The coming surge in health provider M&A

How historical forces and healthcare reform will combine to drive activity
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Executive summary

Merger and acquisition activity among U.S. hospitals and integrated health providers increased in late 2010 after several slow years, and we expect it to expand significantly during the next several years — even if courts or legislators reverse some of the key provisions of the 2010 Affordable Care Act. Health systems will strive for scale and financial stability, and will seek to develop or acquire the capabilities they will need in order to undertake risk for clinical outcomes as they move toward population-based health accountability. These factors, along with corporate and structural changes to maintain the religious identity of Catholic hospitals, will drive a multiyear wave of greatly increased M&A activity in the provider sector.
The need to deliver more seamless, transparent, and significantly lower-cost care existed before anyone uttered the words “healthcare reform” and will continue unabated even if portions of the Affordable Care Act are gutted by court challenges. What will definitely survive the legal and political wrangling is the paradigm on which the law is based — strong incentives to reduce cost through more scientifically based bedside-care plans and better overall care management; success driven by more holistic measures than cost per episode; and raising the industry’s focus to population-based cost performance. In addition, nearly revolutionary changes in the industry’s infrastructure will continue, most notably the government-mandated and -assisted implementation of sharable and interactive information systems (at both the provider level and the state, regional, and national levels).

Furthermore, the new world will flatten reimbursement rates across public and private payors — in ways that will drive down revenues, rather than enhance them. As opportunities fade for recouping losses on Medicare and Medicaid patients by raising commercial-plan prices, providers will need to reduce costs by 15 to 25 percent (depending on an individual provider’s current competitiveness locally). Cost reductions of that magnitude won’t happen by working harder and faster. New and/or enhanced capabilities will be needed, along with coherent geographic coverage and asset deployment. Standardized care plans (integrated into new information technology) and state-of-the-art care management techniques across entire illnesses and even chronic conditions will be indispensable. The basic models for success are fairly well known — at least at a high level — and whether the needed capabilities can be developed organically or have to be acquired will be a critical strategic question on every CEO’s agenda.

These macro-level forces will drive changes at the hospital and system levels and lead to increased M&A activity. In addition, three specific factors will accelerate the trend by enabling increased opportunities and permutations in the provider M&A space: Increasing numbers of at-risk institutions (an estimated 19 percent of all hospitals operated at a significant loss in 2011) will seek shelter from the storm; some safety-
net hospitals will become less unattractive financially as reimbursements (public vs. private) flatten; and many Catholic hospitals will seek new corporate arrangements to enhance their compatibility as health system partners. We expect these factors to intersect and reinforce one another, creating a far more robust stream of M&A activity over the next three to five years.
In 2010 (the most recent year for which we have full data), the total number of hospital transactions was up after several years of decline — due in part to the gradual recovery from the recession. The bounce in 2010 occurred mostly after March, when the reform act was passed — signaling to some extent the formalization of many of the features of the new paradigm. At the same time, more capital became available as the worst of the recession ended and lending practices regained some degree of normalcy. These developments combined to spur M&A activity, much of which was aligned to the expected restructuring of the industry.

The value of the announced deals based on revenues acquired (which more accurately reflect activity than acquisition prices, because some deals’ details are private and mergers don’t involve cash) showed a remarkable jump as well. In 2010, the 73 announced deals totaled US$21.4 billion — up dramatically from $5.9 billion in 2009, but barely two-thirds of the pre-recession total in 2006 ($30.1 billion).

At first blush, it would seem that M&A activity is poised for a major spike that will affect the industry broadly and deeply. But the reality is somewhat more nuanced. The six largest deals in 2011 were all by for-profit acquirers (or private equity players, both foreign and domestic). Many of these deals could be classified as asset and/or financial plays — driven by factors other than healthcare reform or by strategic moves in specific markets. The more interesting (and far more numerous) deals, however, involved nonprofits, either on one side or both sides of the deal. Typical deals included the following features:

- Bankruptcies or distressed sales involving little or no cash and no post-deal promises to reinvest in the acquired hospital(s).

- Horizontal consolidation of religion-sponsored (mostly Catholic) hospitals — both in cases of distress and in cases driven by a desire for administrative scale. Some deals may also involve — eventually — local market integration.

- Significant changes in ownership of public hospitals (usually “safety net” hospitals that serve low-income areas) and religion-sponsored hospitals by for-profits. Clearly, these are focused on local market integration and are signs of reform-propelled repositioning strategies.
• At least one regional play (by Health Management Associates) in Florida involving public teaching hospitals (Shands) and a private integrated system to build a strong regional system, in concert with smaller for-profit institutions.

• Many plays in individual markets by nonprofits to gain geographic coverage and increase their degrees of freedom in structuring a new local/regional delivery system.

At a high level, the strategic landscape can be characterized by several proprietary chains making local/regional plays; Catholic-sponsored systems exploring new ways to work with for-profits and other nonprofits to build local delivery systems; and a large number of primarily local plays by existing nonprofits seeking to build out greater geographic coverage and/or to integrate their clinical services.

Of course, hospitals aren’t the only entities in the provider sector of the industry. Physicians/physician groups and non-acute care services are the other major categories of provider M&A activity. The largest of these subsectors is long-term care, but the action there is usually limited to existing players. Hospitals are not crossing this “adjacency” boundary — hardly surprising, given that long-term care was barely addressed in reform legislation, and the prospects for margin growth are virtually nonexistent, despite what will surely be exploding demand from aging baby boomers. The physician subsector is far more active and interesting, with most transactions falling into the following groupings:

• National (for-profit) medical groups expanding their geographic coverage or range of services — usually in hospital-based specialties such as pathology, hospitalists, emergency services, and anesthesiology. Such transactions are important to the parties involved, but of limited interest when looking at the future structure of the provider sector.

• Continued acquisition of physician practices by local hospitals and systems — clearly focused on both geographic coverage issues and specialty breadth and depth. Perhaps the most significant trend here is the increasing level of activity related to traditionally entrepreneurial (and profitable) specialties such as cardiac services — partly due to already implemented flattening of reimbursements for procedure-driven specialties, combined with the new focus on care management under reform.

• Marquee-level multispecialty group practices expanding local/regional coverage and deepening their clinical strength — some with hopes of being the linchpins of local accountable care organizations (ACOs). Such local and regional powerhouses would logically also be targets of providers seeking winning local ACO plays, but indicative of their strength, none of these powerhouses are showing much interest in being acquired.
The main features of healthcare financing and delivery under reform built on trends and initiatives already under way, especially in the provider sector.

Two other transaction archetypes are also at play — one nearly ubiquitous and the other of keen longer-term strategic interest to the industry. In the first type of transaction, additions of physicians to hospitals and healthcare systems continue unabated (reaching an estimated 20 percent of all physicians in 2010). These activities are mostly below the M&A radar, because the physicians are not being explicitly “acquired” but are being employed and added to existing physician-practice organizations under larger corporate umbrellas. With the bulk of new graduates expecting to be hired by hospitals (as opposed to entering private practice), physician employment percentages will continue to rise for the foreseeable future.

The second type of transaction is a potential boundary buster. While providers and payors have spanned the boundary between their sectors in the past (and some large-scale entities exist and thrive), major M&A initiatives are rarely the means to that end. That may be changing.

Perhaps the most attention-grabbing deal (announced, but not yet completed) was 2011’s proposed acquisition of West Penn Allegheny Health System by Highmark (a Blue Cross Blue Shield plan). Though its completion faces numerous hurdles, the most important question is probably not “Will it happen?” but “Is it an outlier or a bellwether?” While there are other payor/provider transactions in the recent deal flow, most have been more modest forays by insurers acquiring a few local (often primary-care) practices. The scope of the Highmark/West Penn deal is breathtaking by comparison. Strategically, it fits into the old model by explicitly addressing what Highmark sees as a lack of provider competition in its markets, combined with West Penn’s delivery system struggling to survive without a major capital infusion.

In addition to making strategic sense in the old world, such large-scale combinations of payors and providers could, in select circumstances,
create potential winners in the new world of reform and ACOs. In some senses, the healthcare world has come full circle since the HMO boom of the 1990s and the HMO bust of the 2000s. Full-scope clinical services, combined with full financial responsibility — essentially, the Kaiser Permanente model — succeeded before 1990 and continue to succeed today. ACOs are based on very similar assumptions, incentives, and operating models. The most successful of these, however, grew organically from founding principles. Less successful (by far) were those that sought to assemble pieces that were originally created to optimize portions of the financing/care value chain.

As we look ahead to the next few years of provider M&A activity, the importance of such boundary-busting structural plays is only one of several intriguing questions that need to be addressed by the industry’s players.
The road ahead — multi-front initiatives will drive increased M&A

In many ways, the main features of healthcare financing and delivery under reform built on trends and initiatives already under way, especially in the provider sector. Though the specific capabilities needed to win are somewhat different under reform, the positional assets (hospitals, ambulatory-care sites, etc.) are very similar — and healthcare delivery systems have been very busy assembling the pieces needed for at least the past five years. Going forward, we expect to see more industry participants in play and a sharpening focus on capabilities, not just physical assets.

At the highest level of this argument are factors affecting Catholic hospitals, for-profits, and public/safety-net hospitals. Historically, these segments have played limited roles in the otherwise intense efforts to build geographically and clinically coherent local and regional healthcare delivery systems. All three of these segments have significant barriers to full participation in integrated local networks. Catholic hospitals had trouble anchoring a local health system because of real or perceived doctrinal restrictions; for-profits are usually smaller, isolated facilities at the periphery of local networks; and safety-net hospitals have been seen as economically hopeless and plagued by image problems (despite typically first-rate clinical services). Factors now in play may change much of that, perhaps profoundly.

Catholic hospitals feature prominently in the M&A arena because they comprise 12% of all U.S. acute-care hospitals and are by far the largest religion-sponsored group of institutions. While there are many denominations that sponsor hospitals, only the Adventist Health System is nationally and regionally organised, but on a far smaller scale.

Very recently, Catholic Healthcare West (CHW) announced a major change in its healthcare structure and organization — spinning off all of its hospitals (which include both Catholic and secular institutions) into a new entity, Dignity Health. This accomplished a formal divorce from Catholic sponsorship of its religious hospitals, although they will continue to observe church directives involving reproductive services. The result is that Dignity Health facilities will be (it is hoped) more
attractive as network partners and, in some markets, as network anchors. Other Catholic systems have been focused primarily on consolidation into larger and larger aggregations, which bring administrative economies, such as management, IT, and purchasing. That trend is likely to continue, but if CHW’s initiative proves successful, others are very likely to follow — making corporate restructuring the truly strategic change in this space.

The for-profit chains’ most basic strategy over the last few decades has focused on attractive geographies (sole-provider and/or economically attractive markets and locations), with a few instances of locally or regionally integrated delivery networks. In addition, very few of their facilities have the size or clinical depth to anchor a comprehensive delivery network — whether in the old world or in the coming world of reform and ACOs. That said, reform appears to be opening up more possibilities for network/ACO development for the for-profits (and others) because of the potential for public hospitals to become more mainstream players as public and private reimbursements are leveled — and as previously uninsured patients have the purchasing power to buy insurance on state exchanges. We have already seen some transactions in this space, including Vanguard’s acquisition of Detroit Medical Center.

The confluence of these three developments — Catholic hospital restructurings, the changing prospects for some public/safety-net hospitals, and the for-profits’ interest in a greater role in ACOs and networks — will drive new streams of M&A activity in the next few years. This is likely to be in addition to the usual background noise of intra-segment swapping of hospitals among the for-profits and the already strong deal stream of local and regional nonprofits building their delivery systems and infrastructure.
The need for capabilities

We believe that one other major development will also be at work in the M&A world for providers: transactions driven less by traditional asset plays (hospitals, mostly) and more by the need to gain and enhance capabilities to succeed in the new world of reform and ACOs. For example, advanced information systems that not only link patient records to multiple providers (and consumers) but also link directly to bedside plans of care and care management will be critical to success in the new world. Look for transactions that seem to be “old fashioned” asset plays but are in fact targeted at acquiring a jump start in developing and enhancing key capabilities. Again, it is important to remember that talk and strategies focused on, say, ACOs are really about getting control over cost at multiple levels of the value chain. Controlling a market geographically is necessary but not sufficient for success. Managing health and healthcare costs at the population level and at the bedside will challenge all players to develop new capabilities in depth.

Of course, some of the steam may come out of the M&A arena if healthcare reform is repealed or even if just the universal mandate is ruled unconstitutional. While this would be unlikely to affect much of the deal flow (driven by pre-reform factors and strategies) or the ongoing subsidized investment in advanced information systems, it would have a chilling effect on some of the possible transactions between public/safety-net hospitals and potential acquirers and partners. Without reform, hopes would fade significantly that reimbursement changes and nearly universal insurance coverage could dramatically improve the financial prospects of struggling public hospitals.

Over the next few years, we expect to see M&A activity continue its upward path. With an improving economy, this would likely occur even without reform. With healthcare reform in place (or just viewed as likely to survive), more degrees of freedom are available to acquirers and targets alike.
Network building among local/regional nonprofits will continue to generate the greatest number of transactions. As in the past, the bulk of these deals will be mergers — often involving little or no cash up front, but with promises of major downstream reinvestment.

Physician-group acquisitions may slow somewhat, due to the shrinking universe of attractive targets and opportunities to grow via hiring/employment in existing practices within integrated delivery systems. The recent trend of acquiring traditionally entrepreneurial specialties will continue, but more because of doctors seeking “shelter from the storm” than because of major strategic imperatives for hospitals and systems. However, geographically and organizationally attractive practices (many of them primary care) will see intense interest, as local/regional systems seek to build out non-acute assets in preparation for ACOs and similar arrangements.

Some marquee-level multispecialty group practices may seek acute-care assets to develop or enhance their own integrated delivery systems. While such transactions will receive headlines, they will be relatively few in number.

Catholic hospital systems will closely watch the downstream implications of CHW’s ownership changes and, if they are generally successful, will soon follow their lead. This should raise the profile of Catholic hospitals and make them among the most active M&A segments among providers — as they seek to become more important players in local/regional integrated systems. If successful, we expect to see additional consolidation of Catholic hospitals into the larger, national conglomerations.

Many public/safety-net hospitals will receive much more attention going forward as potential players in integrated systems. This interest should come from all sides — for-profits, secular nonprofits, and Catholic hospitals. Although Catholic hospitals are potentially well positioned as they alter their ownership arrangements (à la CHW), they may still be disadvantaged as local politics trump promises (as recently occurred in Louisville). However, if constitutional issues impinge on reform, activity in this segment will decline sharply.

Although many payors are flush with recent profits and cash, boundary-busting deals like Highmark/West Penn are unlikely to be common. That deal is probably sui generis and driven by specific local issues. Neither do we see provider systems making major M&A moves into the payor space — since many of the issues in play can probably be resolved through alliances and partnerships. That said,
we do expect some payors to cross the provider/payor boundary more modestly — acquiring primary-care group practices, the key to gaining some degree of control over population-based costs and care management.

- Most existing boundaries on the value chain will remain in place. Acute-care players will avoid the risks and vagaries of long-term care, for example, and we see no strong rationale for acute-care players to move into such areas as hospital-based physician specialties.

- Look beyond the headlines of announced deals to see if specific transactions are asset plays or capability plays (or a combination of the two). Though hospital assets may represent the bulk of a given transaction, the real gems in the deal may be capabilities-based, such as advanced patient-management IT, established and successful physician-management models and brands, ambulatory-care locations, and operating models.
Conclusion

Ultimately, new provider M&A strategies and transactions will be judged by their ability to maintain and build market share, improve outcomes, and sustainably drive down the real costs of care (measured holistically, not episodically). Achieving these ends will not be the result of the deals themselves, but rather the hard work of integrating, enhancing, and managing the reconfigured pieces of the puzzle. We wish all players good hunting and good luck.
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