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Health-Care Transactions 2016 Forecast




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The past year was a very strong one for merger and acquisition activity, as witnessed in part by the list of select transactions announced and completed in December 2015. There do not appear to be any signs of significant slowing in the year ahead. The Affordable Care Act (ACA) continues to influence M&A activity, driving a number of vertical and horizontal transactions and creating health-care sectors populated by fewer, larger players. Continued movement away from a health-care payment landscape based predominantly on the fee-for-service model to one utilizing a variety of value-based payment models is increasingly shifting financial risk to providers and consumers.

Advances in health-care information and connected health technology, as well as the ability to capture, categorize, analyze and then use patient information to proactively intervene in patient care is helping health-care providers to better manage the health of targeted patient populations. Improved health-care IT also enables health-care providers to better respond to a health-care landscape that places greater risk upon them and provides more targeted incentives that reward optimal patient health outcomes and effective management of health-care costs.

These and other trends continue to drive a variety of hospitals, health systems and other providers to find new ways to collaborate and affiliate with one another and continue to attract substantial private equity interest and investment. Notwithstanding the presence of an active regulatory enforcement climate—including active enforcement on both the antitrust and fraud and abuse compliance fronts—all of the factors noted above should continue to drive robust health-care transaction activity through 2016.

Below are five trends related to the variety and types of health-care transactions, participants in the health-care sector and certain areas of health care where we expect to see strong deal activity in 2016.

Variety of Health-Care Provider Transactions. Hospitals and health systems continue to actively pursue consolidation to meet the ''Triple Aim'' of (i) improving patient care, (ii) improving the health of patient populations and (iii) lowering the per capita costs of health care. Merger and acquisition interest primarily has been spurred by access to capital, need for scale, rising valuations, changing payment methodologies that shift more financial risk to providers, the need to acquire the capabilities to manage the health of populations and a related desire to build market share and achieve geographic indispensability. At a time of exceptionally low interest rates, many health systems believe they're more creditworthy together and better protected against the downward reimbursement pressure related

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to the ACA. Hospital M&A activity includes the following: (i) large hospital/health-care systems are growing further through acquisitions of small hospitals and systems, (ii) national for profit hospital chains are actively pursuing hospital acquisitions of all sizes and (iii) ''mega-hospital'' systems are forming through the merger of large hospital systems in various regions.

Although traditional mergers and acquisitions, both horizontal and vertical, are expected to continue at a healthy pace, the significant number of hospitals, health systems and other providers entering into strategic affiliations or other partnership structures also has increased. These partnerships facilitate collaboration and the realization by each partner (and its patients) of benefits derived from the relative strengths and attributes of the other partner. These may take the form of clinically integrated networks, health-care collaboratives or other similar affiliation structures. In such strategic affiliations there is often a shared governance committee or other structure devoted to governing and managing the particular, agreed upon areas of collaboration between the parties. The parties, however, often concurrently maintain their respective traditional identities, missions and separate governance structures. We expect this targeted, strategic affiliation trend to continue in 2016.

Along these lines, we expect to continue to see significant activity utilizing joint venture structures between larger, national or regional providers and smaller, local health-care providers, where a full acquisition is neither desired nor indicated. The joint venture structure can give a smaller provider access to capital and the operating synergies of a larger system, while maintaining significant local control. Clinical affiliations, particularly in certain health-care specialty areas related to stroke care, cardiology, neurology and orthopedics, enable smaller providers and their communities to benefit from the clinical expertise of larger academic medical centers. Through an affiliation agreement, the larger provider typically provides clinical, management or technical and other assistance to health-care providers in other geographic regions and markets under an agreed upon brand (usually a derivative of the provider with the recognized expertise in the particular specialty). These types of affiliations are expected to continue to proliferate in 2016.

Transactional activity around formation and expansion of ACOs is likely to continue at a modest rate in 2016, notwithstanding the somewhat mixed record that they have had in achieving both improved patient health outcomes and cost savings. The continued pressure to move patients out of the inpatient and emergency settings and into outpatient settings also is likely to result in continued strong transactional activity in the urgent care sector—by hospitals, health systems, other providers and private equity firms—and involve assets that support the expanded use of the patient medical home model.

We also expect to continue to see significant transaction activity related to the formation or further development of narrow networks in an effort to achieve the aims of both cost management and improved patient quality metrics. Providers that are actively collaborating with each other and with health plans in participating in such narrow networks will need to be mindful about how they navigate pressures to contain and reduce costs and attempt to maintain or improve patient care quality while also responding to varying degrees of regulatory pressure to maintain certain minimum levels of access and patient choice.

Finally, we are reminded that, although many health-care structures, networks and affiliations are evolving and changing rapidly, many are not necessarily new. As payment models and the regulatory and payment landscape continue to change in fundamental ways, it is likely that 2016 will be a year for reassessment. Continually reviewing and updating a wide range of contractual arrangements by and between a variety of provider types to ensure that they adequately provide for sufficient alignment and are in sync with today's cost and quality goals and incentives will be a key focus in 2016.

Private Equity Investment. We expect private equity to continue to be a major participant in the health-care sector in 2016. Notwithstanding the tremendous consolidation that we have already seen in health care as of late, there remains significant fragmentation in certain health-care sectors, including, but not limited to, post-acute care providers and behavioral health providers, which will be discussed in more detail below. Greater scale, efficiencies and reduction of redundancies that private equity investors can bring to these health-care sectors can potentially do much to improve cost-containment goals and improve overall coordination and quality of care, in line with the goals of the Triple Aim. Success on these fronts may present an opportunity for substantial return on investment.

In addition to private equity and provider investment in these areas, we expect to see an increase in investment in inpatient care. We also expect to see investment in a large primary care and multi-specialty groups as well as wider variety of physician specialty practice areas, including, without limitation, ophthalmology, women's health, orthopedics and ear, nose and throat.

Health-care information technologies are still in relatively early stages (either in terms of development or in terms of degree of adoption and use). Notwithstanding, they are already showing great promise to potentially help better organize and use patient information to more proactively manage the health of patient populations in an effort to contain costs, provide better preventive care, better management of chronic health-care conditions and potentially improve overall health-care outcomes. We expect to see continued substantial investment in health-care information technologies and companies throughout 2016.

Outsourcing of former in-house, facility-based services also is likely to continue. In fields such as anesthesia, hospitalist medicine, nursing and radiology, it has become more common to utilize a service provider on an outsourced basis as opposed to incurring the full time fixed cost of the service. Specifically of continued interest is an ability to show reduction of costs for high-dollar areas of care in a hospital or facility setting such as operating room services, for example. Unique outsourced services that can target high fixed-cost areas and turn them into variable costs with greater efficiencies are a very attractive area for investment and consolidation. Given continued pressure on hospitals to reduce costs, as well as the rapid growth and success of large entities that have capitalized on this particular service outsourcing trend, the sector has continued to

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attract the interest of private equity groups and will likely continue to do so in 2016.

Post-Acute Care. Important changes in payment methodologies, increased focus on population health management and the Triple Aim and the increasingly pervasive shift of additional financial risk to providers are all contributing to heightened activity and investment in post-acute care providers. Health systems and investors are targeting, among other capabilities, nursing facilities, home health agencies, hospices, medical transportation and rehabilitation and therapy services providers. As mentioned briefly above, we expect to see continued significant activity in this sector in 2016.

In particular, the sector should continue to attract interest and investment from private equity firms, as demand for accessibility to such services should continue to increase as a result of an aging population and the need to better manage value-based payment risk across episodes of care. The introduction of bundled payments that may span multiple care settings and may include post-acute care after appropriate discharge from a more costly acute care facility, will further drive the activity in the sector. Fragmentation and inefficiencies in the post-acute care sector also should provide significant opportunities for return on investment, further attracting private equity investment and interest by hospitals, health systems and other providers.

Behavioral Health. Many of the factors noted in the discussion about what is likely to drive sub-acute care investment and transaction activity in 2016 are likely to drive increased transactional activity related to the behavioral health sector as well. Behavioral health services can include a range of professional services designed to improve mental and emotional well-being. Such services can include, without limitation, efforts to help patients improve how they cope with daily life challenges, treatment of mental illness—such as depression or personality disorder—and treatment of substance abuse disorders and other addictive behaviors.

The health-care industry's shift toward population health management and the Triple Aim is focusing attention on greater integration of behavioral health as a potentially potent means of reducing costs and improving the quality of patient care. Unnecessary hospitalizations and use of emergency room resources have often been linked to patients with behavioral health needs that have not been addressed adequately. Providers have long recognized the comorbidity of acute or chronic health concerns with patients who also have behavioral health issues. As a result, it is possible that greater access to appropriate behavioral health care may help prevent more expensive and avoidable medical care, furthering the goals of the Triple Aim.

In addition to the foregoing, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related legal developments that are directed at equalizing insurance coverage for behavioral health conditions are driving additional payment streams to behavioral health services. The MHPAEA mandates group health plan and health insurance coverage that includes both medical benefits and mental health or substance abuse disorder benefits to equalize those benefits in terms of cost sharing, treatment limitations and access to providers. The greater availability of coverage for behavioral health services, occasioned by both generally greater availability of health insurance coverage under the ACA and passage of the MHPAEA, may combine with previously stifled demand for such services to create not only a notable opportunity to improve health care and potentially lower health-care costs, but also an attractive opportunity for business growth and development.

Providers and private equity investors appear to be recognizing the increased opportunities for growth and potential for high returns from creating economies of scale, improved availability of insurance coverage and greater interest in and pressure to reduce spending and per-patient costs. Consolidation may enable behavioral health-care providers to align payment strategies and invest resources in the development of clinical standards and best practices and implementation of health information technology across facilities, which may enhance their ability to provide consistent quality care across facilities and collaborate with traditional health-care providers to achieve overall population health goals.

Connected Health Technologies. Connected health involves use of health information technology to help providers and patients manage a range of health conditions—and treatment and medication regimens—thereby improving clinical outcomes and the quality of patients' lives and potentially avoiding preventable admissions to more acute care settings and lowering overall costs. Examples of connected health include smart phones and applications, computers and networked devices, social media, personal health trackers, sensors in clothing or other wearables and other devices and remote monitoring tools. Specific applications may include a text message reminding a patient to set a follow up appointment or maintain a particular regimen, remote monitoring of a patient's heart rate to detect potentially abnormal patters and need for care and the full diagnosis, treatment and monitoring of diabetes through mobile solutions.

Connected health has the potential to advance the Triple Aim. It implicates key strategies enunciated under the Triple Aim, such as patient engagement and empowerment, by delivering information to the consumer that allows for better health and wellness choices and engagement in self-management of chronic medical conditions. It enables capture and delivery of patient information and data obtained through remote monitoring to clinicians and electronic health records and thereby extends access that should improve clinical outcomes. It can empower patients by providing greater access to health information and greater potential for them to make informed health-related decisions and engage in better self-management of chronic health-care conditions.

Connected health technology, although making great strides, still appears to have significant room for growth and development. Many emerging technologies are in development and even the connected health technology that is available to providers and patients in the market is often under-utilized. Ongoing movement away from more traditional fee-for-service models toward value-based purchasing models and more recent changes and developments in providing separate payment for care management services may help facilitate greater adoption and use of existing and emerging connected health technologies.

All of the above, with the promise to achieve improved care and outcomes, while lowering costs and of-

fering opportunities for significant financial return on investment, are expected to drive substantial transactional activity by private equity and hospitals, health systems and other providers alike.

Conclusion. Cost pressures, reimbursement declines and profound changes in payment methodologies are driving many of the ongoing trends in health-care transactions. The focus is on delivering improved care to patients and patient populations at a lower per capita cost, with an overall aim to make the U.S. health-care system more sustainable in the long term. An important, concurrent development is advances in health information and connected health technologies that are, in turn, also contributing substantially as health-care stakeholders strive for a better and more efficient health-care system.

Notwithstanding the continued presence of an active health-care fraud and abuse and antitrust enforcement climate, all of these factors continue to lead to a vibrant health-care merger, acquisition and affiliation landscape. An increasingly diverse range of deal structures used to accomplish the goals of traditional health-care providers and private equity investors will continue to alter health-care transactions in 2016.

The need to deliver better care more efficiently and the shift of financial risk to providers, among other factors, also should continue to drive significant transactional activity in the subacute care, behavioral health and connected health sectors. Providers and private equity investors are likely to continue to pursue and implement initiatives to better manage risk, coordinate care and improve clinical standards across various levels of care. The complex array of strategic business and legal considerations in pursuing such a range of transactions and initiatives will continue to necessitate careful attention and close coordination by and among health-care providers, private equity investors and their respective business, financial and legal advisors.

The list of select transactions involving health-care providers, managed care and services companies for December 2015 was compiled by health-care investment bankers using publicly available information, including articles, websites and press releases. The list is at http://src.bna.com/b5R.

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