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Diverse Activity Showcases New Rationale

By Anu R. Singh | May 17, 2017

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Healthcare transactions are becoming more varied in scope and type as entities seek to position themselves to compete in an evolving market.

Historically, the rationale for a healthcare merger or acquisition revolved around capital. Transactions typically involved acquisitions by larger entities of smaller hospitals, physician practices, or other providers that were struggling financially.

Recent trends in healthcare M&A demonstrate that partnerships are occurring between entities of all sizes and types, and for reasons that center on strategic advancement or repositioning. Looking at the broad landscape, providers are seeking the ability to form—or the opportunity to join—an integrated system or network that:

- Delivers health and healthcare services to meet consumer needs along the continuum of care under a population health model
- Finances that delivery system, assuming the risk for managing the health of a defined population
- Is committed to pursuing the Triple Aim

This new rationale reflects the fact that under the value-based model, the strategic goals of health systems, physician groups, and other providers will be accomplished by offering services with the best possible quality, access, and patient experience at the most efficient cost—and across clinicians, services, and sites, whether in person or virtually.

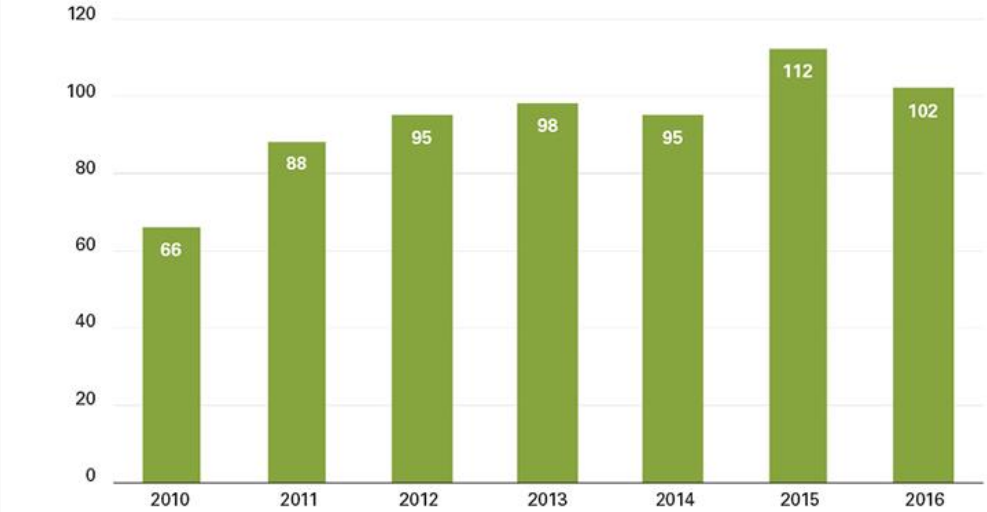
A high-performance delivery network includes hospitals, physician offices, clinics, labs and testing facilities, skilled nursing, home health, hospice, rehabilitation, and telehealth. Providers are partnering to gain the desired competencies (e.g., clinical integration, purchaser relationships, health IT infrastructure) along with pieces or the whole of the delivery continuum. In many cases they also seek to own or contract with a health plan that can finance the care.

Hospital-Hospital: Larger Players, Innovative Partnerships

For the second year in a row, the number of announced hospital-hospital transactions in 2016 exceeded 100, representing a 55 percent increase since 2010, according to a Kaufman Hall analysis (see the exhibit below). Many of the transactions involved partnerships between strong systems and took various forms and structures, including mergers, acquisitions, joint ventures, and joint-operating agreements. Four announced transactions involved organizations with annual revenues of more than $1 billion, led by the merger between Catholic Health Initiatives ($14.5 billion) and Dignity Health ($13.3 billion).

ANNOUNCED HOSPITAL TRANSACTIONS, 2010-16

This chart shows the reported combinations of acute care hospitals in the United States, including but not limited to mergers, acquisitions, joint ventures, and member substitutions.



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In 13 transactions during the past five years, smaller but strong organizations—those with a credit rating equivalent to "A-" or above—merged with large players. For example, Susquehanna Health, with an "A" category credit rating and four hospitals in north-central Pennsylvania, considered partnership opportunities through a strategic-options assessment. UPMC, in the western portion of the state, emerged from a group of more than 35 potential partners as the best choice to position the organization to operate in a population health model. The organizations merged in October 2016, with local Susquehanna governance retaining a two-thirds share.

In many cases, partnering organizations formed a new entity and transactions occurred across acute-care segments, including not-for-profit, for-profit, rural, urban, and academic entities. For example, RWJBarnabas Health was created through the 2016 merger of Robert Wood Johnson Health System, with its urban anchor university hospital and children's hospitals, and Barnabas Health, with its community-based teaching hospital and medical centers. Led by a single board

of trustees with equal representation of both partners, the new entity forms the most comprehensive health system in New Jersey. The goals are to support an academic mission and achieve the scale needed to advance population health in a broad geographic area.

Physicians: Hospital Employment, Bigger Groups

The scale objective also is a key driver in the physician space, where hospitals place strategic value on expanding their physician referral network to ensure that their patients have access to comprehensive primary and specialty care. In 2012, about 25 percent of physicians were employed by a hospital, at about 36,000 hospital-owned physician locations. By 2015, 38 percent of physicians were employed by hospitals across 67,000 hospital-owned physician locations.[1]

With a broad, regional network of physicians, hospitals can offer a comprehensive array of services to consumers and a convincing platform for arrangements with health plans and employers. Beyond the employment model, hospital-physician integration arrangements include joint ventures and other looser affiliations. To grow its integrated healthcare delivery network in a neighboring state, for example, California-based Dignity Health recently affiliated with Phoenix-based Integrated Medical Services, the largest multispecialty physician group in the Arizona Valley.

Many of the largest independent practice organizations (IPAs) in the Pacific Northwest and Southern California have partnered with a provider organization that was seeking to tap into the IPA's experience with managing risk. For example, 150-physician Pacific Medical Centers has affiliated with Providence Health & Services, Swedish Medical Center, and Seattle Children's Hospital.

The number of announced physician group transactions has averaged 78 per year since 2011, with a high of 108 in 2011 and a low of 60 in 2014, according to Kaufman Hall data. This level of activity reflects both the difficult operating environment for independent practices and physician groups and the interests of partnering entities in bolstering referrals and pursuing clinical integration.

With goals similar to those of hospitals, large physician groups and provider services management companies increasingly have been engaging in M&A activity. For example, in March 2016 DaVita HealthCare Partners, a leading independent medical group, merged with the Everett Clinic, a 20-site group practice in the Seattle area. The merger supports the goal of both organizations to expand their ambulatory care footprint in the Seattle region, which is moving rapidly to value-based care.

Private-equity buyers also are demonstrating renewed interest in physician groups, especially those that have strong management teams and are seeking growth capital to pursue strategic initiatives. An example is the recent acquisition by Summit Partners of DuPage Medical Group, the largest independent physician group in the Chicago area.

Post-Acute Care and Labs: Purchase and Partnering

The strategic rationale for M&A is evident also in the increased activity in the post-acute and non-acute spaces, with health systems and other large entities moving to shape their desired care-continuum networks.

Publicly announced nursing home transactions increased from 90 in 2013 to 148 in 2015.[2] Some of this activity involved hospital arrangements with skilled nursing companies, either to monetize non-core facilities or to secure joint ventures. Given that hospitals face increased responsibility for post-acute expenditures under new payment arrangements (e.g., mandatory bundles), many are forging closer alliances with nursing homes, home health and hospice agencies, and other entities to improve care coordination and reduce total cost of care.

Meanwhile, hospitals account for 59 percent of lab services. With continuing downward pressure on prices, hospitals are assessing strategic options and looking to partner to achieve their objectives on the laboratory front. Last year, for example, four-hospital West Tennessee Healthcare agreed to provide local testing services in partnership with Quest Diagnostics, which would provide IT/connectivity solutions and billing, courier, and client services.

Health Plans: Vertical Growth With Risk Arrangements

The strategic rationale for M&A activity extends vertically as well. In recent years, integration of health systems into the health plan space through built, bought, or partnered provider-sponsored health plans (PSHPs) has increased. More than 10 percent of U.S. health systems operate more than 100 health plans covering about 18 million individuals, or 8 percent of insured lives.[3]

By assuming full risk for a population through PSHPs, health systems receive the full premium dollar, with which they can achieve greater improvements in quality, access, and cost efficiencies, enabling growth of the covered population. To attain further growth, for example, Partners HealthCare, the Boston-based hospital and physician network, acquired Neighborhood Health Plan in 2012. No exchange of capital occurred, but Partners promised to provide grants to dozens of community health centers affiliated with the plan.[4] Other health systems have pursued joint ventures or contractual arrangements to build risk and financing capabilities as alternatives to full ownership.

PSHPs also are merging. For example, Unity Health Insurance, an affiliate of University of Wisconsin Health, and Gundersen Health Plan, a subsidiary of Gundersen Health System, merged last year to serve members throughout southern and western Wisconsin and parts of Illinois, Iowa, and Minnesota. The expanded geography and portfolio of products enhance the combined company's ability to manage the health of larger populations.

Long-Term Implications

By 2025, healthcare costs are expected to comprise 20 percent of the nation's gross domestic product.[5] Unsustainable economics, consumers with high-deductible health plans, nontraditional

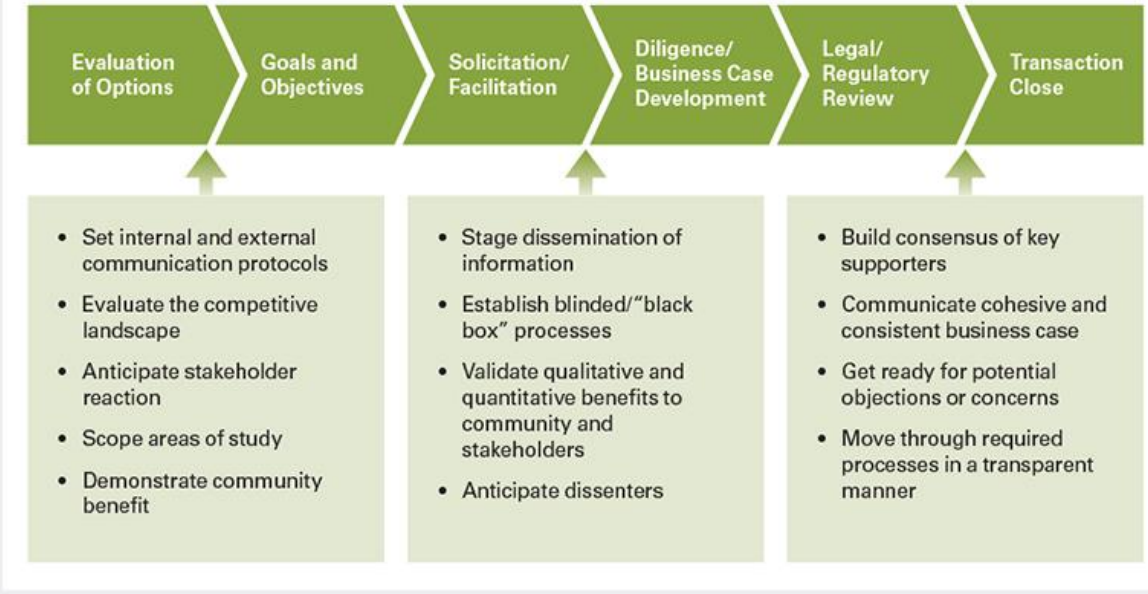
competitors, and new virtual and digital technologies are compelling organizations to find ways to improve quality and access while lowering costs.

Hospital and health system leaders believe that size and breadth of services will be critical factors in meeting the demands of health care's new model.[6] Much of this scale will be achieved through partnerships. For hospitals, strategic partnerships with physician organizations and with post-acute and ancillary providers will become more common as legacy systems expand their care continuums to manage or participate in an optimized network.

Efforts to build value-based capabilities will include horizontal (provider to provider) and vertical (provider to health plan) integration. In some markets, scale may not require a multibillion-dollar revenue base. An organization with significantly less annual revenue may be able to assemble a sustainable delivery continuum to lower costs and improve quality and outcomes for a defined patient base in its specific geography.

BEST-PRACTICE PLANNING FOR HEALTHCARE PARTNERSHIPS

A "partnering roadmap" based on solid planning and best practices can help healthcare leaders achieve successful strategic partnerships going forward.



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With the pool of potential strategic partners narrowing, organizations that lack an approach to partnerships should start developing a strategy. Timely and thorough planning is critical to demonstrate community benefit, ensure common goals, and address issues and regulatory concerns.

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Footnotes

1. "Physician Practice Acquisition Study: National and Regional Employment Changes," Physicians Advocacy Institute, September 2016.

2. Irving Levin deal database as cited in "Industry Flash Report—U.S. Nursing Home Sector," Kaufman, Hall & Associates, July 2016.

3. Khanna, G., Smith, E., and Sutaria, S., "Provider-led Health Plans: The Next Frontier—or the 1990s All Over Again?" McKinsey& Company, 2015.

4. Overland, D., "Partners affiliates with Neighborhood Health Plan," *Fierce Healthcare*, undated.

5. Keehan, S.P., Stone, D.A., Poisal, J.A., et al., "National Health Expenditure Projections, 2016-25," *Health Affairs*, March 2017.

6. Noether, M., and May, S., "Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis," Charles River Associates, January 2017.

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