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# Provider scale strategies: A 2018 update on the evolving landscape

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# Provider scale strategies: A 2018 update on the evolving landscape

*M&A remains an important option for health systems, but targets and strategies are shifting. While traditional economies of scale will continue to be a strong stimulus for M&A, providers will likely seek and achieve value creation much differently in the future.*

**Scott Lichtenberger, MD; Rupal Malani, MD; Neha Patel; and Saum Sutaria, MD**

Although proposed mergers involving large health insurers have garnered most of the headlines last year, provider M&A deal volume remains strong. On average, in the past five years, more than 70 deals were struck annually (Exhibit 1), up from about 60 per year in the previous five years.

Although deal volumes have decreased slightly, deal value has increased (Exhibit 2). Average annual revenues per acquired hospital also grew, from $99 million to $168 million. The growth in deal value reflects the overall increase in provider consolidation, not just the impact of a few especially large deals. The three large provider mergers that occurred in 2016 and 2017 accounted for less than 25% of the aggregate revenues ($89 billion) of all health systems targeted for M&A between 2014 and 2017.[1]

In the past several years, health systems have also been growing through non-M&A deals such as joint ventures and partnerships. These capital-light deals are often struck not only to achieve scale benefits but also to improve care coordination, attract and retain physicians, or better position the organization for value-based contractual arrangements (e.g., accountable care organizations).

The increase in provider deal activity has been prompted by a range of industry changes, including payer consolidation, the emergence of narrow networks, rising regulatory pressures and compliance costs, and shifts in where care is delivered. Today's health systems recognize a growing need for network adequacy if they are to capture greater share in a risk-based world, and are beginning to appreciate that they cannot rely solely on traditional economies of scale if they are to withstand the pressures on their profitability and balance sheets.

However, a comprehensive analysis of recent provider deals reveals that the landscape is evolving in several important ways, with important implications for the future of health system M&A. In particular, three trends have emerged from the most recent wave of consolidation:

- Midsize systems—those with $1 billion to $5 billion in revenues—are now in the lead as both buyers and targets, and they are focusing significantly on in-market scale.
- The number of small health systems (those with less than $1 billion in revenues) is dwindling, and most that remain are not ideal acquisition targets.
- Health systems are becoming increasingly deliberate about what they hope to achieve through M&A and have pursued strategic and opportunistic acquisition patterns that go beyond just adding more acute care beds.

In this article, we discuss these trends, their implications for health systems, and key issues provider executives should consider.

[1] The mergers between Dignity and CHI, Kennedy Health and Jefferson Health, and Aurora Health and Advocate Health had aggregate target revenues of about $22 billion.

## Rise of the midsize systems

Despite the increase in deal activity, the provider landscape remains comparatively fragmented, especially when compared to other segments of the healthcare industry. The top 20 health systems' share of overall admissions rose only from 24% to 28% between 2011 and 2016 (Exhibit 3).

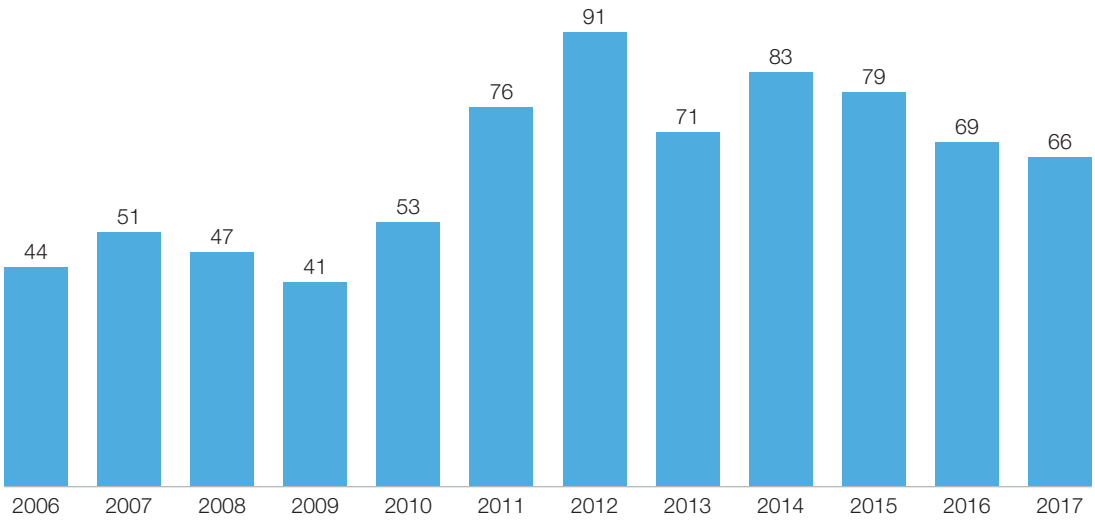
Part of the reason the provider industry remains fragmented is that most deals in recent years—especially since 2013—have involved small or midsize health systems. Between 2011 and 2016, the number of midsize systems increased by about 30%,[2] and these systems now account for about 42% of all US health systems. Although some midsize systems have expanded their geographic reach,[3] much of the consolidation has been within existing and adjacent markets.

Midsize systems were either the first- or second-largest care provider in 444 core-based statistical areas (CBSAs) in 2011 but in 521 CBSAs in 2016 (Exhibit 4). On average, midsize systems today operate in three markets and have a 36% share of inpatient admissions within those markets; the comparable figures for large systems are 17 markets and 36% share.

In the past five years, midsize systems have been more active as *buyers* than large systems, and have been acquisition *targets* more often than small systems (Exhibit 5). The shift may reflect a change in strategy at some midsize systems. Rather than acquiring relatively underperforming smaller assets as a way to add acute care beds, some midsize systems may be pursuing M&A with similarly sized players to improve their scale and performance.

EXHIBIT 1 **M&A hospital deal volumes are slowing slightly**

**Number of deals**[1]




[1]Only deals involving a hospital or health system target are included. Acquirer is either a private equity investor or hospital/health system; private equity investments are either buy-outs or add-on investments. Does not include joint ventures and partnerships, or deals involving specialty hospitals (e.g., behavioral, rehab, inpatient cancer facilities etc.). Each can include more than one hospital but is counted as a single instance.

Sources: CapitalIQ; Dealogic; Levin; McKinsey analysis

[2]Analysis does not include independent hospitals (those not part of a health system).

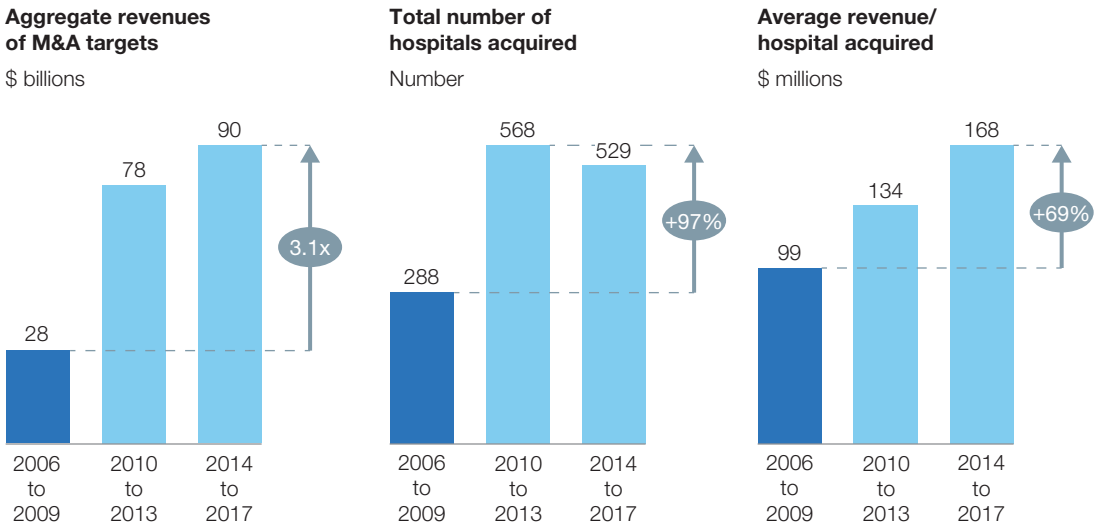
[3]Midsize systems covered 445 core-based statistical areas (CBSAs) in 2016, compared with 380 CBSAs in 2011.

The midsize systems acquired during the past three years had an average operating margin of 3.8%,[4] close to the average of nonacquired peers of similar size. By contrast, the average operating margin was –2.1% among the small systems acquired by midsize players and 1.8% among their nonacquired peers.

## Dwindling number of attractive small systems

In the past decade, the number of small health systems has dropped,[5] and those that do remain cover fewer geographic areas and are less likely to be market leaders (Exhibit 4).

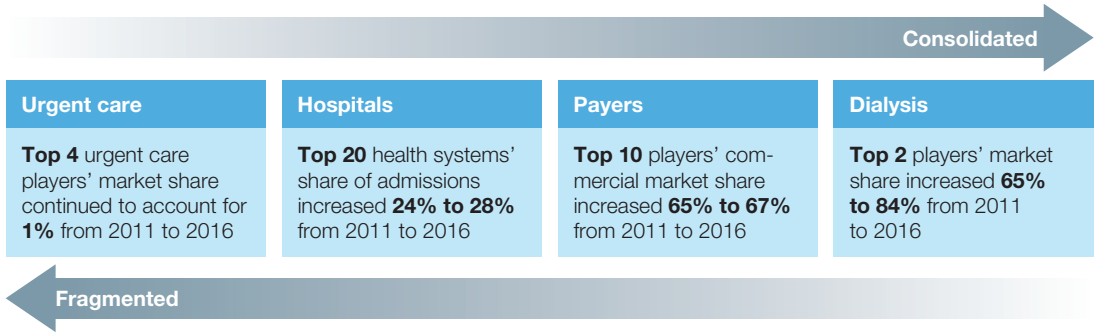
EXHIBIT 2 **The size of deals have grown significantly**




Note: Does not include specialty hospitals (e.g., behavioral, rehabilitation, inpatient cancer facilities). Revenue numbers are in nominal dollars. Medical cost inflation grew by a 3% compound annual growth rate during the 10 years evaluated.

Sources: CapitalIQ; Dealogic; Levin; McKinsey analysis

EXHIBIT 3 **Segments across the continuum remain consolidated at varied rates**




Sources: American Hospital Association hospitals reports 2011 and 2016; Interstudy 2011 and 2016; Press

[4]Historical five-year operating-margin data are not available.
[5]This statement applies to health systems, not to individual facilities.

Between 2011 and 2016 alone, the number of small systems that were leading providers in their markets decreased by about 1% per annum, and the average number of admissions at small systems fell by about 2% per annum.

The small systems acquired by another system of any size had worse financial performance than nonacquired peers of similar size (operating margins of –0.6% and 1.8%, respectively[6]), suggesting that the acquired systems may not have been strong enough financially to remain resilient in the face of acquisition interest. It may also suggest that the small systems remaining today may be too expensive to purchase.

## Expanding acquisition strategies

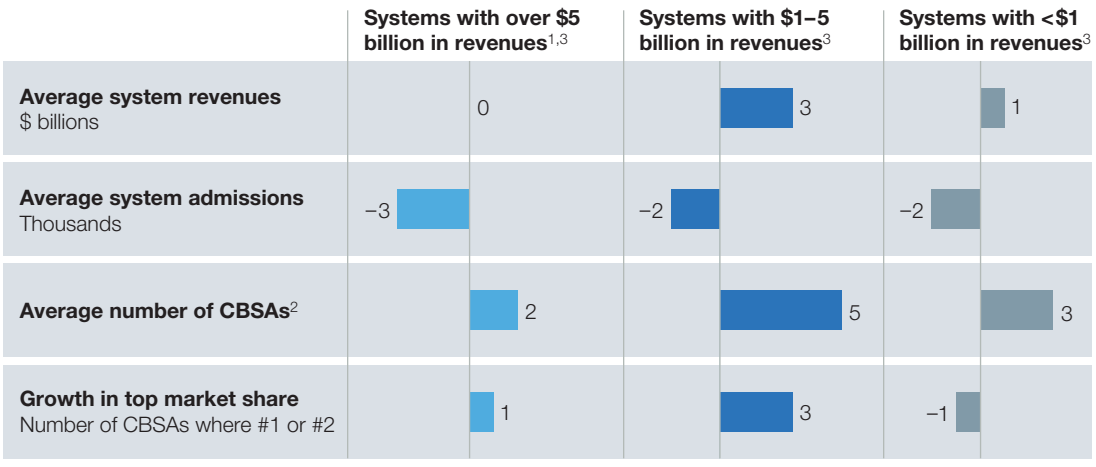
In the past few years, health systems appear to have pursued M&A for a variety of reasons, not simply to achieve traditional economies of scale. When the deals are analyzed carefully, several strategic and opportunistic patterns emerge. Among the most important of these are differences in geographic preferences and increased activity by academic medical centers (AMCs) and faith-based systems.

### Geographic preferences

Proximity has been a focus for many systems (presumably, to build or maintain local relevance). Not-for-profit systems, in particular,

EXHIBIT 4 **Systems with revenues over $1 billion have become more efficient and expanded geographically, at the expense of systems with <$1 billion revenues**

**Compound annual growth rate**, 2011–2016, %




CBSA, core-based statistical area.
[1]Systems with zero or negative reported revenue are excluded, as well as systems with zero acute beds reported. Top market share is determined by the number of admissions. Government systems are also excluded.
[2]Market share for systems with $1 billion to $5 billion in revenues takes into account the 156 mid-sized systems that existed in 2016 and 120 mid-sized systems in 2011.
[3]Analysis does not include independent hospitals.

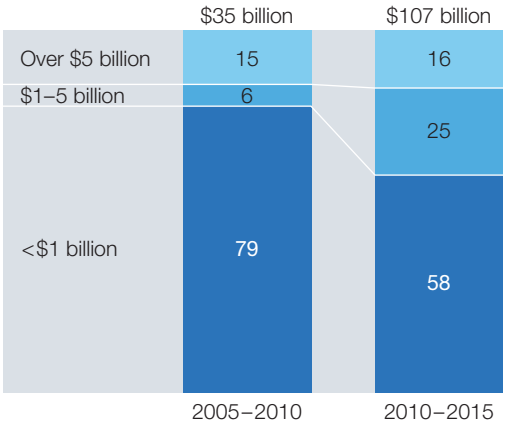
Sources: American Hospital Association hospitals reports 2011 and 2016

[6]These numbers are based on all health systems with less than $1 billion in revenues acquired between 2012 and 2015, regardless of the size of the acquirer. Historical data for 2010 and 2011 were not available for this analysis.

EXHIBIT 5 **Midsize systems are increasingly becoming both acquirers and targets of M&A**

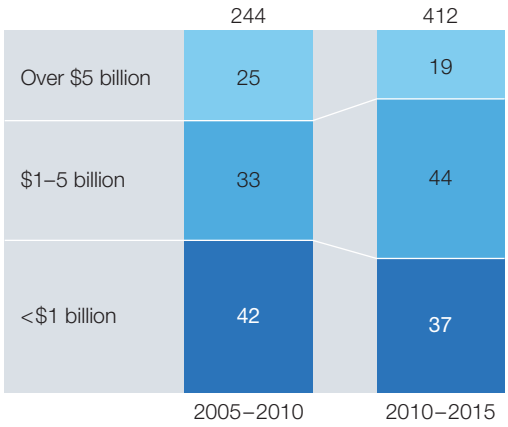
**Systems with $1–5 billion in revenues have increasingly become targets of M&A…**

**Aggregate target revenues, %**[1]




**…at the same time, they have become more active buyers**

**Number of deals by buyer size, %**[2]




[1]Numbers may not sum to 100%, because of rounding.
[2]Breakdown of small, medium, and large buyers by number of deals shown instead of aggregate target revenues because the latter skews the analysis in favor of larger systems, since they, on average, make larger acquisitions.

Sources: Levin; McKinsey analysis

have favored deals within their existing areas. Between 2013 and 2015,[7] 66% of the targets acquired by not-for-profit systems operated in MSAs where the acquirers had existing facilities; 93% of the targets were in states where the acquirers had a presence.[8] For example, OSF HealthCare, Novant Health, and Piedmont Healthcare all made acquisitions in which there was overlap between MSAs where they already owned at least one facility and where the target had a presence.

Investor-owned systems appear to be more willing to pursue deals across regions. Between 2013 and 2015, only 52% of the deals undertaken by these systems were in MSAs where both the acquirer and target had at least one facility; 64% were in states where both were already present. In the Tenet/Vanguard deal, there were no shared MSAs; the two companies did share one state, however.

## Academic medical centers

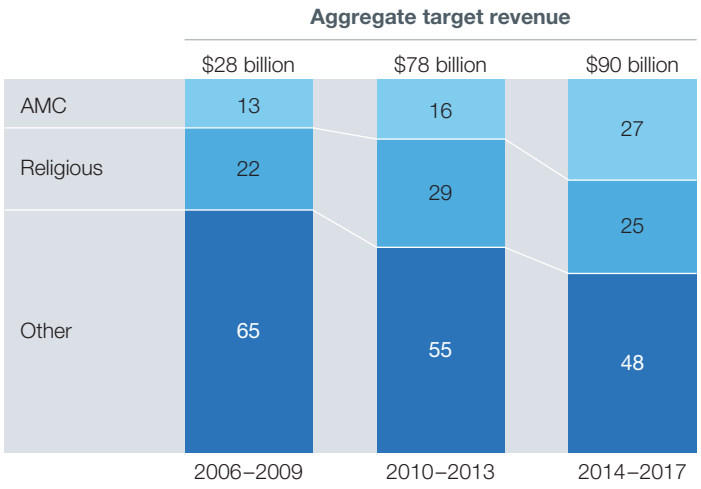
AMCs are making an increasing number of acquisitions—from 29 in 2006–2009 to 59 in 2014–2017. Acquisitions by AMCs accounted for more than 27% of aggregate target revenues over the past four years (Exhibit 6).

In most cases, AMCs have focused on building in-market scale via hub-and-spoke arrangements with community hospitals or, in larger markets, "hub-and-hub" relationships with other tertiary providers. About two-thirds of the 86 AMC acquisitions between 2010 and 2015 involved community hospitals,

[7]The data points in this section are based on a detailed analysis we conducted two years ago. Our experience since then strongly suggests that the trends we discuss here have continued.
[8]This statement refers to all transactions in which the acquirer was a not-for-profit health system but not a faith-based system or academic medical center. Transactions were evaluated to determine whether the acquisition target operated within a metropolitan statistical area or state in which the acquirer already had a presence (as determined by data from the American Hospital Association and Irvin Levin Associates).

EXHIBIT 6 **AMC and faith-based systems have recently become more acquisitive**

**Acquisitions by system type, %**




AMC, academic medical center.

Sources: CapitalIQ; Dealogic; Levin; McKinsey analysis

and about 70% of the acquisitions operated within 50 miles of their acquirers, which suggests the AMCs are making a network and referral management play. Recent examples of AMCs creating in-market scale through acquisitions include the Northwestern/Cadence deal in Illinois, the Penn Medicine/Lancaster General Health deal in the Philadelphia area, and Jefferson Health's multiple acquisitions in that area. In 13 cases, AMCs targeted other AMCs.

### Faith-based systems

Faith-based systems, too, are showing growing interest in M&A. Acquisitions by faith-based systems accounted for 25% of aggregate target revenues from hospital M&A deals between 2014 and 2017, up from 22% in the 2006–2009 period.

Although most faith-based systems are Catholic, they often acquire secular targets. In 2015, for example, ten of the 14 acquisitions made by these systems were secular. Recent examples of faith-based/secular deals include the St. Mary's Health Care System acquisition of Ty Cobb Regional Medical Center in Georgia and Mercy Medical Center's acquisition of Skiff Medical Center in Iowa. A recent example of a deal involving two faith-based systems is Trinity Health System's acquisition of St. Joseph's Hospital Health Center in New York.

## Implications for providers

Evolution of the M&A landscape has important implications for provider executives. Here, we describe the four decisions that are most important for them to make, as well as the rationale for each recommendation. Once these decisions are made, provider executives should be well positioned to identify appropriate targets for acquisition.

## Define your role in the midmarket battleground

*Consolidation will likely continue, but the players will change*

Although the regulatory environment may become increasingly challenging (as the Federal Trade Commission's objections to the NorthShore/Advocate merger suggest), deal activity will likely continue. We believe three major acquirer archetypes are emerging:

Super-regionals (e.g., Carolinas, Baylor Scott & White) will continue to expand within existing and adjacent markets to increase local relevance. Much of the deal activity in the past few years supports this hypothesis. A number of midsize systems began to pursue M&A only recently and have yet to unlock the full benefit of scale. As a result, a growing number of super-regionals could emerge.

Academic aggregators (e.g., Partners) will continue to build on their hub-and-spoke models. In some cases, the expansion will come in the form of partnerships, but many AMCs appear to have a clear preference for full integration to achieve economies of scale across a larger set of assets and to gain other benefits. About 100 US AMCs have revenues between $1 billion and $5 billion. Of these, about 60 currently have limited networks (zero to two hospitals) beyond their main teaching hospital. In all but a single case, these AMCs have at least one community hospital within 50 miles they could potentially target.

Nationals (e.g., Tenet, HCA, Ascension, Catholic Health Initiatives) will likely continue to make acquisitions within their existing markets and expand into new markets when it makes sense to do so. However, these organizations may be more cautious in pursuing M&A now than they were in the past, given the existing debt on their balance sheets (they have three times or more the level of debt of a typical midsize system), as well as their need to protect cash reserves and, in some cases, continue integrating existing assets.

## Be bolder in realizing synergies

*The imperative to realize value will become increasingly important*

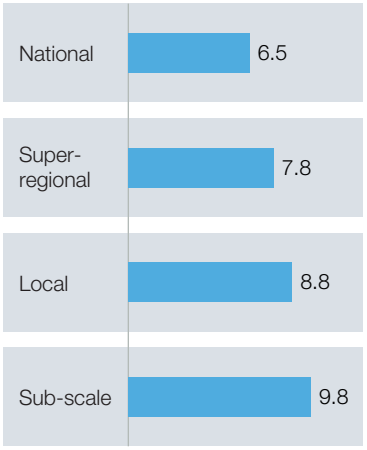
The targets' size and multiples (enterprise value to revenue) are rising. Because the need to achieve greater value creation has become more pressing, provider executives will be increasingly compelled to identify potential synergies, articulate a deal's rationale to justify the purchase price, and then realize the synergies once the deal is completed. Two factors may hamper their efforts, though. As health systems grow larger, there are fewer traditional synergies to capture and more organizational complexities to deal with.

- Fewer traditional synergies. Many health systems have realized value from acquisitions through traditional synergies (e.g., back-office administration). Once a health system reaches scale, however, traditional synergies will deliver at best only marginal returns, and the remaining value-creation opportunities will be in areas more difficult to capture—in particular, those more clinical in nature. Greater emphasis will thus need to be placed on clinical integration of assets to improve care coordination, physician alignment, and growth, as well as to decrease variability in clinical decision making.

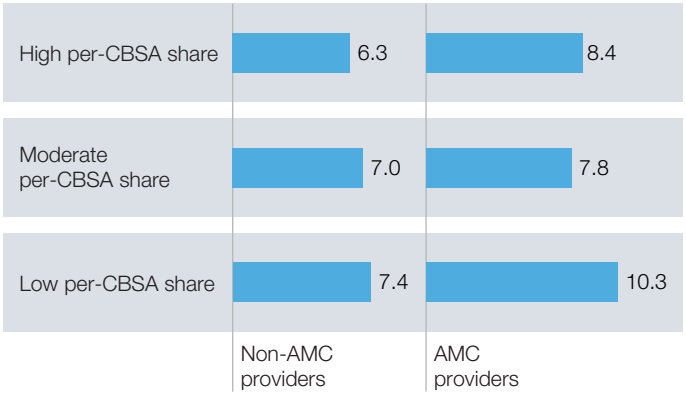
- Organizational complexities. A multitude of challenges are inherent in all large integrations, but the challenges are especially acute when the integration involves a health system, rather than a single hospital. Among the

EXHIBIT 7 **On average, health systems with greater geographic scale and market concentration are more efficient**

**Operating expenses per case mix index-adjusted admission, by system type**[1]




**Operating expenses per case mix index-adjusted admission, by market share**




AMC, academic medical centers; CBSA, core-based statistical area.
[1]Includes AMCs; systems with zero or negative revenue reported, systems with zero acute beds reported, are excluded; top market share is determined by the number of admissions. Analysis does not include independent hospitals.
[2]Health systems were defined as follows: national if at scale in 6 or more CBSAs; super-regional if at scale in 3–5 CBSAs; local if at scale in 1–2 CBSAs; sub-scale if not at scale in any CBSAs. "At scale" is defined as having >15% share of inpatient admissions in a given CBSA.
[3]Weighted average share of inpatient admissions across CBSAs in which system provides care; define as high if weighted average share is >30%; moderate if weighted average share is 15–30%; low if weighted average share is 2–15%.
Sources: American Hospital Association hospitals reports 2011 and 2016

difficulties the acquirer will face are the need to manage a range of multifaceted organizations, many of which may have different cultures, and to employ more complicated value-capture levers. As a result, the acquirer will have to establish clarity on organizational structure, decision-making rights, and expectations during the deal phase; it should not count on settling those issues after the close.

Nevertheless, it is crucial that provider executives be able to accurately assess the true value-creation opportunity before executing a deal and put in place plans that can achieve savings or growth.

## Define your portfolio of scale

*Scale continues to be relevant, but the type of scale will matter*

Regardless of what further changes occur in the healthcare industry over the next several years, scale will continue to be important for health systems. Our analysis shows that greater size correlates with stronger performance and a better ability to withstand growing pressures on profitability, balance sheets, and market structure (Exhibit 7). On average, operating costs are more than 35% higher at smaller, "local" systems than at national systems.

In the future, however, traditional economies of scale such as improved cost management will not be sufficient to enable health systems to compete effectively, so health systems must seek other advantages that scale can bring. For example, greater size can provide better access for patients and broader networks of coordinated care that lead to improved outcomes.

Scale can also help build brand value and consumer loyalty. Employers also gain value from scale: they can develop agreements with a health system to reduce costs, but only if the system has a network large enough to cover all of their employees.

Although many health systems have already achieved scale, they may want to consider new consolidation opportunities. As they do so, they should be thoughtful about where to invest. Acquiring facilities in disparate markets provides limited additional value once minimum effective scale has been reached. It is often wiser to focus on gaining local market leadership (i.e., first or second position in share) and integrating care delivery more effectively. Our analysis of 50 MSAs shows that health systems with high market share are, on average, about 20% more efficient on a cost basis than those with low share for non-AMCs and 38% for AMCs. Interestingly, the majority of the high-market-share systems are midsize.

## Key insights about provider M&A

- The total volume and value of provider deals remain high—and not just because of a few megadeals.
- Midsize systems, which now account for more than one-third of all US health systems, are playing an increasingly prominent role in deal activity. These systems are currently more active as *buyers* than large systems, and are acquisition *targets* more often than small systems. We expect this trend to continue, especially because the number of high-performing small systems is dwindling.
- Many acquirers, especially not-for-profit health systems, are focusing on geographic proximity, not expansion to new markets. However, investor-owned systems appear to be more willing to pursue deals across regions.
- Academic medical centers and faith-based health systems are making an increasing number of acquisitions. Together, they now account for more than half of aggregate target revenues.
- Scale matters. Our analyses show that systems with higher local market concentration are more cost-efficient. Furthermore, the imperative to achieve cost synergies will only increase, given the size, complexity, and multiples of likely future deals.
- When contemplating acquisitions, provider executives need to think beyond the traditional economies of scale. They should carefully define their strategic approach to M&A (especially in the midmarket battleground), be bolder and more aggressive in realizing synergies, consider the other advantages scale can bring, and use consolidation to build or obtain the advanced capabilities needed to compete in the future.

For health systems that have not yet reached minimum effective scale, aggregating facilities in existing or adjacent markets is likely to be another wise move. Aggregation will not only enable the systems to reach sufficient scale, but also allow them to afford the corporate capability building required to succeed in a value-based environment.

The health systems operating on a national scale appear to have grasped this point. Their actions suggest they believe that success within markets requires share leadership; they focus on building local market scale and exit a market when this is not possible. If they continue on this path, they will likely make additional investments in existing markets—for example, to acquire ambulatory facilities.

## Enhance capabilities along the way

*Economies of scope and skill become more relevant*

Consolidation can also allow health systems to acquire or develop economies of scope and skill. Greater scale can help them avoid what would otherwise be duplicate investments, such as spending on patient engagement platforms. Perhaps more important, it can establish a more robust asset base to support next-generation strategies. For instance, greater scale can permit health systems to acquire new capabilities that provide a near-term competitive advantage and may become table stakes in the near future. Examples include advanced analytics to identify trends that could influence clinical interventions (e.g., disease prevalence analysis, readmissions prevention tools), precision medicine, digital technology to improve patient engagement and care coordination, and more sophisticated management tools. By using scale to gain these capabilities, health systems put themselves in a better position to succeed in an increasingly complex environment.

• • •

Although provider M&A deal volume remains strong, the nature of the deals and the strategic intentions are evolving. When considering future acquisitions, provider executives should think beyond traditional synergies; they deliver at best only modest returns once minimal efficient scale is reached. Instead, provider executives should ground future deals in a clear strategy and focus on identifying and extracting value from economies of scope and skill. In that way, they can create significant value and compete more effectively in this dynamic healthcare environment.

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