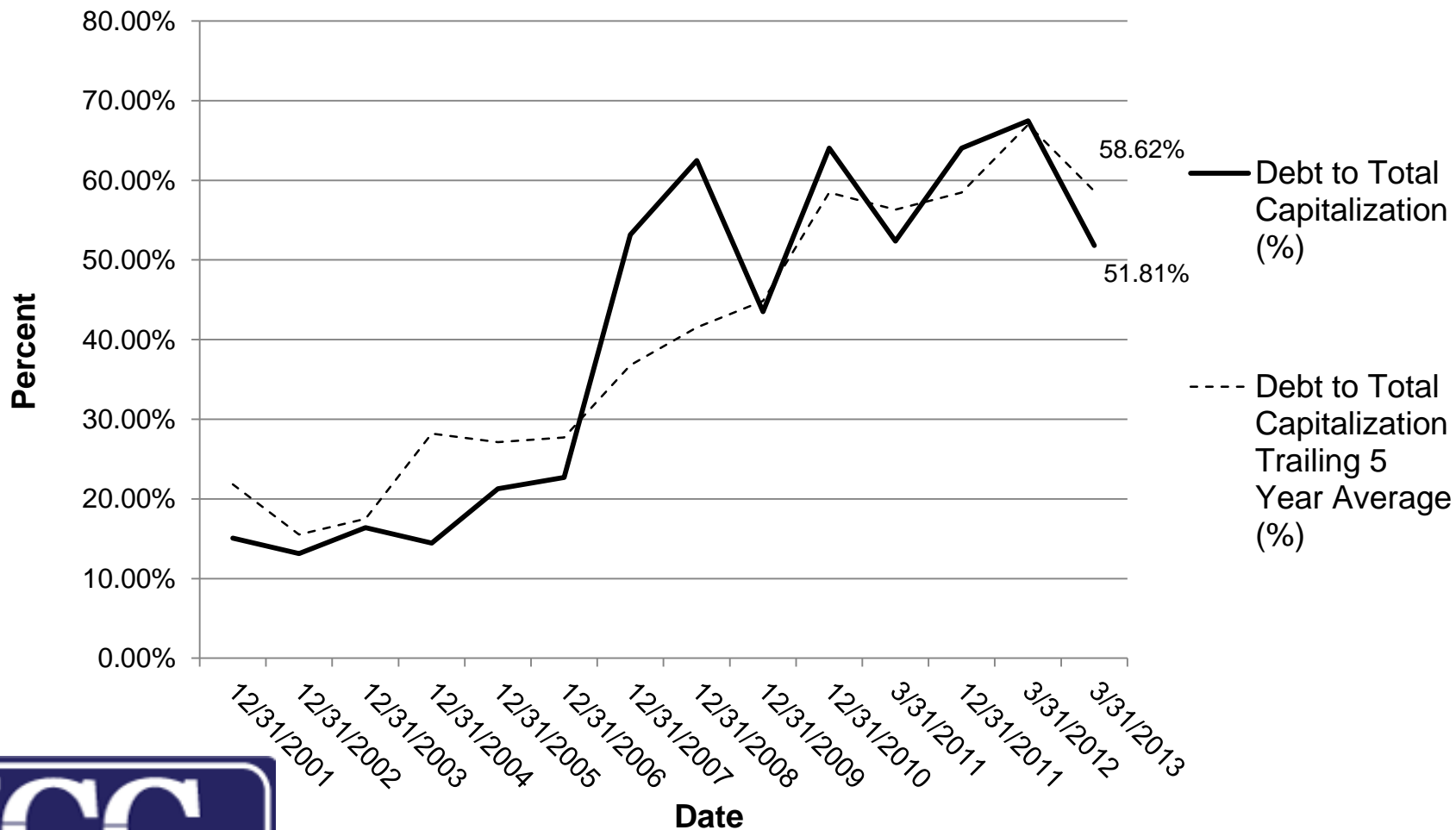


Capital Structure Decisions

- Theory of optimal capital structure typically viewed as “*a unique mix of debt and equity that minimizes the overall cost of financing assets*”
- Historically:
 - Capital structure ratios of nonprofit health entities were relatively consistent
 - Capital structure ratios of for-profit entities tended to reflect sensitivity to market conditions



Historical Debt to Total Capitalization in the Healthcare Industry



"Ibbotson SBBI: 2012 Valuation Yearbook - Median data for SIC code 806: Hospitals 2001-2011," Morningstar, <http://ccrc.morningstar.com/IndSearch.aspx#> (last visited Apr. 25, 2012); "Ibbotson Cost of Capital: 2013 Yearbook," Morningstar, Section 8 (2013); "Ibbotson Cost of Capital: 2012 Yearbook," Morningstar, Section 8 (2012); Ibbotson Cost of Capital: 2011 Yearbook, Morningstar, Section 8 (2011).

Overview of Capital Budgeting

- **Capital Budgeting:** “*The process of selecting long-lived assets, projects, and programs according to financial criteria*”
- ACO investment can be financed either:
 - *Externally*
 - Drive funding from sources outside of the organization
 - Either debt or equity
 - Debt financing utilized by healthcare entities to meet extended goals and sustain continued viability
 - *Internally*
 - May be possible once an ACO becomes fully functional and begins generating revenue
 - Funded from reserves or cash flows of the organization



Overview of Capital Budgeting

Long-term Debt Financing

- Long-term debt financial composition between non-profit and for-profit healthcare entities often differ
- Non-profit entities
 - 95% of the long-term debt of hospitals and health systems is comprised of tax-exempt debt
- For-profit entities
 - Typically carry significantly higher percentages of long-term debt compared to nonprofit organizations



Overview of Capital Budgeting

- Large health systems may be best suited to transition quickly to an ACO model
 - Less likely to require significant changes to normal operations
 - Smaller organizations will require a business plan in order to manage the substantial restructuring
- Long-term debt financing for large health systems will likely share significant similarities in composition and source between existing organization and an ACO



Overview of Capital Budgeting

Long-term debt financing challenges unique to ACOs may include:

- Variable creditworthiness of the individual ACO participants
- Division of contributions among participants to repay long-term debt
- How the individual capital needs of ACO participants can be adequately met through an umbrella ACO with disparate participating provider entities



Overview of Capital Budgeting

- Issues of attaining capital have grown in importance for many healthcare entities
 - Providers have begun looking toward alternative forms of long-term financing
- The availability of capital sources for emerging ACOs may continue to increase as the economy recovers from the post-recession period
- Organizations must be willing to:
 - Explore a wider array of options than in the past
 - Efficiently and accurately assess the risk associated with each option



Overview of Capital Budgeting Small / Rural ACOs

- May need to be more creative in seeking out partnerships and capital sources
- Example – *National Rural ACO*
 - Consists of *Rural and Critical Access Hospitals, Federally Qualified Health Centers (FQHC), Rural Health Clinics*, and independent physician practices across 9 rural communities in CA, IN, & MI
 - Aims to alleviate some of these problems and “*help rural providers that don’t have the deep pockets, size or scale to participate*” traditionally



Overview of Capital Budgeting

Possible Sources of Capital Funding

- Hospitals
- Insurance Companies
- Venture Capital
- Pharmacies
- Private Equity
- Federal Funding

Overview of Capital Budgeting Hospitals

Large, integrated health systems may be more willing to form an ACO

- Better-equipped to handle the risk
- More likely to have the needed technology in place
- Access to more capital, resources, providers, & management staff

Originally expected that hospital involvement in ACOs would increase by 52% (of survey respondents) by the end of 2013

- Progress slower than expected – hospital involvement expectations in 2014 down to just under 33%
- Participation increased 15% between Fall 2013 & Spring 2014



Overview of Capital Budgeting Venture Capital Funding

- Accessing *venture capital* may be difficult because ACOs have not yet been proven as a financially viable investment, even at the threshold level of venture capital risk expectations, due to:
 - The evolution from a *volume-driven* to a *value-based* reimbursement system
 - Concern regarding potential implementation delays of various ACA provisions
 - The uncertain probability that ACOs will generate revenue, or even break even, in the first year of operation
- Venture capital has decreased in recent years (peaked in 2007 at \$10 billion), to \$7 billion in 2013



Overview of Capital Budgeting Venture Capital Funding

Examples of Venture Capital Funding:

- Dr. Farzad Mostashari
 - Formerly worked at Office of the National Health Coordinator for Health Information Technology
 - Started Aledade, a company that provides financial support to cover start-up costs for ACOs
 - Started with \$4.5 million from Venrock (venture capital firm)
 - Anticipated to fund ACOs in 4 states in 2015
- Venture capital firm Kleiner Perkins Caufield & Byers
 - Provided early funding for Genentech, Amazon.com & AOL
 - Invested \$61 million into Essence Group Holdings Corporation, which aids physicians in building ACO networks



Overview of Capital Budgeting Private Equity Investment

- Recent increase of private equity investments in the healthcare industry
 - Seems to indicate venture capitalists may be more confident in the financial potential that ACOs possess than ACOs themselves
- Amount of venture capital investments in the overall healthcare industry totaled \$286 million in 2013
 - Down from \$333 million in 2012



Overview of Capital Budgeting Private Equity Investment

Examples of Private Equity Investment:

- Bain Capital Ventures
 - Invested \$77.5 million in MedHOK, a healthcare software provider that markets clinically integrated technology to ACOs
- Kaiser Permanente
 - Invested \$8 million in Health Catalyst, a healthcare data warehousing company that aggregates data utilized by ACOs
- Great Point Partners
 - Financed merger of Orange Health Solutions (which provides services to establish ACOs) and MZI HealthCare (which assists ACOs with data modeling, data analytics, etc.)



"MoneyTree Report," PricewaterhouseCoopers, <https://www.pwcmoneytree.com/MTPublic/ns/nav.jsp?page=historical> (Accessed 2/12/14). "In Their Own Words: Digital Health Investors Boost Venture Capital Outlook for 2014," Atlantic Information Services, Inc., Health Plan Week, Vol. 24, No. 3, Feb. 3, 2014, <http://aishealth.com/print/31016> (Accessed 8/19/14). "Bain Capital Ventures, Spectrum Equity invest in MedHOK," Nicola Leske, Reuters, January 8, 2014, <http://www.reuters.com/article/2014/01/08/us-baincapital-spectrumequity-medhok-idUSBREA070EJ20140108> (Accessed 8/26/14). "Private Equity Firm Invests in ACO Company's Data Analytics Merger" By Bob Herman, Becker's Hospital Review, April 16, 2014, <http://www.beckershospitalreview.com/accountable-care-organizations/private-equity-firm-invests-in-aco-company-s-data-analytics-merger.html> (Accessed 8/25/14).

Overview of Capital Budgeting Insurance & Pharmacies

Examples of insurance companies:

- Blue Shield of California pledged \$20 million in grant funding in 2010 2011 to aid healthcare enterprises participate more effectively in ACOs
- UnitedHealthcare announced in 2013 that it would increase its accountable care contracts to \$65 billion over the next 5 years

Examples of pharmacies:

- Walgreens is aiding in ACO formation in New Jersey, Florida, & Texas



Overview of Capital Budgeting Federal ACO Financing Options

Medicare Advance Payment Initiative

- For small, rural, or modestly funded healthcare enterprises in the *Medicare Shared Savings Program* (MSSP) with less access to capital
- Currently funds 35 ACOs that generate less than \$80 million in yearly revenue through 3 distinct types of payments:
 - An *upfront, fixed payment* of \$250,000
 - An *upfront variable payment* of \$36 per “*preliminary, prospectively assigned*” beneficiary
 - A *monthly payment* of \$8 per “*preliminary, prospectively assigned*” beneficiary
- The first 2 payments are delivered to the organization in the first month of operation



The 2007-2009 Great Recession - Lingering Effects On Capital Formation

- Increased risk perception from potential investors leads to increased capital costs for healthcare entities
- The majority of hospitals have returned to pre-recession levels of financial stability
 - Total margins rebounded by 2011 due to growth in non-patient care revenue
 - Operating margins of less financially-stable entities have not yet recovered
- Currently, stronger healthcare systems are borrowing & warehousing money, due to:
 - Pent up demand and easing of healthcare reform fears
 - Relatively low costs of borrowing
 - Expectations for interest rates to climb



The 2007-2009 Great Recession - Lingering Effects On Capital Formation

- Success or failure of many ACO projects may rely on ability to appropriately assess and mitigate risks, including:
 - Macroeconomic trends
 - Impacts of unrelated economic events
 - The availability of funding for healthcare services
- Narrow profit margins and high costs often make traditional lenders reluctant towards healthcare financing
 - Healthcare entities are more reliant on credit than most industries
 - Requires lenders that understand intricacies of healthcare capital expenditures



Initial Capital Investment for ACO Development

- ACO development will initially require significant levels of capital investment to establish necessary infrastructure, including:
 - Network Development and Management
 - Care Coordination, Quality Improvement and Utilization Management
 - Clinical Information Systems
 - Data Analytics



Initial Capital Investment for ACO Development

- CMS initial estimated ACO startup costs – \$1.7 million
- *American Hospital Association (AHA)* estimated ACO startup costs – \$5.3 million (for a smaller hospital system) to \$12 million (for a larger hospital system)
- Actual average ACO start-up costs - \$2 million (for first year of operation of federal ACOs), per 2013 NAACOs Survey
 - Lower start-up costs may be due to participation of those healthcare entities that were most prepared for ACO in terms of integration
- Initial capital requirements will be significant compared to continued operational expenses



Initial Capital Investment Network Development and Management

- Capital for *network development* will likely be focused on fostering relationships between ACO participants and merging their various, divergent goals
- *Network development and management* includes provision of:
 - Management & staff
 - Legal & consulting support
 - Contracting proficiency
 - Management resources
 - Primary care professionals
 - Financial & management information support systems
 - Compensation to physician executives



Initial Capital Investment Care Coordination, Quality Improvement, Utilization Management

- ACOs may require capital contributions in order to coordinate care, improve quality, and manage healthcare utilization rates among patients through programs such as:
 - Disease registries
 - Hospitalists
 - Care coordination and follow-up post-discharge
 - Attaining designation as a patient-centered medical home
- May be developed internally or through an outside management services organization



Initial Capital Investment Clinical Information Systems

- Includes programs such as:
 - Electronic health records (EHR)
 - Implementation expected to account for a vast majority of clinical information systems costs
 - EHR interoperability
 - EHRs to health information exchanges (HIE)
- 43% of enterprises anticipate telecommunications and IT spending to account for largest part of 2014-15 capital budgets
- Average initial HIT capital requirement may total around \$850,000
 - Roughly \$500,000 for smaller ACOs (5,000-10,000 beneficiaries)
 - Over \$1.6 million for larger ACOs (16,000-25,000 beneficiaries)



"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011), pp. 19599-19600; "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register, Vol. 76, No. 212 (November 2, 2011), p. 67902; "National ACO Survey: Conducted November 2013" National Association of ACOs, January 21, 2014, <https://www.naacos.com/pdf/ACOSurveyFinal012114.pdf> (Accessed 8/6/14); "Healthcare trends from the C-Suite" Premier, Inc., Economic Outlook Spring 2014, (Spring 2014), p.1-6; "Healthcare trends from the C-Suite" Premier, Inc., Economic Outlook Spring 2014, (Spring 2014), p.1-6.

Initial Capital Investment Data Analytics

- Defined as the nonclinical data management of a healthcare entity
- Includes:
 - Analysis of care patterns
 - Quality reporting costs
 - Other activities and costs
- CMS's ACO quality measures require data collection and analysis for reporting progress on outcomes and claims
- Likely to require capital for separate data analytics systems designed to monitor necessary data regarding quality measures



Expenses Related to Ongoing ACO Operation Network Development and Management

- Includes a variety of services and infrastructures that must be maintained in order to keep the organization functional
- Many ACOs are adding staff to aid in managing *population health*
 - Social workers
 - Outreach coordinators
 - Resource specialists
 - Behavior specialists
 - Coders
 - Technical experts
 - Psychiatrists
 - Nurses



Expenses Related to Ongoing ACO Operation Care Coordination, Quality Improvement, Utilization Management

ACOs may experience ongoing expenses associated with:

- Specialty-specific disease management
- Integration of inpatient and ambulatory approaches in service lines
- Patient education and support
- Medication management



Expenses Related to Ongoing ACO Operation Clinical Information Systems

- ACOs must maintain clinical information systems in order to function properly
- Needed to:
 - Coherently maintain all of the patient information that is constantly created and exchanged
 - Be able to keep up with the organization's daily management needs



Expenses Related to Ongoing ACO Operation

Data Analytics

- The utilization of technology to collect and analyze data will likely increase as healthcare enterprises seek to evaluate new forms of information to:
 - Target potential cost savings
 - Track quality measures for reporting
 - Manage population health
- Important to target potential cost savings and track quality measures
- Estimated that it will require approximately four years of data mining to gather data for meaningful information



Concluding Remarks

- 522 total ACOs have been established
 - 368 Federal ACOs
 - 154 Commercial ACOs
 - Providing services to over 5.3 million Medicare beneficiaries
- Approximately 17% of Americans are patients in organizations with ACO arrangements
 - 2/3 of the U.S. population live in areas served by ACOs
- Important to decide how to address demanding capital requirements before beginning to develop and operate an ACO
- Available capital to healthcare organization has diminished due to:
 - Effects of *Great Recession*
 - Low profits and high costs
 - Uncertainty regarding the outcome of various ACA provisions



Concluding Remarks

- An viable financial model for an ACO should include:
 - Debt financing
 - Equity financing
 - Internally generated capital
- Developing ACOs need to address capital considerations in unique ways dependent on size and status
 - Capital structure will differ between for-profit and non-profit entities
 - Different investment options will be feasible for large vs. small entities