DOCTORS' ORDERS: WHY THE HEALTHCARE INDUSTRY NEEDS AN M&A SUPPLEMENT

by Tony Kong

BUSINESS CONSULTANTS

DEEP TECHNOLOGISTS

The healthcare landscape continues to evolve as payers strive to meet healthcare reform requirements and providers strive to find ways to reduce costs and improve the quality of care. Now that much of the ambiguity around healthcare reform has been resolved – at least in the short term –payers and providers are seeking to transform themselves to remain competitive and relevant. For smaller payers and providers, the breadth of regulation and industry changes that they are facing are pushing M&A activity as they look to remain competitive, or to just survive. The call to action for payers is to understand the shifts that are occurring and to define an M&A strategy that anticipates and meets the needs of the changing landscape.

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LOWERED COSTS. COORDINATED CARE. IMPROVED QUALITY. INCREASED ACCESS

These are words that have been heard in the healthcare space for years and more so now that the Supreme Court and the subsequent re-election of President Obama have effectively solidified the direction of healthcare reform. While these objectives have certainly been a focus from a policy perspective, when we look at the industry and the readiness of payers and providers to implement these changes – there is a significant gap.

One CEO of a regional healthcare plan recently lamented, "I have to take my best people off of their primary duties to explore all of these initiatives." This is a challenge many face, and what this means is that either key resources are being diverted from driving current business operations, or organizations are not getting the time to pull back and evaluate if their current strategies need to be adjusted to the new healthcare environment.

The path forward for many will not only be to re-organize staff, but to transform operating models through mergers and acquisitions. Key to being successful will be to understand trends across the ecosystem and for players large and small to identify the investment strategy that will help meet the challenges ahead.

PROVIDER TRENDS

Healthcare reform and the current state of the U.S. economy have created a noticeable divide between small and large healthcare providers. Each group currently contends with its own unique set of pressures, strategic challenges and potential solutions to ensure longevity and competitiveness.

Facing the realities of reform, providers are under significant pressures to consolidate, merge, and more effectively manage risk.

Key investments that are being made include:

- Population, Geographical, and Delivery Network Expansion and Transformation
    - Investing in geographical expansion through group practice and hospital acquisitions
    - Incorporating population mix into acquisitive strategies to reach a more diverse population and manage risk
    - Partnering with payer organizations to develop accountable care and shared-risk based compensation models
- Capitalization of Branding, Standards, and Expanded Bargaining Power
    - Leveraging "name brand" to make unique partnerships and expansions
    - Establishing branded treatment protocols that can be licensed by external institutions for a fee
    - Utilizing back-office and revenue cycle efficiencies to effectively manage costs across broad operations

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- Expanding presence and brand to increase bargaining position with payer organizations

Large, advanced healthcare institutions are well-positioned to take advantage of the changing environment, even while risk management becomes an increased focus

Large, advanced healthcare institutions – like the Cleveland Clinic or Geisinger Medical Center – have been leading the way in advancing treatment protocols and improving healthcare outcomes, even before healthcare reform was front-and-center. As a result, these institutions, and institutions like them, are well positioned to make strategic acquisitions and further expand and diversify the care and services they provide. Examples of investments that will likely to continue to provide strategic advantage:

- Early and ongoing investment in technology and electronic health and medical records
- Participation in healthcare exchanges to increase the coordination of care while reducing handoffs and variability in care
- Alignment with academic institutions to transition research work into patient care best practices
- Rigorous focus on Revenue Cycle Management to improve cash flow
- Investment in innovation centers and technology transfer institutions

Small physician groups and struggling hospitals are being pushed out of the market

While large, well-funded and well-known medical institutions are in a position to take advantage of the current environment, small providers and hospitals are struggling. From an M&A perspective, there is likely to be significant activity in the coming years as providers look to either exit the market, or consolidate to increase their bargaining position and realize operating investments and efficiencies.

Key drivers that are influencing this trend, include:

- Costs associated with meeting Meaningful Use requirements as part of the HITECH Act along with associated HIPAA compliance requirements, and implementing ICD-10 requirements by October 2014
- Low operating margins for smaller provider institutions – especially for non-profits and institutions that rely on significant reimbursements from states – many of which have dramatic budget deficits
- Patterns of physicians moving from entrepreneurial ventures to become "employees." This trend is gaining traction as traditional entrepreneurs exit the market and younger doctors become more comfortable with an employee relationship model of employment
- Alignment with ancillary services like medical imaging that are seeing severely eroded reimbursement rates

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PAYER TRENDS

Payers are pushing to diversify and expand their capabilities to remain competitive, taking a "test and learn" approach that is resulting in untraditional transactions.

Key investments that are being made include:

- Technological and Capability Improvements –
  - Investing in data, analytics, and platforms to support alternatives to fee-for-service reimbursement, including: bundled payments, patient centered medical home and accountable care organizations
  - Acquiring and expanding capabilities to participate in public or private healthcare exchanges
  - Integrating and expanding wellness and population health programs to help members and patients live healthier lives
  - Focusing on business process optimization through consolidation, outsourcing, and automation
  - Prioritizing service and information transparency around care delivery and related costs – especially as consumers move towards consumer-driven plans like Health Savings Accounts
- Population, Geographical, and Delivery Network Expansion –
  - Expanding lines of business to increase investments in Medicare, Medicare Advantage, and Medicaid in anticipation of approximately 32 million new members joining the ranks of insured healthcare consumers
- Acquiring provider networks
  - Gain access to populations and have control over healthcare delivery as an integrated delivery network.

While not all payers are pursuing all of these strategic enhancements, it is fair to say that just about all payer organizations have or are currently tackling a sub-set of the investment opportunities outlined above.

Large payers remain focused on delivering value from strategic investments made before reform was finalized

For large healthcare payers, the diversification of their portfolios is a continuation of trends that began several years ago due to the broad consensus building around aligning reimbursements with quality outcomes, and moving away from a fee-for-service model. Large payers have been making significant investments in health information technology and analytics to help them identify variances in care delivery and gain better insights into the outcomes providers are able to deliver based on their treatment approach.

What has changed for the larger healthcare payers is the need to engage in the individual marketplace and exchanges, the oncoming expansion of Medicare and Medicaid, and the mandatory requirement of Medical Loss Ratios (MLR) (which became effective in 2012, requiring payers to meet the 85% MLR or else reimburse

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the difference to their members).

Small payers are looking to M&A activity to remain competitive and meet new Federal requirements

For smaller payers, the state of affairs is a bit more challenging; they are struggling to diversify and expand to remain relevant in the new, post-reform environment. Smaller payers are hit harder by the requirements of MLR, and are driving to expand their geographical reach and establish Medicare (and especially Medicare Advantage) business lines. Additionally, many smaller payers struggle to understand how they are going to engage in exchanges, how they can adapt their existing product portfolio and service an entirely new type of customer base.

WHAT CAN BE LEARNED FROM THESE TRENDS, AND HOW CAN PAYER ORGANIZATIONS TAKE ACTION?

Similar to healthcare providers, payer organizations have different lessons to learn and options for moving forward based primarily on their size. Ultimately for payers, the best bet for the future is to partner with other organizations of a different size. Integration will be a critical solution to achieving the audience and offering diversity that these organizations need to stay afloat.

If you are a large payer you should consider:

- **Partnering with Smaller Payers to Diversify Populations Served**: The best balance for insurers is to have a membership base that contains a balance of healthy patients who need little care and patients who require high levels of care. A better membership population balance allows insurers to pay out less in utilization costs than they receive in premiums. With anticipated expansion of Medicaid funding and elimination of pre-existing conditions (all who want to buy insurance must be accepted), the member mix may contain patients who need more care (utilization costs) than incoming premium costs.

  Payers can further diversify their population base by acquiring smaller payer organizations that may not have the reserves to implement changes related to reform, but have demographic advantages.

- **Implementing Quality Outcomes Based Programs like ACO or PCMH:** To keep utilization costs under control, large payers should explore implementing quality outcomes-based programs like an ACO or PCMH. For example, Payers can fund an ACO to partner with a physician practice group, establish an outcomes-based reimbursement model, and hire a neutral third party administrator to pay the incentives as providers achieve quality metrics. This strategy looks to shift risk across the delivery network and moves the reimbursement model from fee-for-service to focus on outcomes. The promise of this model of care is that costs can be driven down as providers have more

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incentives to focus on preventive care, and fewer incentives to pursue tests or treatments that are key cost drivers.

If you are a small payer you should consider:

- **Partnering with a Larger Payer:** If you are struggling to find the cash to make it through the Meaningful Use requirements, outcomes based measures and reduced reimbursement rates for Medicare and Medicaid patients, then merging with a larger organization can give you the resources and diversified network you need to survive.
- **Becoming an Integrated Delivery Network:** If your strategy is community-based, pursuing a partnership with a primary care practice group (like a Physician Health-owned Group – PHO), may be a better alternative. This approach enables you to align with providers and focus on serving your local market well with small incremental growth each year. This model serves a community case-based model rather than a growing institution that is raising profit and revenue.

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Operational change can be difficult for the best of organizations; strategic changes can be almost impossible if not executed well – especially in the midst of M&A. Payers should look for partners with experience navigating complex transactions, and with strong competencies in delivering transformational initiatives in order to realize the full, long-term benefits of a merger or acquisition.

The path ahead is going to be challenging, it's time to roll up your sleeves.

CONTACT

Tony Kong is a director in West Monroe Partners' Private Equity and M&A practice.
(206) 905-0184
tkong@westmonroepartners.com

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