STEP AWAY FROM THE BARGAINING TABLE: THERE'S A NEW HOLY TRINITY IN HEALTH CARE M&A

In the beginning, there was fee-for-service health care, and volume ruled the Garden of Eden. And then volume begat specialization, which begat economies of scale, which begat a search for more gardens, and, you know, more opportunities to begat.

And from this sprung the absolutely, positively, no doubt about it (unless you're in health care IT[1]) prime growth and consolidation strategy in health care services:

Step 1: Identify a growing health care service sector and acquire a platform provider with the management, operating, and technology infrastructure necessary to support further growth.

Step 2: Leverage the platform through new startups and acquisitions, never straying far from the platform's core services to capture the marketing and operating synergies that come from specialization, and generally along contiguous markets. The goal? To create local and regional density and perhaps later, become a "National."

Step 3: Sell out to a private equity group or another regional or national market player, generating valuation arbitrage from increased earnings, greater leverage, juiced exit multiples accorded to larger entities, and the simple economics of a limited number of sizeable acquisition candidates in a market with high demand.

The gospel was buy, bolt-on, and bail – the holy trinity of health care M&A.

And so it went. First it was home medical equipment, then Medicare certified home health, then infusion therapy, ambulatory surgery centers, physical therapy clinics, skilled nursing and assisted living, (take a breath), health care staffing, hospice, specialty pharmacy, group homes, psychiatric hospitals, addictions and substance use disorder, (almost done), urgent care, and most recently, private duty home care, autism services, and Medicaid home health.

Talk about ubiquitous.

But then came the Affordable Care Act, or the End of Days (depending on which side of the pew you sit).

Interestingly, while the insurance mandates, exchanges, Medicaid expansion, and guaranteed issue regardless of pre-existing conditions got all the attention, it was language that got nary a mention that may ultimately be remembered as the real game changer in health care – and health care M&A.

For it was written, and it came to pass, that reimbursement should no longer be fee-for-service, but rather fee-for-outcome.

Perhaps owing to divine intervention, the Centers for Medicare and Medicaid Innovation actually lived up to its name and authorized a panoply of new payment schemes, the common theme of which was establishing some form of global payment to cover all the health care services attendant to a specific population or surgical procedure. In so doing, the financial incentives of health care fundamentally changed from volume to efficiency, from disintegrated services, to coordinated care, from income to outcome.

And unlike many of the other flavors of the week that were going to change everything we knew about health care (managed care 1.0, disease management, hospital "systemization," to name a few), this is real, it's happening, and it's happening fast.

[1] Given (a) the lack of uniformity among health care information technology companies (even in specific sub-segments such as revenue cycle management, data analytics, population health, etc.) and (b) HIT is rarely tied to a specific coverage area or geography, with few exceptions (electronic health records), the space has never been conducive to traditional roll-up strategies.

CMS set an ambitious target of getting 50% of Medicare reimbursement under these alternative payment models by 2019. And they're well on their way, with an estimated 25% already in the queue.

Implications for Health Care Mergers and Acquisitions

In such an environment, value is no longer created by simply amassing armies on a map, like a game of RISK. It is created by **coordinating and directing care**, across **many disciplines** (from primary, to acute, to post-acute services), **in multiple settings**, over a **geographic footprint** consistent with a **defined population** (be it covered lives or patients undergoing targeted surgical procedures) to **improve outcomes** while, at the same time, **reducing costs.**

What was once a ***narrowly-focused, multi-location size play,*** is fast becoming a ***multi-discipline, efficiency (clinically and financially), and density play.***

The holy trinity is now land, link, and leverage (to reduce costs or secure contracts with insurers, population health "conveners," ACOs, employers, etc.)

And this new reality is giving way to a new day in M&A.

It's why…

Insurance giant ***UnitedHealthcare*** concluded it was worth spending 5.5 x revenues (yup, revenues) to acquire ***MedExpress*** to encourage beneficiaries to ditch the ER when urgent care will do;

HealthSouth acquired home health and hospice provider ***Encompass***, to encompass its rehab clinics with other post-acute services;

The previously Medicare pure ***Amedisys*** acquired ***Associated Home Care*** to add long term, paraprofessional services to fill in the gaps left by intermittent skilled care;

Countless ***hospitals*** – many of which had just finished divesting themselves of the businesses they acquired during the Great Hospital Systemization Movement in the 90s – are hearing the siren call once again to affiliate, partner, or buy ancillary service providers – urgent care, Medicare and private duty home health, behavioral health, and other upstream and downstream providers – to position themselves to go at-risk in accountable care organizations, population health contracts, and bundled payment initiatives;

Skilled nursing and assisted living providers are fast becoming the "go-to" buyers for home health and hospice as they look to differentiate themselves as end-to-end post-acute companies.

Not only are these new consolidation patterns occurring ***across*** sectors, they are also emerging ***within*** the sectors themselves.

One of the best examples here is what we are seeing in substance use disorders. Although SUD is a narrow niche within behavioral health, it has its own sub-segments including residential and outpatient programs (partial hospitalization, intensive outpatient, counseling), medication assisted treatment, and sober living. As we described above, consolidation initially occurred within these extremely narrow straws (silos just don't cut it here). But as it is becoming increasingly accepted that addictions treatment is a life-long (or at least an extended) pursuit that naturally progresses from intensive inpatient care to sober living and periodic counseling, the movement afoot is to offer the full-monty in campus-like treatment settings.

Perhaps there is no better example of this than ***Recovery Centers of America***, which has raised more than $330 million in venture capital funding to develop centralized, comprehensive, and fully integrated program offerings through combinations of de novo development and acquisition.

Implications for Sellers

As you might expect (if you're still with us after a thousand words and counting), if buyers are switching up ***what*** they want to buy and ***where***, divestiture strategies must evolve accordingly.

A given seller's ideal buyer is no longer reflexively a national player in the same niche.

The most strategically driven deals – i.e. the ones buyers are willing to pay the most for – will increasingly be between buyers and sellers that inhabit adjacent horizontal or vertical markets. The kind of pairings that trot out all of the "ates" that make health care visionaries swoon – coordin**ate**, integr**ate**, and domin**ate**.

Equally important, in such a highly strategic environment, serial buyers of the past are rapidly being replaced by the "one-and-dones." Because if I'm a skilled nursing provider seeking to build out my post-acute capabilities, I only need to acquire one home health provider that mirrors my footprint.

All this makes divestiture more complicated – and far less predictable – then it was in the past.

Not only does it behoove sellers to be more creative in identifying potential buyers in adjacent markets that could benefit most from a deal, it behooves them, part deux, to consider that in a one-and-done environment, selling opportunities can be both fleeting and limited. So if timing was of the essence before, it is even more "essence-r" today.

Now to be sure, the buy, bolt-on, and bail strategies discussed above have not been excommunicated from M&A doctrine, if for no other reason than a good number of such plans are well underway, and the kind of valuation arbitrage derived in Step 3 from the first book of consolidation can still be realized.

But there's no denying that a reformation is underway.

The good news is that when it comes to making acquisitions to create sustainable competitive advantages in health care today, buyers got religion.

And we say Amen to that.

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