Did you know?
Healthy Merger and Acquisition (M&A) activity in the healthcare sector led to strong results in 2011. The M&A market saw 980 deals worth $227.4 billion, exceeding the $205.6 billion generated in 2010 by 11%. The payer and provider sectors have had a particularly robust year in terms of the volume and value of deals. In 2011, 481 deals were announced, exceeding the 383 deals announced in 2010 and the 353 deals announced in 2009. The 2011 deals generated approximately $76 billion, surpassing the $56 billion generated in 2010 and the $12 billion generated in 2009. PwC expects strong M&A activity in the payer and provider sectors to continue into 2012.

Issue
This noticeable activity was preceded by a period of calm. Prior to the start of the recession and the push for healthcare reform, when the U.S. economy was stable and growing, reimbursement was steady with no major changes on the horizon. Confident of a regular income stream, the industry expected continued healthy returns. Post-recession, the number of deals continued to stay low, partly due to challenging or tight credit conditions as a result of the fallout from credit default swaps.

But then things changed. Declining reimbursement levels, increased capital needs, a weak economy, and easier access to credit have all been attributed to the significant consolidation occurring in the healthcare arena. In fact, these factors and others have all contributed to healthcare being an increasingly difficult business, a business in which the chances of survival — and profit — can sometimes increase with size.

The downside of consolidation
A confluence of events is forcing healthcare leaders, particularly those at hospitals, to re-examine their long-term growth strategies. In some parts of the country, a poor economy, rising uncompensated care, a growing Medicaid population, and declining Medicare reimbursement are conspiring to make it difficult for small hospitals — particularly rural ones — to survive on their own.

But consolidation does not make good business sense for everyone. Even small-scale mergers carry a lot of risk, and the industry is littered with deals gone bad. In fact, two-thirds of all deals do not achieve pre-merger expectations, making the stakes of not “getting it right” high. Exhaustive due diligence before a deal is essential, and any warning signs should be heeded. While it is easy to get swept up in the “bigger is better” mentality, unforeseen consequences await those hospitals that leap before they look.

Common reasons transactions do not meet expectations include overpaying, culture clashes, inadequate due diligence, failure to retain key employees, ineffective communication programs, excessive debt, and extended integration. Some red flags may signal the potential of a deal going bad:

- “Deal fever,” causing underestimation of the impact of key issues
- Overly aggressive projections
- Reimbursement changes
- Compliance issues
- Unrecorded liabilities
- No robust integration plan

Hospitals would do well to keep in mind the mistakes that followed the rush to consolidate in the 1990s. Learning from history is the best way not to repeat it.

Footnote
1 Findings from PwC’s 2011 M&A Integration Survey
When consolidation makes sense
Consider a stand-alone, not-for-profit small hospital that has been a pillar of its community for the past 50 years. As a safety-net hospital, it attracts a significant Medicaid population and serves a considerable number of uninsured. It has always had thin operating margins, which have limited capital improvements, but disproportionate share payments (DSH), philanthropy, a balance of commercial payers, and a healthy return on investments have enabled the hospital to maintain its infrastructure well.

The recession hit the hospital’s community hard, and it has had to care for an increasing number of non-paying patients. Declining reimbursements from governmental and non-governmental payers and historically predictable rate updates not keeping pace with increasing costs have added to the fiscal pressure on the hospital. Healthcare reform will reduce DSH payments significantly, and philanthropic income has fallen to new lows. And now the hospital is told that its reimbursement from its largest payer — Medicare — will soon be conditional on its ability to report clinical information. It must invest in an electronic health record to gain these capabilities; if it doesn’t, it will face even more Medicare cuts. Loath to close its doors on the community it has served for so long, the hospital expresses its desire to merge with a well-capitalized partner.

To succeed under today’s new payment schemes and regulations, significant infrastructure investment — in IT, quality, and clinical care — is necessary. Sometimes, the only option left to a hospital that cannot afford these investments is to seek out a partner or put itself up for sale. Financially weak providers can often attract buyers in today’s market without much trouble. Meanwhile, strong players stand to gain a significant return on investment if they can cut waste in an acquired hospital and quickly turn it around.

In this atmosphere, consolidation is not an unfortunate byproduct of healthcare reform and new payer reimbursement schemes. Rather, it is an expected result of a healthcare delivery system that is incentivizing providers to be larger and share a financial risk for patient populations in the name of driving efficiency and cutting cost. Less reimbursement and enhanced regulation mean that providers must learn how to create economies of scale to be profitable. To accomplish this, some providers are merging with one another or assuming risk-taking capabilities. Heavy M&A activity in 2011 reflects the movement of large hospitals absorbing smaller hospitals and local physician practices in an attempt to gain market share and control costs. As 24/7 businesses, hospitals have high fixed costs. Through the years, many hospital systems have been able to acquire other hospitals, consolidate volume, and reduce duplicative fixed costs.

Health reform, however, has added another impetus to merger activity. The more a hospital system can control costs inside and outside hospital walls, the more it can engage in the new risk-based payment models.

Managing populations
The Affordable Care Act directed Medicare officials to address rising costs through a new shared savings model called an accountable care organization (ACO). ACOs are tasked with managing the health of a regional population of at least 5,000 Medicare beneficiaries. Reimbursement under accountable care rewards providers that can manage their population’s health outcomes and prove their success through reported quality and savings metrics. The model encourages providers to establish comprehensive medical homes that encourage prevention and coordinate physician services and other treatments.

Many providers view risk-based models such as ACOs, bundled payments, and value-based payments as the inevitable wave of the future, although the structure of a successful delivery model is still evolving. Some providers have determined that to engage in a population health strategy, they need to control costs along the continuum of care. These providers view mergers as a way to control costs under risk-based payment models. They know that the more patient care they control, the better their chances of successfully managing patient outcomes. And outcomes are the new premium in determining payment.

The advantage of size
The ability of merged institutions to leverage their scale can give them a marked advantage in the marketplace. Larger institutions may enjoy:

- Reduced levels of management and service line redundancy
- Strengthened brand equity
- Superior pricing power
- Better access to financing and credit
- Consolidated billing and administrative processes
- Group purchasing
- Streamlined contracting
- Labor efficiencies
- Expanded local and regional provider networks
- Better access to patients through physician referrals
- Expanded scope of services
The best of frenemies: Payers and providers

Payers and providers have traditionally operated within their own boundaries, and a tremendous amount of inefficiency has resulted as each one has tightly guarded its own turf. Now, in the rush to build scale and prosper under accountable care models, payers and providers are reaching out to one another to collaborate through care coordination initiatives. They are realizing that there are potentially significant returns to be gained from better coordinating with the entire healthcare system and tearing down the walls that separate them. A significant amount of waste is hidden within the disconnects that have historically divided payers and providers.

Payers believe they can bring risk management and efficiencies to healthcare delivery, and, toward that end, they have been slowly adding physician groups and hospitals to their operating portfolio. In fact, in the past year, health insurers have committed more than $2 billion to acquire or align with physician groups, clinics, and hospitals, according to PwC estimates. Consequently, four of the five largest health insurers increased their physician holdings during the past year. Some payers are launching physician management companies with their new assets.

But as payers and providers eye one another as potential partners in care delivery, they are also new rivals in the rush to control primary care. At the epicenter of care management, primary care is one of the most attractive assets under the accountable care model, which rewards providers that successfully monitor patients throughout the continuum of care. There is already a shortage of primary care physicians (PCPs), which is projected to get worse as more people obtain insurance under healthcare reform. Expect the land grab for PCPs to heat up as healthcare reform progresses.

With quality ultimately expected to replace volume as the main determinant of reimbursement, the traditional roles of payers and providers are shifting in fundamental ways.

Private equity wary

The potential gains from increased efficiency and economies of scale are inciting some experienced private equity (PE) firms to invest further in the healthcare services market. There has been increased interest from dedicated healthcare funds to explore evolving business models that incorporate integrated delivery models and greater outcomes risk.

But many firms — in particular, those that are not already invested in the healthcare arena — are, for now, staying away from hospitals and other providers. With the current uncertain regulatory environment, it is likely to be a while before we see many PE firms investing in providers. Investors hate uncertainty, and they are unlikely to undertake significant deals when potentially large changes to regulations and reimbursement are unresolved.

In the meantime, PE firms that want to invest in the healthcare arena are likely to be more attracted to medical device businesses and pharmaceutical companies where there is greater visibility around reimbursement issues.
Firmly established in healthcare systems outside of the United States, a public-private partnership (PPP) is a contract between the public sector and the private sector in which both parties agree to furnish a service or an asset for the public benefit. The two parties subsequently share in the associated risks and benefits of their venture. In the U.S. healthcare industry, a unique brand of PPPs is emerging in which private capital is used to invest in public assets or deliver public services with the end goal of providing a return on investment.

Converting public sector to for-profit

Given the increasing frequency of distressed public sector hospital transactions, the U.S. provider sector is adapting its own flavor of PPPs to accommodate the needs of buyers, sellers, and community stakeholders. In the past, for-profit organizations (e.g., private equity firms and for-profit health systems) have been the buyers of last resort in public sector transactions. These hospitals have historically been wary of pairing themselves with for-profit companies. Yet public sector hospitals are among the entities most in need of outside investment to build and maintain their infrastructures and service offerings. In many cases, today’s public sector hospitals are faced with the choice of closing their doors or going to a for-profit provider or private equity firm for rescue.

As these institutions come together, a growing trend is taking root through the PPP model whereby buyers convert distressed public sector hospitals into for-profit entities while also preserving the community benefit of the original entity. This trend recognizes the often-competing interests of for-profit buyers, mission-driven public sector hospitals, and the surrounding communities. The PPP model attempts to reconcile these interests via sophisticated purchase terms and operating models that ensure individual interests are protected and risks are allocated among stakeholders. This allocation of risk and benefit between the public and private sectors is the hallmark of a PPP.

Aligning interests

The PPP model in the United States will likely increase in scope as public sector providers grow more savvy in their consideration of strategic transaction alternatives. Communities and these providers are recognizing that there is intrinsic value to their market areas under new models of care, and the value of these assets are worthy of concessions from for-profit buyers. These concessions may include economic benefits such as minimal levels of future capital improvements, limits on potential reductions in workforce, or assumption of certain liabilities (e.g., pension funds). More aggressive PPP models may be structured to preserve community benefits by guaranteeing access to care (e.g., 24/7 emergency department access), funding community outreach programs, or continuing representation at the local board level for community representatives. In return for these private sector concessions, the public sector may share in the operating and financial risk of the new organization by contributing other public sector assets. These assets may include favored tax incentives, lower-cost financing vehicles, zoning or other regulatory waivers, or the contribution of land or other fixed assets.

PPPs make conversions to for-profit operators more palatable to the community and the public sector provider, while also protecting the interest of investors. The challenge for both the private and public sectors will be to learn to speak the other party’s language — “profit” for investors and “mission” for the public sector — and then negotiate toward a middle ground.

Transforming care

PPPs are not new in healthcare; they have been used globally to create highly efficient healthcare systems that generate attractive returns while also providing a public benefit. The American style PPP has the potential to do the same through careful risk allocation, whereby each party exchanges skills or assets and accepts the risks they are best able to bear. PPPs can be highly flexible and diverse arrangements, representing a unique vehicle for transformation to a more sustainable health system. Most important, PPPs offer a mechanism to ensure that private partners maintain a community mission for the long term.
Additional reading

The following reports can be found on pwc.com/healthcare:

**Speed of integration improves M&A success***
PwC M&A Integration Survey Report 2008

**Breakthroughs: hospital merger and acquisition strategies**

**From transaction to transformation**

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