Why so many deals have failed, and how to succeed in the future
Contacts

Beirut

Jad Bitar  
*Partner*  
+961-1-985-655  
jad.bitar  
@strategyand.pwc.com

Gabriel Chahine  
*Partner*  
+961-1-965-655  
gabriel.chahine  
@strategyand.pwc.com

Berlin

Peter Behner  
*Partner*  
+49-30-88705-841  
peter.behner  
@strategyand.pwc.com

Chicago

Gary Ahlquist  
*Senior Partner*  
+1-312-578-4708  
gary.ahlquist  
@strategyand.pwc.com

Minoo Javanmardian,  
*Ph.D.*  
*Senior Partner*  
+1-312-578-4712  
minoo.javanmardian  
@strategyand.pwc.com

Igor Belokrinitsky  
*Partner*  
+1-312-578-4808  
igor.belokrinitsky  
@strategyand.pwc.com

Anu Sharma  
*Principal*  
+1-312-578-4553  
anubhuti.sharma  
@strategyand.pwc.com

New York

Joyjit Saha Choudhury  
*Partner*  
+1-212-551-6871  
joyjit.sahachoudhury  
@strategyand.pwc.com

Jack Topdjian  
*Partner*  
+1-212-551-6601  
jack.topdjian  
@strategyand.pwc.com

Shanghai

Sarah Butler  
*Partner*  
+86-21-2327-9800  
sarah.butler  
@strategyand.pwc.com
About the authors

Sanjay B. Saxena, M.D., was formerly a partner with Booz & Company.

Anu Sharma is a principal with Strategy& based in Chicago. She focuses on M&A, new operating models, and large-scale cost and capabilities transformations for hospitals, health systems, and health plans.

Anne Wong is a principal with Strategy& based in Chicago. Part of the firm’s health practice, she focuses on M&A and strategy development for hospitals and health systems.

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Brett Spencer, M.D., Gary Ahlquist, Gerald Adolph, Sara Richlin, Tatiana Ridley, Avtar Varma, Minh Chau, and Sam Semerjian all contributed to this report.
Executive summary

Federal healthcare reform and deep budget cuts at the state level are reshaping the competitive landscape among U.S. hospitals and health systems, and spurring a wave of mergers and acquisitions (M&A). Yet many of these deals have been opportunistic and reactive. With so much activity under way and more on the horizon, Strategy& conducted a pair of studies to better understand the factors critical to success.

Our first study showed that the majority of recent deals in the sector have been financially unsuccessful; only 41 percent of hospitals acquired between 1998 and 2008 outperformed their market peer group. Further, we found that time-honored M&A drivers, such as geographic proximity, increase in bed capacity, and payor concentration in the market, do not predict success. By contrast, our second study found that an M&A strategy aimed at leveraging the capabilities systems of the partners is overwhelmingly successful. Our analysis of the 30 largest transactions during a similar period showed a 27 percent premium over deals with a limited capabilities “fit.”

These findings have profound implications for M&A strategy. A recent Strategy& report, “Charting a Clear Course in Rough Seas: A New View on Hospital & Health Systems Strategy,” described five operating models that we predict will become increasingly relevant for hospitals and health systems: scaled portfolio, geographic cluster, hub-and-spoke, innovation, and location-based systems. Each of these choices requires a distinct set of capabilities that is essential to success. M&A strategy must begin with a clear model choice and deliberately seek out targets and markets that complement it. Without this capabilities fit between the acquirer and acquired, the odds are high that the result will be an expensive mistake.
A merger wave

Hospital and health systems merger and acquisition (M&A) activity is on the rise again, after years of near zero growth. The total number of U.S. deals in 2012 topped 100, double the number from three years earlier. The forces behind this M&A trend are powerful, complex, and interconnected. Federal healthcare reform is changing the reimbursement mix for Medicare and Medicaid, deep budget cuts are occurring at the state level, and commercial payors are successfully holding the line on costs. These developments are putting intense financial pressure on hospitals and health systems. At the same time, credit markets have tightened for many organizations, reducing access to the capital necessary to fund critical IT and infrastructure projects. The net result is a new wave of consolidation among healthcare providers to lower costs, raise capital, better coordinate care, and more efficiently manage a population’s life cycle of health needs (see Exhibit 1, next page).

Virtually every hospital and health system will be touched by the new wave of deals, as an acquirer, an acquired company, or an organization contemplating such moves. Even if a hospital or health system does not intend to pursue M&A activity, or wants to remain independent, it must have a plan in place to thoughtfully consider M&A opportunities and offers as they arise, to effectively navigate the changing post-reform landscape.

We are already beginning to see some patterns in the current wave of M&A activity, much of which has been opportunistic and reactive. For-profit hospital and health systems (FPs) on the whole demonstrate a stronger financial position than their not-for-profit (NFP) counterparts. Unsurprisingly, FP health systems have initiated some of the largest acquisitions recently, including HCA’s purchase of the remaining interest in HealthOne for US$1.4 billion and Health Management Associates’s purchase of Mercy Health Partners for $532 million. For their part, NFPs are making local acquisitions to build geographic coverage and/or integrate service lines, such as Ascension Health’s
Exhibit 1
Hospital and health systems M&A activity is rising again

1994–97
Threat of managed care drives a frenzy of M&A activity in mid-1990s, reaching a peak in 1997

2004–07
Access to low-cost debt drives private equity–fueled buyouts and megamergers

2010–present
M&A activity picks up again as PPACA is signed into law


Source: Capital IQ; Irving Levin Associates; Strategy& analysis
acquisition of Alexian Brothers Health System and Trinity Health System's acquisition of Loyola University Health System. Both FPs and NFPs continue to acquire physician practices to expand geographic coverage and build attractive specialties such as cardiac care.

Stand-alone hospitals have become increasingly vulnerable targets, as payor contract negotiations and government spending cuts put pressure on revenue and margins. These hospitals are increasingly seeking health system partners that provide access to a larger revenue base, economies of scale, breadth and scope of services, and larger investment portfolios. Being geographically dispersed also helps to offset localized cost and competitive pressures (see Exhibit 2).

Exhibit 2
Stand-alone hospitals are increasingly vulnerable as takeover targets

<table>
<thead>
<tr>
<th></th>
<th>Health systems</th>
<th>Stand-alones</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>7.1%</td>
<td>2.8%</td>
</tr>
<tr>
<td>2011</td>
<td>7.5%</td>
<td>-2.1%</td>
</tr>
<tr>
<td>2010</td>
<td>-2.3%</td>
<td>-2.4%</td>
</tr>
<tr>
<td>2011</td>
<td>-2.3%</td>
<td>-2.3%</td>
</tr>
</tbody>
</table>

Median operating margins (2010–11)

Source: American Hospital Association (AHA) database; Fitch Ratings 2011; S&P, U.S. Not-for-Profit Health Care System Fiscal 2010 Median Ratios; Strategy& analysis
With so much M&A activity in the works, and more expected on the horizon, we conducted a pair of studies to understand the historical success of hospital and health systems M&A, and to determine which factors are critical to success. Our first study found that most deals have failed to live up to financial expectations. A Strategy& examination of a representative sample of 219 hospital and health systems M&A deals between 1998 and 2008 found that only 41 percent of acquired hospitals outperformed their market peer group, defined as hospitals that share the same ownership type, facility size, state, and tax status (see Exhibit 3). This calculation is based on the acquired hospital’s operating income and margins during a five-year period — two years before, one year during, and two years after the deal.

Exhibit 3
Fewer than half of acquired hospitals outperformed their peer group

Percentage of U.S. hospitals with superior relative operating performance improvement*  
Number of acquired hospitals = 219

* Calculated as relative change in operating income and operating margins vs. those of peers over the five-year period between two years before and two years after deal closing. Peer group was defined as hospitals that share the same ownership type, facility size, state, and tax status.

Source: Capital IQ and American Hospital Association (AHA) databases; Strategy& analysis
Disturbingly, about one in five acquired hospitals (18 percent) actually went from having positive margins before a deal to negative margins two years after the deal (see “Study One Methodology,” page 12).

Further, our study found that market-related variables traditionally used to justify M&A — such as similar tax status or religious affiliation of the partners, geographic proximity of acquirer and target, or payor concentration in a market — do not predictably lead to better performance. Likewise, operating variables — such as the number of beds, occupancy rates, and length of stay — are also inconclusive.

For example, of those deals that resulted in more beds, 39 percent outperformed the broader market; of the deals that resulted in fewer beds or no change in the number of beds, 42 percent outperformed the broader market. In other words, whether a deal increased or decreased beds, the level of outperformance was virtually the same. Occupancy rates and length of stay show a similar lack of predictive strength.

Interestingly, deals involving academic medical centers, which are frequently considered attractive partners because of their depth of clinical research expertise, have an even lower success rate, less than half that of hospital and health systems deals generally.
A new M&A playbook is needed

Now more than ever, the industry needs an innovative way to look at M&A strategy. Hospital and health systems deals are growing more complex, not less. As the industry moves toward new care delivery and financing models that focus on the total health needs of a given population, M&A deals will involve “unlike” combinations that consist of insurers, academic partners, and physician groups compared to traditional horizontal consolidations of similar organizations. As experience from the 1990s shows, history does not favor such deals.

One thing is certain: The industry needs a new M&A playbook that draws on the lessons of the past and the needs of the post-reform world. To this end, we looked for lessons from other industries. We found particularly relevant insights in “The Capabilities Premium in M&A” (strategy+business, Spring 2012), written by our colleagues Gerald Adolph, Cesare Mainardi, and J. Neely at Strategy&. In 2011, this team analyzed the 40 largest closed deals between 2001 and 2009 across eight industry sectors: industrials, electric utilities, consumer staples, media, healthcare, chemicals, information technology, and retail. They found that across industries, successful acquirers enhanced their distinctive capabilities systems, leveraged those capabilities systems, or did both. Those with a limited fit between capabilities faltered. Overall, the average compound annual growth rate (CAGR) for limited-fit deals was 12 percentage points lower than that of the others.

We define a capabilities system as three to six mutually reinforcing, distinctive capabilities that are organized to support and drive the institution’s strategy, integrating people, processes, and technologies to produce something of value for customers. These are not the “keep the lights on” capabilities that every major organization needs just to stay in business, such as bare-bones legal, tax, HR, and facilities management capabilities. Nor are they the competitive necessities, or “table stakes,” that apply to particular industries (though there may be some overlap).
Rather, they are differentiated and complementary, working together reliably and consistently to deliver a specified outcome, in support of an organization’s long-term strategy and market position. For example, Mayo Clinic’s distinctive capabilities system, which focuses on team-based medicine supported by a robust electronic medical record (EMR) system and thoughtfully designed facilities, enables diagnosis and treatment in a short period of time, and lies at the heart of the institution’s destination medicine strategy.
Methodology

Study one methodology: Do hospital acquisitions result in superior performance?

We analyzed a representative sample of 219 hospitals acquired by other hospitals or health systems between 1998 and 2008 whose performance data was available. These hospitals represent 32 percent of all deals that occurred during this period. To test deal performance, we calculated the change in operating income and operating margins for the acquired hospital from two years before a deal to two years after the deal. We then compared the change in operating income and margins for the acquired hospital to that of its market peer group.

The market peer group included hospitals in the same state, of similar size, and with the same tax status. We identified “outperformers” as those acquired hospitals whose change in both operating margins and operating income was greater than for their market peer group. We conducted further analysis to identify any predictive variables that explain outperformance, including tax status, religious affiliation, academic affiliation, level of payor concentration in the market, size of the acquirer, and change in discharges, beds, and occupancy rates.

Study two methodology: Do capability considerations result in superior M&A performance?

In our second study, we analyzed the 30 largest M&A deals completed by publicly held health systems that involved acquisitions of other hospitals or health systems during the last 15 years. The analysis was limited to publicly listed organizations because of data availability. We compared the change in stock price for the acquired organization, from one week before the deal was announced to two years after the deal closed, to the change in the market index (S&P 500) during the same period. In parallel, we evaluated deal intent and level of capabilities fit based on publicly available press releases, organization statements, annual reports, and Strategy& expertise. In the sample, 40 percent of the deals analyzed were found to enhance or leverage capabilities, and the remaining 60 percent demonstrated a limited capabilities fit.
In our second study, we wanted to see if our colleagues’ cross-industry results would hold true for hospitals and health systems. To that end, we looked at the 30 largest M&A deals involving publicly owned health systems during the last 15 years. The results were unambiguous: M&A deals based on capabilities fit decisively outperform deals with limited capabilities fit (see “Study Two Methodology,” page 12).

To measure deal performance, we compared the change in the acquired company’s stock price, from one week before the deal was announced to two years after the deal, to the change in the market index (S&P 500) during the same time period. In parallel, we evaluated each deal’s intent and level of capabilities fit. To help understand the intent, we examined corporate announcements, external press coverage, and SEC filings. Our “fit” classifications included the following:

- **Enhancement deals** in which the acquirer added new capabilities to fill a gap in its existing capabilities system or respond to a change in its market;

- **Leverage deals** in which the acquirer took advantage of its current capabilities system by applying it to incoming products and services; and

- **Limited-fit deals** in which the acquirer largely ignored capabilities. These deals didn’t improve on or apply the acquiring institution’s capabilities system in any major way. In fact, these deals often involved a product or service that required capabilities the buyer didn’t have.
For the fit classification, we ultimately relied on our judgment, analysis, and experience with clients. When deals appeared to have multiple goals, we slotted those deals into the single main category that we believed they fit best. We were also careful to keep the financial analysis of each deal separate from our capabilities-fit assessment to avoid biasing any judgments.

The results were stark, and every leader contemplating an M&A deal should take note. Our research showed that deals intended to enhance or leverage capabilities enjoyed a total premium of 27 percentage points over deals with a limited capabilities fit. Further, the average return for deals with a limited capabilities fit was negative 32 percent.
**Why capabilities matter**

M&A deals focused on a capabilities fit outperform for several reasons. First, a capabilities-based M&A creates “coherence,” which is a better starting place for value creation than an attractive valuation or seemingly complementary asset portfolios or missions. Coherence is the advantage an institution accrues when it has a seamless alignment among three elements: its capabilities system (the way it delivers its value proposition to stakeholders); its market position (its distinctive way of serving patients, physicians, and payor stakeholders); and its lineup of products and services (its clinical offerings and targeted patient segments). In short, coherence creates an “essential advantage” and is the source of sustained value creation.

Second, focusing on capabilities gives leadership a sharper perspective on what M&A plays are most advantageous and how to apply capabilities to greatest effect in the future. In other words, hospitals and health systems with a capabilities lens tend to be selective in their acquisition targets and markets, and have a clear understanding of the contexts in which their specific capabilities system can be applied effectively. This is in sharp contrast to bending themselves to seemingly attractive opportunities in reaction to the actions of competitors or short-term business performance considerations.

Last, focusing on capabilities enables a more nuanced integration approach, one designed expressly to capture identified value, and can better unlock the benefits in “unlike” mergers, which will become increasingly more prevalent. Traditional integration approaches are primarily concerned with merging assets to maximize synergy opportunities; they focus on the footprint, head counts, operations, and cost reductions. In the process, organizations frequently end up destroying the unique capabilities they have acquired. Other times, the pendulum swings too far in the other direction. Leadership assiduously avoids inappropriate integration and winds up not merging the two entities at all.

A capabilities-based integration, by comparison, is clearly focused on preserving and enhancing the value of the acquired capabilities and blending them into the core. In other words, the end-state business model — instead of the single-minded pursuit of synergies — drives the integration of assets and processes.
In a recent Strategy& report, “Charting a Clear Course in Rough Seas: A New View on Hospital & Health Systems Strategy,” we described five operating models that we predict will become increasingly prevalent among hospitals and health systems. Each model implies a distinct capabilities system with a unique way of creating value. M&A strategy must focus on finding targets and markets that enhance or leverage the capabilities system that underpins the model. These are the five operating models:

- **Scaled portfolio systems** operate a portfolio of care delivery assets, typically across a broad geographic footprint. This model drives value creation by sharing capabilities (through facilities such as electronic medical records, revenue cycle management, or regulatory compliance) across the portfolio to generate economies of scale and lower costs. In addition, these entities can identify clinical best practices and protocols through their learning experience within the network and apply them throughout the system. LifePoint Hospitals is an example of a system pursuing a scaled portfolio play (see “Case Study: LifePoint,” page 18).

- **Geographic cluster systems** concentrate care delivery assets in a contiguous market, typically close to where patients live. This model drives value creation by enhancing market power and building mutually beneficial physician referral relationships within the network. Steward Health Care in Massachusetts is an example of a geographic cluster system.

- **Hub-and-spoke systems** position a care delivery facility as a central hub and build a network of “feeder” care delivery facilities around it. The feeder facilities are typically tertiary- or quaternary-care hospitals, which refer only complex cases to the central hub. These systems create value by generating learning curve benefits at the hub (for example, by giving physicians opportunities to perform procedures like relatively complex heart transplants) as well as by operating all assets within the network at maximum utilization. Northwestern Memorial Hospital and Ochsner Health System are examples of hub-and-spoke system plays.
• **Innovation systems** offer a distinctive product or service. Innovation can take place across any dimension of care delivery, from clinical care to patient experience to care financing. The intellectual capital obtained by codifying innovation may be exported and monetized at other health systems — for instance, through cobranding. Cleveland Clinic is an example of a system pursuing an innovation play.

• **Location-based systems** are embedded in local communities. This is perhaps the most common operating model, especially dominant in rural areas, but also the most exposed to profitability pressure. Value creation comes from channeling demand from the captive local population, and providing more cost-effective ways to satisfy it. Once the market is outgrown, M&A plays can follow any of the paths described above.

Innovation can take place across any dimension of care delivery, from clinical care to patient experience to care financing.
Case study: LifePoint
How to build a coherent portfolio

Founded in 1999 as a for-profit spin-off from HCA, LifePoint began with 23 hospitals mostly in the southeastern United States. Since then, it has grown steadily using a scaled portfolio M&A play. With this approach, LifePoint has acquired about 20 hospitals, increased revenues to US$3.7 billion by 2011, and outperformed the S&P 500 since 2000. This impressive M&A performance is thanks, in large part, to a specific set of criteria and processes that ensure the organization acquires hospitals with the right capabilities so that LifePoint can capture their full value. This criteria and process include the following requirements:

• Targets must be acute-care hospitals with strong positions in nonurban markets with unmet specialty-care needs. Margins should be in the low teens with a potential to increase through operational improvements.

• After a deal closes, LifePoint applies a three-pronged capabilities system to acquired hospitals:
  
  Service line expansion: Win business from local competitors by strengthening existing service lines and building new specialties, such as cardiology and neurology;

  Physician recruitment: Attract high-quality physicians to undersupplied markets, in part by offering location preferences and flexible employment options, such as working a certain number of hours or seeing a certain number of patients; and

  Operational excellence: Integrate acquired hospitals into its IT systems and other operational processes to drive scale efficiencies across the system.

• Operate a “transition services division” that manages the M&A process and maintains communication and cooperation for several years after the deal closes to ensure a smooth transition to the LifePoint model in order to capture full value.

• Invest in leadership development so managers understand how to leverage LifePoint’s resources and technologies across the enterprise, and build specific skills in operating small hospitals in small towns.

Describing this philosophy, LifePoint CEO William F. Carpenter III recently told Becker’s Hospital Review, “We created strategies for each of our hospitals designed around recruiting the right physicians in the community, establishing new service lines that had not previously been provided in the community, and making appropriate capital investments in the hospital to allow physicians to provide care under these new service lines.”
Conclusion: Implications for success

Given the relentless financial pressure on the healthcare industry, it is clear that a new wave of M&A will reshape the industry in the next few years. But given the poor performance of past deals, leaders need a new M&A strategy that focuses on the best capabilities fit, not only on financial attractiveness.

This insight has four major implications for hospital and health systems leaders contemplating M&A in the current landscape. First, it is critical to begin with a clear choice of operating model and a deep understanding of the capabilities system that underpins it, and management must stay true to this choice. Second, evolve capabilities deliberately, not opportunistically. Third, instead of trying to bend toward targets and markets that appear “attractive,” select those that will thrive in your capabilities system. Last, when pursuing integration, ensure that the pursuit of synergies does not dilute or destroy the capabilities system that lies at the core of long-term value creation.

With these principles as a guide, M&A strategy has a higher likelihood of success, creating a new organization that is stronger and better positioned to weather the changing healthcare landscape than the old one. These principles will also help leaders of target organizations to judge the wisdom of a deal and objectively evaluate whether to wait for another suitor. Without the capabilities fit, as our research shows, the odds are high that most deals will end up being an expensive mistake.
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