Mesirow

Healthcare sector report

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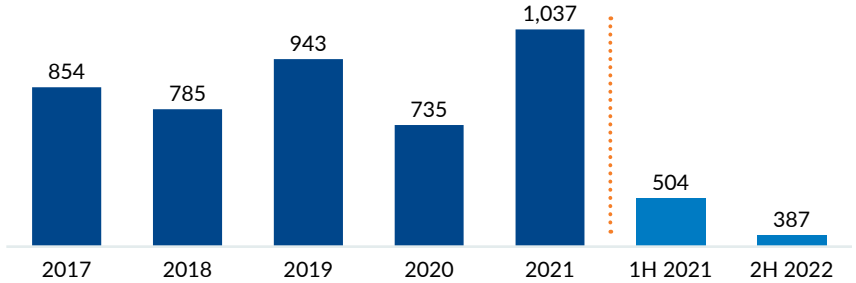
2022 Mid-year update

Healthcare Services M&A activity in the first half of 2022 has backed off 2021's torrid pace. This does not come as a surprise given today's landscape compared to the red hot M&A market in 2021 that was fueled by a backlog of delayed transactions created by COVID, a healthy stock market, the availability of cheap debt, low interest rates, upbeat forecasts and dealmakers hurrying to complete transactions before a potential increase in capital gains taxes. We believe the relatively modest number of deals in the first half of 2022 compared to the first half of 2021 is a response to several factors: taking stock after 2021's fervent activity, continued evaluation of COVID and its effect on the marketplace, and concerns about rising inflation/slowing economic growth. Our expectation for mid-market M&A is that conditions will continue to favor consolidation as companies strive to optimize margins, diversify service lines and capture market share.

CHART 1: **HEALTHCARE SERVICES M&A ACTIVITY**



Data as of 6.30.2022. Source: S&P Capital IQ.

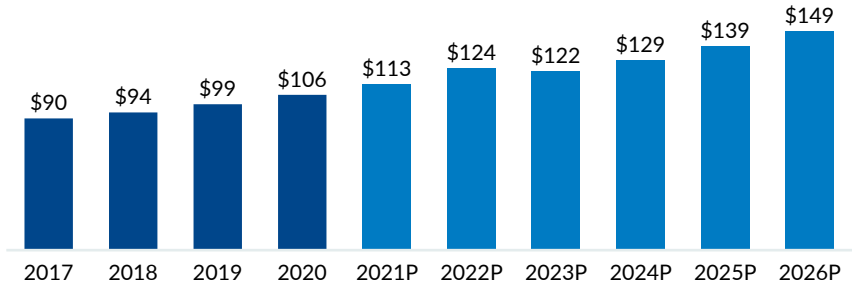
Similar to the broader Healthcare Services market, Home-Based Care M&A transaction volume is down in 2022 compared to 2021. Home-Based Care saw an accelerated number of exits in 2021 primarily due to continued strength in valuations, private equity's intense appetite for the sector, a backlog of transactions that were placed on hold due to COVID and concerns around an increase in the capital gains tax rate. Although appetite for assets remains strong amongst strategic players and private equity groups, the U.S. Centers for Medicine & Medicaid Services' (CMS) new proposed payment rule may influence parties to place potential acquisition opportunities already in process on hold until the impact of this change is finalized later in 2022.

Sector Spotlight: New CMS rule poised to trigger change in the home health care industry

The $124 billion home health care sector is one of the largest and most fragmented service sectors in America. There are an estimated 429,000 home care providers[1] in the U.S. and over 99% of Medicare beneficiaries live in a county served by at least one home health agency (HHA) while 88% live in a county served by five or more HHAs. The number of HHAs in the U.S. has been declining since 2013. There were 11,474 HHAs in 2021, down from the peak of 12,613 HHAs in 2013 (decline of 1.2% / year).[2] Continued investments in home health by public companies and financial sponsors has helped fuel consolidation in the parent providers that own individual HHAs.

CHART 2: **HISTORICAL AND PROJECTED U.S. HOME HEALTHCARE EXPENDITURES**

(in $billions)



Source: Centers for Medicare & Medicaid Services. Totals include expenditures for out of pocket, health insurance (private, Medicare, Medicaid and other health insurance) plus third-party payers and programs..

Given relatively low barriers to entry and increasing demand as the population ages, the industry is intensely competitive. While there are a few large operators, the nature of the services offered does not lend itself to economies of scale. The result has been a proliferation of extremely low margin businesses with a disproportionate number of smaller operators. A byproduct is an increased likelihood for fraud, billing irregularities and sub-par healthcare.

According to the recently published Medicare Payment Policy Report to Congress, Medicare margins for freestanding HHAs averaged 20.2% in 2020, even though the cost per 30-day period increased by just 3.1% from 2019 to 2020. "These high margins indicate that increases in payments exceeded the increase in costs. Medicare's payments have always been in excess of cost under prospective payment, with the Medicare margin for HHAs averaging 16.2% from 2001 to 2019. The projected margin for 2022 is 17.0%."[3]

The report recommends that, for calendar year 2023, "Congress should reduce the 2022 Medicare base payment rate for home health agencies by 5 percent."

The situation is exacerbated by surging demand for at-home recovery options and hospitals experiencing staffing challenges. Capacity restraints have generated an urgent situation: despite a 33% increase in referrals per patient to home health providers, there has been a 15% decrease in acceptance.[4]

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New CMS reimbursement policy may lead to further consolidation among home health agencies

Under a CMS draft policy announced in mid-June, HHAs would see a net $810 million Medicare pay cut in 2023.

In 2020, CMS imposed a new reimbursement policy for HHAs that pays them based on patient characteristics rather than the number of therapy hours they provide. This new model, called the Patient-Driven Groupings Model (PDGM), calls for a 4.2% overall reimbursement decrease, which is primarily due to negative pay adjustments to cover increased expenditures that CMS says resulted from the policy.

PDGM isn't allowed to cause higher Medicare spending, so CMS reduced HHA pay by 4.4% starting in 2020 to account for how HHAs would respond to the model.

Starting next year, CMS proposes a 7.7% cut to maintain budget neutrality. The $1.3 billion cut would be partially mitigated by a 2.9% increase in home health rates, according to CMS.

Due to the expected net reduction in reimbursement, we anticipate that many smaller HHAs who are challenged to maintain profitability right now are more likely to close or be acquired by larger providers. We believe that M&A activity in the industry will be further fueled by agencies looking to improve or sustain margins and a continuation of the surging demand for in-home health care.

The government's response: new "review choice demonstration" rules

To address the situation, in 2017 CMS issued the Review Choice Demonstration (RCD) pilot program. Essentially, RCD gives HHAs three choices of the review level for claims they submit to CMS to receive payment for service, including:

- **Pre-Claim Review:** HHA seeks provisional affirmation of claim coverage before a final claim payment submission. Claims submitted without a Pre-Claim review undergo prepayment review and are subject to a 25% payment reduction.
- **Post-Payment Review:** HHA seeks review of claims after a claim payment submission. This is also the default if no selection is made by the HHA.
- **Minimal Post-Payment Review:** All claims are subject to a 25% reduction in final payment. Once selected, the provider remains active on this choice for the duration of the Demo.

In essence, this means that claims must be submitted beforehand or HHAs are liable for a 25% reduction in payment. If the HHA wants 100% reimbursement, they must fulfill detailed requirements and do so within a specified timeframe. Initially, the RCD pilot program was rolled out in five states: Florida, Illinois, North Carolina, Ohio and Texas. The pandemic delayed the initial institution of the program, but a phased rollout began in earnest last year. The expectation is that this program will be the norm for all states in the future.

A possible death knell for smaller operations

The intention of the program is admirable: cut back on abuse, reduce fraud, and lower costs for taxpayers. As often happens, however, the reality is less happy. Most HHAs will likely have to hire additional staff and invest in systems just for billing to ensure claims get submitted accurately and on time. Even if they're accurate, there's still a look-back period down the road. As many HHAs are lower-margin businesses, the rules may hobble or even force smaller operations out of business.

HHAs: A fertile area for M&A activity

The high degree of fragmentation in the home health care industry opens the door for a continued wave of M&A activity. While larger HHAs will be impacted by the new rules, they likely have the staffing ability and capital to adapt appropriately. They also have experience navigating multiple types of billing paradigms and to invest/leverage technology to automate their systems. Smaller HHAs with thinner margins and fewer resources will likely have little choice but to either merge or go under. Mergers offer these businesses a way to address several headwinds:

- **Low margins.** HHAs are not 50% margin tech businesses that will now go to 35%. These are lower margin businesses (20% or less) that will likely have to take on additional staffing to comply with this new regimen. In addition, instead of collecting payments in 60 days, additional review rules may push payment out to 120 days, which can be the death knell for smaller, lower margin businesses. Operators that have the capital to acquire other businesses may be able to merge and gain economies of scale and thus survive. For smaller operators, selling may be the only viable option.
- **Caregiver shortage.** Caregivers are becoming more scarce and companies must pay more to attract and retain them. Against the backdrop of high demand for people who want to be treated in the home but can't find a clinic, smaller businesses will be hard pressed to compete for talent.
- **Post-COVID reassessment.** One thing we're hearing in talks with HHA businesses is how much operating in a post COVID-peak world has changed their outlook. Many were struggling previously and burnout was a real issue for HHAs given the slim margins and struggle to recruit and retain caregivers. The new rules, for many, are a bridge too far. For them, the RCD program signals an inflection point that may make them more open to offers to sell, either to larger HHAs or private equity firms.

Should RCD perform as CMS hopes, it's highly likely it will be rolled out in more states, setting the stage for a transformation of the sector nationwide. As has happened with other similar industry-wide disruptions (think banking, hospitals and hospitality) we expect an active environment for M&A in the sector going forward.

> "Congress should reduce the 2022 Medicare base payment rate for home health agencies by 5 percent."
>
> – MedPac report to Congress

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1. Source: IBISWorld Industry Report on Home Care Providers in the U.S., August 2021. Companies in the Home Care Providers industry primarily provide services in the home, which may be medical or nonmedical and include skilled nursing care, personal care, homemaker and companion services, physical therapy, medical social services and in-home hospice care providers

2. Source: MedPac July 2022 Data Book: Health Care Spending and the Medicare Program. https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec8_SEC.pdf

3. Source: MedPac Report to the Congress. https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf

4. Source: Home Health Care News