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The Changing Participants in Today's Health System M&A Market

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There are two standout participants in today's health system M&A market: 1) local government-sponsored hospitals seeking larger partners and 2) academic medical centers (AMCs) pursuing scale. Both are playing an outsized role in the composition of the industry.

Thirty years ago, there were about 1,350 political subdivision hospitals in the U.S. (i.e., those owned and controlled by cities, counties, districts, etc.). That number is down to around 900 today. Many of the 450 or so "sellers" formed partnerships with larger, multi-hospital systems.

A similar transformation has occurred within the AMC "acquiror" universe, where AMCs are participating in and winning more competitive change-of-control processes. Historically content being ivory tower teaching institutions performing quaternary care from a single urban campus, AMCs have newfound medical and economic incentives to grow—both horizontally and vertically. AMCs are sought after by sellers due to their medical quality prestige, strong operating position, utilization of technology, and favorable regulatory stature. They generally have strong financials, the full continuum and breadth of services, access to talent, and strong brand recognition. State-sponsored AMCs are generally viewed as de facto safety net institutions statewide with a new imperative to grow.

This article explores:

- The participants and motivations of parties in the non-profit health system M&A market.
- Strategic needs of independent public hospitals (e.g., seeking scale for operational durability, medical quality enhancements, and access to coordinated health information technologies).
- Strategic needs of AMCs (e.g., to provide step-down levels of care in community settings, treat patients closer to home, grow the referral base for quaternary care, alleviate occupancy constraints at downtown trauma centers, and withstand bundled payments and risk-based contracts).

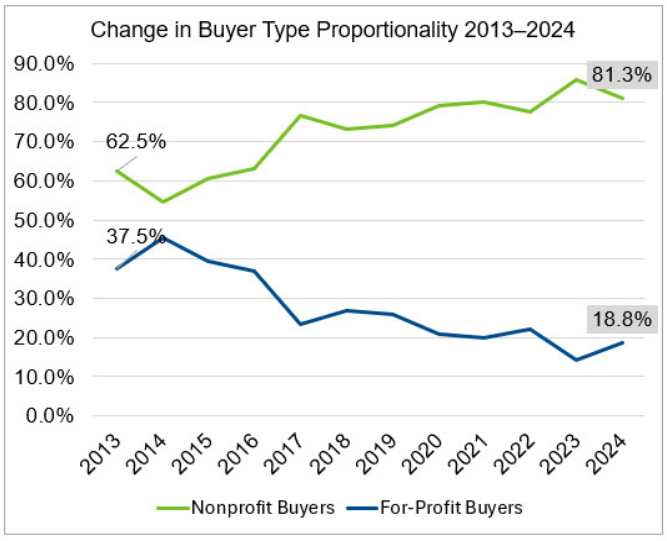
The Strategic Rationale for M&A

A material shift has occurred in the health system M&A market, widening the difference between non-profit and for-profit companies. Ten years ago, non-profit systems won roughly 60 percent of change-of-control transactions. Today, they are responsible for over 90 percent.

Long associated with a reputation for medical quality, non-profit health systems benefit from tangible financial advantages that have propelled this growth. Here we examine the capital markets, operating, and regulatory conditions that created such disparity. Factors include low cost of capital for municipal bonds and loans (driven by AMCs' high credit ratings), programs like 340(b) drug pricing, tax exemptions, and the availability of state and philanthropic support.

HEALTH SYSTEM M&A MARKET *participants*

- Widening difference in acquisition success
- As for-profits have exited the sector, non-profits have become a larger proportion of the buyer pool and have become increasingly commercially oriented



Source: Scope Research, transactions with reported consideration.
Notes: 1. Includes transactions reported with and without consideration.

Active Buyers and Sellers 2020–2025[1]

Top 501c3 Acquirors	Net Change
Atrium Health	+36
Sanford Health	+11
Orlando Health	+10
Aspirus Health	+8
Ochsner Health	+8
Top Academics	
WVU Health System	+9
Medical U. of South Carolina	+6
UNC Health	+5
University of Chicago	+4
UCI Health	+4
Vanderbilt	+3
University of Michigan	+3
Top Divestitures	
CHS	-25
Ascension	-23
Tenet	-19
Steward	-16
HCA	-12
Lifepoint	-11

Let's assess five ownership types in the acute care hospital industry:

1. Academic
2. Secular 501(c)(3)
3. Faith-based
4. Local government
5. Investor-owned

The latter forms owned by groups of people, whether congregations of Catholic sisters (#3), elected commissioners (#4), or shareholders (#5), are exiting the sector.

The common denominator is that such bodies have purpose beyond the governance of a healthcare system. As the acute care hospital industry has matured, it is now a capital-intensive, regulated, and complicated business. Some of our Generation X client relationships suggest "it's no fun anymore; the reasons we entered the medical field are no longer achievable; the headwinds are too great."

The phrase "quiet quitting" has been used to describe the practice of workers exerting the bare minimum effort to maintain their positions—effectively "coasting" on steroids. We have all heard the lore of young tech workers in Silicon Valley sunbathing and drinking beer on an office rooftop, neglecting to notify managers about a "side hustle" or second job, or simply not returning to a workplace after COVID-19. Applied to the hospital industry, the post-COVID environment has been defined by burnout, workplace safety concerns, and declining support from communities.

Employment experts cite job apathy and changing priorities among today's workforce as leading culprits. Loyalty to corporations largely ended in our grandparents' generation when it was common to spend one's entire career at the same firm. Twelve is now the average number of jobs that a worker will hold over their professional lives.[1] To be fair, employees are rational economic actors. If they can fulfill their job commitments in a "four-hour workweek"[2] in the creative economy, more power to them.

Companies, meanwhile, and as the critique goes, are too busy striving for hockey stick growth or engineering equity valuations that they fail to realize. It is a combination of the "hardcore" mentality that Walter Isaacson describes in his biography of Elon Musk[3] and the financial self-interest chronicled in "Downfall: The Case Against Boeing" the Netflix documentary.[4]

Like workers, companies too are rational actors. Incentive architecture has created an environment where late-stage financial engineering (stock buybacks, splits, dividend programs, and other share-price manipulations) prioritize near-term quarterly financial performance over long-term success. Such actions come at the expense of research and

1 Douglas Broom, "Having Many Careers Will Be the Norm, Experts Say," World Economic Forum, May 2, 2023.
2 Tim Ferriss, *The Four-Hour Workweek*, 2007.
3 Walter Isaacson, *Elon Musk*, Simon & Schuster: New York. 2023.
4 *Downfall: The Case Against Boeing*, Netflix, 2022.

development investments or pursuing deeper technical prowess. Capital markets pundits like Andrew Ross Sorkin say the financial engineering omertà is especially alluring during bull market cycles.[5]

Society may not notice a small number of niche tech employees phoning it in. But what about in other industries that perform higher-stakes functions like hospitals? It's starting to happen and the results are concerning.

Hospital systems, like their employees, don't advertise quiet quitting, but the transaction activity shows a trend-line. The ability to recruit and retain workforce, capital demands, and regulatory complexity caused many to seek strategic partnerships. Those organizations with clear, human owners are divesting hospital assets. In contrast, teaching institutions and secular 501(c)(3)s exist to "self-perpetuate." Their mission is to ensure that they are vibrant operators next year and the following.

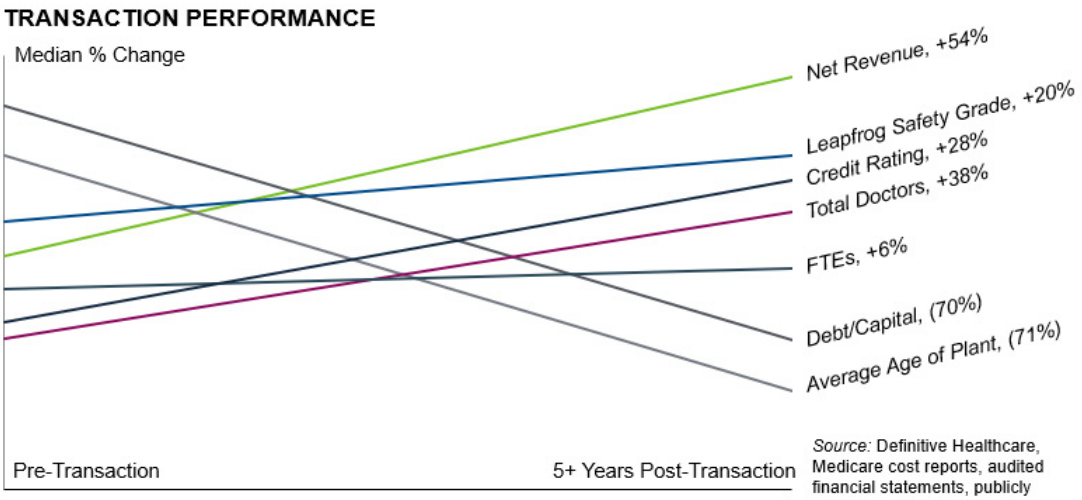
Experts suggest that systems with regional density that can drive care volume to centers of excellence are key components to improving both economic and medical outcomes. Clinical integration and IT sophistication are increasingly difficult to achieve for sub-scale providers (those with less than $2 billion in revenue). As healthcare leaders and industry experts, we are monitoring the supply of faith-based, local government, and investor-owned sellers outpacing the demand from academic and secular 501(c)(3) buyers.

Favorable regulatory conditions are playing an important role too. State-sponsored AMCs in particular benefit from less oversight (notably attorneys general) and the Federal Trade Commission. Some even enjoy sovereign immunity.

Common AMC motivations include improving access close to home (a major focus of state legislatures), contending with bundled payments, managing risk-based contracts, avoiding facility closures, servicing the full-continuum of care, spreading high fixed costs (e.g., infrastructure, EPIC) across a larger asset base, responding to credit rating pressures, and staffing specialists. State AMCs located outside of major metro markets sometimes struggle to recruit to non-urban settings, so having a presence in population centers improves attractiveness for graduate medical education programs. Serving a larger population lessens the reliance on any one geography and attempts to narrow health inequities.

Promisingly, business combinations among non-profit hospitals work better in practice than in other industries. The following chart shows enhancements that accrue to hospitals that enter into partnerships with larger organizations. It is standard for buyers to commit to preserve services and employment.

5 Andrew Ross Sorkin, *Too Big to Fail*, Penguin Random House: New York, 2009.



Source: Definitive Healthcare, Medicare cost reports, audited financial statements, publicly available information, Leapfrog Safety Grades.

Core Accomplishments

Expand Medical Staff
- Ability to attract talent & enhance care

Improved Quality
- Leapfrog safety grades
- Patient outcomes & operational excellence

Modernized Facilities
- Investments in infrastructure & technology

Strengthened Financial Health
- More stable, less risk
- Significant revenue growth

Conclusion

Historically, AMCs were risk averse and content with loose affiliation limiting the scope to service lines or programmatic support. Today, more are adopting fully integrated structures that align clinical and financial. Senior physician leaders are communicating that the prospect for advancing medical progress is greatest when organizations are aligned operationally.

Key Board Takeaways

- AMCs are leading the industry in innovation and quality but are new to the M&A market.
- Local government hospitals have a strategic imperative to achieve scale and access scarce medical resources.
- The two forms of ownership are identifying the attractive logic and fit of business combination transactions.

As public hospital boards evaluate potential partnerships and affiliations at their own organizations, they should consider the following questions:

- What are the most pressing operational or strategic challenges our organization faces today, and how might a partnership or affiliation help address them?
- What types of partnerships or M&A structures are most aligned with our mission and patient care goals?
- How should we evaluate potential partnerships in terms of their ability to help us manage financial risk, participate in value-based payment models, and remain competitive in a rapidly consolidating market?
- How do we balance the need for operational scale and access to advanced resources with the importance of preserving local autonomy, community identity, and governance?

TGI thanks Raghu Adiga, M.D., CEO, Liberty Market, University of Kansas Health System, Joseph B. Clamon, Chief Legal Counsel and Chief Clinical Strategy Officer, University of Iowa Health Care, and Rex Burgdorfer, Partner, Juniper Advisory, for contributing this article. *They can be reached at radiga@libertyhospital.org, joseph-clamon@uiowa.edu, and rburgdorfer@juniperadvisory.com.*