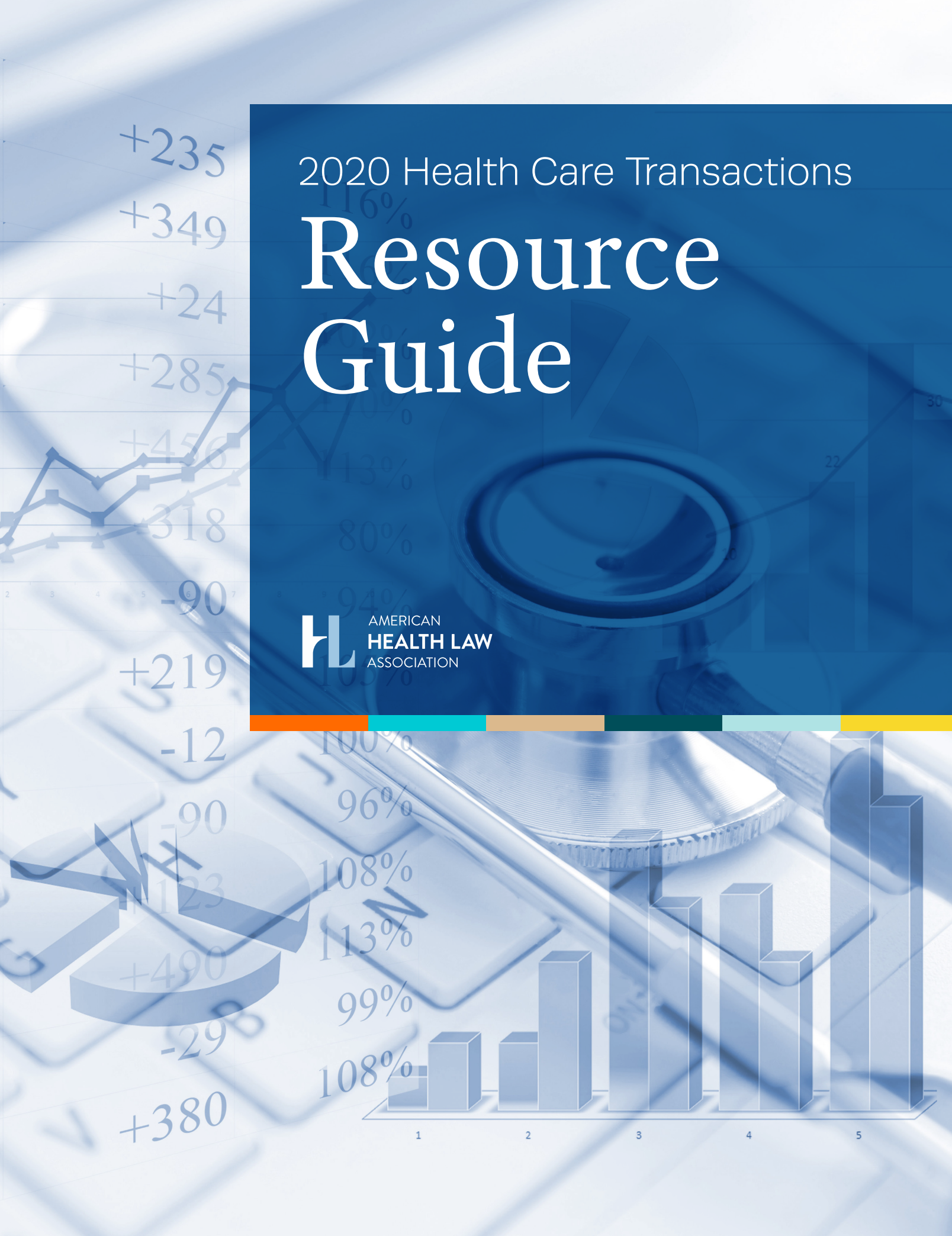


2020 Health Care Transactions

Resource Guide



Experts in Health Care Transactions Share Valuable Analyses and Commentaries

Welcome!

For the first time since AHLA hosted its first Health Care Transactions program eight years ago in Nashville, Tennessee, we—like many other associations—have had to quickly convert an in-person conference into a virtual one due to the current COVID-19 crisis. We hope, first and foremost, that you and your loved ones are safe and healthy during this time.

In spite of the quick pivot we had to make in turning our in-person conference into a virtual program, our commitment to providing you with quality and timely coverage of trends, issues, and best practices in the world of health care transactions remains uncompromised. Once again, we are pleased to offer our business partners the opportunity to profile their expertise on a wide range of health care transaction issues.

A number of them—Coker, HSG, JTaylor, PYA, RTG, and Wipfli—have graciously contributed to this year's Health Care Transactions Resource Guide, and they have provided AHLA with educational sponsorships to support its development. This Guide contains valuable analyses and commentaries on significant transaction issues from leading health care experts, all of whom are recognized dealmakers in the health care industry.

We are pleased to publish this collection of timely, practical, and valuable articles for the benefit of our members and the broader health care community, and we are pleased to add this resource to our impressive array of products and services. Thank you to each of our sponsors for making this possible. ♦



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2020 Health Care Transactions Resource Guide

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Pursuing the Private Equity Model for Hospital-Physician Transactions—A Viable Option

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Hospital and physician alignment transactions typically fall under a few common structures, the two most common models being practice acquisitions with physician employment, and professional services agreements (PSAs). Another option is available, however. The market for the purchase of medical practices by private equity (PE) firms has shown significant growth in recent years, with expectations the trend will continue. This article will discuss hospital and physician alignment transactions that occur under the PE structure and how they differ from traditional transaction models; address private equity buyers and the advantages and disadvantages of PE acquisitions; and conclude by taking a closer look at private equity-like transaction models between hospitals and physicians.

What Are the Options?

Physician groups looking to sell now have more options as they look for buyers other than hospitals. Some practices are exploring the possibility of selling, usually in part, to private equity (PE) firms or private equity-backed platform companies. These transactions differ from typical hospital-physician deals in structure and terms. Following are some common characteristics that describe these PE-based models and the qualities that make them unique:

Hospital Acquisition of the Practice with a Physician Employment Agreement

1. The acquisition usually includes only tangible assets; thus, minimal upfront money is necessary.
2. The practice usually sells ancillaries separately at fair market value (FMV).
3. The compensation plan is typically based on individual physician production, along with some quality incentives.
4. Acquisition normally makes sense for primary care or practices where the priority is to reduce risk and attain more income stability over upfront dollars. Some specialty practices are also of interest, depending on the field.

Professional Services Agreement

1. The practice maintains its independence but receives no upfront

money due to no sale of the practice. The tangible assets may be sold or more likely leased through the PSA.

2. The practice can sell its ancillaries separately at FMV; however, these may be included in the overall transaction and, therefore, considered only within the tangible asset valuation and sale.
3. The PSA rate is based on a group rate per Work Relative Value Unit (wRVU); payments are usually distributed by the practice, subject to their income distribution plan (IDP).
4. The PSA typically applies to specialties, such as surgeons or proceduralists, where reimbursement has declined significantly (and employment often more difficult), as well as in areas where ancillary reimbursement has decreased, such as cardiology.
5. Surgical practices are more likely to have ancillaries with a higher value (e.g., ambulatory surgical centers (ASCs)), which would garner upfront dollars if the hospital acquires those ancillaries.
6. The PSA arrangement essentially is the same as going to a single-payer contract where the PSA rate with the hospital ultimately becomes the sole payer and sole source of revenue.
7. The practice maintains the flexibility to determine how it will distribute compensation dollars to the group; however, the practice retains some risk and overhead obligations through their independence, though the hospital often reimburses for overhead as a pass-through cost based on an agreed-upon budgeted total. Other typical employment requirements, such as restrictive covenants, etc., are in force.

Private Equity Acquisition of The Practice

1. Generally, upfront value, i.e., intangible value or *enterprise value* in the practice, comes from the application of a physician compensation reduction.
2. The compensation reduction, known as “the haircut,” is treated as newly created EBITDA,¹ which can then be applied in a discounted cash flow (DCF) model that determines enterprise value. Also, a market multiple approach can be considered wherein the value is determined based on a varied rate akin to current comparable transactions.
3. The haircut is permanent, so physicians may make less income

going forward; however, they would receive the value of that reduced income in upfront dollars.

4. Some prospective offset to the haircut may come through improved access to services and organic growth.
5. The new owner may decide to sell or consolidate the practice quickly.
6. Typically, the PE firm attains a majority interest, and the seller retains a significant minority interest. This joint ownership allows for a *second bite* in that the minority interest, along with the PE majority, may sell for an even higher multiple some three-to-five years later.
7. Also, the transaction may afford some favorable tax opportunities. Depending on the structure, the proceeds (or a portion) may be taxed at lower capital gains rates.

Private Equity Purchasers

Private equity deals involve a purchase by privately funded groups that come in all shapes and sizes. The acquisitions have primarily centered on specialty areas, such as dermatology, pain management, anesthesia, and dental practice arenas that offer the potential for additional income. The forecasted shortage of primary care physicians could make these medical practices attractive, as well. Standard surgical/proceduralist specialties are also realizing interest in—and completing—many transactions. These include ophthalmology, orthopedics, gastroenterology, urology, and others.

To achieve their desired returns, private equity firms focus on acquiring *platform practices* that are large, well-managed, and reputable in their community. These practices serve as *flag-planting* opportunities within a new area, too. The firms sell these practices after augmenting their value by recruiting additional physicians, acquiring smaller practices to merge with larger practices, increasing revenue (e.g., bringing pathology services into a dermatology practice), and by decreasing costs by substituting physician assistants for physicians. Growth makes it possible to spread fixed costs, exploit synergies across merged practices, expand ancillary revenues, and increase negotiating leverage with health insurers.²

Physicians are understandably concerned about the impact that of private capital and possible conflicts regarding the quality and affordability of care to patients and payers—might have on patient care. Thus, it is in the best interest of PE firms to leave all decisions about patient care in the hands of the physicians. Every state has its own set of corporate practice of medicine laws and exceptions, and many prohibit the corporate practice of medicine. Essentially, a corporate entity is prohibited from having control over the independent clinical judgment of a physician.

Many PE firms use a physician practice management model to acquire the non-clinical assets of a physician practice and enter into a management agreement with the practice. The physician entity holds the payer contracts; provides patient care; and employs the physicians, nurses, and clinical personnel. The legal distinctions are important because they reinforce a critical boundary in the practice of health care. In the end, the relationship between a physician practice and a PE investor/partner must be one of trust, including each

party's ability to excel at their respective roles, both of which should be centered on patient care.³

A Private Equity–Like Alternative

Hospitals have been reluctant to pay significant upfront dollars to practices in the past, and for good cause. Medical practices fundamentally have no intangible value as they, in effect, distribute all of their profits as excess compensation to their physicians/partners. The FMV of a medical practice is therefore typically limited to tangible assets. While all entities are under compliance limitations, hospitals undergo the most scrutiny. PE firms or private, for-profit corporate entities are not under as much regulatory constraint, but they are concerned for return-on-investment (ROI) purposes. The PE model facilitates succession planning and may appeal more to the older physician, who is five or fewer years away from retirement. Conversely, younger physicians are often less interested in a PE transaction, given that they are usually in the earlier stages of their medical careers.

The perspective on affiliation is shifting slightly, although not on the value of medical practices. Some hospitals are exploring whether they could use the same structure as PE firms in acquiring medical practice entities. Hospitals maintain their position against paying significant upfront dollars tied to intangible value alone; however, they may explore more significant upfront money if those dollars link to something more tangible, such as the compensation haircut. This concept makes sense because, until now, hospitals have watched PE firms enter their local markets and write large checks for practices, followed by the implementation of significant changes that have had broader implications, as well as some adverse effects on the local health care market. In addition, this model has a unique component for how a valuation can be derived, which can increase the appeal for physicians and increase their likelihood of partnering with a hospital (rather than a PE firm) under this type of structure, which is addressed in greater detail below.

What is the Seller's Priority?

Before discussing the valuation in these transaction structures, it is essential to understand the key deal drivers from the practice's perspective. In evaluating options from the practice's standpoint, the initial question the seller must answer is, "Why are we doing this?" Specifically, "What is our highest priority to achieve in doing a deal?" On the flip side, the buyer must ask if one of the following considerations is a priority for doing the deal:

1. Maximize the upfront value.
2. Accept lower upfront value in exchange for a more stable income. Maintain income but reduce the risk of reductions from the Centers for Medicare and Medicaid Services (CMS) and commercial payers.
3. Remove the risks and difficulties of running an independent practice.
4. Maintain independence while attaining income stability.
5. Partner with another organization to increase opportunities for income diversity.

Figure 1: Acquisition by PE Firm

Practice Revenue	\$50,000,000
Total Physician Compensation (Pre-Haircut)	\$25,000,000
Total Number of Physicians	10
Haircut (10%)	\$2,500,000
Reduced Compensation per Physician	\$250,000
Multiple on Haircut	9
Transaction Value	\$22,500,000
Proceeds of Transaction per Physician	\$2,250,000

6. Address the needs of succession with the practice.
7. Maximize value via the initial and second transaction (sale).
8. Address succession planning and access to capital for this matter.

If the selling physicians' primary objective is to maximize the valuation paid at the time of the transaction and forego their independence to a hospital or PE firm, then the PE model may be their best option, especially for primary care or a group with few ancillaries. The PE model is probably the only *real* option for maximizing upfront value for that type of entity. However, even with ancillaries involved, that will only increase the upfront value if the hospital will purchase them, which makes this structure even more appealing to surgical specialties.

How does the valuation work in the PE model? The approach is relatively simple, though significant technical analysis, modeling, and assumptions must occur to derive an accurate dollar amount. Generally, the following factors are the critical components of calculating enterprise value in the PE model:

1. Determine the haircut (i.e., compensation reduction) to be applied across all physicians.
2. Develop a pro forma financial model in which the haircut is ultimately turned into EBITDA, with growth over a five-year projection period. (Note: Although there are critical and detailed steps that must go into developing these models, for this discussion, the assumption is the model follows all relevant and appropriate standards.)
3. Calculate a DCF valuation model using the financial tenets from the pro forma. This calculation will obtain an enterprise value for the entity following appropriate guidelines and standards. Again, a caveat also may be to apply a market approach using an EBITDA multiple.

The following table (Figure 1) illustrates a high-level, generic description for how the process works, showing how the numbers might calculate (Note: This example is hypothetical and uses round numbers that are simple to follow.):

In Figure 1, each physician in the group receives \$2.25 million in upfront value for his or her practice (assuming the even distribution of the proceeds), compared to the \$250,000 in compensation

relinquished each year. This model also assumes the PE firm applied a multiple of 9x to the haircut amount to derive their transaction value. However, few *true* market multiples can apply for such deal models. As such, applying a multiple against the haircut to derive the value entails a varied multiple in each transaction, based on the financial resources, risk, and flexibility of the parties involved. (Note: This valuation calculation relates solely to the sale of the practice. If the transaction includes the sale of ancillaries or other related entities, these assets would be valued separately and ultimately bring additional value to the sellers in those deals. Typically, the ancillary services are a separate legal entity, such as an ASC, or for purposes of the transaction, is treated separately.)

To validate the upfront dollars, the standard approach for applying this model with PE firms is for the haircut to be a *permanent* reduction applied throughout the life of the post-transaction relationship. The PE investor requires this to allow an adequate ROI over a relatively short timeframe. Then, there likely could be another transaction or liquidity event soon after. Another point worth mentioning is that after all analyses are completed, a discussion regarding salary reduction would be appropriate. Depending on the length of the relationship, the reduction is really a *swap* of up-front funds versus compensation over several years, with the latter being lowered but offset for the funds received at closing. While the factors of present value and capitalization rates are in play, the funds received at closing from either a hospital or a PE firm are, in essence, compensation received *early*. Further, some of those monies may qualify for more favorable capital gains income tax rates.

The potential differences for a hospital pursuing a transaction with a practice under a *PE-like* model compared to a PE firm transaction are the following:

1. A hospital can factor in its ROI in a variety of ways;
2. In most cases, it would not consider flipping the practice in five or fewer years as a PE firm often does, which makes a longer-term affiliation more likely; and
3. A hospital's outlook is different, which creates room for flexibility in the structure and economics of a potential transaction. While the regulatory constraints are considerable, opportunities still abound for a mutually beneficial affiliation.

How Can Hospitals Compete?

Hospitals that are competing with PE firms must be willing to provide more upfront value than what is offered under other models. A hospital, generally, would not seek to purchase a medical practice by writing a check for as high an upfront value as a PE firm. But, the hospital-driven PE model has the potential to present a more appealing offer wherein it implements the haircut for a defined, limited period, such as in three years. Instead of the sellers receiving all their

intangible value upfront in exchange for a permanent compensation reduction, they could pursue the same structure where the upfront value is less than a PE offer (though significant), with compensation restoration after a relatively short period (generally three years). The hospital-driven PE model could potentially look like the numbers provided in Figure 2, using the same generic figures from our previous chart in Figure 1:

Figure 2: Acquisition by Hospital Using PE Model

Practice Revenue	\$50,000,000
Total Physician Revenue	\$25,000,000
Total Number of Physicians	10
Haircut (10%)	\$2,500,000
Reduced Compensation per Physician	\$250,000
Term of Haircut	3
Total Reduced Comp per Physician	\$750,000
Multiple on Haircut	N/A
Transaction Value (under DCF Approach)	\$19,125,000
Proceeds of Transaction per Physician	\$1,912,500

In Figure 2, the value of the practice was derived not by using a multiple applied to the haircut, but by applying a DCF model. This process is separate and requires a discussion that explains the mechanics and how a valuation is derived. However, it is a valuation methodology widely used and accepted if implemented under the proper guidelines and standards. Nonetheless, the monetary value of the practice paid through the upfront proceeds of the transaction is less than the value paid in the PE acquisition. The more important distinction is that while the physicians received \$1.913 million in upfront dollars, this amount was in exchange for giving up \$750,000 of compensation over three years. After Year Three, though, the compensation is restored with appropriate increases, meaning the physicians would continue to receive value from the transaction going forward, more, in fact, than if they did the same deal with a PE buyer.

Conclusion

In evaluating a PE-like structure, the primary question is what the physician-sellers hope to obtain from a transaction. If they want as much money upfront without concern about the impact on future compensation, then a hospital may not be the best option. However, if they seek a significant portion of the practice’s value off the table through the upfront distribution of funds while maintaining the ability for the restoration of this compensation after a time, the PE-like model can be attractive for both a hospital and the physician group.

Both scenarios have merit. Both are worthy of consideration, but aligning with PE firms generally stems from very different perspectives than aligning with health systems. Aligning with a PE firm offers a corporate mentality that is profit motivated. Health system affiliation provides economic opportunities, as well, but typically include a longer-term strategic, community, patient care-driven, and even mission-supported objectives. Although both are worthy of consideration, the practice should first evaluate and determine the reasons it wants to pursue alignment and then, attempt to connect with the appropriate partner.

Endnotes

- 1. Earnings before interest, tax, depreciation, and amortization (EBITDA) is a measure of a company’s operating performance. Essentially, it is a way to evaluate a company’s performance without having to factor in financing decisions, accounting decisions, or tax environments.
- 2. Lawrence P. Casalino, MD et al., *Private Equity Acquisition of Physician Practices*, 170 ANNALS OF INTERNAL MED. 114 (2019).
- 3. Eli Boufis, *Why are PE Firms Hot for Physician Practices?*, FORBES (Aug. 30, 2019), <https://www.forbes.com/sites/eliboufis/2019/08/30/pe-firms-hot-for-physician-practices/#6f31bab71191>.



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Jeremy Biggs

President and CAO
Methodist Medical Center of Oak Ridge

HSG completed an assessment of our anesthesia staffing, our group's revenue cycle function and operations, as well as other factors affecting our anesthesia subsidy. HSG listened to our needs, talked to our anesthesiologists, CRNAs, and leadership, and came to understand our culture, challenges and unique needs. They made impactful recommendations for our health system and our relationship with anesthesia going forward. HSG did an exceptional job for us.

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Anesthesia Subsidy Assessment: Fair Market Value and Beyond

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Introduction

HSG has completed more than 30 anesthesia subsidy assessments since 2011. According to a 2009 article from *Becker's Hospital Review*,¹ "Around 2000, anesthesia providers started approaching hospitals for subsidies on top of their contractual arrangements." Additionally, a 2012 white paper by *North American Partners in Anesthesia*² stated, "Many hospitals have experienced 30 to 40 percent increases in their anesthesia subsidy over the past few years, yet they may not have received any additional services for that investment. In some cases, coverage has actually gotten worse, and hospitals are left asking, 'What have we been paying for?'" At HSG, our experience reflects both these sentiments. Not only have hospitals seen growth in an area where there used to be no additional cost (anesthesia), but now they are concerned they are not getting true value from their subsidy dollars and/or there is waste inherent in their anesthesia arrangement.

Hospitals and health systems do not want to subsidize poor operations, bad business decisions, and inefficiencies. Additionally, they do not want to subsidize a group that does not share their values and goals for efficiency, volume, superior quality, and customer satisfaction (i.e., the patients and surgeons they serve). Surgery is the one area in which hospitals and health systems can achieve a healthy margin on their patient volume. As such, anything that affects surgery should, and typically does, have their utmost attention. Anesthesia not only affects surgery; it is critical to the delivery of surgery. It is not wise to allow issues in anesthesia to linger. Doing so can be crushing to a hospital when those issues come to a head.

Because compliance is of the utmost concern for hospitals and health systems, most of HSG's anesthesia subsidy assessments have resulted in a formal fair market value and commercial reasonableness opinion regarding a hospital or health system's financial support of an independent anesthesia practice for the group's provision of anesthesia and peri-operative services. However, other assessments have resulted in more than an opinion of fair market value and commercial reasonableness. Sometimes findings require a performance improvement plan with the existing anesthesia group, and sometimes findings require a complete change of direction finding new management for anesthesia.

Over the last decade, HSG's work on this area has covered 11 different organizations. Total financial support provided by our hospital clients to their contracted anesthesia provider group has ranged from

\$500,000 to \$3.7 million per year. The number of anesthesia providers included in HSG studies has ranged from a low of 3 to a high of 66, with an average subsidy per provider ranging from a low of \$35,000 per provider to a high of \$209,000 per provider.

This article will discuss the central focus of typical anesthesia subsidy reviews and appraisals—fair market value for provider salaries and benefits (total provider compensation). It will also highlight other key areas and factors that influence the level of subsidy that health care organizations provide to independent/contracted anesthesia providers. The text that follows provides an approach to holistically evaluate key factors and functions that impact the level of an anesthesia subsidy.

Compensation

Evaluating the fair market value of provider compensation must take into consideration the relative level of provider production (units and cases per provider). While there is a baseline level of compensation expected for a position in most markets (i.e., base salaries between the 25th and 50th percentiles), achieving higher levels of compensation (e.g., in the 75th to 90th percentile), requires additional validation. While sub-specialization, unique expertise, and call coverage requirements and burden are prime examples of factors that can drive compensation up into these higher percentiles, one common and key driver of compensation is production. In anesthesia, the number of cases and total American Society of Anesthesiologists (ASA) units are primary metrics of productivity. In other specialties, the metrics used tend to be Work Relative Value Units. It is logical that providers producing between the 75th and 90th percentiles should be able to earn between the 75th and 90th percentiles. It is equally logical that providers producing at a median level, should not be earning between the 75th and 90th percentiles—not without other unique circumstances. The Medical Group Management Association (MGMA) Provider Compensation and Production Survey, the Sullivan Cotter (Sullivan Cotter) Physician Compensation and Productivity Survey Report, and the American Medical Group Association (AMGA) Compensation and Productivity Survey are three primary and widely utilized sources of physician compensation and production. The reports are leveraged by the team at HSG and are heavily relied upon as a reference for our evaluation of compensation and production levels for anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs), as well as a host of other specialties.

Table 1: GasWork.com CRNA Compensation

Survey	Metric	Specialty	n	Mean	25th	Median	75th	90th
GasWork.com	Compensation	CRNA	64	\$222,031	\$200,000	\$220,000	\$250,000	\$275,000

The level of after-hours and weekend call coverage per provider is another factor that must be considered when evaluating the appropriateness, fair market value, and commercial reasonableness of compensation for anesthesia providers. Call coverage is a service that is a real-life burden on the providers who make themselves available. From a hospital's perspective, call coverage is an extremely valuable and necessary service, and without call coverage, patient safety and quality of care are compromised. Depending on the culture, mix, and size of a provider group, call coverage could be non-existent, frequent, or infrequent. What's more, the intensity of each call response may vary depending upon the hospital, its medical staff, and the market. HSG has experience with groups in which the CRNAs take no call, and all of the call coverage is provided by the anesthesiologists. Conversely, HSG has worked with groups in which the CRNAs take all the call coverage. Clearly, all other factors being equal, a CRNA who is not required to take call should probably make less than a CRNA who takes one in five days of call.

While our traditional benchmark sources (MGMA, Sullivan Cotter, and AMGA) do not have data on the level of call coverage or data that ties the level of call to a level of CRNA or anesthesiologist compensation, other sources are helpful to gauge the level of call with a corresponding level of compensation, such as CRNA and anesthesiologist job posting sites like GasWork.com. These sources often list position expectations, such as frequency of call coverage with a posted level of compensation. These job sites are particularly useful in certain situations, such as when evaluating CRNA-only groups and/or groups with autonomously practicing CRNAs. Traditional benchmark sources do not provide a description of position expectations (i.e., level of call coverage and types of cases). Frequently, HSG tailors the job search to match as closely as possible the position in question. HSG searches for jobs posted in a particular region and eliminates jobs that do not match the subject position in terms of call coverage requirements—part-time versus full-time status, types of cases, level of autonomy, etc. After eliminating positions deemed not comparable, HSG takes the remaining data and create percentile tables to use in our analysis, often supplementing or replacing traditional benchmark sources (see Table 1).

Benefits

Each assessment and resulting fair market value-commercial reasonableness opinion is always acutely focused on anesthesiologists and CRNA salary and benefit costs—of these, salary is paramount; its importance is clear to the casual observer. However, benefits costs are an important, and sometimes forgotten component of value. We've seen a number of coverage proposals in which practices have consciously decided to put more value into benefits packages. In some cases, salaries have appeared conservative and relatively low, but when considered in conjunction with benefits, the collective package has pushed the envelope and the limits of what we might be willing to consider as fair market value, hence not commercially reasonable. Therefore, a prudent and responsible valuator must include the value of benefits into his/her assessment and appraisal process. Sullivan Cotter has proven to be a great source of provider benefits cost—providing data on a per provider basis and as a percentage of salary. MGMA's Cost Survey has also been utilized, as it provides data regarding physician benefits cost per physician. According to Sullivan Cotter's survey, benefits costs include:

The cost of health, life and disability insurances; employer contributions to qualified defined benefit and contribution plans (e.g., 401[k], 403[b]) and nonqualified retirement plans; continuing medical education (CME) expenses; FICA, payroll and unemployment taxes; and professional license fees. The costs do not include the cost of malpractice insurance or paid time off.

Operating Expenses and Overhead

When determining an appropriate level of subsidy for an anesthesia provider, direct provider cost (compensation and benefits) is not the only area that must be evaluated. Operating expenses and overhead (including malpractice) must also be evaluated. While many of an anesthesia practice's operating expenses are largely out of the group's direct control (i.e., the level of malpractice cost), there are some expenses that could be considered discretionary (i.e., support staff bonuses and charitable contributions). In addition, evaluation of operating expenses and overhead can shed light on poor business decisions, inefficiencies, and failing functions that the hospital should not subsidize. HSG's primary source for this part of the evaluation is MGMA's Cost Survey, as well as direct experience and proprietary data gathered from the variety of assessments completed over the years by HSG. The MGMA Cost Survey provides operating expense data in a variety of metrics that are key to evaluating an anesthesia practice's performance. Frequently used metrics are provided in Table 2 below.

Table 2: Determining Appropriate Subsidy Levels

% of Revenue	Total operating costs Professional liability cost Management fees paid to MSO or PPMC Billing and collection purchased services
Per Physician	Total operating costs Professional liability cost Management fees paid to MSO or PPMC Billing and collection purchased services
Per Provider	Total operating costs Professional liability cost Management fees paid to MSO or PPMC Billing and collection purchased services

Calculating a group's value in these metrics and then comparing it to survey data for these same metrics can provide direction and shed light on areas and functions where issues may exist.

The compensation, benefits, and overhead metrics, as well as the evaluation process described above, are the key components of an overall assessment that many hospitals and health systems should, but rarely conduct on the operations of their contracted and subsidized anesthesia provider. In addition to direct provider costs and overhead levels, periodically completing a comprehensive assessment of a group's operations is recommended, including an evaluation of the following components:

Table 3: Operating Expenses and Overhead Assessment

Assessment Components	
✓	Management fees and other management-related costs;
✓	Billing and collections cost;
✓	Total operating cost;
✓	Physician to CRNA staffing ratios;
✓	OR utilization rates; and
✓	Accounts receivable (AR) management, including: • Payer mix • Payer rates

Some groups choose to manage operations internally by allowing the physician owners and employed management personnel to manage the day-to-day operations of the group. Others outsource management to third-party management companies, and some have become part of large regional or national anesthesia groups. Regardless, the level of management cost requires and deserves attention. Groups, like the people that comprise them, settle-in, and get comfortable with the "way we've always done it." They do not realize there is a better way and how they compare to others in the market.

The same is true with billing and collections costs. HSG has witnessed the impact on subsidy levels and provider compensation due to the deterioration of a group's internal revenue cycle function. In one particular case, internal weakness resulted in the hospital forcing the group to find a new external billing and collections provider. Without a suitable change in billing infrastructure, the hospital moved forward with a Request For Proposal (RFP) process, by which other anesthesia providers were invited to bid on the right to provide exclusive anesthesia services at the hospital. HSG has also experienced groups that were not receiving value for what they were paying their billing agency. For the level of fees and the percentage of collections they were paying, they were not receiving the effort or results they deserved, hence a change was needed.

Total operating cost is a broad category that includes all practice expenses, with the exception of provider salary and benefits costs. Total operating costs are inclusive of staff costs, malpractice costs, management and billing fees, administrative supplies, accounting, and legal costs, among other expenses. If a group's operating cost is determined to be out of line with benchmarks, a deeper dive is undoubtedly required to find the root cause of the difference and to understand if anything can be done to address the variance.

Revenue Cycle

Comprehensively assessing accounts receivable management requires evaluation of processes from the beginning to the end of a revenue cycle process. Answers must be found to some of the following key questions:

1. Are providers appropriately credentialed?
2. Is the group being paid according to its contracted rates and are those rates sufficient and reflective of the true market for anesthesia services?
3. Are claims filed timely?
4. Are claims filed with minimal errors?
5. Are denials significant? If so, what are primary denial reasons?
6. Are delinquent claims followed up on and worked to resolution in a timely manner?
7. Are denials worked to resolution timely and appropriately?
8. Are providers completing their documentation sufficiently and expeditiously?

Some common metrics and datapoints utilized in a comprehensive revenue cycle assessment include:

1. Gross FFS collection rate;
2. Adjusted FFS collection rate;
3. Adjustments by adjustment type;
4. Collections per ASA unit (or wRVU);
5. Days in accounts receivable (AR);
6. AR aging, particularly the percentage of AR over 90 days;
7. Denial rates;
8. Denials by denial reason; and
9. Charge lag rates.

Gauging a group's performance by comparing its value versus benchmark data for applicable metrics can provide direction regarding issues and concerns that exist with a group's revenue cycle function. Provided below are median AR metrics for anesthesia, according to MGMA's 2019 Cost and Revenue Survey.

Table 4: Revenue Cycle Assessment

	Results
Gross FFS collection rate	32.71%
Adjusted FFS collection rate	94.03%
Collections per ASA unit (or wRVU)	\$37.24
Days in accounts receivable (AR)	37.28
AR aging, particularly the percentage of AR over 90 days	16.06%
Denial rates ³	9%
Charge rates ⁴	3

Evaluating payer rates and payer mix are other key areas to study when gauging a group's performance. Even more important is how that performance impacts the level of an organization's anesthesia subsidy. Evaluating the payer mix provides context more than anything. It informs the evaluator about the type of ecosystem in which

the group is living. Does the group have a favorable payer mix with a significant commercial payer base? Or is the group's payer mix burdened with an overwhelming proportion of Medicare, Medicaid, and indigent patients? If the latter is true, that might explain a standard "Gross FFS collection rate" and lower than median "Collections per ASA unit." If this is the case, take this into consideration when thinking about the appropriateness of the group's level of subsidy, as the payer mix is out of their control. This is a fact that the hospital is certainly already aware, as it shares the same mix. If, on the other hand, the group has a favorable payer mix with a significant commercial payer base, favorable comparisons for Gross FFS collection rate and Collections per ASA unit would be expected. If not, and AR process-related benchmarks such as "Days in AR," "Denial Rates," and/or "Percentage of AR Over 90 Days" are favorable (or at least acceptable), perhaps the group has a payer rate problem.

Assessing payer rates is the next logical step in a revenue cycle assessment. In evaluating payer rates, two main questions arise: 1) Is the group being paid appropriately according to its contracted rates? And 2) Are the group's rates appropriate for the market, or is money being left on the table? Unfortunately, many groups we encounter neglect to negotiate or pursue better rates with their commercial payers; in fact, many have not reviewed their rates in years. Ultimately, their size and volume may be a limiting factor in their ability to influence payers enough to negotiate more favorable rates. Nevertheless, one never knows until they try, and a hospital should not automatically increase its subsidy dollars if its contracted group is not putting forth the effort to try for better rates.

Operating Room and Block Utilization

Operating Room (OR) and Block Time utilization rates are areas that the hospital can influence and has a significant effect on the group's staffing requirements and its ability to generate revenue. OR utilization is often defined as the total time it takes to complete each surgical procedure (from patient prep time in the OR through the administration of anesthesia to completion of the case) plus the total turnover time, divided by the total scheduled time available in the OR. OR blocks are defined OR times usually set aside for specific surgeons. Block utilization is simply the total OR time consumed throughout a case (or cases) divided by total block time provided to a surgeon. If ORs and blocks are not being utilized efficiently and consistently, it may be time for the hospital to make changes.

In the case of OR utilization, this may indicate the need to recruit more surgeons, or it may mean consolidating and/or closing ORs, compressing the OR schedule by having fewer ORs open late, or taking other steps to improve OR efficiency. For block time, this means making sure your block policies and procedures still make sense and are being enforced appropriately and consistently. Does your organization have a minimum utilization rate before releasing blocks to other surgeons for scheduling (i.e., 70%, 75%, or 80%)? If so, is the policy being followed? Are surgeons starting cases on time, and are they being held accountable for being habitually late and adversely

affecting the daily OR schedule? Are definitions of “emergent” and “elective” cases consistent, and what cases can be added to the schedule “after hours?”

These can be tough questions that require challenging and politically charged decisions to be made. Undoubtedly, this will test how serious OR efficiency is taken and its impact on an organization’s anesthesia subsidy. Perhaps, focus on these areas can help reduce the subsidy. If nothing else, examining these factors should create assurances that the value of an anesthesia subsidy is maximized.

Staffing Ratios

Physician-to-CRNA staffing ratio is another area in which HSG has helped hospitals impact their subsidy. Sometimes the impact is immediate, but many times it is a gradual transition over the years. More

typical are physician-to-CRNA staffing ratio issues with longstanding groups that have been very physician-centric—more recently, they have started aging out. Regardless, they have not yet embraced the utilization of CRNAs within the group. Clearly, using a physician to administer anesthesia is more expensive than having it administered by a CRNA. Illustration (provided below is a table presenting recent CRNA and anesthesiologist compensation data).

Routinely, an anesthesiologist is 2 to 2.5 times more expensive than a CRNA. Often, HSG’s role is to help establish a recruitment and transition plan. As older anesthesiologists slow down and retire, the group will replenish its capacity through the addition of CRNAs, not physicians. As the hospital expands by adding ORs, the anesthesia group and the hospital will collectively plan to staff them with CRNAs and not physicians. Occasionally, financial incentives have been created by the hospital to encourage the group to intention-

Table 5: Staffing Ratios and Compensation Comparison

CRNA Compensation

Survey	Speciality	Cut	Providers	wt	Mean	25th percentile	Median	75th percentile	90th percentile
2019 MGMA	CRNA	National	1,843	15%	\$189,288	\$165,042	\$181,858	\$207,475	\$236,331
2019 SC	CRNA	National	8,353	70%	\$178,471	\$160,214	\$178,500	\$194,064	\$208,250
2018 AMGA	CRNA	National	1,701	14%	\$178,450	\$156,312	180,000	\$197,425	\$218,00
Weighted Average			11,897	100%	\$180,144	\$160,404	179,235	\$196,622	\$213,994

Anesthesiologist Compensation

Survey	Speciality	Cut	Providers	wt	Mean	25th percentile	Median	75th percentile	90th percentile
2019 MGMA	Anesthesiology	National	2,622	26%	\$457,140	\$381,096	\$461,052	\$537,699	\$631,446
2018 IHS	Anesthesiology	National	946	9%	\$462,084	\$381,654	\$426,417	\$482,726	\$557,537
2019 SC	Anesthesiology	National	4,816	47%	\$402,751	\$337,825	\$402,751	457,500	\$523,668
2018 AMGA	Anesthesiology	National	1,797	18%	\$430,648	\$364,475	\$430,754	\$481,000	\$553,250
Weighted Average			11,10,181	100%	\$426,863	\$357,745	\$424,907	\$484,646	\$559,793

ally and aggressively make this transition. The goal is never to push physicians out. The goal of such a plan is to find the most efficient and cost-effective staffing model for the organization, whether that be in one of four medical direction variations (1 to 1, 1 to 2, 1 to 3, or 1 to 4) or a supervisory model (1 anesthesiologist supervising more than 4 CRNAs). This type of transition requires physician buy-in, engagement, and leadership. Most organizations we work with have a hunger for anesthesiologist leadership.

Structure

Finally, what is the appropriate financial structure for an organization's anesthesia subsidy? HSG has seen a variety of different structures, from CRNAs who are employed by the hospital but the anesthesiologists are independent, to fixed stipends where monthly payments do not vary, to revenue guarantees in which actual payments may vary. From HSG's perspective, a revenue guarantee is the best approach. This entails prospectively determining and establishing what level of revenue the group needs to compensate its anesthesiologists and CRNAs with fair market value salaries and benefits, and covers costs associated with appropriate overhead and operating expenses. With this overall revenue number established, the hospital or health system must determine the limits of its financial exposure. The question that a hospital or health system must answer, therefore, is what is the maximum amount it is willing and able to subsidize the group?

For example, if the group requires \$30 million to provide fair market value compensation to its 30 physicians and 38 CRNAs—as well as cover billing costs and other operating expenses—what is the hospital willing to risk in order to “guarantee” that the group will realize \$30 million in revenue? Typically, the group has a history of case volume and professional revenue, a track record of cases performed, and professional revenue collected on these cases. Using this \$30 million revenue requirement example, assume that the group has shown the ability to collect \$24 million per year in professional revenue, with expected improvements in revenue cycle and additional OB/GYN and GI cases estimated to bring in an incremental \$2 million in revenue, which would allow a projection of \$26 million in professional revenue. In this scenario, the question the hospital must therefore answer is whether it is willing to take the risk of potentially subsidizing the anesthesia group to the tune of \$4 million? If the answer is no, then negotiations and discussion of alternatives begins. If the answer is yes, a huge hurdle has been cleared, but there is likely still more work to be done with the subsidy structure.

HSG advocates the building of incentives into the subsidy structure. Referring back to an earlier statement that hospitals and health systems “don't want to subsidize a group that doesn't share their values and their goals for efficiency, volume, superior quality, and customer satisfaction,” an organization can attempt to influence behaviors and align goals with appropriately structured incentives. This can be done as a withhold of potential subsidy dollars (i.e., withholding 5 to 10%

of every eligible subsidy dollar) as a fixed and predetermined amount carved out of total expected subsidy payments (the “stick”), or it can be done with additional dollars on top of potential subsidy payments (the “carrot”). Whether an organization chooses the carrot or stick, HSG advocates operational, efficiency, quality, outcomes, communication, leadership, and customer satisfaction incentives.

Regardless of the group's size or the size of the anesthesia subsidy, HSG is confident that following the approach described throughout this article will yield positive results for the hospital or health system; enable the organization to better track and monitor its anesthesia and peri-operative services; and maximize the value it receives for each dollar of subsidy paid to its anesthesia provider.

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Health Care Reimbursement Trends: A Driver of Consolidation and Affiliation

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Introduction and Background

Anyone involved in the health care industry or who watches the news is aware of the plethora of consolidations in recent years. What are the driving forces behind the uptick in such activity? The industry is responding to a variety of pressures coming from many angles. Medicare, the largest payer for health care services in the United States, is under increasing budgetary pressure to reduce its cost to taxpayers while incentivizing value and quality care, not just volume of services. Commercial payers continue to fight growing business and consumer dissatisfaction with rising insurance premiums and a growing financial burden on patients. Employers are striving to find more cost-effective avenues for providing health coverage to their employees and are exploring creative alternatives to traditional commercial payers. Patients are becoming more educated—and vocal—and are demanding greater value and continuity in their interactions with the health care delivery system. The United States spends more per capita and as a percentage of GDP on health care than any other developed country,¹ so while there are differences in opinion regarding how to fix the system, most believe that the current landscape is not sustainable.

As these pressures build, both traditional health care entities as well as new players are entering the fray to vie for a piece of the \$3.6 trillion health care market.² In 2019, ninety-two hospital merger transactions were announced, which is consistent with the level of merger activity in the prior year.³ As hospital “mega-mergers” continue, multiple types of partnerships across a diverse mix of entities are being formed. Health systems, commercial payers, physician groups (increasingly private equity backed), and digital health companies are forming alliances as they seek ways to improve upon the patient experience and the overall value of health care services.⁴

Consolidation trends are expected to continue as the health care industry and investors respond to the firestorm of increasing pressures. Private equity firms are sitting on \$1.5 trillion in “dry powder,” and health care has proven to be an attractive landing place for available capital.⁵ Additionally, private equity firms continue to gamble that such scale will allow physician practice management platforms

to improve infrastructure, technology, clinician recruitment, and clinical support,⁶ ultimately leading to improved profitability. Other players, such as rural hospitals and independent physician groups, are simply looking for ways to survive amidst tightening reimbursement, increased regulatory requirements, and rising costs.

Changes in reimbursement, regulatory complexity, competition, and the availability of capital have all contributed to an environment that rewards size and scale at every segment of the health care continuum. The lines between for-profit and not-for-profit, provider and payer, physician group and hospital continue to blur as these players pursue various strategies for growth and improvement of health care delivery across the spectrum.

Health care reimbursement, or the manner in which health care services are funded by the government and commercial insurers (and ultimately patients and taxpayers), is a complex world of payment formulas, fee schedules, policies, and procedures that continues to evolve as insurers and policy makers look for ways to incentivize healthy outcomes *and* control costs. Understanding current and anticipated changes to reimbursement is necessary for anyone facilitating or evaluating transactions, as revenue critically impacts the ability of a provider to meet its mission or provide a return to its investors. Furthermore, reimbursement changes will not only have a significant financial impact but will also drive changes in provider behavior and operational structures that should be considered in any health care organization’s long-term strategy.

This article will focus on current and anticipated changes to health care reimbursement and how such changes influence the churn within the health care industry. Significant changes are occurring across the acute care, physician, and post-acute care spectrum, and these transformations are in turn driving organizations to grow in scale or find new partners in order to be prepared for a post-fee-for-service landscape.

The first section of this article will provide an overview of reimbursement trends and expectations across various health care settings, and the second half will examine keys to success in affiliation transactions as well as different strategies for health care consolidation and affiliation.

Reimbursement Trends

Population Health

Population health is a term that gained wide usage after the passage of the *Patient Protection and Affordable Care Act* (ACA) in 2010. The term is defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group,”⁷ and it is a guiding principle of many health care reimbursement policies and changes that have occurred in recent years. More broadly, population health fits within the “Triple Aim” of health care reform: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations.⁸

Population health changes the reimbursement paradigm from the historical “fee-for-service” or “paying for volume” model to reimbursement based on health outcomes. Outcome-based reimbursement and reimbursement that incentivizes cost reduction is referred to as *value-based care*. There are numerous programs in place, led largely by the federal government, that are pushing providers towards value-based care models. Private payers have been slower to adopt value-based arrangements for their commercial populations, but are expected to eventually catch up to the government based on the industry adage that, “as Medicare goes, so goes the private market.”⁹ This push towards value-based care is happening across the care continuum with major initiatives underway that affect acute care facilities, physicians, and post-acute care providers.

Acute Care

Hospitals and other acute care providers are seeing a number of programs intended to shift these entities away from fee-for-service reimbursement. These programs fall under the primary categories of *Value-Based Programs*, *Bundled Payments*, and *Shared Savings Plans*.

The term *Value Based Programs* specifically refers to several programs run by the Centers for Medicare and Medicaid Services (CMS) that reward health care providers with incentive payments for the quality of care they provide to Medicare beneficiaries.¹⁰ According to CMS, these programs are part of its larger strategy to reform how health care services are delivered and reimbursed. These programs support the “Triple Aim” of better care for individuals, better overall health for populations, and lower cost.¹¹

Bundled Payments, which describe a single payment for both hospital and physician services related to specific episodes of care, have been discussed in various forms since the late 1980s. This idea gained traction beginning in 2013 with CMS’s introduction of the *Bundled Payments for Care Improvement Initiative* (BPCI). The purpose of bundling is to encourage care coordination and align incentives for all providers—hospitals, physicians, post-acute care providers, and other practitioners.¹² There are currently over 900 providers across the U.S. participating in BPCI demonstration projects that cover 35 different episodes of care.¹³ If these projects prove to be effective in improving outcomes and reducing costs, this form of reimbursement is expected to expand in coming years.

The concept of *Shared Savings* was introduced with Accountable Care Organizations (ACOs) that were established with the passage of the ACA in 2010. ACO members receive a portion of any cost savings associated with treating a patient who is a part of the ACO. When

introduced in 2010 under the *Medicare Shared Savings Program* (MSSP), providers were subject to “upside risk” only, meaning they would receive a percentage of the savings if costs were below a predetermined baseline, but would not be penalized if costs exceeded such baseline. Higher risk “two-sided” models involving both upside and downside risk are now a part of MSSP also and were expanded by CMS with *Next Generation ACOs* (NexGen) and now *Direct Contracting* (DC), which was introduced in April 2019.¹⁴ In these higher risk models, participants share in the losses if treatment costs are above a calculated threshold. In some DC models, participants participate in 100% of both shared savings and shared losses.¹⁵

All these models are anticipated to grow in popularity over the next decade¹⁶ as the pressures associated with the “Triple Aim” increase. In order to expedite movement towards value-based reimbursement, it is anticipated that many of the voluntary alternative payment programs such as BPCI could become mandatory.¹⁷

Physician Services

Similar to the shift experienced in the acute care spectrum, physicians also feel the pressure to focus on quality and patient outcomes in order to achieve optimal reimbursement levels from Medicare and other payers to allow their practices to remain viable.

As a part of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), a *Quality Payment Program* was created to streamline multiple quality programs under the *Merit Based Incentive Payments System* (MIPS) and give bonus payments to providers for participation in eligible *Alternative Payment Models* (APMs).¹⁸ MIPS was created to link payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of health information, reduce the cost of care, and update and consolidate previous programs. Participants in MIPS receive a score related to four performance categories (quality, promoting interoperability, improvement activities, and cost), and the aggregate score determines a payment adjustment for Medicare reimbursement.¹⁹ An APM can apply to a specific clinical condition, a care episode, or a population, and is defined as “a payment approach that gives added incentive payments to provide high quality and cost-efficient care.”²⁰

Historically, value-based payment model options for primary care have been limited. However, an emphasis on primary care and a coordinated effort between public and private payers has resulted in the introduction of primary care value-based programs. Such programs include *Comprehensive Care Plus* (CPC+), a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ is a unique public/private partnership, which currently has 2,851 participants in 18 regions and is centered on five key functions: access and continuity, care management, comprehensiveness and coordination, patient and care giver engagement, and planned care and population health.²¹

Primary Care First (PCF) is another new program, launching in 2021. PCF will build upon the ideas of CPC+, creating a seamless continuum of care. This program provides two payment models that test whether delivery of advanced primary care can reduce the total cost of care. Under PCF, advanced primary care practices ready to assume financial risk will experience reduced administrative burdens and re-

ceive performance-based payments. A second payment model under PCF encourages providers enrolled in Medicare who provide hospice or palliative care services to take responsibility for high need, seriously ill Medicare beneficiaries who do not currently have a primary care practitioner or effective care coordination.²²

In addition to these programs aimed specifically at improving the value of physician services, physicians may also participate in coordinated programs such as ACOs, Bundled Payment initiatives, or Direct Contracting models described previously.

Post-Acute Care

Post-acute and other long-term care providers are also seeing a shift to value-based care payment models as a component of population health management. The most notable recent shift is Medicare's implementation of the *Patient-Driven Payment Model* (PDPM) for *Skilled Nursing Facilities* (SNFs), effective as of October 1, 2019. This program is designed to incentivize treatment of the whole patient and focuses care on the patient's condition by adjusting Medicare payments based on each aspect of the patient's care and specific needs.²³ Under this program, the amount of Medicare spending on therapy services is expected to decrease dramatically, while dollars are shifted to more medically complex cases (e.g., congestive heart failure). This initiative is expected to be budget-neutral in totality. This shift to value-based reimbursement will benefit those who provide care to the most complex patients, while challenging those who have historically focused primarily on the volume of services provided.

Though it was not Medicare's intention, providers should expect (and have already found) that the reporting requirements and documentation of patient assessments under this model are more rigorous and require additional coordination of care with acute care providers than previous reimbursement models.

Price Transparency

While reimbursement changes related to population health attempt to influence how health care providers deliver care, in November 2019 the Trump administration issued rules aiming to influence patients and other consumers of health care by providing them more information about rates paid by insurers to hospitals. It is theorized by policy makers that patients, armed with this information, will be enabled to understand their anticipated out-of-pocket costs and "shop around" for health care services. The stated purpose of these rules is to promote competition among hospitals and insurers to drive down health care spending.²⁴ These rules are slated to go into effect in January 2021 and will require hospitals to post in an electronic manner information regarding the hospital's negotiated prices with insurers for certain "shoppable" services, which include a variety of common procedures or episodes of care.

The rules face a strong legal challenge from both hospitals and insurers, and it is unlikely these rules will go into effect in their current form. A similar rule requiring pharmaceutical companies to disclose list prices for drugs in television ads was recently overturned by a judge who opined that the administration overstepped its regulatory authority.²⁵ Regardless of the current legal challenges, it is unlikely that the push towards transparency and increased information for pa-

tients will go away anytime soon as patients, employers, the government, and the general public push for changes to the status-quo.

Consolidations and Affiliations: Keys to Success

As these reimbursement dynamics create pressure and opportunities for consolidation and affiliation within the health care industry, it is important that the goals for any contemplated affiliation strategy align with drivers of success under evolving payment models. These keys for success fall under three primary categories: *Healthcare Delivery*, *Technology and Data Analytics*, and *Operational Efficiency*.

Health Care Delivery

Health care delivery impacts the patient experience and health outcomes and is the primary purpose of any health care enterprise. The purpose of population health reimbursement models is to improve health care delivery and efficiency by incentivizing coordination among all the various providers of health care services. Care coordination can be defined as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."²⁶

If payment for services is based on an episodic global payment encompassing hospitals, physicians, and ancillary providers, or one that measures the quality of care provided, then the delivery of health care needs to become highly coordinated with all parties communicat-



KEYS TO SUCCESS

To successfully navigate the affiliation landscape, we've identified three critical areas organizations need to focus on when considering their strategic options:



HEALTHCARE
DELIVERY



TECHNOLOGY AND
DATA ANALYTICS



OPERATIONAL
EFFICIENCY

ing effectively with one another. This requires clear communication protocols and systems as well as highly qualified and well-trained clinicians and support staff.

Proposed updates to the *Anti-Kickback Statute* and *Stark* law regulations, which were published by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) and CMS, respectively, in October 2019, attempt to remove regulatory barriers to the adoption of value-based arrangements and promote care coordination among providers. These proposed updates contain three new safe harbors that would provide protection for providers participating in value-based care arrangements.²⁷ These proposed safe harbors are intended to provide protection to *Value-Based Enterprises* whose purpose is to “foster better care at lower cost through improved care coordination with patients.”²⁸ The safe harbors cover the following types of arrangements:²⁹

- Care coordination arrangements to improve quality, health outcomes, and efficiency (1001.952(ee));
- Value-based arrangements with substantial downside financial risk (1001.952(ff)); and
- Value-based arrangements with full financial risk (1001.952(gg)).

The updates, which are expected to be issued in final form in 2020, are a clear indication of the government's intent to steer the industry towards value-based models in connection with the broad goals of improving patient outcomes and reducing the overall cost of care.

Technology and Data Analytics

Technology will play a significant role in the success of any affiliation transaction. Electronic health records and related systems must be able to communicate and integrate with one another, particularly as providers work to gather and submit data required for value-based reimbursement initiatives. Accounting systems, inventory systems, asset tracking systems, and many others need to work together or be merged as well. Technology must be deployed in such a way to facilitate provider communication, patient tracking, and patient outcomes in a cost-effective manner.

A vital component of tracking patient outcomes and costs of care associated with such patients will be deploying deep data analytics to convert all the data generated by new technologies into meaningful information to enhance revenue, decrease cost, and improve outcomes. An affiliation that does not consider the role of data analytics will not be well-positioned for the upcoming changes to reimbursement. As one physician group executive stated at a recent industry conference, his group has a “focus on data collection in anticipation of value-based care.”³⁰ It is widely understood that data collections and analytics will play a vital role if value-based care is to be successful at scale.

Technology and data analytics are two of the reasons non-traditional players such as Optum have entered the provider side of health care. As noted in a recent article, Optum Health is “wiring” together its network of recently acquired primary care practices, surgery centers, and urgent care clinics in order to provide physicians with advice based on Optum's massive stores of data and analytics capabilities.³¹

Operational Efficiency

Efficiently delivering health care services to patients in a constrained reimbursement environment will increase in importance over the coming years. As value-based reimbursement and price transparency increase, cost-shifting—which is the subsidization of unprofitable services or payers by profitable ones—will become more difficult. For example, in many markets, commercial payers in essence subsidize health care providers for losses incurred in providing services to Medicare and Medicaid patients, given that reimbursement by these government payers is often at or below the cost associated with providing care. However, this will become more difficult in an environment of increased market competition through price transparency combined with an emphasis on reimbursement tied to patient outcomes and cost reduction, regardless of payer. In addition, as two-sided risk payment models are introduced and providers are penalized financially for failing to provide care within predetermined cost benchmarks, operational efficiency must increase.

The goal of operational efficiency is a driver of affiliation strategies focused on increased size and scale. Participants strive to achieve economies of scale through consolidation of large fixed cost components such as electronic health record systems, revenue cycle operations, and administration. This is one of the primary reasons private equity has entered the health care arena. Their strategy hinges on significant improvements in operational efficiency that will enable the post-transaction profitability to greatly exceed the historical financial results of the entity, achieving a financial return to investors.

Consolidations and Affiliations: Different Models

As the consolidation trend continues, different models of consolidation and affiliation have taken shape. These models can range from loose affiliations to a full merger of two entities. Each potential structure should be considered within the context of the changing reimbursement environment and the keys to success noted above.

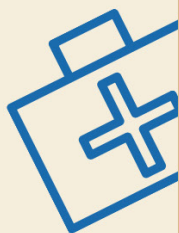
Clinical Affiliation

A *Clinical Affiliation* is an agreement for two or more entities to collaborate on an initiative or provide a specific service together. This may involve local, regional, or national partners. For example, the Mayo Clinic Health Care Network is a nationwide network in which hospitals and health systems enter into clinical affiliations with the Mayo Clinic to improve the quality and delivery of care in their regions by taking advantage of Mayo's expertise and gaining access to various Mayo resources.³² Clinical affiliations also help align physicians, nurses, and other providers across the care continuum, which is important in the era of bundled payments and population health initiatives.

Regional Collaborative

A *Regional Collaborative* is a flexible structure for two or more entities to partner on specific initiatives and build the foundation for potential future integration. As the name suggests, these collaboratives usually involve independent entities in a common geographical area. An example of this type of model is the formation of Southwestern

TYPES OF AFFILIATION



Hospitals can affiliate through several different avenues, each of which provide varying levels of independence versus support.

CLINICAL AFFILIATION

Agreement to collaborate on an initiative or provide a specific service together.



Most independent



REGIONAL COLLABORATIVE

A flexible structure for partnering on specific initiatives and building the foundation for potential future integration.

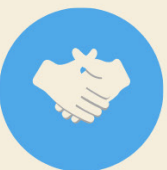
ACCOUNTABLE CARE ORGANIZATION

An independent entity owned by constituent organizations and formed for the purpose of entering risk-based contracts.



JOINT VENTURE

Short or long-term arrangement between unrelated entities to form and operate a common enterprise that pursues a new or existing activity or purpose.



MERGER/AQUISITION

The formal purchase of one organization's assets by another, or the combination of two organizations' assets into a single entity.



Most support



PRIVATE EQUITY

The involvement of private equity can exist at any aspect of the affiliation scale and is increasingly common. PE investors often focus on fragmented specialties to achieve efficiencies.

Health Resources, in which UT Southwestern and Texas Health Resources combined electronic record-keeping and coordinated patient care across their facilities in the North Texas area.³³

Accountable Care Organization

As discussed earlier, an ACO is an independent entity owned by constituent organizations and formed for the purpose of entering risk-based contracts. ACOs resulted from the ACA that was passed in 2010, and their purpose is to encourage continuity of care, reduce the cost of care, and create shared accountability. Providers in an ACO are jointly accountable for the health of their patients, receiving financial incentives to collaborate and reduce the cost of care by avoiding unnecessary or redundant tests and procedures.

Joint Venture

A *Joint Venture* can be a short-term or long-term arrangement between unrelated entities to form and operate a common enterprise that pursues a new or existing activity or purpose, while allowing for some level of involvement by all parties in the management or control of the activity. The entities that partner in a joint venture share both the risks and rewards of the activity. Many hospitals have entered joint ventures with operators who focus on specific ancillary services, such as imaging or ambulatory surgery.

Merger/Acquisition

At the far end of the affiliation scale is a *Merger*, which is the formal purchase of one organization's assets by another, or the combination of two organizations' assets into a single entity. One of the largest hospital mergers in recent history was the combination of Baylor Health Care System and Scott & White Healthcare to form Baylor Scott & White Health in 2013. The past two years have seen significant levels of hospital merger activity as entities pursue strategies of increasing their size and scale. However, these types of mergers should be carefully considered going forward, as "mega-mergers" are facing increased scrutiny. In January 2020, Federal Trade Commission (FTC) head Christine Wilson said that the agency would increase its scrutiny of the health care sector by challenging "every hospital merger."³⁴ This increased scrutiny of merger activity is occurring at the same time that hospitals are being asked to deliver on their promises of efficiencies and cost savings.

Private Equity

Private Equity transactions, in which owners of a health care service company sell a portion of their equity to a private equity investment firm, have become increasingly common in recent years. A 2019 article noted that "private equity investors are attracted to more consumer-friendly, alternative care-delivery models as the market shifts away from acute-care settings. Investors thus have been looking for ways to build scale in fragmented categories and geographies," according to the report.³⁵ Many of these private equity "roll-ups" hope to consolidate fragmented specialties to achieve efficiencies that will create value under new reimbursement models. Private equity investments have been made across all health care sectors, including acute care, physician medical groups, long-term care, and ancillary services (lab, MRI, Dialysis, etc.).³⁶ In recent years, private equity has dramatically increased its investments in physician services and has focused

on physician specialties such as orthopedics, dermatology, urology, and gastroenterology. Primary care practices have become a new target as private equity investors seek to create large regional physician groups and gain efficiencies of scale and drive contract rates.³⁷

Conclusion

Given the many pressures that exist for health care providers across the health care continuum, consolidation and alternative forms of affiliation are likely here to stay. In order for providers to remain competitive and serve their patients effectively in a climate of changing reimbursement, cost pressure, increased competition, collaboration, and accountability, it is essential that health care entities determine which, if any, affiliation and/or consolidation models work best to achieve their needs. When providers consider an affiliation strategy, it is critical to have knowledgeable advisors on their team who not only understand the macro drivers of consolidation, but also the micro-mechanics of reimbursement models that will transform the delivery of care in the future.

Amidst all the uncertainty in the health care industry, one thing is for certain—health care organizations must adapt to the changes that are inevitably coming in order to be viable for the long-term. This involves first understanding the expected changes to reimbursement and creating care delivery models that will position the organization to be successful in that environment. This may involve affiliation with other players in the market to achieve desired size, scale, interoperability, quality outcomes, and operational efficiencies. In the end, health care providers all have the same goal: to provide high quality care to achieve healthy communities. Exactly how they get there is the question.

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MERCY HEALTH**


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Baystate  **Health**

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Brand for Your Buck: Leveraging Brand as an Asset in Healthcare Alliances

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The Cleveland Clinic, Mayo Clinic, and MD Anderson—each is a familiar brand name that signals high-quality patient care and outcomes. The far-reaching impact of these brands extends beyond the communities in which they first located. Hospitals seeking to strengthen their clinical know-how and differentiate themselves from other competitors within their respective markets have long sought alliances with these healthcare giants.

Similarly, regional and academic healthcare organizations with strong reputations, highly regarded service lines, and a commitment to high quality, are also exploring ways to leverage their organizations' valuable brands. Many smaller community hospitals lacking the resources to effectively compete on their own seek opportunities to affiliate with academic medical centers (AMCs) and larger health systems in their region. Such dynamics afford health systems with strong brands the opportunity to leverage their names for economic benefit through various forms of affiliations.

Typically, when an AMC or other health system with a strong brand enters into a joint venture, its ownership interest is determined based on its cash contribution or the value of contributed tangible assets. However, if the joint venture is to use the health system's brand post-transaction, this valuable intangible asset can also be considered a capital contribution. With greater awareness of the way in which a strong brand can help drive value in a new relationship, organizations across the United States are deploying various forms of branding arrangements as part of larger affiliation arrangements between healthcare providers.

Some branding arrangements are relatively simple, with standard rights and offerings provided by the licensor through a traditional royalty arrangement. These royalty arrangements usually involve annual payments for the association of the brand with local provider services and also may come with some clinical services or access to proprietary competencies of the licensor. Other more complex arrangements, such as clinical service lines, ambulatory services, or whole hospital joint ventures, may involve equity, control rights, monetary consideration, and/or preferred returns to the licensor in exchange for brand use in the venture.

An important first step in forming affiliations that leverage the brand's strength is to evaluate the brand's value, specifically the anticipated

incremental value that it will bring to the arrangement. Such valuations require a thorough analysis of multiple factors, such as each party's brand strength, competition for services, the margins achievable through the new venture, and ultimately, the anticipated impact of brand on cash flows. In the healthcare space, it is especially critical that the financial terms of these branding arrangements be at fair market value.

Brand as an Asset

A strong brand in healthcare can influence purchasers of care to select one provider over another in an otherwise intensely competitive market. Strong brands are usually tied to high quality, clinical innovation, and superior outcomes. Strong reputations and brands also help attract and retain top-quality physicians, academicians, and other clinical support staff. With the Association of American Medical Colleges predicting a national shortage of up to 121,900 physicians by 2035, attracting and retaining top-quality clinicians is a high priority for many hospital organizations.¹ While patients needing specialized services do seek out healthcare institutions that offer cutting edge treatment options, for many of the routine health services, patients can choose from a number of providers for the services they need. In such instances, a strong brand creates top-of-mind awareness, reduces perceived risks of seeing an unknown provider, and simplifies the decision-making process.

Patients needing specialized services sometimes must make the difficult decision to travel outside of their communities for medical care due to limited local resources. Fortunately, hospital alliances are making a positive impact on this issue. For example, an affiliation with cancer care networks, such as the Roswell Park Care Network² and the MD Anderson Cancer Network³ (to be elaborated upon later), allows community hospitals to benefit from these institutions' clinical expertise, signaling a higher level of care to their local communities, and thus reducing outmigration.

Brand affiliations almost always result in some knowledge transfer. The website for the Memorial Sloan Kettering Cancer Alliance elaborates as to why a partnership with such an organization may make sense for community hospitals:

“Across the United States, more than 80 percent of people with cancer seek treatment for their disease at a local provider in their community. But the latest advances in care and research can take years to reach these hospitals. The Memorial Sloan Kettering Cancer Alliance aims to bridge this gap through dynamic collaboration that allows community providers to offer state-of-the-art cancer care. With more than 130 years of experience in treating cancer, MSK has a unique opportunity to share the knowledge and best practices we have pioneered.”⁴

Types of Branding Relationships

The following are two examples of healthcare affiliations that typically involve co-branding:

Network Affiliations

Network affiliations provide a formal way for smaller organizations to gain access to additional clinical resources, otherwise difficult to obtain. Such arrangements typically include provisions requiring affiliates to adhere to certain clinical protocols and other processes in order to help prevent brand erosion. The Mayo Clinic Care Network and the MD Anderson Cancer Network are examples of such affiliation networks.

Mayo Clinic Care Network

In 2011, Mayo Clinic launched the Mayo Clinic Care Network (MCCN), a network of provider organizations that benefit from having access to Mayo’s expertise and physicians. The MCCN presently includes approximately 45 hospitals and health systems throughout the United States and internationally, each of which proudly proclaims its Mayo Clinic affiliation via marketing materials, on its website, and through other avenues. As part of the Mayo Clinic Care Network, affiliates can access Mayo Clinic’s clinical protocols, patient education materials, and physician resources, elevating the services they can provide.⁵

MD Anderson Cancer Network™

MD Anderson Cancer Network™ is a program of The University of Texas MD Anderson Cancer Center. The network offers three levels of membership: “certified,” “associate,” and “partner.” Certified and associate affiliates gain access to MD Anderson quality assurance programs and best practice guidelines. Partnering members receive full clinical integration. Associate and partner organizations are allowed to promote their affiliation on websites and in advertising. Cancer centers interested in becoming an affiliate undergo a rigorous review process, which typically takes six months and includes site visits and quality assessments by MD Anderson representatives. The review process also includes full assessments of potential candidates’ surgical, radiation, diagnostic imaging, and oncology departments.⁶ The implication is clear: only those organizations with the capability of maintaining, or advancing, the MD Anderson brand are admitted to the program.

Joint Ventures

Co-branding arrangements are common in healthcare joint ventures. Typically, the joint-venture parties contribute a variety of tangible and intangible assets, such as cash, equipment, clinical and administrative staffing, access to clinical protocols, and their respective brands. As indicated earlier, brands and other similar assets contributed to the joint venture can lower the amount of the cash investment otherwise required to obtain the desired ownership interest. Healthcare joint ventures are common in today’s competitive operating environment. Take Duke LifePoint Healthcare, for example, which involves a co-branding arrangement.

Duke LifePoint Healthcare

Formed in 2011, Duke LifePoint Healthcare collaborates with hospitals, physicians, and patients to bring quality and innovative healthcare services to communities.⁷ Better known as Duke LifePoint, this collaboration started many years prior when LifePoint Hospitals Inc. (LifePoint) approached Duke University Health System (Duke) for assistance in evaluating and improving a LifePoint area hospital’s cardiovascular service line. LifePoint saw clear benefits from leveraging Duke’s clinical and operational expertise and invested in a partnership that now helps bring about tangible improvements to an increasing number of facilities.⁸ Duke LifePoint pursues acquisitions, shared ownership, and governance of community hospitals seeking to participate in a stable, quality-outcomes-focused, well-funded system. Within that system, the functional roles of Duke and LifePoint clearly are delineated. Duke offers community hospitals clinical and quality guidance, as well as access to highly specialized medical services. LifePoint provides financial and operational resources, including access to capital for ongoing investments in new technology and facility renovations.

Evaluating Brand Strength

Determining the economic value that a brand may bring to a new affiliation transaction or arrangement is an involved process that requires analyzing a significant number of quantitative and qualitative factors. One such key factor is an entity’s brand strength. A brand strength assessment evaluates how interested parties (e.g., customers, patients, clinicians, etc.) view the entity’s services relative to those of competitors. Information and insights gained from evaluating an entity’s brand strength will assist in determining its value both on a stand-alone basis and relative to a transaction or arrangement.

A number of factors can influence a hospital’s brand strength, including:

Reputation

Among the elements that can shape the public’s perception of a health system, is its historical role in the community. For example, AMCs often serve as community safety net hospitals, ensuring care is available for the uninsured. While every community understands the critical need for access to care, such a designation can prove chal-

lenging to an AMC's brand value. As a result, many AMCs devote significant resources to ensure the markets they serve are also aware of the research, medical advancements, and high level of specialized care they provide.

A hospital's clinical accomplishments also influence reputation. Reports of bad outcomes, medical malpractice lawsuits, or the public release of data showing above-average infection rates can tarnish a provider's hard-earned reputation.

Competition

To understand brand strength, it is important to evaluate the competitive landscape. Larger cities often afford multiple options for meeting patients' medical needs. Brand recognition can be a key differentiator for healthcare organizations operating in highly competitive urban markets. The stronger the brand name, the greater the likelihood of retaining a loyal patient base and rising above the competition to be the provider of choice.

Provider Networks

Patients rely on their primary care providers to direct them to the right facility for surgery, imaging, and other services. Although health systems have frequently acquired provider practices over the last several years, many hospitals are now also employing non-acquisition strategies to affiliate with provider practices, such as co-management arrangements, joint ventures, and clinically integrated networks. These alignment strategies can be essential to the development of adequate provider networks, as well as improving hospital financial and clinical performance. They also create additional touchpoints and expand the visibility of the hospital or health system brand. A strong and extensive provider network is likely to have a positive impact on brand strength.

Patient Awareness and Loyalty

Evaluating brand recognition is a significant component of assessing brand strength. In the brand awareness continuum, potential patients first may become knowledgeable of a healthcare provider's existence through advertisement, feedback from family and friends, or simply the provider's physical presence. Through reinforcement, they move from "recognition" to a level of "familiarity," resulting in top-of-mind awareness. Moving patients from brand familiarity to "loyalty" is the end goal of a healthcare marketing plan. However, the ultimate measure of the marketing plan's success is the use of and patient promotion of the provider's services.

Customer loyalty commonly is evaluated and measured by an organization's Net Promoter Score⁹ (NPS), which is a metric developed from customer responses to just one or a few questions (e.g., "How likely would the individual recommend the [subject organization] to a friend or relative?"). Survey responses subsequently are compared to actual behavior over time, such as repeat business and referral activity, and then scored on a scale of 0 to 10. A comparison of NPS metrics among competitors also can be an effective way of evaluating brand strength. A comparable metric for hospitals is published on the Centers for Medicare & Medicaid Services (CMS) Hospital Compare website (Hospital Compare), where the percentage of "*patients who reported YES, they would definitely recommend the hospital*" is captured and updated each year.¹⁰

National Rankings

Multiple organizations, such as *U.S. News & World Report*, The Leapfrog Group, and Healthgrades, rank hospitals on a regular basis. The *U.S. News & World Report*'s annual "Best Hospital" rankings are highly coveted by many hospital executives seeking to distinguish their hospital's services from competitors. Individuals can evaluate their options for healthcare services using Hospital Compare—its expanded hospital rankings include readmission rates, quality scores, efficiency measures, hospital-acquired conditions, and "never events" (e.g., surgery on the wrong limb).¹¹ Many hospitals pay—often at significant costs—to brand their websites or collateral marketing materials with rankings, awards, and scores.¹² Evaluating these rankings and ratings is an important part of brand strength assessments.

Brand Valuation Methodologies

Methodologies commonly used to value brands typically focus on the incremental value brands bring to the business enterprise. A brief overview of the most commonly used valuation methods in valuing brands follows. (The appropriateness of using one or more valuation methodologies will depend upon specific facts and circumstances.)

Relief-From-Royalty Method

The relief-from-royalty (RFR) method provides an indication of value based on the estimated royalty fees that could be avoided through ownership of the underlying asset, rather than licensing it from an outside party. As it relates to brands, the RFR method tends to be the primary approach when trying to determine what an upfront or ongoing payment should be to compensate for the use of the brand under an affiliation or a joint venture.

Brand Strength Continuum



The primary inputs for the use of this method are: (a) the selected royalty rate (or range of royalty rates) and (b) the attributable revenue stream. A royalty rate can be identified based on market data for similar assets, and certain other quantitative and qualitative factors relevant to the subject brand. This royalty rate is a proxy for the rate that a licensor and a licensee would negotiate for use of that brand if both had reasonably and voluntarily attempted to reach such an agreement. Because royalty rates from actual licensing agreements using hospital names are limited, the data search should consider related industries. Also, additional corroborative approaches may help create “bookends” to the analysis. The attributable revenue stream may include an existing revenue base or only consider incremental revenue. This will need to be assessed based on the facts and circumstances of each arrangement.

Incremental Benefits Calculation – “With and Without Scenario”

A provider deciding whether to affiliate with another organization must determine whether it will realize a positive return on its investment. To understand the incremental benefits of an affiliation, an organization can apply another approach commonly known as the “with-and-without scenario” calculation. The partnering provider will first assess the present value of future cash flows of its operations on an “as-is” basis and compare this business enterprise value to what would result from its affiliation with a national brand.

Such analyses are not pure financial calculations and can be complicated, as the affiliation also may involve management and professional services. To comply with Stark and Anti-Kickback regulations, it is imperative to first establish these agreements at fair market value before the eventual incremental benefit calculation is performed.

Protecting Brand Value

When developing arrangements that facilitate the contribution of the brand asset, it is important to document how the brand is to be applied in the context of the arrangement. Lack of clarity on form and function of brand use can create issues as the joint venture matures. For example, if an additional facility is constructed in a new location, or if a new service line is introduced, there must be clear guidelines for brand application to avoid ambiguity.

It is also important to make certain that the governance and operating structures provide the licensor with the necessary protection to ensure services delivered by the licensee are reflective of the desired level of quality and competency. In the healthcare industry, this can be achieved by establishing separate professional services agreements (PSAs) that provide for physician services and clinical expertise, or management services agreements (MSAs) that deliver administrative expertise that can elevate the customer experience at the affiliate or joint venture level.

Case Studies

It is helpful to consider every arrangement’s unique set of circumstances when determining if value can be attributed to the brand, and if so, what brand value would be. The following case studies illustrate varying arrangements and how brand value was determined in each circumstance.

Case Study 1: Cancer Center Joint Venture Between AMC and Community Hospital

In order to help elevate its clinical capabilities and to signal to its patient base that quality care was available within the community, a community hospital, inclusive of its existing cancer treatment facility, sought to establish a joint venture with an AMC whose brand was widely recognized, and also demonstrated high quality oncology care to its markets. The local hospital believed that its affiliation with the AMC would create opportunities for collaboration, provide access to clinical know-how, and help curb outmigration of patients who would drive past the community hospital’s facility to seek care elsewhere.

The initial allocation of joint venture ownership interest was based on the fair market value of the operations contributed by each joint venture participant. Additional ownership interest was then allocated to the AMC based on the fair market value of its brand name in the context of this proposed joint venture.

Here, the RFR method was used to determine the value of the AMC brand name in the context of the joint venture. A reasonable royalty rate range consistent with market observations for similar arrangements and assets was selected based on the strength of the AMC brand. This royalty rate range was applied to estimated and projected incremental net patient revenue based on market data for patient migration and the understanding that more patients would seek oncology services at the joint venture facility under an affiliation with the AMC.

Ultimately, this analysis determined a current value of the future benefits anticipated from the use of the brand within the context of the arrangement. The ownership percentage attributable to the AMC was more than merely the relative weight of contributed operations and cash, due to the value of the brand.

Case Study 2: Micro-Hospital Joint Venture Between AMC and Community Hospital

An AMC with strong brand recognition partnered with a community hospital to build a micro-hospital to serve a nearby rural community. The AMC was a significant provider of tertiary and quaternary services in the region and had invested heavily in marketing and community outreach. The community hospital was a much smaller market participant, known mainly within its immediate geography. The micro-hospital would be built to provide access to much needed care in the outlying community.

Under the proposed arrangement, the micro-hospital would be co-branded with both the AMC and community hospital. As part of the creation of the joint venture, each health system would contribute capital for the development of the micro-hospital. Additionally, the AMC evaluated its relative value contribution in the context of the joint venture.

A study of the AMC's brand was undertaken to determine its strength and competitive advantage in the primary and secondary service areas, where significant competition from other hospitals existed. The study involved the review of hospital ratings and rankings, accreditations, safety scores, breadth and depth of provided services, and the results of consumer surveys that measured patient awareness, and further, whether that awareness was translating into patient use of services (patient preference).

Once the brand strength in the primary and secondary service areas was evaluated, and it was established the AMC brand name was a contributory asset to the cash flows to be generated at the micro-hospital, a reasonable royalty rate was selected based on benchmark data, contribution margins, and other factors. This royalty rate was then documented within the arrangement as the formula for ongoing royalty payments during the term of the arrangement.

Case Study 3: Radiation Therapy Joint Venture Between AMC and Community Hospital

A community hospital operating a radiation therapy center sought an affiliation with an AMC to help improve the utilization of its center in a highly competitive environment. The cancer center also needed access to additional, highly specialized professional clinical services, and assistance with the center's administrative functions. As such, the parties entered into a joint venture, a PSA, and an MSA to support the enterprise.

The initial allocation of joint venture ownership interest was based on the fair market value of the operations contributed by each existing facility. Additional ownership interest was then allocated to the AMC based on the fair market value of its brand name in the context of this proposed joint venture.

The Incremental Benefits Calculation approach was used to determine the fair market value of the AMC's brand contribution. Once the incremental benefits were quantified, the result was translated into a percentage ownership interest. Part of the evaluation included an analysis to determine whether any AMC patients would seek care at this community facility due to proximity or other factors, thus cannibalizing the AMC's own patient base. Had that been the case, the revenue from these patients would have been excluded from the calculations.

Summary

Building and maintaining a strong brand in the healthcare industry involves substantial investments of time and capital. Strong healthcare brands are valuable because of their ability to support growth and profitability. Co-branding arrangements can have a material impact on joint ventures and other types of affiliation transactions, and the owner of such brands should be fairly compensated for allowing others the benefit of use.

PYA's valuation team has substantial experience assisting clients with a wide range of affiliation transactions including co-branding arrangements. For more information about PYA's transaction advisory and valuation services, contact Michael Ramey, Jim Lloyd, or Annapoorani Bhat at (800) 270-9629.

Endnotes

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Complex Challenges, Smart Solutions
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Real Estate Due Diligence Considerations for Health Care Merger and Acquisition Transactions

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Introduction

Within the past few years, health care mergers and acquisitions have repeatedly hit record-breaking numbers. Mergers and acquisitions allow health providers to increase access to care, improve quality of care, increase revenues thereby helping ensure long-term viability, enter new geographic markets, and retain or even increase market share. Additionally, recent shifts to value-based reimbursements have increased the financial pressures on health care organizations, requiring them to decrease their costs and become more efficient, thereby further incentivizing consolidation. No signs point to this trend slowing down. That is not to say, however, that mergers and acquisitions are without risks. Health care organizations understand this and regularly engage in comprehensive due diligence efforts to identify and assess the risks and benefits of transactions before they are consummated. Most mergers and acquisition transactions in the healthcare context, whether hospital-to-hospital transactions, hospital-physician practice acquisitions, or other similar types of transactions, involve the consolidation of real estate, not just in terms of the physical assets themselves, but also in terms of real estate strategies, real estate policies and procedures, real estate administration, and, perhaps most importantly, real estate compliance infractions. To that end, it is critically important for health care organizations' due diligence efforts to include, in part, a real estate review, which, at a minimum, should focus on the following: (1) Compliance Considerations; (2) Strategic Considerations; and (3) Physical Considerations.

Compliance Considerations

In fiscal year 2019, the Department of Justice obtained more than \$3 billion in settlements and judgments from civil cases involving fraud and false claims against the government.¹ Of the more than \$3 billion, \$2.6 billion involved the health care industry, including drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories, and physicians, and \$2.1 billion arose from whistleblower lawsuits, which are filed under the qui tam provisions of the False Claims Act.² The recoveries in 2019 marked the tenth consecutive year in which civil health care fraud settlements and judgments involving the Department of Justice have exceeded \$2 billion.³ Simply put, the health care industry is in the government's crosshairs.

Despite these astronomical numbers, many health systems, and especially those that are being acquired, do not allocate adequate resources to create, implement, and administer effective compliance programs. Viewed by many organizations as cost centers, many compliance departments are not adequately funded and staffed, and they are not given the necessary authority within the organization to enforce and maintain a culture of compliance. In addition, many organizations view compliance as the responsibility of only the compliance and the legal departments and not of the entire organization.

One of the areas of health systems' compliance programs that is often overlooked and neglected involves real estate lease arrangements between health systems and physicians. Although health care fraud lawsuits that stem from real estate lease arrangements with referral sources represent a relatively small percentage of the total annual recoveries referenced above, a recent study by a health care law firm⁴ of Voluntary Self-Referral Disclosure Protocol settlement data (published by the Centers for Medicare & Medicaid Services and Provider Self-Disclosure Protocol settlement data that is published by the Office of Inspector General) revealed that in the period between 2009 and 2016, the cost of settlement of a potential violation involving a real estate arrangement was 66 percent higher than the average settlement that did not involve a real estate arrangement.⁵ The study also found that "the average settlement involving a real estate arrangement was \$731,654.17 compared to the average settlement amount of \$439,097.43 for matters not involving a real estate arrangement."⁶

Even though real estate lease arrangements with referral sources pose regulatory risks for health systems and have a tendency to increase the average settlement amount health systems have to pay, compliance considerations often have less time and resources devoted to them during the due diligence process than other business considerations. Many health systems view compliance considerations as something that can be handled down the road instead of potential "deal killers" that can lead to large fines and even exclusion from federal health care programs. Health systems that are in the process of acquiring other health systems should conduct real estate compliance risk assessments as part of their due diligence analysis to ensure that they will not be inheriting noncompliant real estate arrangements or, if they will be, to adjust the business terms of the transactions to address the compliance infractions or walk away from the deal altogether. The real estate compliance risk assessment should be

split into three major focus areas: (a) real estate compliance program assessment, (b) real estate arrangement testing, and (c) post-closing operational compliance risk assessment.

Real Estate Compliance Program Assessment

The real estate compliance risk assessment should begin with the assessment of the health system's real estate compliance program, assuming one even exists. The due diligence review should focus on the following:

- General review of the health system's current approach to negotiating and maintaining real estate arrangements with potential referral sources;
- Obtaining an understanding of the individuals in key roles, the various departments, the responsibility of each department, their interdependence on other departments, and the role of external partners as it relates to real estate;
- Review and assessment of the health system's real estate policies and procedures, including, but not limited to, policies for obtaining real estate FMV valuations in support of health system's real estate arrangements with referral sources;
- Obtaining an understanding of the real estate arrangement approval process for different types of real estate arrangements (e.g., new leases, lease renewals, leases with referral sources, leases with nonreferral sources, master leases, subleases, income leases,⁷ expense leases,⁸ timeshare leases, timeshare licenses, ground leases, real estate purchase and sale agreements, etc.);
- Review and assessment of the health system's standard real estate contract templates;
- Review and assessment of current systems used to track real estate information and processes supporting those systems;
- Obtaining an understanding of key regulatory compliance risk areas including documentation for fair market value and commercial reasonableness opinions for real estate transactions;
- Becoming familiar with the health system's compliance and audit functions and how they interact with real estate;
- Review and assessment of the health system's real estate compliance training and education for its employees; and
- Becoming familiar with health system's compliance investigations and remedial measures processes.

The primary goal for the reviewing entity should be to determine whether the entity has established a robust real estate compliance program that is designed to prevent real estate compliance violations. If no real estate compliance program exists, it is highly likely that at least some real estate arrangements from the entity that is to be acquired are in violation of the applicable regulations, which could in turn have negative financial consequences for the acquiring entity if the transaction is consummated. Careful consideration should be given to the financial contingencies that should be included in the deal if there is an increased likelihood of there being real estate compliance violations as a result of the acquired entity's poor or non-existing real estate compliance program. Additionally, the reviewing

entity should think about the efforts that will need to be undertaken to identify potential real estate compliance infractions and, if any are found, to resolve those issues after the deal is consummated.

Real Estate Arrangement Testing

After determining whether the health system that is to be acquired has a real estate compliance program and assessing its effectiveness, the next step in the review should be selecting a sample of real estate arrangements to test. Sampling criteria should be established to ensure that a cross-section of the arrangements is chosen that are illustrative of the portfolio as a whole; if the entire real estate portfolio can be reviewed in a cost-effective and timely manner, this is the best option. A variety of lease types should be sampled—income leases, expense leases, full-time leases, timeshare leases, master leases, ground leases, subleases, etc. In addition to lease arrangements, the sample should include purchase and sale real estate arrangements between the health system and referral sources as well as any joint-venture arrangements between health systems and referral sources related to the development and ownership of real estate projects. As part of the real estate arrangement testing, the following questions should be asked to assess whether any compliance concerns exist or could arise in the future:

- Do the lease arrangements and other real estate arrangements have fair market value support? If not, are there other ways to show that the terms of the arrangements are consistent with fair market value?
- Do the lease arrangements and other real estate arrangements have business justification memorandums or other types of documents illustrating that the arrangements are consistent with industry practices and are commercially reasonable?
- Do the lease arrangements and other real estate arrangements have some method for determining and documenting whether the arrangements are with referral sources?
- Have the OIG Exclusion List of Excluded Individuals and Entities (OIG LEIE) and GSA System for Award Management (SAM) searches been conducted to ensure that the contracting parties are not excluded from participating in federally funded health care programs?
- Do the lease arrangements and other real estate arrangements contain all documentation required under the other entity's existing policies?

In addition, the reviewing entity should review and analyze payment information for the selected real estate arrangements by focusing on the following:

- Rent collection;
- Rent reconciliation;
- If appropriate, late fee charges;
- Operating expense reconciliations; and
- Enforcement actions that have been taken in the event of non-payment under the selected real estate lease arrangements.

Detailed summaries of the observations, assessments, and findings at this stage will allow the reviewing entity to assess any existing compliance concerns and determine how they should be remedied if the transaction is consummated or if the concerns present too great a risk to allow the transaction to proceed. If the real estate arrangement testing reveals compliance violations, the reviewing entity should determine whether these concerns should be remediated as a condition of consummating the transaction, whether the reviewing entity is comfortable with remediating these concerns once the transaction is consummated, or whether another course of action is warranted.

It is also important to remember that if only a sample of the acquired entity's real estate arrangements are reviewed instead of all of the arrangements, a prudent health system would be wise to assume that a similar percentage of issues would be found in the remaining arrangements. For example, if a sample of the reviewed real estate arrangements represents 10% of the entity's total real estate arrangements, and 25% of the arrangements in that sample have potential compliance issues, the total number of potentially affected arrangements needs to be determined by multiplying the number of affected arrangements in the sample by ten. Operating under this assumption will give the acquiring health system a better understanding of the financial implications of the potential compliance violations it could be inheriting if the deal is consummated.

Post-Closing Operational Compliance Risk Assessment

The final component of the compliance risk assessment should focus on gaining an understanding on the feasibility and ease of transitioning the acquired entity's real estate practices to those of the acquiring entity. All due diligence conducted here is focused on the reviewing entity's ability to effectively and efficiently adapt to the acquiring entity's real estate policies and procedures to ensure future consistency across the acquiring entity's real estate portfolio.

The first goal for the reviewing entity at this stage should be to determine the efforts that will need to be undertaken post-closing for the real estate compliance programs of the two entities to come together and operate as one. All of the aforementioned items will need to be modified to some extent. At a minimum, real estate policies and procedures will need to be changed, responsibilities of various individuals and departments may need to be shifted, and certain jobs and positions will likely need to be consolidated. All of this will result in additional costs, but the amount of those costs will depend on how similar the real estate compliance programs of the two joining entities are. Those real estate compliance programs that are similar should require less effort and cost to consolidate than those that are completely different.

Additional work and effort will be needed if the two entities have completely different approaches to real estate. For example, one health system may internalize all of its real estate functions, while the other may outsource it to third-party providers. If a decision is made to internalize the real estate functions post-closing, significant efforts and financial investment will need to be made to create an internal real estate department, including, but not limited to, hiring qualified individuals and conducting the necessary real estate compliance training as well as training on the new real estate policies and procedures.

The second goal for the reviewing entity at this stage should be to determine whether the entity that is to be acquired has and practices a culture of compliance. If an organization takes compliance seriously, the implementation of many of the items outlined above can be achieved with less effort and cost. Conversely, if an organization that is to be acquired does not take compliance seriously or, worse, has a culture of noncompliance, serious considerations should be given about whether the deal should be consummated at all. Not only will it be more difficult and costly to implement many of the items outlined above, but the culture of noncompliance could inadvertently infect the acquiring organization as well.

All of these factors should be taken into account when conducting the real estate compliance risk assessment. Only after it has been determined that there are no compliance concerns that will derail the transaction, or once it has been determined how the identified compliance concerns will be addressed, should the acquiring entity proceed to performing real estate due diligence related to strategic and physical considerations.

Strategic Considerations

Although it is easy to get bogged down in the details while performing real estate due diligence activities, it is imperative for health systems to remember the strategic objectives of the transaction and real estate's role in achieving those objectives. Viewing real estate as simply a place to put more patients and doctors vastly undervalues its importance and forecloses the strategic advantages that real estate can provide to health systems. An effective real estate strategy can help eliminate costs and create value at a time of increased financial pressures that result from the numerous and constant changes that occur in the industry. When a real estate strategy works to further a health system's core organizational and clinical missions, the strategy can reduce costs, create value, increase efficiencies, and, most importantly, create a better patient experience. To that end, for those transactions involving, in part, the acquisition of real estate, the role of the real estate to be acquired in achieving the objectives behind the transaction should always remain top of mind.

The first step in the real estate due diligence process as it relates to strategic considerations is for the acquiring entity to create a summary of the real estate portfolio, both owned and leased, that is to be acquired. The real estate portfolio summary should include the following property information:

- Property Name
- Tax Parcel
- Address
- Acreage
- Square Footage
- Year Built
- Parking
- Owned vs. Lease Considerations
- Fee Owner
- Fee Owner Affiliations (if available)

- Lease Abstracts of Material Terms (if applicable)
- General Property Description / Class
- Current Vacancy Rates in Owned Buildings
- Lease Expirations
- Rent Rolls for Owned Buildings
- Costs of Ownership
- Property Use / Tenant Mix
- Aerials and Parcel Maps
- Photographs of facilities
- Demographic Reports for the Market

Once the real estate portfolio summary has been developed, entities should conduct a portfolio analysis to determine whether the real estate that will be acquired as part of the transaction will meet the strategic objectives of the transaction. Specifically, the analysis should be guided, in part, by the following questions:

- Will the real estate allow the entity to expand its service offerings?
- Will the additional real estate help satisfy the demand for increased space for a growing service offering?
- Will the real estate allow the acquiring entity to offer services in desired geographic areas?
- Can the acquired real estate be sold to generate capital to reinvest into the organization?
- Will the real estate compliment other strategic objectives behind the transaction?

If the aforementioned questions are answered in the affirmative, the acquiring entity can focus its portfolio analysis more specifically on the buildings that are to be acquired. One of the key parts of the due diligence surrounding the strategic considerations phase should be title review. The goal during a title review should be to determine first whether there are any issues with title currently and secondly whether there are any restrictions on title that could impede the long-term strategic goals for the real estate to be acquired in the transaction. The reviewing entity should assess whether there are any restrictions on title—covenants, codes, and restrictions; easements; liens; etc.—that could cause an issue for future development and growth. For example, if there is an easement that runs across the northern side of the property that currently does not overlap with the building, it could become a problem if the reviewing entity hopes to eventually be able to expand the size of the building into the space where the easement is located. The easement on its own does not necessarily prevent this option, but it does force the reviewing entity to consider its future plans for the other property to determine whether it supports the type of growth and future use that they have planned and what obstacles they will eventually face. Or, and perhaps even more important, the properties that are to be acquired may contain certain restrictions that would prohibit the acquiring entity from using the properties to provide certain medical services, which

could defeat one of the objectives of the transaction in the first place. Many health systems that employ effective real estate strategies as critical components of their overall business strategies may purchase certain properties for the sole purpose of placing restrictive covenants on the land to prevent their competitors from coming into their geographic market and competing against them. Therefore, health systems venturing into new geographic markets should pay attention to their competitors as well and ensure that the real estate that is to be acquired will not prevent them from competing effectively.

The analysis should also focus on how the acquired buildings will be utilized following the transaction and on their financial performance. If the acquiring entity determines that following the transaction, certain acquired buildings will serve duplicative functions to those that are already a part of its portfolio, it should determine whether those buildings can be repurposed or whether they can be sold. The acquiring entity should also examine the vacancy rates, the rent rolls, and operating expenses in the buildings to determine their profitability. Buildings with high vacancy rates, high outstanding receivables, or high operating costs could potentially be excluded from the deal, sold after the transaction is consummated, or improved in their operations following the transaction.

An effective real estate strategy that aligns with a health system's overall strategy can be a market differentiator within the competitive health care landscape. To that end, a health system's decision to merge with another health system is presumably motivated, in part, by the real estate aspects of the transaction. Therefore, when conducting real estate due diligence, it is important to check and confirm that the acquired real estate will in fact help the acquiring health system achieve the desired objectives and, if not, to create a plan of action on how to deal with real estate that fails to achieve those objectives before or after the transaction is consummated.

Physical Considerations

The final aspect of the real estate due diligence should focus on the physical considerations of the buildings that are to be acquired, which will ultimately have a financial impact on the transaction. The acquiring entity should perform environmental and facility condition assessments for the properties to be acquired, which should generally consist of the following activities:

- Conduct walk-throughs/site inspections of all hospital facilities, office buildings, residential buildings and parking facilities.
- Photograph existing conditions.
- Meet with facility staff to discuss known building conditions.
- Conduct a limited review of maintenance records to determine type and scope of routine and unforeseen maintenance work.
- Review all mechanical, electrical, plumbing (MEP) engineering systems and determine whether a more in-depth study of those systems is necessary.
- Review The Joint Commission's Statement of Conditions and determine status of outstanding issues, if any.

- For each building, review existing conditions of:
 - » Roof
 - » Interiors
 - » Structure
 - » MEP systems and mechanical rooms
 - » Elevators
 - » Parking Lots / Structures
- Review of budgeted capital repairs and improvements for next fiscal year.
- Develop order of magnitude pricing for deferred maintenance items, if any.
- Develop order of magnitude pricing for significant capital improvement items, if any.
- Prepare a final comprehensive report detailing findings and recommendations.
- Conduct environmental site assessments.⁹

The facility site condition assessments should help the acquiring entity project future financial costs that will be incurred in connection with the acquired buildings. The acquiring entity will then need to determine whether the need to acquire the buildings is outweighed by the cost to improve the buildings to a certain standard. If not, an adjustment will need to be made to the ultimate price of the transaction because of the investment that will still need to be devoted to improving the real estate being acquired. Rough plans should be created at this stage to address any of these necessary repairs and/or updates and factor their costs into the overall strategy for the transaction.

Conclusion

For those mergers and acquisition transactions that involve, in part, the acquisition of real estate, it is critically important for health care organizations' due diligence efforts to include, in part, a real estate review. Although compliance is often not a major component of a real estate due diligence analysis, it should be because compliance violations could have significant financial impacts on the acquiring organization, not just in terms of compliance infractions that may be inherited but also in terms of future compliance infractions that could arise if the acquired entity has difficulties transitioning to the real estate policies and procedures of the acquiring organizations. Similarly, strategic and physical considerations should also be carefully analyzed because even if they are not necessarily deal-breakers for the transaction, they can impact the ultimate purchase price for the transaction. As mergers and acquisitions continue to occur in the health care industry, prudent health care organizations would be wise to invest time, money, and energy into conducting comprehensive due diligence reviews, as failure to do may very well result in a "penny wise and pound foolish" scenario following the consummation of the transaction.

Endnotes

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5. Andrew A. Dick, *OIG Data Confirms That Non-Compliant Real Estate Arrangements Are Costly*, Lexology (Oct. 20, 2016), <https://www.lexology.com/library/detail.aspx?g=fb738fb-9868-4ca9-b76c-dec8e67684fe>.
6. *Id.*
7. The term "income lease" is referred to herein as a lease in which the relevant party is the lessor receiving rental and other payments from the lessee.
8. The term "expense lease" is referred to herein as a lease in which the relevant party is the lessee remitting rental and other payments to the lessor.
9. Regardless of whether the target entity provides copies of prior environmental site assessments, it is recommended that acquiring entities obtain their own current environmental site assessments, in order to take advantage of so-called "Innocent Landowner" or "Bona Fide Prospective Purchaser" defenses to liability that would otherwise attach to successor owners regardless of the pre-existing nature of the environmental contamination (See, e.g., the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 USCS § 9601, et seq.)).



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Why Fraud-Based Due Diligence Is Critical in M&A—And the Steps to Take

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Fraud can take many forms. Sometimes it comes in the form of stealing from a company, and other times it takes the form of inflating earnings. Both fraud types can be prevalent in many companies, even the ones where it is least expected.

Fraud can have a major impact on the earnings of an entity and have an impact on value and price. Finding fraud before a transaction occurs would be in the best interest of both the buyer and seller. For the seller, it could potentially increase the value or price a buyer is willing to pay, as the relative earnings would potentially increase in the future. For the buyer, if the fraud is something that would decrease earnings in the future or increase risk of incurring costs, a buyer would want to understand and estimate the impact of that fraud prior to the purchase.

The focus of transaction due diligence is typically on financial performance and making sure the deal can fulfill its promises to both sides of the transaction. And while due diligence also focuses on uncovering potential problems or risks, steps in typical due diligence are not specifically developed to uncover fraud.

But when fraud-based due diligence is not performed, the future consequences could be detrimental to either party's return on investment.

Buyers typically perform some level of due diligence prior to a transaction, but sellers should also consider performing due diligence in advance of a sale. Such a proactive approach provides three significant benefits: First, it allows the seller to identify and address fraud and compliance issues in a timely and early manner. Second, being proactive allows the seller to better position itself to potential buyers, making it more likely to garner its desired price and set the transaction up to have a smoother and faster close. Last, if the fraud is identified by the buyer during their due diligence, it could either decrease the price the buyer is willing to pay or derail the transaction all together.

For buyers, the risks are even greater! Finding fraud that could entail future fines, penalties, criminal sanctions, and other results prior to a transaction can save the buyer from major hardship. Depending on the nature of the fraud, it may have such a significant impact on the future operations or potential liability as to warrant withdrawing from the transaction.

Additionally, both buyer and seller can experience a smoother post-acquisition integration because the information identified during the due diligence, whether positive or not, provides valuable guidance for post-acquisition integration and remediation planning.

Fraud: Prevalence and Impact

In 2018, \$3.6 trillion was spent on health care in the U.S. The National Health Care Anti-Fraud Association (NHCAA) conservatively estimates that at least 3% of that number was lost to fraud—indicating the revenue lost to fraud totaled \$108 billion.¹ Not all entities would be impacted by such losses, which means the impact for other entities would be more and could be significantly more than 3%.

With those levels of potential staggering impacts, it is critical for entities to consider fraud-based due diligence in their transaction.

Risky Areas to Consider

There are many different types of fraud that can be perpetrated in a company, including:

- Noncompliance with regulations
 - » Stark, Anti-Kickback, private inurement, licensing, etc.
- Corruption (e.g., bribery and illegal gratuities)
 - » Kickbacks for referrals, procurement fraud
- Financial statement misstatement
 - » Off-balance sheet debt
 - » Recording assets at higher than fair market value
 - » Inflating revenue
- Tax return misstatements
 - » Decreasing earnings to pay lower taxes
- Asset misappropriation (e.g., embezzlement and larceny)
 - » Using assets for personal use
 - » Increasing personal compensation
 - » Using company purchased supplies for personal use
-

- Theft of intellectual property and trade secrets
 - » Using company-created products, technology, or information for personal gain

Some of the above types of fraud may be more or less prevalent in health care entities. For example, stealing of company resources could range from stealing pharmaceuticals to pocketing cash payments from patients. Using company assets for personal gain could include use of the company's vehicles or diagnostic equipment for personal gain. Theft of intellectual property could include stealing employee or patient information, which also has the potential to result in significant regulatory fines in addition to the underlying loss or liability.

Noncompliance with regulations could relate to billing for services or providing services by unlicensed personnel. A type of corruption could include payment to physicians to prescribe certain drugs or perform additional or unnecessary procedures.

If any of the above types of fraud are discovered during the due diligence process of an M&A transaction, that could dramatically change the value and/or decision to continue with the transaction. For example, if an acquiring company performed a standard due diligence and did not disclose a theft of intellectual property resulting in a privacy violation, it may have also acquired the compliance fine for that violation without an appropriate adjustment to the purchase price.

Likewise, it is extremely important to ensure that all physicians in the target are compliant with the Anti-Kickback Statute and Stark Law. Not only would a violation compromise the M&A transaction, but it could also cause a serious disruption to the book of business being acquired and the resulting value by not allowing the physicians or the organization to bill Medicare in the future.

Detecting the fraud types noted above requires special due diligence that is not always the focus of entities engaged to perform traditional due diligence.

What is a Fraud Risk Assessment?

So how exactly do we dive into these areas? Fraud is, by nature, hidden and difficult to uncover. Compliance issues in health care are complex and multifaceted. Relying on an experienced third party who knows what to look for and where to look for it can help identify potential and actual compliance and fraud within the targeted health care organization. By having a third party assist with a risk assessment, the acquirer benefits from the independence and objectivity the third party brings to the analysis, thereby increasing confidence in the transaction, yielding a better understanding of the target's value, and establishing a foundation for a successful post-merger.

With the organizational vulnerabilities identified, analysis can proceed on the target's past efforts to manage those risks and the residual risk to the acquirer.

A risk assessment will ask the following questions: Have they identified relevant risks? What have they done to address risks? Do they have adequate controls? Are they monitoring employee compliance with policies and procedures? If there were past compliance failures or fraud, were the remedial measures adequate, and is there monitoring in place to help ensure those measures are being followed? Have the processes and controls been reviewed? Do they need to be updated?

A fraud risk assessment has the flexibility to adjust to the specifics of each business and limit areas where financial loss could be detrimental to the acquisition or merger.

Four Signs of Potential Trouble

There are certain areas where a fraud-related assessment will focus to assess the risk of fraud or other noncompliance. Highlighted below are a few of those areas:

High turnover

Look for high turnover in key roles. This can indicate that the former employees knew inappropriate activities were going on and disagreed with them. If the targeted organization has an anonymous reporting mechanism and has received whistleblower complaints, review those complaints and the resolutions as part of the due diligence process.

Spikes in inventory, receivables, or other key accounts

Unexpected spikes in key financial accounts such as inventory or receivables can be indicators of manipulation to appear better than actual performance to bump up the value of the targeted organization.

Similarly, unexpected spikes in key performance metrics can indicate a range of issues, from intentional manipulation of results to actual, but unsustainable, performance. Thoroughly researching these unexpected spikes can help determine whether the results are sustainable and whether the metrics were the result of intentional manipulation in light of the proposed deal.

For example, a benchmarking analysis performed for a client showed higher than average supply costs. A review of the information revealed that an employee was using company funds to pay for personal expenses through an extra credit card taken out in her name.

Another example may be where accounts receivable are high, and the days outstanding are higher than normal. It could mean cash is being misdirected and not applied to the customer receivables.

Extraordinary results

While it's natural for an acquirer to be looking for a great performer to join forces with, acquirers should beware, or at least be skeptical, of a target with extraordinary results.

Perform data analytics on financials and look at how the targeted entity compares to similar entities. Where exactly do they stand out from the herd? Can management articulate reasonable explanations accounting for the extraordinary performance? Are there components with subjective elements, such as management estimates for reserves or methodologies that could be affecting the results?

Performing such data analysis and making comparisons to similar entities will help identify areas that warrant additional scrutiny during the due diligence. Whether numbers that look too good to be true are the result of (1) a truly outstanding organization, (2) poorly designed or implemented processes, or (3) intentional actions by that organization attempting to bolster its current position and fetch a higher price, the additional scrutiny can be valuable "insurance" for an acquirer. If these are identified by a target's pre-deal diligence, as mentioned earlier, the information can help correct issues before en-

tering the market, or the information will help to proactively address the issues with potential M&A partners and even show increased value warranting a higher price.

Experiences of comparable organizations

Paying attention to what similar organizations have gone through with fraud or compliance failures can provide insights into where risks may be. Not all organizations experience or are even susceptible to the same risks, but similar organizations (and employees of similar organizations) operating in the same or similar environment can face the same pressures and risks that lead to inadvertent or intentional missteps. Ignoring those realities can lead to a “head in the sand” mentality and needlessly overlook potential risks.

What to Include in Your Compliance and Fraud-Based Due Diligence Process

There are seven key steps to follow when looking for fraud or other inappropriate activities during the due diligence process.

1. Engage a third party

An experienced fraud expert brings valuable experience in knowing what to look for when it comes to fraud and other compliance risks. They also bring the independent and objective perspective that can be invaluable when considering what should potentially be included in the due diligence and evaluating the potential impact the items identified in the due diligence can have on both the acquirer and the target organization. This can also reduce or eliminate the concern that risks will be overlooked to “make the deal happen” or that unfounded risks will be used to scuttle a deal.

Additionally, as M&A activity continues at a rapid pace, a comprehensive due diligence process likely needs outside assistance to adequately address all aspects in a timely manner.

2. Go beyond standard due diligence

Fraud and compliance-based due diligence requires steps beyond standard due diligence, potentially including:

- Conducting background checks on and interviews with key executives and employees.
- Fully identifying the target’s jurisdictions and regulatory environment.
- Adequately reviewing the target’s business practices.
- Using technical skills such as data analytics to identify red flags and uncover issues.
- Reviewing the target’s third-party relationships.
- Examining relevant key policies and procedures.
- Identifying areas that may require including representations or warranties in the final agreement.
- Monitoring the target’s business activities until the transaction is finalized.

3. Conduct a risk assessment

Explained earlier in this article was the fraud and compliance risk assessment and why performing one is so valuable. Its importance is reiterated here to emphasize how vital of a step it is in the comprehensive due diligence process. A fraud and compliance risk assessment should be significantly more in-depth than a general due diligence report. The format of a formal risk assessment also allows the assessment to be tailored to the specific type, industry, services and/or products, and practices of each organization.

The fraud and compliance risk assessment may indicate red flags in areas such as changes in reimbursement; relationships between physicians, hospitals, vendors, and clinics; or data privacy and cybersecurity. It can also be used to highlight employee-based issues or deficiencies in internal control procedures that would not otherwise be evident in traditional financial due diligence.

4. Review the target company’s relevant fraud and compliance-related programs

Does the target organization have a robust fraud and compliance program and department? Does that include an anti-corruption program? If so, understand the intended scope, the intended and actual controls and effectiveness, and then identify any gaps. In addition, make sure to review the results of prior fraud or compliance issues uncovered, the organization’s response(s), and the residual risks, if any, to the organization.

5. Review prior internal audit findings (and other self-assessments)

Does the target organization have a robust internal audit department? Has it performed in-depth analyses of key anti-fraud and compliance-related business processes? If so, these can be key sources of information both as to the past risks to the organization and potential future issues that may impact the value of the target.

Conversely, the failure of the target organization to have a robust internal audit department may portend previously unidentified issues, indicating that an even more robust due diligence plan is necessary.

In any event, it is important to look at internal audit findings and other self-assessment results as part of the due diligence process.

6. Evaluate corrective measures for previously identified issues

What did the organization do to correct previous issues? What was management’s response and approach? Did they bolster policies and procedures and provide training for staff? Did they regularly and effectively communicate to staff that they, and the organization, could be successful by “doing the right thing?” Did they monitor the ongoing effectiveness of remedial measures?

Understanding the organization’s response to previously identified issues can be an important indicator of potential future issues, and it also provides a way to understand the organization’s past approach to fraud and compliance-related issues, which can have a significant impact on the value or price of the proposed transaction.

7. Begin to develop plans for implementing additional compliance measures

Even the best organization can have unidentified or under-appreciated issues. If an acquirer is going to go through with an acquisition, developing and implementing a robust anti-fraud and compliance program to prevent future missteps is just as important as uncovering past issues. Utilize the results and findings identified during due diligence to develop plans to close the gap(s) post-transaction with appropriate anti-fraud and compliance programs.

Don't Forget the International Aspect

The health care industry is composed of more than just medical practices, clinics, and hospitals in the U.S. The industry also encompasses entities that provide health care goods and products, such as pharmaceutical companies that produce drugs and manufacturers that produce gloves, surgical equipment, hospital beds, etc.; keep in mind that these pharmaceutical companies and manufacturers can also be deeply involved in business with other countries.

For those targeted organizations involved in international trade, the acquirer must consider the potential for prior Foreign Corrupt Practices Act (FCPA) violations.² For example, the acquirer could inherit liability from an organization that committed bribery overseas and be responsible for paying fines and even undergoing court-ordered monitoring to ensure future compliance.

If no FCPA violations have been identified, consider the risk environment(s) in which the target operates and then evaluate the adequacy of their compliance program, including the robustness of their FCPA compliance program and what actions they take to monitor compliance. Do not overlook third-party relationships, such as joint ventures, business partners, and sales relationships because responsibility for a target's FCPA failures can be imputed to the domestic partner. All should be looked at during the due diligence process.

Potential FCPA liability can be particularly vexing if the acquiring entity is prevented from adequately assessing the FCPA and anti-corruption risk prior to the acquisition. In a 2008 Opinion Procedure Release, the Department of Justice (DOJ) addressed the issue, which was posed by Haliburton Company relating to its potential acquisition of an unidentified U.K. entity.³ The DOJ noted that it did not intend to take any enforcement action against the acquirer for pre-acquisition unlawful conduct of the target if the acquirer was unable to complete pre-closing due diligence due to the laws of the target's jurisdiction **and** the pre-acquisition conduct was disclosed and halted within 180 days of the closing, *or* if the conduct could not be fully investigated within 180 days, the conduct does not continue beyond such time as it could—in the judgment of DOJ—be reasonably stopped.

Post-Acquisition Impact From M&A Due Diligence

As noted earlier, information identified during the due diligence, whether positive or not, provides valuable guidance for post-acquisition integration and remediation planning. Key post-acquisition considerations resulting from due diligence include:

- If the risks identified were not or could not be addressed before closing, what post-acquisition remediation needs to be completed, and what is the timeline?
- Are there pending legal or regulatory actions? If yes, what are the potential consequences, and how do those consequences affect the newly united organization? Can that impact be mitigated or managed?
- Do any of the identified issues potentially impact participation in federal or state programs? What actions are needed to avoid, minimize, and manage those impacts?

What to Do When Issues Are Discovered Post-M&A

Even the most well-planned due diligence can result in the development of post-M&A issues. Examples abound about organizations that acquired entities without incorporating a robust compliance or fraud element into their due diligence, only to discover issues after the M&A transaction was completed. Is it too late to take action? Is the acquirer about to experience an unwelcome financial or regulatory hit?

Not necessarily. Following are three actions to take when fraud or other compliance-based issues are discovered after an M&A transaction has been completed.

1. Implement an improved compliance program promptly

Businesses are becoming more complex all the time, and even an exceptional due diligence program may not identify every single issue prior to completion of the transaction. But once completed, what matters is how the organization addresses those previously unidentified issues.

Promptly implementing an improved compliance program immediately after discovering the issue is very important. Make improvements to policies, procedures, training, monitoring activity, etc. If the acquirer self-discloses or the issue is revealed another way, showing a robust response will help mitigate the potential impact.

2. Consider the risks and benefits to self-disclosure

These days, more organizations are determining that there are benefits to self-disclosing the identified misconduct to the appropriate regulatory body; however, disclosure brings its own risks, not the least of which can be increased scrutiny and the potential for litigation from relevant stakeholders at many levels.

To disclose or not disclose is a determination that must be carefully weighed based on the totality of the organization's circumstances, including the particular inappropriate behavior, the actual impact of the inappropriate behavior, and potential impact going forward.

3. Cooperate in an investigation

When/if an investigation is launched, cooperation is key. Merely appearing to cooperate is not sufficient. Seasoned attorneys know how important it is for a health care organization's legal counsel to work and cooperate with any government investigation. This can help lessen both the severity of the regulator's response as well as any impact to the organization from third parties.

Post-transaction action, such as cooperation, self-disclosure, or changes to the anti-fraud and compliance environment, can have significant impact to the organization. A failure to act can open the door for a more severe response by the regulator or government.

Learn More About Fraud and Compliance-Based Due Diligence

Fraud-based due diligence is developed to identify potential fraud before a transaction and help a company proactively deal with issues before they evolve into bigger problems. Fraud-based due diligence requires a special knowledge of what to look for and how to uncover issues that are likely well hidden. To find the right professionals to help, seek individuals who are "Certified in Financial Forensics" or fraud. The American Institute of Certified Public Accountants issues the CFF (Certified in Financial Forensics) and the Association of Certified Fraud Examiners (ACFE) issues the Certified Fraud Examiners (CFE) certification. Look for these certifications when seeking professionals in fraud-based due diligence.

Authors

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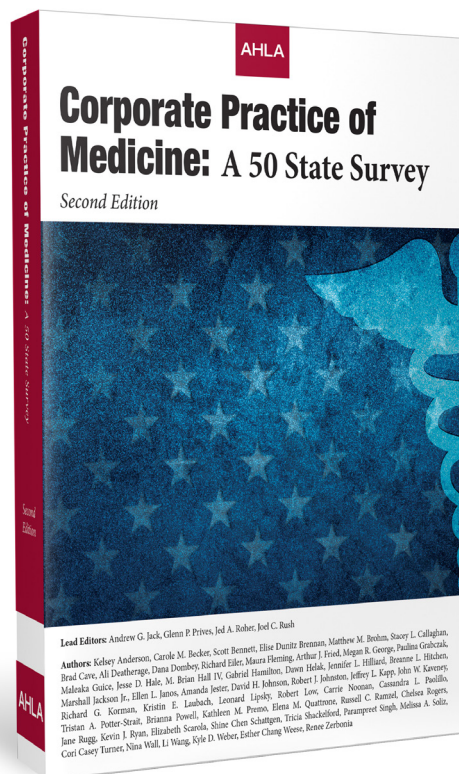
Dru Carney holds an MBA in Forensic Accounting and is a Certified Fraud Examiner in Wipfli's Forensic and Litigation group. Dru is also a retired police officer where he worked for 15 years after graduating college and serving in the military.

If you want to learn more about how to detect fraud—whether it's through fraud risk assessments and data analytics or other tactics like benchmarking and horizontal and vertical analyses—contact Wipfli. Our seasoned CPAs, fraud examiners, data analytic experts, auditors, and compliance specialists can help health care entities uncover fraud and mitigate risks before a merger or acquisition is completed.

Endnotes

1. National Health Care Anti-Fraud Association, *The Challenge of Health Care Fraud* (Feb. 18, 2020), <https://www.nhcaa.org/resources/health-care-anti-fraud-resources/the-challenge-of-health-care-fraud/>.
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