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Health-Care Transactions 2017 Forecast




By Paul A. Gomez, Gary W. Herschman, Mike Tierney and Robert Aprill

Strong and innovative merger, acquisition and affiliation activity made 2016 an interesting year for the health-care industry. In early 2016, as we looked at the year ahead, we noted the Affordable Care Act's (ACA) influence on merger and acquisition (M&A) activity and forecast that it would continue, driving a number of vertical and horizontal transactions and creating health-care sectors populated by fewer but larger players.

The list of select transactions announced in December mimicked prior months, showing activity in a wide variety of sectors and demonstrating that no one area is immune from the factors driving affiliations. Long-term care led the list, followed by hospital and health system and physician practice deals.

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At the start of 2017, however, the ACA's survival is very much in doubt. Most observers wouldn't have considered that development to be a serious possibility a year ago, although most agreed that some change was coming, as the fate of the insurance exchanges was in considerable doubt.

But as of early January, the Republican-led Congress already had taken steps to prepare for the ACA's potential repeal. There was, however, no clear consensus as of this article's publication on the preferred path for replacement. Yet another reminder of how much can change within a year!

Most Active Sectors for Health-Care Transactions in 2016

Continued movement away from a health-care payment landscape based predominantly on the fee-for-service model to a variety of value-based payment models disrupted the status quo throughout 2016. Providers have either adapted to new payment models internally or aligned with other providers that had the necessary expertise.

Employers and insurers shifted financial risk to consumers and providers through high deductible plans and increased co-pays and co-insurance arrangements. Advances in health-care information and connected health technology, as well as the ability to capture, categorize, analyze and use patient data to proactively intervene in patient care in a targeted manner paved the way to help health-care providers to better manage the health of patient populations, but carried a significant implementation price tag.

As the list of select transactions for 2017 shows, these and other trends drove a variety of hospitals, health systems and other providers to find new ways to collabo-

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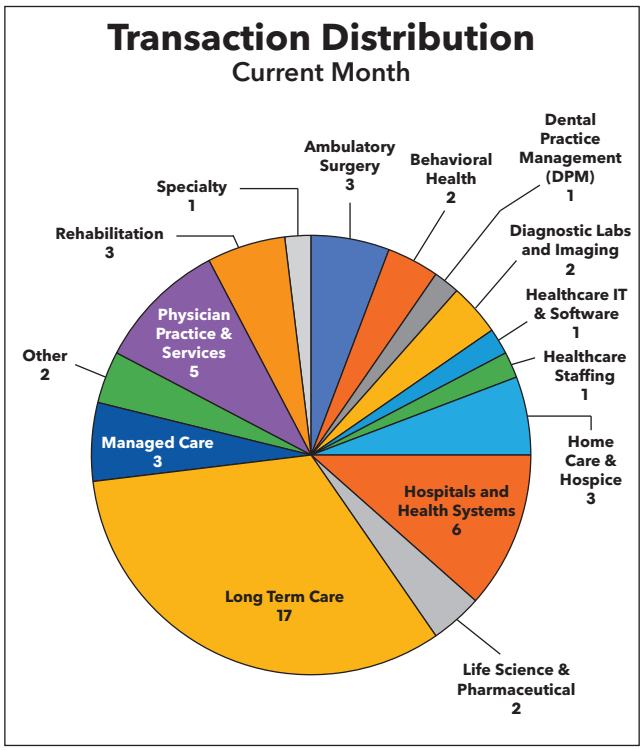
rate and affiliate. Notwithstanding the presence of an active regulatory enforcement climate—including active enforcement on both the antitrust and fraud and abuse compliance fronts—merger activity continues to be robust.

Unsurprisingly, transactions in the physician practice and services, post-acute care, health information technology (HIT), hospital and health system and behavioral health sectors were among the most active in 2016. Considering the need for greater coordination among providers across the continuum of care, outcome-based payment models, shifting risk to providers and need for a greater ability to capture, analyze, use, communicate and share patient information and data, both providers and private equity investors made substantial investments in these sectors over the past year. http://src.bna.com/lwd



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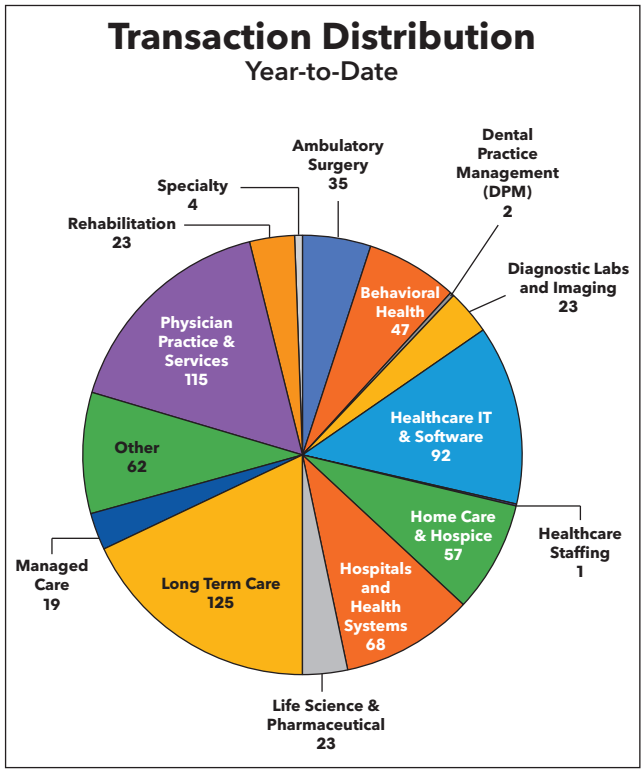
Impact of the 2016 Election and Trump Administration on Health-Care Transactions

Health-care stakeholders continue to watch Congressional action, comments by federal legislators and President-elect Donald Trump to gauge not only what potential repeal and replacement of the ACA will really entail, but also the timing of both. At present, it appears more likely than not that the ACA will be repealed in whole or in part in 2017. The repeal's effective date, however, may be delayed to create a transition period of sorts until the ACA's replacement takes shape and gains support for passage.

Although most Republicans appear to be behind this repeal and delayed replacement plan approach at present, several Democrats have criticized it. Even a few Republicans recently expressed some reservation about moving forward with ACA repeal before an acceptable replacement plan is ready to be voted upon. House



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Speaker Paul Ryan (R-Wis.) recently stated that his goal is to have as much of a replacement plan as possible concurrent with repeal, and Trump echoed the desire for concurrent repeal and replace approach at a recent press conference. Stakeholders will have to keep monitoring this very fluid situation to discern what the actual substance and timing of ''repeal and replace'' will be.

Nevertheless, strong health-care transactional activity is not likely to be derailed in 2017. There may be some slowing of activity in the early part of the year, partly because health-care providers will be carefully watching legislative and legal developments under the new Trump administration to gauge how they should react, and partly because transactional activity in general often slows a bit in the early part of the year.

There are a number of reasons why health-care transactions are not likely to be derailed in 2017, even if the ACA is repealed. Initiatives and approaches to payment, including value-based care and more cost-effective payment models, are not likely to disappear. Not all such models derive their existence from the ACA, and many were underway before the ACA was enacted. The value-based reimbursement model has bipartisan appeal, and reducing health-care costs will be achieved only through a value-based approach. Consumers, providers and insurers have found that the fee-for-service approach contributed to rapidly escalating costs, and that these costs are unsustainable.

New business models designed to enhance quality, increase provider coordination and improve cost containment and outcome are likely to continue, but compliance with these models will be challenging. In order to adapt to the changing environment, health-care entities will be looking to align, and we expect this to continue to drive strong transactional activity. Additionally, other payment reforms and models that drove health-

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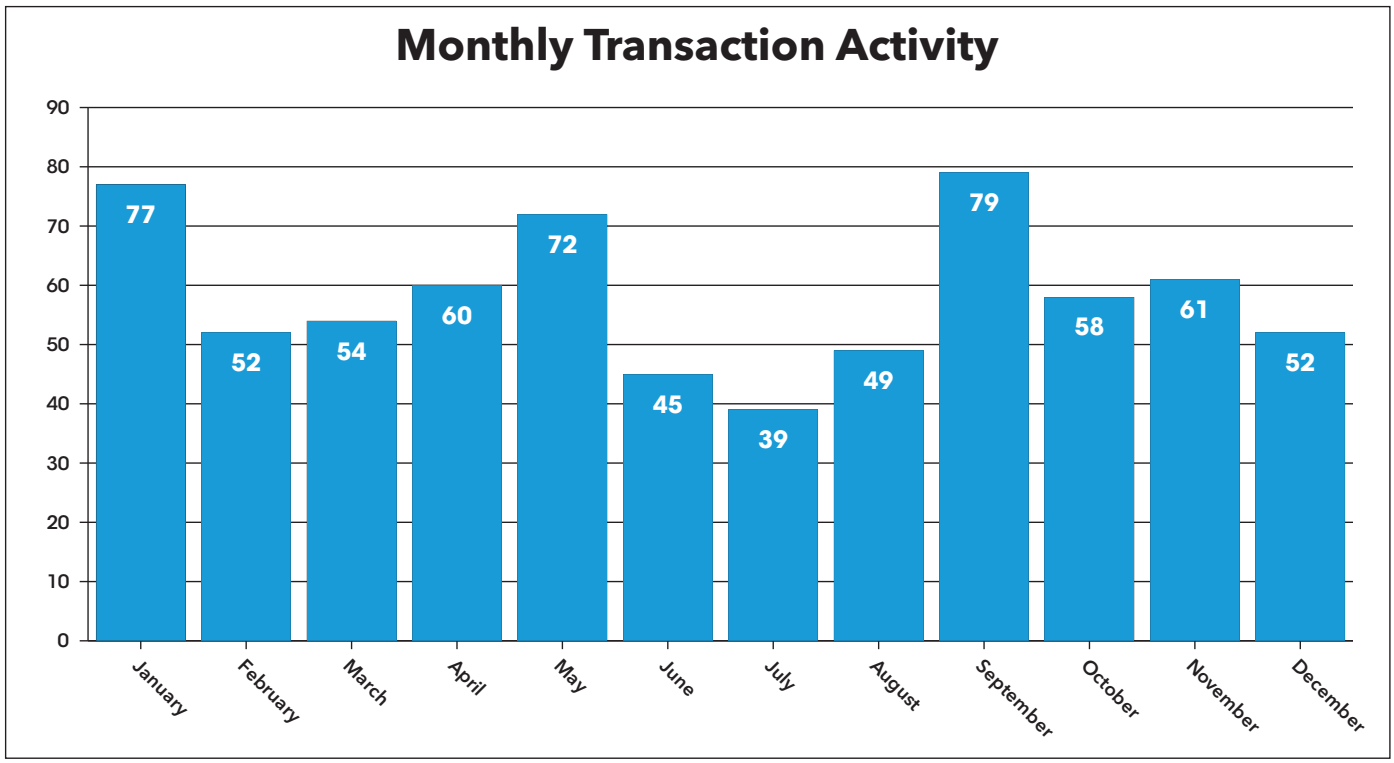

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care transactions, like those tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which was passed with widespread bipartisan support (unlike the ACA), appear far more likely to remain intact and will continue to drive transactional activity.

In sum, the ACA's repeal and replacement isn't likely to spell the end of the value-based payment movement or the greater financial risk and accountability placed on providers that we have witnessed over the last several years. Moreover, efficiencies achieved through economies of scale, improved geographic reach, enhancement of patient care capabilities, greater and more convenient access to patient care, better branding and greater coordination of care throughout the health-care industry are factors that will continue to drive strong health-care transactional activity as well.

Most of the key drivers of health-care transactions will remain in 2017, contributing to another busy year.

2017 Forecast for Health-Care Transactions

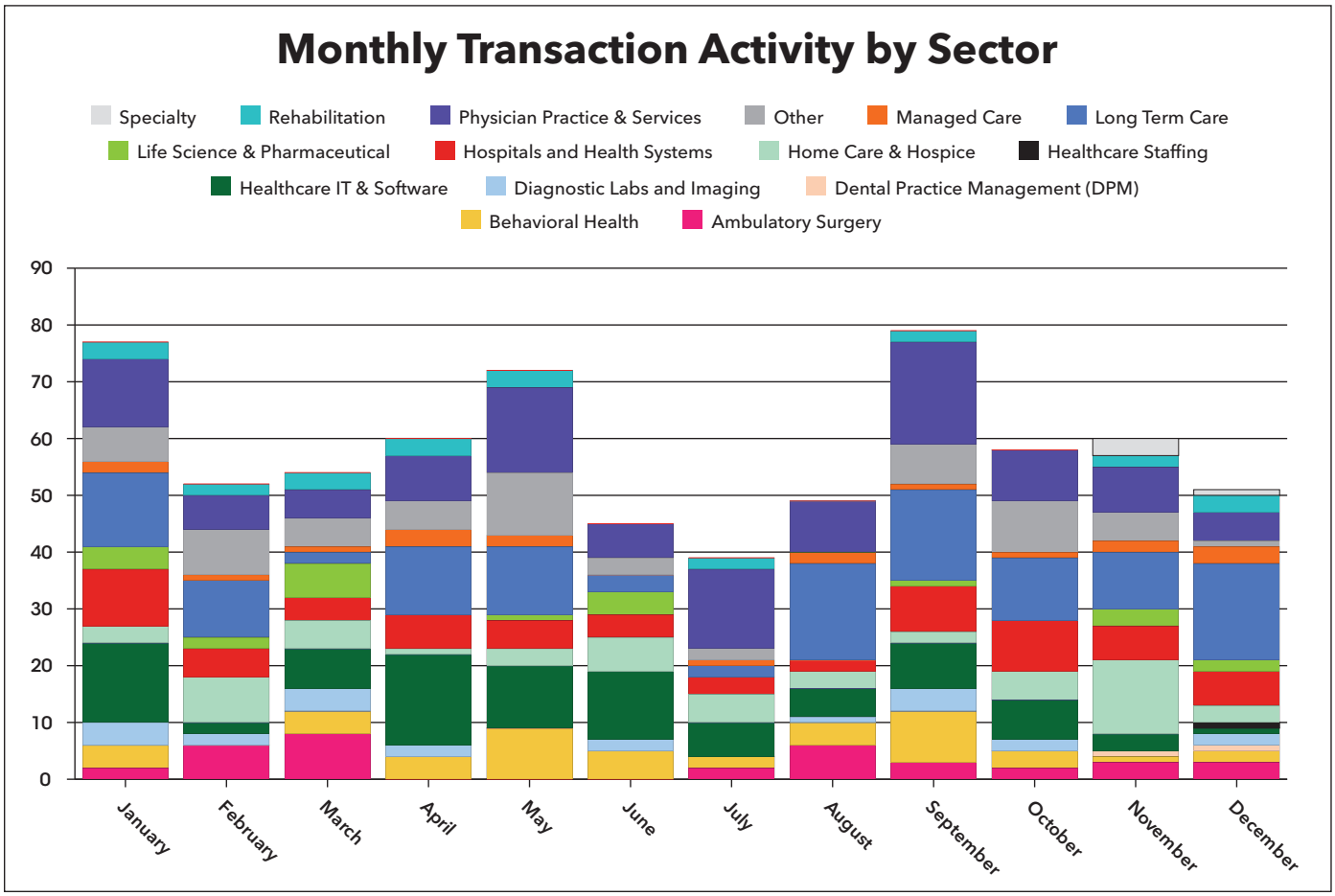
Hospital and Health System M&A, Consolidations and Affiliations. Hospitals and health systems saw considerable M&A and affiliation activity in 2016. That trend is expected to continue in 2017.

M&A activity was spurred primarily by access to capital, a need for scale, rising valuations, changing payment methodologies, the need to expand the geographic footprint and a related desire on the part of health systems to make themselves more attractive patient care networks to payers and employers. Whatever the ultimate form ACA repeal and replacement takes, these factors are expected to continue to drive significant hospital and health system affiliations, M&A, formation of accountable care organizations (ACOs) and ACO-type arrangements, various forms of joint ventures and the continued pursuit of increased outpatient points of access in the community, including urgent care centers and other outpatient strategies.

Many health-care stakeholders and observers are watching the ongoing negotiations between Catholic Health Initiatives, a large, nonprofit Catholic-based health system headquartered in Englewood, Colo., and Dignity Health, another large, Catholic-sponsored nonprofit health system headquartered in San Francisco. Public reports indicate that a merger or alignment—the form of the proposed transaction isn't clear at present—would create the nation's largest nonprofit health system, benefiting from complementary geographic locations and a common Catholic heritage. The combined entity would boast 142 hospitals and combined gross annual revenues of $27.8 billion. Leaders of both health systems are expected to decide how and whether to proceed with a merger or other form of alignment early this year.

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 an acquisition is neither necessary nor desired. The joint venture structure can provide a smaller provider the scale and sophistication of a larger system, while maintaining significant local control.

Clinical affiliations—particularly in certain health-care specialty areas like cancer centers, stroke care, cardiology, neurology and orthopedics—enable smaller providers, and larger providers looking to improve specialization and quality in a given patient service line. They also allow their communities to benefit from the clinical expertise of larger academic medical centers or others with a recognized superior brand and clinical expertise in a given patient service line. While no assets



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change hands, the larger provider typically provides clinical, management or technical assistance to the smaller health-care providers. These structures are prevalent in underserved geographic regions and markets and in major urban settings where clinical expertise can be shared easily. These types of affiliations, which may include Centers of Excellence or similar structures, are expected to continue to proliferate in 2017.

Transactional activity involving the formation and expansion of ACOs or ACO-type arrangements is likely to continue in 2017. Commercial payer ACOs that are not dependent on the ACA's fate and novel direct-to-employer ACO arrangements are growing in popularity.

Direct-to-employer ACOs typically involve arrangements between large self-insured employers and health systems or other providers for the provision of comprehensive care and population health management for their employees and employees' dependents. One of the most recent examples of this relatively new but growing model is a large-scale, first-of- its-kind arrangement in California between MemorialCare Health System and The Boeing Corporation (Boeing). Boeing and other large employers and hospitals and health systems have entered into similar arrangements in other parts of the country as well and have expressed an interest in continuing to pursue such models in an effort to promote better management and quality of care for a defined employee patient population, better sharing of important information and data that can help promote better care and more predictable employee health-care costs.

We also expect to continue to see significant transactional activity related to the formation or further development of narrow networks in an effort to achieve cost management and improved patient quality metrics. Providers actively collaborating with each other and with health plans by 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 choice for patients.

Finally, the continued pressure to move patients out of the inpatient and emergency settings and into outpatient settings is also likely to result in continued strong transactional activity in 2017 in the urgent care sector. Hospitals, health systems, other providers and private equity support the expanded use of the patient medical home model.

Physician Practice Acquisitions. We expect continued strong M&A, affiliation and consolidation activity for physician practices, involving both private equity investors and health-care providers. The ACA's fate is uncertain, and some value-based payment models may be subject to alteration, although many are tied to laws that passed with bipartisan support, and some were underway prior to the ACA and/or derive from commercial and private payer and provider initiatives and are

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market-based. Along with the resulting need for greater cooperation and communication with patients and with other health-care providers and better HIT, this will continue to drive investment in physician practices and consolidation of physician practices with one another.

Physician practices, and in particular physician practices that are relatively small, rural and/or unaffiliated with a larger system, are increasingly concluding that operating successfully in the current health-care landscape and improving patient care and management of patient populations requires increased technology, personnel and even business expertise that they oftentimes do not have the internal resources to invest in sufficiently on their own. As a result, many are either consolidating with larger medical practices or aligning with hospitals or health systems that have the resources to make the necessary technological, personnel and other investments. This in turn, frees medical practices to spend more time on patient care, research and medical education.

In addition, many private equity investors and health systems are actively engaged in building large regional or national platforms for comprehensive or specialized physician services. Others, like ambulatory surgery center companies, likely will continue to make synergistic acquisitions of physician practices across the country.

Outsourcing of former in-house, facility-based services is likely to continue as well. In fields such as anesthesia, hospitalist medicine, nursing and radiology, among others, 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 at a hospital or other facility. Specifically of continued interest is an ability to reduce costs for high-dollar areas of care in a hospital or facility setting, such as operating room services. Unique outsourced services that target high fixed-cost areas and turn them into variable costs with greater efficiencies are a very attractive area for investment and consolidation. Given the pressure on hospitals to reduce costs, as well as the rapid growth and success of large entities that have capitalized on this service outsourcing trend, physician practices have continued to attract the interest of private equity groups.

The past year also was marked by a dynamic political shift that has left many questioning the ACA's future. As more health-care professionals sense that the movement from fee-for-service payment to value-based payment is here to stay, groups are moving towards at-risk reimbursement. The shift in payment methodology is putting more emphasis on the importance of maintaining and controlling the continuum of care for patients.

Groups such as DaVita Healthcare Partners and Optum are expanding their physician services arms with numerous acquisitions across a number of subspecialties. As this shift continues, we expect to see a broader array of groups looking to acquire multispecialty and primary care providers as well, including single specialty providers, payers and outpatient surgical groups.

Mega-mergers, such as the recently announced Optum acquisition of Surgical Care Affiliates, demonstrate that some of the country's largest outpatient providers are broadening their ability to improve the patient experience, quality and cost of care. These types of industry-transcending mergers are expected to continue as companies align their corporate strategies to support value-based payment models and multi-payer approaches.

In light of all of the foregoing, the physician practice sector should remain very active for health-care investment and transactions in 2017.

Post-Acute Care. An aging population, important changes in payment methodologies and the increasingly pervasive shift of additional financial risk to providers are all contributing to heightened activity and investment in post-acute care. Health systems and investors are targeting nursing facilities, home health agencies, hospices and rehabilitation and therapy services and, increasingly, nonmedical home care. Access to and coordination with appropriate post-acute care resources, including skilled nursing facilities, home health and nonmedical home care, as appropriate, have been shown to decrease the rate of preventable readmissions to hospitals, which is important both in terms of quality of care and quality of life issues for the patient. This also benefits the hospital, which bears increased financial and clinical responsibility for management of the patient's care across the continuum, in part as a result of changing payment models that promote and require such accountability.

The sector should continue to attract interest and investment from private equity as well, for many of the same reasons noted above. Bundled payments that include care metrics, requirements and payment for patient care across multiple care settings, including post-acute care after appropriate discharge from a more costly acute-care facility, may further drive the activity and investment in the sector.

We recognize that certain value-based and bundled payment models may be more vulnerable at this time than other payment models to the extent that they are directly tied to the ACA, including mandatory bundled payment models that were developed and implemented by the Center for Medicare & Medicaid Innovation (CMMI). However, we believe that it is more likely than not that the value-based concepts and incentives for better coordination across the continuum of care will survive and continue to march forward, even if some of the details and requirements of such payment methodologies change to some degree. Moreover, continued 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 contributing to sub-acute care investment and transactional activity in 2017 are likely to continue to drive increased transactional activity in the behavioral health sector as well. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), nearly one in every five adults suffers from a diagnosable mental health disorder, and health-care professionals are increasingly trying to improve patients' mental and emotional well-being. Behavioral health services include, without limitation, efforts to help patients improve how they cope with daily life challenges, treatment of mental illnesses such as depression and treatment of substance use disorders and other addictive behaviors.

The health-care industry's shift towards population health management and the Triple Aim is focusing at-

tention on integrating behavioral health services with other health services. Unnecessary hospitalizations and use of emergency services resources often has been linked to patients with unmet behavioral-health needs. Providers have long recognized that patients with acute or chronic health concerns also often 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, which are to improve the patient's care experience, to improve population health and to reduce per capita health-care cost.

Additionally, reimbursement for behavioral health services is improving. The Mental Health Parity and Addiction Equity Act (MHPAEA) and related legal developments 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 mental health or substance abuse disorder benefits equal to medical care benefits in terms of cost sharing, treatment limitations and access to providers. Wide-spread media coverage of the ''opioid epidemic'' and the increasing awareness of behavioral health's impact on medical outcomes also have prompted efforts to promote greater parity of coverage benefits.

Although mental health coverage has bipartisan support, efforts under the Trump administration may take on a different character, depending upon whether the ACA is actually repealed and what a replacement will really entail. However, it is also worth noting that the 21st Century Cures Act, which included certain mental health reforms aimed at increasing coordination and greater payment and coverage parity, was passed with widespread bipartisan support. Trump voiced support for some of these mental health reforms during the presidential campaign.

Additionally, providers and investors are taking notice of the changing landscape and appear to increasingly recognize the growth opportunities and potential for high returns. Successful behavioral health operators have become attractive partners and have the expertise and capital to enable behavioral health-care providers to align payment strategies and invest resources in the development of clinical standards and best practices.

In 2016, Providence St. Joseph Health created the Institute for Mental Health and Wellness, supported by an initial $100 million investment. Its purpose is to identify and advance innovative solutions in mental health. As a part of the effort, Providence St. Joseph Health and its advisory panel will collaborate with national and local organizations with expertise and long histories of addressing mental health.

HIT and Connected Health Technologies

HIT. Strong private equity and provider investment in HIT and software is likely continue in 2017. Technology that enables providers to capture, categorize, analyze and use patient information to better target and coordinate health-care efforts, initiatives and care resources is aiding health-care providers to better manage the patient population health. Improved HIT 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.

It is hard to conceive of any health-care sector or subsector that is not impacted substantially by HIT. As investment capital continues to fund innovation and provide solutions with definitive positive downstream benefits to the cost structure of health-care providers, consolidators, investors and stakeholders of all types will likely continue to invest in these services on a software-as-a-service/business-to-business basis for true technology buyers, or providers and other health-care organizations implementing and integrating certain technologies to improve patient care, coordination, communication and cost reductions, and to gain a competitive advantage over competitors.

Connected Health Technologies. Connected health involves the use of HIT to help providers and patients manage a range of health conditions and concerns, 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.

Connected health uses, among other things, computers and networked devices, social media, personal health trackers, sensors in clothing or other wearables and other devices and remote monitoring tools, smart phones and applications. Specific applications may include text messaging systems reminding patients to set follow up appointments or maintain particular regimens, remote monitoring of a patient's heart rate to detect potentially abnormal patterns and need for care. It also may be possible for providers to fully diagnose, treat and monitor diabetes through mobile solutions. Connected health technology has great potential to offer beneficial and cost-effective solutions for growing health care, behavioral health and social demands, and in particular, those of an aging society that may have greater incidences of difficulty with mobility and traveling to health-care provider facilities.

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 currently available to providers and patients is often under-utilized. But with its potential to achieve improved patient care and outcomes, while possibly lowering costs and offering opportunities for significant financial return on investment, connected health technologies are expected to benefit from continued substantial investment and transactional activity by private equity and hospitals, health systems and other providers alike in 2017.

Continued Enforcement Headwinds

Health-care providers should expect fraud and abuse enforcement to remain vigorous in 2017, although there may be some changes to the False Claims Act, Stark law and other regulations that could impact some levels and methods of enforcement.

FCA. Enforcement efforts to curtail, trim and discourage fraud, abuse and waste from health care generally has broad bipartisan support. The federal government reportedly recovered approximately $2.5 billion from the health-care industry in FCA claims alone in fiscal year 2016. It continues to recover far more in its en-

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forcement efforts than it spends. Further, the federal government is making effective use of new and better technologies and methods, including use of predictive analytics to sift through massive amounts of data quickly to better target their enforcement efforts.

Notwithstanding the foregoing, some changes pertaining to the FCA-related changes that potentially may impact related enforcement may be on the horizon. The ACA's expected repeal, for example, could include the repeal of several of the law's provisions that made it easier for whistleblowers—known in FCA parlance as qui tam relators—to bring FCA cases. It remains to be seen whether Congress will preserve or reshape these provisions in some way.

Stark Law. Over time, there has been increasing support in Congress to repeal—or at least revise—the Stark law. Many health-care stakeholders and others believe the law has cost far more in administrative costs, compliance efforts and legal fees than its benefits justify. The law has siphoned off resources that could have been better spent on patient care and health-care innovation, these stakeholders say. Additionally, the ACA impacted that Stark law as well, including, among other things, effectively eliminating the whole-hospital exception that provided conditions for physician investment in and ownership of hospitals. The ACA's repeal could return the state of the law in these areas back more to its pre-ACA status.

Antitrust. The Federal Trade Commission had some important successes in 2016, including *FTC v. Penn State Hershey Med. Ctr.*, 838 F. 3d 328, 2016 BL 317602 (3d Cir. 2016) (appeals court blocked the proposed merger of two Pennsylvania health systems), and *FTC v. Advocate Health Care Network*, 841 F. 3d 460, 2016 BL 362072 (7th Cir. 2016) (reversing denial of preliminary injunction, and effectively preventing, for now, the merger of two Chicago-area hospitals). These cases serve as a reminder that the FTC intends to continue to aggressively dispute market definition for given services and the appropriate definition of a given market for patient care services, including how far patients actually travel—and are willing to travel—for health care.

It is hard to know to what extent the intensity of antitrust enforcement in health care may change under the Trump administration. There is some merit to the view that, traditionally, Republicans and Republican administrations have embraced more business-friendly policies and have not promoted as intense a focus on antitrust enforcement. However, Trump has espoused certain policies, including those that impact business, that do not appear to be in line with traditional Republican policy positions. As a result, it will require continued close monitoring to see how antitrust enforcement in health care may change under the Trump administration.

Conclusions

The ACA's repeal and replacement, in whole or in substantial part, will more likely than not occur in 2017. Congress and Trump have declared it to be one of the top priorities—if not *the* top priority—of this Congress' legislative agenda. Congress already has taken procedural measures to make repeal easier to accomplish.

Despite the ACA's vulnerability, we expect a number of the factors that have driven health-care transactions for years will continue to do so. The drive toward value-based care is not tied to the ACA, and the health-care landscape will continue to look for ways to provide care more efficiently. Transactions will continue as patients, providers and payers look to provide care at a lower cost with a better outcome.

All of the above should continue to drive significant health-care transactional activity in 2017, particularly in the physician practice, post-acute care, behavioral health and connected health and HIT sectors. It will also continue to drive major acquisitions and affiliations by and between large health systems and between large or specialized health systems and smaller or less specialized providers across the country.

Health-care fraud and abuse litigation and enforcement is likely to remain vigorous in 2017, although stakeholders should continue to watch the landscape carefully to respond to potential upcoming reforms that may impact FCA cases and the Stark law. The health-care antitrust enforcement climate warrants close monitoring as well, as it remains difficult at this point to discern whether we may witness a shift in the intensity or direction of that enforcement in 2017 with the new Trump administration.

The array of strategic business and legal considerations bound up with the range of transactions and initiatives likely to be pursued by health-care providers and private equity investors was already complex and subject to change, but 2017 promises to be a year of greater change than most. As a result, pursuit of such 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.

Get ready for another busy, interesting year!

The lists of select transactions involving health-care providers, managed care and services companies for December 2016 and for 2016 year-to-date were compiled by health-care investment bankers using publicly available information, including articles, websites and press releases.

The December list is at http://src.bna.com/lwe.

The list for 2017 is at http://src.bna.com/lwd.

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