

HCA Healthcare: where should the next dollar of growth go?

Internal ID: S&F-STR-285

Topic: Growth Strategy, Risk Management, Mergers & Acquisitions

Industry: Health Care Facilities

Source: Strategy & Finance

Publication date: 5 October 2026

License: Not specified

Student case | Information cutoff: 10 November 2023, 11:59 p.m. ET

By the close of November 10, HCA's November 9 Investor Day materials and replay were public. The presentations described a company expanding both hospitals and outpatient access points. They also pointed to a large pool of emergency visits outside HCA's network and to long-term earnings-growth targets. Yet none of the materials compared the expected returns, access effects, or execution risks of the different growth paths on a common basis.

For this case, imagine that HCA's board has asked the executive team to prepare a recommendation on the next phase of growth investment. The board has not announced such a review or set a specific budget. Your task is to advise how HCA should prioritize its marginal growth capital: add inpatient capacity, expand outpatient access, deepen physician and network integration, or combine these approaches in selected markets. What evidence and decision gates should guide that choice?

A network built from hospitals and access points

HCA is one of the largest U.S. hospital operators. At September 30, 2023, it reported 183 hospitals and approximately 2,300 ambulatory sites across 20 states and the United Kingdom. Its Investor Day presentation counted 317 urgent-care centers, 142 freestanding emergency rooms (FSERs), and 148 ambulatory surgery centers (ASCs), including 22 endoscopy centers. The network also included outreach programs intended to connect patients and physicians with HCA facilities.

The settings serve different needs. Inpatient hospitals provide beds, emergency departments, surgery and a range of acute services. ASCs focus on procedures that can be performed without a hospital admission. Urgent-care centers and FSERs provide different levels of unscheduled care; their patient acuity, staffing, reimbursement and role in the local care system can differ. Physician relationships and outreach programs may influence referrals, continuity and access, but do not by themselves add beds or procedure rooms.

HCA's Investor Day deck described its historical in-migration share measure as increasing from 20.5% in 2012 to 25% in 2022. Management also presented an estimated 24 million annual non-HCA emergency-room visits as an opportunity. The estimate used 2022 market data and HCA volume through September 2023. It represents addressable visits, not visits HCA expected to capture. It does not establish how many visits were appropriate for an HCA FSER, how many would be new to HCA rather than shifted from another HCA facility, or what financial contribution they might generate.

Growth in more than one direction

HCA's November 2023 presentation showed continued growth plans across settings. Its two-year projections included one additional acute hospital, 1,558 beds, 51 FSERs, 65 urgent-care sites and nine ASCs. The presentation described these figures as projections based on current plans and expectations. They were not completed results or a commitment to open every site.

The company also listed potential hospital projects and described market opportunities for existing services. Its five-year outlook set management targets of 4-6% adjusted EBITDA growth and 8-12% diluted EPS growth, subject to assumptions and risks. These were company targets, not independent forecasts or project-level return hurdles. HCA said its 2024 operating plan was not complete when it issued the outlook.

Recent operating results offered a snapshot, not a forecast. In the third quarter of 2023, HCA reported same-facility outpatient surgeries up 0.9%, inpatient surgeries up 1.6%, and emergency department visits up 3.5% from the year-earlier quarter. Those are different measures of activity; they do not reveal the incremental contribution or access effect of the next hospital, ASC, urgent-care center or FSER.

Capital was already committed to a substantial development program. For the first nine months of 2023, HCA reported \$3.585 billion in capital expenditures excluding acquisitions, versus \$3.072 billion in the comparable 2022 period, and expected 2023 capital expenditures of approximately \$4.7 billion. Projects under construction had estimated additional costs of approximately \$4.5 billion to complete and equip over the following five years. HCA reported \$39.346 billion in debt at September 30. The filing did not allocate these amounts among inpatient, outpatient and network investments.

Three strategic paths-and a portfolio choice

Add inpatient capacity. New hospitals and beds can support services that require hospital infrastructure and may relieve local capacity constraints. These projects can require substantial capital, construction time, clinical staffing and regulatory approvals. HCA's public materials show a pipeline, but do not disclose comparable market-level demand, returns or staffing feasibility for each possible project.

Extend outpatient access. ASCs, urgent-care centers and FSERs can place care closer to patients and may capture care that otherwise goes to a competitor. But they are not interchangeable assets. Their contribution depends on the services they can provide, payer arrangements, physician availability, local competition, site-of-care substitution and whether the volume is truly new to HCA. A higher count of visits or procedures at one location does not necessarily mean more total HCA demand.

Deepen physician and network integration. Physician affiliations, outreach and coordinated referral networks may help align services and improve access. Ownership or integration can also change where physicians deliver procedures. It is therefore important to distinguish coordination and patient access from site steering, billed charges, collected revenue and profit. The public materials do not disclose a proposed integration transaction or its terms.

A fourth possibility is to combine these paths selectively by market. A hospital with constrained inpatient capacity may call for beds and specialty services; a market with outpatient access gaps may call for an ASC or urgent-care site; a fragmented referral network may call for physician relationships. The public information does not identify which local condition applies to every proposed site.

What research can-and cannot-say

Three studies provide evidence about possible mechanisms. None estimates HCA's project-level returns.

- **Site shifts after integration.** Richards, Seward and Whaley studied Florida outpatient-procedure records and physician ownership from 2009-2015. Their physician and year fixed-effects difference-in-differences/event-study analysis covered 5,329 physicians, including 441 newly integrated physicians. After hospital/system integration, physicians used fewer ASCs; the probability of any ASC use fell 2.9 percentage points, and Medicare and commercial ASC shares fell about 1.6 and 1.5 points. The study found no significant increase in procedure counts, while nominal billed charges rose in some models. Its findings depend on observational identification assumptions and a single-state, older setting. Billed charges are not collected revenue, cost or profit. Richards, Seward & Whaley, "Treatment Consolidation after Vertical Integration," *Journal of Health Economics* 81 (2022), 102569.
- **Freestanding emergency departments.** Ho, Xu and Akhter analyzed commercial claims from 495 areas in Arizona, Florida, North Carolina and Texas during 2013-2017. Models with area and quarter fixed effects and local trends associated an additional freestanding ED with 3.6 percentage points higher emergency spending per enrollee in Florida, North Carolina and Texas, but not Arizona. ED visits rose in three states and not North Carolina; results varied by state. The data did not identify whether each claim came from a hospital or freestanding ED and could not fully account for patient acuity, travel or local substitutes. These are market-level associations from four states, not an HCA forecast. Ho, Xu & Akhter, "Freestanding Emergency Department Entry and Market-level Spending on Emergency Care," *Academic Emergency Medicine* 26 (2019), 1221-1231.
- **Integration and Medicaid acceptance.** Haddad, Resnick and Nikpay used a national SK&A survey of surgical practices from 2007-2017. Their observational logistic models found integrated practices had higher odds of reporting future Medicaid acceptance (odds ratio 2.61; 1.68 with hospital fixed effects). Reported acceptance is not proof of an available appointment, completed care, improved quality or financial sustainability, and integration was not randomly assigned. Haddad, Resnick & Nikpay, "Does Vertical Integration Improve Access to Surgical Care for Medicaid Beneficiaries?" *Journal of the American College of Surgeons* 230 (2020), 130-135.e4.

A competitor offers another reference point. Tenet reported that its USPI segment had interests in 457 ASCs and 24 surgical hospitals as of September 30, 2023. Tenet's ownership mix, scale, locations, payer mix and reporting differ from HCA's, so its results do not establish the return HCA would earn by shifting investment toward outpatient assets.

The decision

Prepare a recommendation for the hypothetical board discussion. Should HCA prioritize hospitals and beds, outpatient access sites, physician/network integration, or a market-specific mix? Explain the strategic logic and identify what evidence would cause you to change course.

Your recommendation should distinguish:

- addressable market estimates from demand HCA can capture;
- volume transferred among HCA sites from system-level new demand;
- gross billed charges from collected revenue, contribution margin and profit;

- management projections and targets from completed results;
- patient access and quality from financial outcomes.

What local market data, investment measures and operational safeguards would you require before committing capital? How should HCA compare different settings without assuming that one visit, procedure or bed has the same economics or patient impact as another?

Selected sources

- HCA Healthcare, [2023 Investor Day legal book](#), especially slides 20, 24, 28, 31 and 195 (9 Nov 2023).
- HCA Healthcare, [2023 Investor Day outlook](#) (9 Nov 2023).
- HCA Healthcare, [Form 10-Q for quarter ended 30 Sep 2023](#), MD&A pp. 18 and 24-25 (filed 26 Oct 2023).
- Tenet Healthcare, [Q3 2023 earnings release](#) (30 Oct 2023).