



American Health Lawyers Association

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2016 Health Care Transactions Resource Guide

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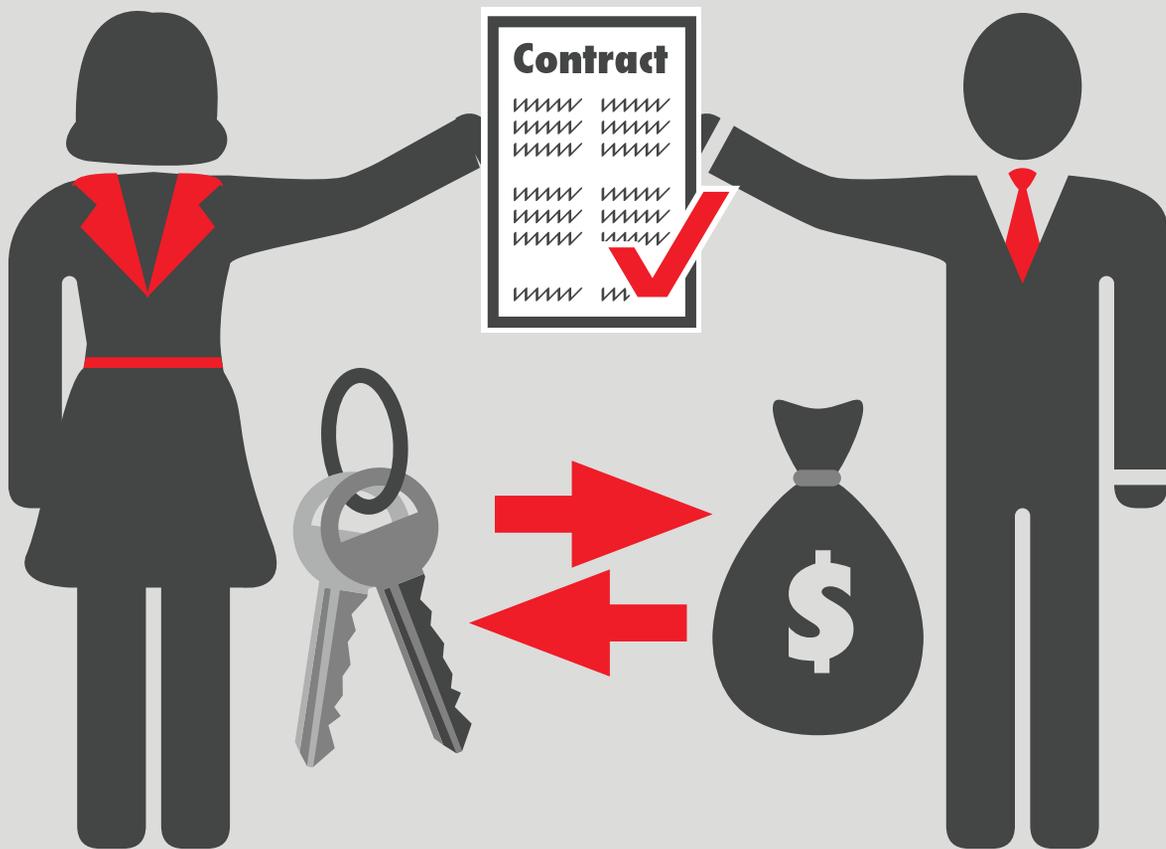
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As part of its ever-increasing coverage on the topic of health care transactions, AHLA is pleased to offer its business partners the opportunity to profile their expertise on this subject. A number of them have graciously contributed to this Resource 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 deal-makers in the health care community.

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.

Each article in this Resource Guide offers valuable data and advice for all professionals who work in the area of health care transactions. AHLA is proud to add this resource to its already impressive array of products and services, and thanks each of our sponsors for making this possible. ♦

A handwritten signature in black ink, appearing to read "David Cade".

DAVID S. CADE
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IT MATTERED DURING THE NEGOTIATIONS.

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Health Care's Strange New Bedfellows and How You Can Be Ready for Them

Denise Ryan, Senior Legal Editor, Bloomberg BNA
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Introduction

The *Affordable Care Act (ACA)* ushered in an era of transformation in the delivery of health care services that has fundamentally affected health care transactions. The potential for a knowledge gap—even for attorneys who have structured many deals over the years—is strong and troubling.

The ACA put a new focus on providing health care services by moving away from a fee-for-service model to a value-based payment model. In short, the ACA is driving provider collaboration and coordinating care is the key.¹ This shift has presented opportunities for health care entities to acquire, merge, or join with other health care entities in novel and unfamiliar combinations.

As a result, health care attorneys must be well-versed in the legal issues that arise in structuring deals involving not only traditional mergers and acquisitions, but also joint ventures between unexpected affiliates, all in the service of advancing improvements in the delivery of health care.

Today's complex health care deals, particularly those involving non-profit and for-profit health care entities, present specialized regulatory issues that call for more than “Googling” the relevant legal question for your client.

In addition to changes in the delivery of health care services, the emergence of the shared economy as a new business model has added yet another financial consideration by attracting the interest of private investors, such as hedge funds, which traditionally did not invest in health care.

Sustained downward pressure on hospitals to reduce costs, as well as the rapid growth and success of national strategic groups like TeamHealth, Sheridan, Envision, and MEDNAX, has made

Merger and acquisition interest has been spurred by access to capital; need for scale; rising valuations; changing payment methodologies that shift more financial risk to providers; the need to acquire the capabilities to manage the health of populations; and a related desire to build market share and achieve geographic indispensability.²

the sector newly attractive to private equity groups seeking physician practice investment opportunities.³

Finally, the advent of mobile apps has fueled a wave of startups, with angel investors and venture capitalists being lured by the promise of profitable, ground-breaking new developments in health care IT.

Trends in hospital mergers and acquisitions (M&A) and partnerships between health care systems and insurance plans are becoming more common throughout the country as another strategy to achieve better outcomes for patients and members.⁴

A knowledge of the current business climate and its implications is crucial for today's health care lawyers who are committed to providing their transactional clients with competent representation. Hospitals and health systems continue to actively pursue consolidation to hit the trifecta of improving patient care, improving the health of patient populations, and lowering the per capita costs of health care.

Health care M&A deals reached a record \$605 billion in 2015, and while 2016 is expected to be another good year, the pace of health care M&A deals will probably slow down.⁵

1 “Provider Realignment, Fraud and Abuse Head 2016 Top Ten List,” *Bloomberg Law Health Practice Center*, 1/7/16.

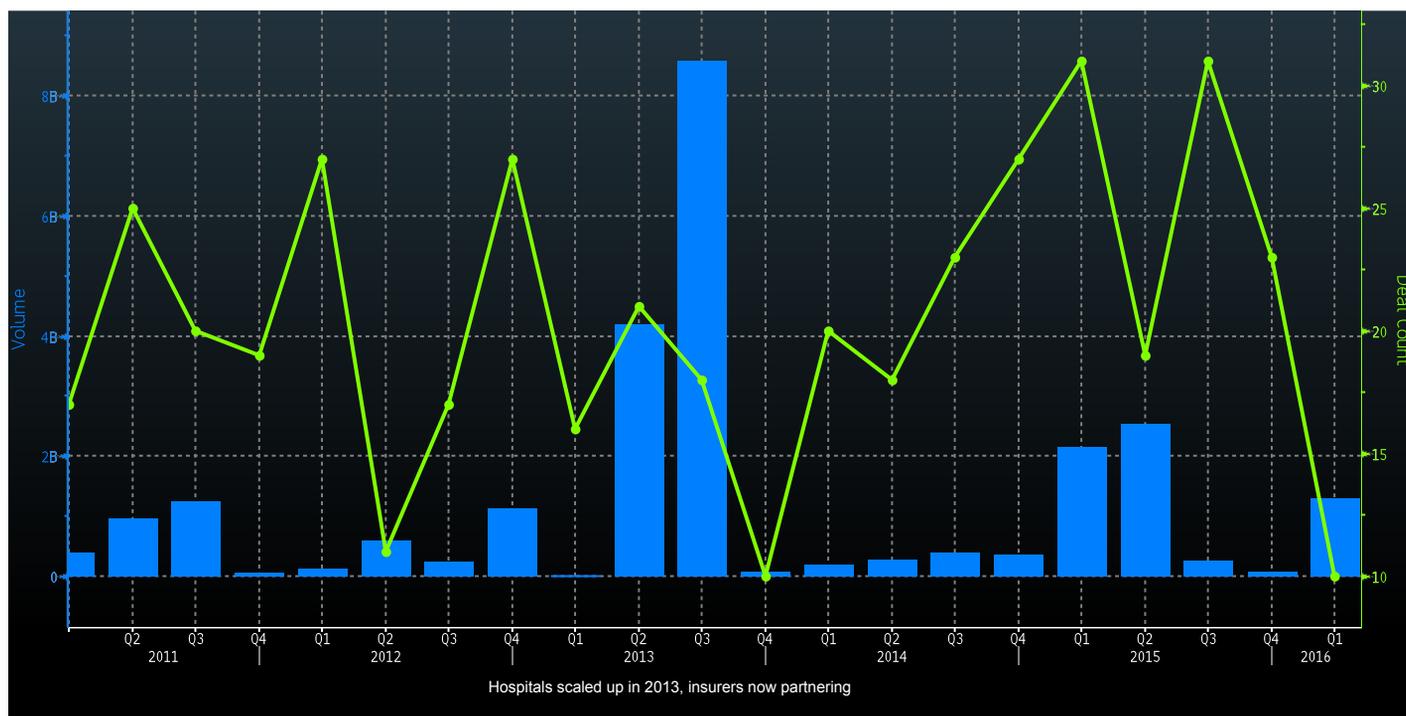
2 “Healthcare Transaction 2016 Forecast,” *Bloomberg Law Health Practice Center*, 1/21/16.

3 “Healthcare Transactions Trends and Analysis: Fall 2015,” *Bloomberg Law Health Practice Center*, 11/20/15.

4 *Bloomberg Law Health Practice Center* highlighted one such affiliation, Fairview Health Systems' recent acquisition of PreferredOne (“Fairview Health Acquires Sole Ownership of Health Insurer PreferredOne”), 2/1/16.

5 “Health Care's \$605B Buying Binge May Slow in 2016,” *Bloomberg Law Health Practice Center*, 1/7/16.

Hospital M&A Trends



The Hospital M&A Trends Chart above shows hospital M&A trends over a five-year period. It suggests that hospitals may be pushed to consolidate to gain more negotiating power in light of consolidation of health insurers over the past year.

As illustrated on page 5, Tenet Healthcare demonstrated that it was strongly positioned for growth because of the consolidation in the ambulatory surgical center (ASC) industry.

Based on this information, analysts determined that consolidation in the hospital industry will continue to focus on outpatient and physician services settings because EBITDA margins tend to be higher than for acute care hospitals (EBITDA stands for earnings before interest, taxes, depreciation and amortization). While it is not an official measure of value under GAAP (Generally Accepted Accounting Principles), it is considered a more realistic valuation of a company for a buyer that is considering acquiring a target.

Recognizing that the \$24 billion ASC market is highly fragmented, Tenet entered into a joint venture with United Surgical Partners, whose 40% EBITDA margin outpaces a high-teens pace for hospitals.⁶

The Tenet/United Surgical arrangement is one of many new joint ventures consummated between larger, national or regional providers and smaller, local ehealth care providers. They are popular in situations where a full acquisition is neither desired nor indicated. The joint venture structure can give a small provider access to capital and the operating synergies of a larger system, while maintaining significant local control.

Moreover, health care entities can more easily buy or enter into a joint venture with a different type of health care entity to provide a health care service than build the service from the ground up.

Facilities like Tenet Healthcare have an incentive to enter into joint ventures with ASCs as the centers have lower surgical costs than hospitals. In turn, the ASC benefits by getting referrals from the hospitals. By using the joint venture structure, a deal is much simpler because two different companies are not trying to merge their functions but are instead agreeing to work together, provide services to each other, or create a third entity.

Like joint ventures, clinical affiliations, particularly in certain ehealth care specialty areas related to stroke care, cardiology, neurology and orthopedics, enable smaller providers and their communities to benefit from the clinical expertise of larger academic medical centers.

Through an affiliation agreement, the larger provider typically provides clinical, management, or technical and other assistance to health care providers in other geographic regions and markets under an agreed upon brand (usually a derivative of the provider with the recognized expertise in the particular specialty). Such affiliations are expected to continue to proliferate in 2016.⁷

The Regulatory Wrinkle

Health care transactions present unique challenges. In addition to the usual deal structuring and due diligence, health care transactions involve complex regulatory compliance. Clients and

⁶ Bloomberg Intelligence, *Industry Primer*, "North American Hospitals 2016 Outlook."

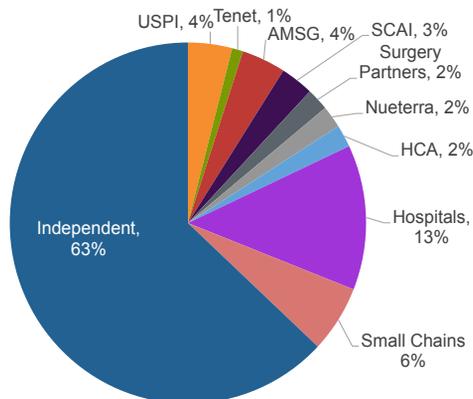
⁷ "Health Care Transactions 2016 Forecast," *Bloomberg Law Practice Center*, 1/21/16.

Strongly Positioned for Growth and ASC Industry Consolidation



Highly Fragmented ~\$24bn Market ¹

Market share by number of facilities ²



1. Source: McKinsey & Co.
2. Source: Jefferies equity research, 10/24/14.



their attorneys must consider not only antitrust and tax issues, but also the Stark law, Anti-Kickback Statute, and laws on the corporate practice of medicine.

A typical health care M&A deal involves intense regulatory scrutiny by the Department of Health and Human Services, the Department of Justice, the Federal Trade Commission, the Internal Revenue Service, and the Department of Labor.

The jurisdiction of state regulators, such as state attorneys general who have approval over certain health care deals, must also be considered. Health care companies often find that dealing with state regulators can be problematic.

At one time, health care transactions required only the health care department of a law firm to protect a client's interests in structuring and documenting a deal. Now, cross-disciplinary specialists in the areas of antitrust, tax, and labor are crucial to structuring a successful health care transaction.

Learning From Others' Mistakes

An understanding of deals that went wrong is crucial to the health care transactional attorney. For example, in late 2015, Prime Healthcare Services (Prime), a hospital management company, claimed that behind-the-scenes political maneuvering led California's attorney general to place such onerous conditions

on a hospital system acquisition that Prime was forced to back out of the deal.

Prime was poised to acquire the Daughters of Charity Health System for over \$800 million, but on Sept. 21, 2015, Prime accused California Attorney General Kamala D. Harris of violating its constitutional rights by refusing to approve the proposed transaction absent Prime's acceptance of over 300 approval conditions that Prime claimed were arbitrary, unreasonable, and unprecedented.⁸

Along a similar vein, a proposed merger between Yale New Haven Health System and two other regional hospitals is being deferred until at least January 2017 as the result of an unexpected executive order issued by the Connecticut governor.⁹

Life Sciences Companies

M&A has become the growth strategy for life sciences companies. Pharmaceutical companies are acquiring other pharmaceutical companies to expand their product lines. Target companies also bring potential new drugs that are in the target's development pipeline. And pharmaceutical companies are increasingly looking outside the U.S. for acquisition targets.

Recently, however, pharmaceutical M&A has experienced a backlash because of rising prices and valuations of drug makers. Consider Intercept Pharmaceutical Inc.'s thwarted effort to

⁸ "Political Maneuvering Scuttled Acquisition, Prime Healthcare Says," *Bloomberg Law Health Practice Center*, 10/1/15.

⁹ "Conn. Hospital Merger on Hold While State Reviews Oversight," *Bloomberg Law Health Practice Center*, 3/7/2016.

protect its stock price by preventing its co-founder from auctioning his disputed patent rights for a liver disease treatment. The court refused to issue the injunction Intercept sought.¹⁰

Real Concern for Real Property

The life sciences and biotechnology industries' growing demand for real estate is another facet of the health care transactions landscape. Consider Blackstone Group's deal to buy landlord BioMed Realty Trust Inc. for \$4.8 billion.¹¹ Shares of REITs (Real Estate Investment Trust) were battered in 2015 as investors prepared for the first interest-rate hike since 2006, which created opportunities for buyers like Blackstone to acquire companies relatively cheaply. Moreover, the rapid increase of health care spending in the U.S. is boosting demand for laboratory space that can accommodate pharmaceutical developers and manufacturers.

Startups and Mobile Apps

The mere mention of tech startups has many people dreaming of developing the next killer app that will result in a multi-million dollar exit for the startup's founders. However, most tech developers have no idea how much they need attorneys to help them navigate the legal minefield of health information on wearable and mobile devices. In the past few years there has been a flood of activity trackers, smart watches, networked glucose monitors, and mobile apps that harness the computing power of the smart

phone. These new digital health products can't get to market without approval by the Food and Drug Administration (FDA), something that most tech developers and venture capitalists don't realize. In addition to regulatory approval, wearable devices and mobile apps must be HIPAA compliant. The extent to which these new products are regulated under HIPAA can sometimes be unclear.¹²

Conclusion

The ACA has brought about a sea change in the way health care is delivered. To that end, physicians and hospitals have felt compelled to enter into new business combinations like joint ventures and affiliations to better enable them to provide value in the health care services they provide. The health care services market will continue to evolve as it embraces new delivery methods, such as mobile apps and telemedicine.

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For more information on Bloomberg Law, call the 24/7 Help Center at 888.560.2529 or email blawhelp@bna.com. ♦

¹⁰ "Court Denies Intercept Pharma Order to Stop Patent Auction," *Bloomberg Law Practice Center*, 2/1/16.

¹¹ "Blackstone Acquiring BioMed Realty Trust for \$4.8B," *Bloomberg Law Practice Center*, 10/16/15.

¹² "The Wearables Explosion and Human Connectivity to Health Information Management Systems," *Bloomberg Law Practice Center*, 8/10/15.

70**Words to Include in Every Health Care Transaction**

“Any dispute arising out of or relating to this contract or the subject matter thereof, or any breach of this contract, including any dispute regarding the scope of this clause, will be resolved through arbitration administered by the American Health Lawyers Association Dispute Resolution Service and conducted pursuant to the AHLA Rules of Procedure for Arbitration. Judgment on the award may be entered and enforced in any court having jurisdiction.”

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Are You Paying Fair Market Value?

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When Contemplating a Transaction, Fair Market Value Considerations are Critical

Health care providers receive scrutiny from regulatory agencies under anti-kickback, fraud and abuse, and pricing regulations. The federal government continues to aggressively pursue health care fraud and abuse with approximately \$2 billion annually in judgments and settlements won or negotiated in recent years. Transactions may be reviewed and/or challenged by the Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, the Internal Revenue Service, and the Centers for Medicare and Medicaid Services, as well as state agencies. In addition to civil penalties, regulators have begun pursuing criminal charges against individuals.

Federal and state statutes govern the pricing that is considered appropriate in deals involving transfers of businesses, or business assets such as property, as well as services. Included in

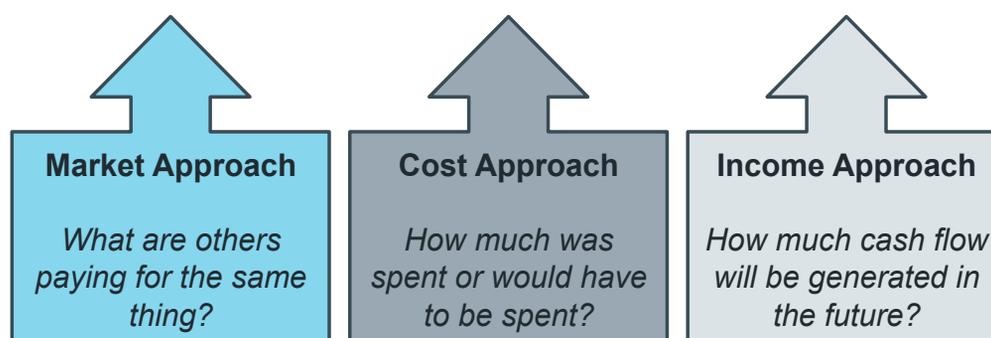
these provisions is the requirement (with some exceptions) that health care entities may not pay more than fair market value (FMV) for the assets or services exchanged. Additionally, certain payments tied to patient volume or referrals are construed as inappropriate inducements and are not allowed. Tax-exempt entities face additional scrutiny to ensure that a contemplated transaction does not result in private inurement.

What is Fair Market Value and How Can It Be Estimated?

Fair market value is defined as the price at which property would change hands between a willing buyer and a willing seller if neither were under any compulsion to buy or sell and both parties had reasonable knowledge of the relevant facts.¹

In addition, court decisions frequently state that the hypothetical buyer and seller are assumed to be able and willing to trade and be informed about the property and the market for

Illustration 1. FMV Estimation Approaches



¹ 26 CFR 53.4958-4(b)(1)(i); Rev. Rul. 59-60, 1959-1 C.B. 237.

such property. Further, the highest price a willing buyer would pay is also the price that a willing seller would accept² (Estate of Newhouse v. Commissioner, 94 TC 193 (1990)). Furthermore, in the context of health care regulatory compliance, FMV means the price that an asset would bring as the result of *bona fide* bargaining between well informed buyers and sellers who are not otherwise in a position to generate business for the other and that does not vary with, or take into account in any way, the referral or potential referral of patients or any other health care business between the parties for purposes of compliance with the Anti-Kickback Statute, the Stark Law, and Stark regulations. Prior to negotiating and closing a deal, a robust valuation supports the pricing of the transaction and helps ensure regulatory compliance during post-deal execution. So how might one value such a transaction? As shown in Illustration 1 (pg. 9), a Market Approach, Cost Approach, and/or Income Approach can support the FMV assessment of a business or service.

Market Approach

Ideally, one looks for the prices that others are paying for similar transactions in arm’s length arrangements. In applying this “Market Approach,” one seeks to find transactions that are as comparable as possible to the one we are reviewing. This is fairly straightforward when estimating the FMV of a relative commodity, such as bags of saline solution or four hours of medical chart coding. When valuing something less commoditized, however, we need to apply well-supported adjustments to the pricing of transactions that are as close to comparable as possible. But because business deals are typically complex multi-element transactions, comparable publicly-reported arm’s length deals are often not found.

Cost Approach

Given the practical challenges in applying the Market Approach, the “Cost Approach,” which values an asset based on what has been spent to create it or how much it would cost to re-create it, is sometimes considered. Here too, challenges exist. It may be difficult to identify relevant historical costs or to estimate the replacement cost. More importantly, the value of the asset may be substantially greater than the cost to create it due to strategic value that goes above and beyond the asset’s cost.

Income Approach

A third approach, the “Income Approach,” overcomes many of the challenges we have mentioned by valuing the business, asset, or service based on projected incremental cash flow. A discounted cash flow (DCF) estimates the present value of this cash flow by applying a discount rate that a market participant would consider appropriate given the riskiness and timing of the cash flow. When there is significant uncertainty surrounding the cash flow, for example, whether synergies projected for an acquisition will be fully achieved, multiple scenarios may be considered. Cash flows associated with each scenario are weighted by the corresponding likelihoods of the scenarios. The FMV pricing of the transaction would then be based on the resulting expected or probability-weighted DCF of the acquired business. If the transaction consideration involves multiple components (for example, an up-front payment and milestones tied to post-deal performance), then the analysis will consider the FMV of the transaction consideration as well as the FMV of the acquired business.

The Income Approach is not without its own set of challenges. The valuation is sensitive to the cash flow projections and other inputs, such as discount rate, tax rate, long-term growth rate, etc. As such, the assumptions behind these elements need

Table 1. Spectrum of Transactions

Business Transactions	Property & Equipment Transactions	Distribution Services	Marketing, Advisory, & Educational Services	Data-Related Services
Practice or other health care entity acquisition	Lease transaction	Drug or device distribution services	Advisory boards, product reviews	Utilization data and analyses
Re-branding of an existing practice or entity	Real estate purchase or sale	Specialty pharmacy distribution services	Meetings, speaker events, CME programs	Sales or marketing data
Clinical or professional services arrangements	Medical equipment purchase or sale	Enhanced services such as product pedigree control	Market research studies, health provider surveys	Outcomes data and health economics studies
Co-marketing arrangement	Mobile equipment rentals	Reimbursement training to provider staff	Sales calls to physicians	Customized research studies
Other types of partnering arrangement	Facility-sharing arrangement	Managed care contracting support	Training and communications to patients, physicians, and pharmacies	Customized analyses and decision support tools

2 26 CFR 53.4958-4(b)(1)(i); Rev. Rul. 59-60, 1959-1 C.B. 237.

Table 2. Considerations in FMV Analysis

Potential Buyer/Seller Considerations
Income Taxes
Capital Expenditures
Depreciation and Amortization
Space and Rent
Staffing Levels
Corporate and Administrative Compensation
Physician Compensation
Personal Expenses
Favorable/Unfavorable Contracts

to be well supported. Additionally, in structuring payments and developing the corresponding cash flow projections, we must be cognizant of the regulations governing payments tied to volumes or referral inducements.

When Does Fair Market Value Matter?

Table 1 on page 10 provides examples across the spectrum of transactions in which FMV considerations are relevant. Although the complexity and materiality of a transaction may determine the depth of analysis and documentation that is appropriate, it is highly advised to address the FMV of any transaction in which relevant legal issues may apply.

FMV Considerations in Business Transactions

Focusing on business deals in particular, we find that many health care entities believe they are paying FMV in a transaction based on historical financial information and observed data points in the marketplace. However, upon closer analysis of an entity, certain nuances of the business or specific facts and circumstances in a transaction reveal that FMV is not as clear-cut. Table 2 above includes a list of some common items to consider in a FMV analysis. The considerations in this article are strictly that—considerations; and specifically, as part of the Income Approach and Market Approach. Furthermore, the considerations in this article must be analyzed in the context of the facts and circumstances of a particular transaction.

Income Taxes

The U.S. health care system includes a significant proportion of not-for-profit (NFP) entities. The IRS and courts recognize health care entities that promote health for the benefit of the community as a charitable purpose. Assuming certain criteria are met, NFP health care entities are exempt from paying federal income taxes under I.R.C. 501(c)(3). However, a hypothetical buyer in a transaction can be either a for-profit entity or not-for-profit entity. Excluding income taxes in the FMV analysis of a health care entity can potentially violate certain private inurement restrictions.

Some have argued that for-profit entities will not enter certain markets due to the competitive landscape. However, many examples dispute this argument as there are typically no legal barriers (although there are certainly hurdles) that restrict a for-profit entity from entering markets historically served only by NFP entities. Recently, for example, LifePoint Health made acquisitions enabling it to enter new markets in Wisconsin and Pennsylvania that were historically served by NFP entities.

Capital Expenditures

When applying the DCF method within the Income Approach, it is critical to include the appropriate future capital expenditures as part of the projected future cash flow. Many health care entities are capital intensive in nature and require significant building improvements, new equipment purchases, and even new facilities to meet the standards driven by the market.

An imaging business with an aging or obsolete MRI machine is an example. FMV could potentially be overstated if the appropriate capital expenditures to invest in a new MRI machine are not included. At times, a health care entity may be able to refurbish an imaging machine to extend the economic life. However, the time will come when the machine needs to be replaced.

Alternatively, FMV could be understated if an imaging business has a new machine that is being underutilized or not operating efficiently. It is also important to analyze projected volumes and the capacity of machines. For example, if the local market demographics and competitive landscape support significant annual volume increases, will the imaging business require an additional machine(s) to satisfy demand? For an existing or new machine, what is the capacity to support higher volumes? For example, a 16 slice CT versus a 64 slice CT can impact the time and efficiency of a machine, which impacts the volume capacity of the business. Of course, the corresponding capital expenditure outlay will differ based on the type of machine purchased.

Depreciation and Amortization

Related to the capital expenditures, it is necessary to incorporate the tax depreciation of existing plant, property, and equipment (PP&E), as well as new PP&E from future capital expenditures. Book depreciation does not reflect actual cash flow of a business, which is why it is critical to project depreciation based on the appropriate tax methodology and lives.

Amortization is derived from acquired intangible assets, both existing and new, if any. In estimating FMV, it is critical to reflect the transaction structure, taxable or nontaxable. The transaction structure will drive certain assumptions related to depreciation and amortization.

Space and Rent

In establishing FMV, hypothetical buyer and seller assumptions must be utilized throughout the valuation analysis. Some businesses operate inefficiently and are deemed not to be representative in estimating the FMV. It would then be necessary to adjust certain income statement items. For example, a business may have obtained excess space with a long-term business plan of growing and utilizing the space. However, if the business plan

has not been achieved and is not projected to come to fruition, an adjustment to the required space may be appropriate. Likewise, if the transaction involves a rental agreement that is at an above or below market rate, an adjustment to the rental amount may be appropriate. As mentioned earlier, it is necessary to reflect the facts and circumstances of a transaction or proposed transaction.

Staffing Levels

Similar to space and rent previously mentioned, staffing levels may not be appropriate based on current patient volumes. For example, a practice with declining volumes may continue to maintain a staffing level that is no longer necessary. In order to reflect a hypothetical buyer or seller, it may be appropriate to adjust staffing levels. Alternatively, if a physician practice or ancillary business is projecting a significant increase in volume, is the appropriate staffing level in place to support the increased volumes?

Corporate and Administrative Compensation

It is not uncommon to observe a private company pay above market compensation to certain employees, or even family members. Within a physician practice, the physician owner may have a long-term business relationship with a practice administrator which has resulted in above market compensation. Other times, we have observed family members receiving a salary that does not match the contributions to the business. Although acceptable for a privately-held company to operate at its own discretion, these expenses are not representative of FMV and may be adjusted accordingly.

Physician Compensation

It is critical to incorporate post-transaction compensation in a DCF analysis. Not doing so may overstate FMV. Often we see transactions where the post-transaction compensation is yet to be determined. In these situations, it may be appropriate to include the proposed post-transaction terms; however, if there are any changes to the proposed terms, it is important to update the valuation before closing. In many physician practice transactions, there are highly productive physicians who will leave the practice post-transaction. In these situations, it is important to consider whether a single replacement for that physician will be sufficient to support the projected post-transaction volumes.

Personal Expenses

Private companies often include personal expenses, such as automobile, insurance, and travel, and categorize those expenses as business expenses. If these are not required business expenses from a FMV perspective, it may be appropriate to adjust accordingly.

Favorable/Unfavorable Contracts

Depending on the size, competency, and negotiating power of a target company, other contracts or agreements such as leases may be favorable or unfavorable relative to market rates or benchmarks. In an FMV analysis, it may be appropriate to normalize these contracts or agreements to reflect a hypothetical buyer or seller. For example, if an assisted living business has a relationship with a lab supply company and executes a supply

contract that is not at arm's length, it is generally appropriate to adjust accordingly.

FMV Considerations in Services Transactions

Table 1 (pg. 10) provides examples across a spectrum of distribution, marketing, advisory, educational, and data-related areas. When services arrangements are already in place prior to executing a business transaction, existing contracts should be reviewed carefully to ensure compliance with applicable regulations, including an analysis of whether pricing terms are at FMV. This should typically be done as part of, or in concert with, the due diligence process. If yellow flags are raised in reviewing the existing contracts, they should be addressed either by seeking suspension, modification, or carve-out of questionable contracts, or by incorporating contingent consideration or indemnifications into the current transaction to help control risks.

In reviewing contracts in place, a process similar to ordinary course-of-business FMV analysis is advisable, albeit on a more expedited path given the typical timeframes for consummating a deal. The valuation approaches described earlier (see Illustration 1, pg. 9)—Market Approach, Cost Approach, and Income Approach—may apply, and so do their challenges. As with all valuations, when multiple approaches can be used, there will be stronger support for the concluded value.

Payments to Health Care Providers

We focus now on two areas of particular concern: payments to health care providers and payments for data.

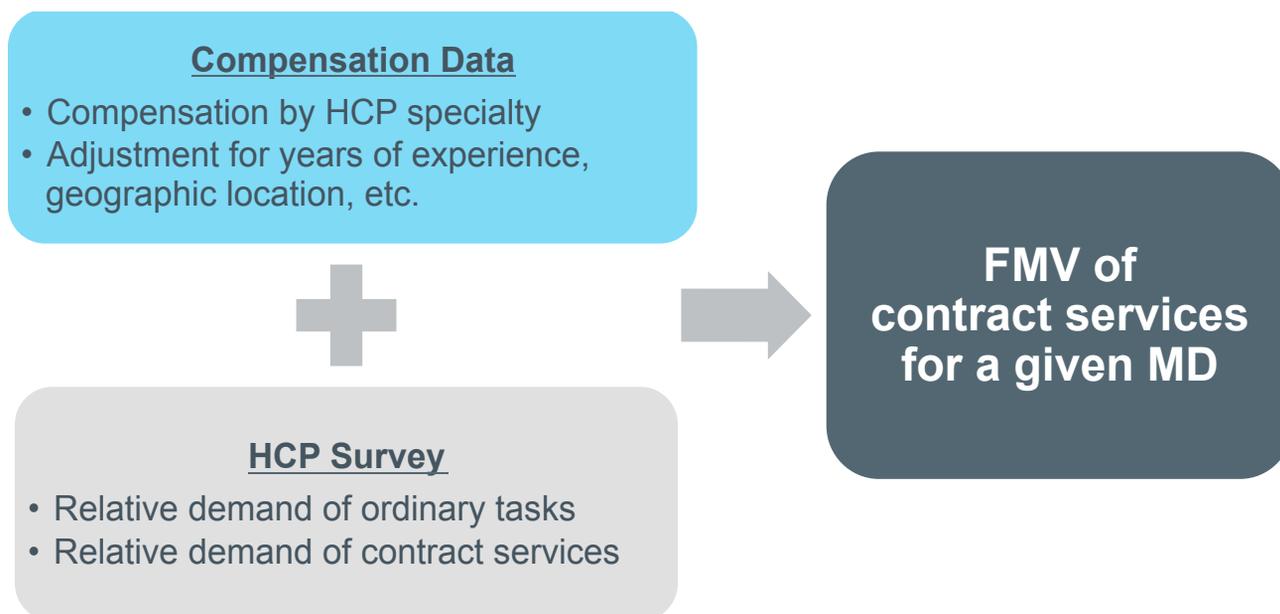
Manufacturers enter into contracts with Health Care Providers (HCPs) for a wide variety of marketing, educational, and advisory services, and HCPs may expect and be entitled to receive levels of compensation that reflect the varying degree of effort and expertise that is demanded by a given activity. These arrangements can create an actual or perceived conflict of interest. Payments to HCPs for these services could be viewed as a kickback in exchange for using a manufacturer's products if the payments are not at FMV.

From 2013 to 2015, dozens of companies have been investigated with publically disclosed penalties and settlements for allegations of inappropriate pricing and off-label promotion averaging over \$750 million per year. Additionally, payments to HCPs for clinical services can receive scrutiny; notable cases include *U.S. v. Tuomey* and *U.S. v. Halifax*, which resulted in a verdict of over \$200 million and a settlement of \$85 million, respectively.

The following scenario demonstrates how a valuation that properly reflects the difficulty of a given task and the characteristics of the physician can support compensation greater than \$500 per hour for certain activities and individuals.

A manufacturer and distributor of medical devices to orthopedic surgeons, spine surgeons, and neurosurgeons planned to contract with selected surgeons for various services, including assistance with product development, product evaluation, training product marketing representatives, serving on advisory boards, and serving as medical advisors. They needed to ensure that payments for these services were at FMV. Typically, most approaches begin by identifying a baseline compensation range for the each

Illustration 2. Demand-Adjusted Compensation



physician specialty using third-party compensation data. This data can go beyond differentiating only by physician specialty to provide support for levels of compensation that vary with the HCP's location, years of experience, and other characteristics.

Compensation data alone provides limited support for remuneration that reflects the nature of the services being contracted for. Specifically, some services place greater demands on the HCP. For example, payment for an hour of an HCP's time to serve on an advisory board should likely be greater than an hour of the same HCP's time to complete a product survey. Depending on the task, the required effort, knowledge, skills, risks, and responsibility can justify a relatively higher or lower remuneration than reliance only on compensation benchmarks would suggest.

As an example, to implement this "demand-adjusted compensation" approach (see Illustration 2 above), we measured how HCPs view the burdens of a given activity through a brief telephone survey with orthopedic, neurological, and spine surgeons. After defining the "demand" of an activity as described above, HCPs were asked to rate the demand of specific activities, including both ordinary activities as a surgeon and those such as providing training, advisory board service, and product evaluation that they might be contracted to provide on behalf of a manufacturer. Activities that are rated as more demanding justify a relatively higher level compensation.

Integrating compensation data and HCP ratings of the demands of each activity provides a well-supported FMV conclusion. The FMV of each service is the compensation range appropriate for a provider in a given region with similar specialty and years of experience, adjusted to reflect the demand of the activity.

This demand-adjusted compensation approach works well when the services to be valued are well-defined, easy to communicate to HCPs, and have limited variability (i.e., where an

hour of the service is essentially the same regardless of which manufacturer contracts for it or which HCP provides it). An alternative approach, conjoint measurement, infers preferences for product and service attributes through trade-off questions that pose choices between hypothetical products and services. In the context of payments to HCPs, we have used conjoint measurement to provide highly refined, robust valuations of services that vary on numerous characteristics or in subtle ways from one another, such as in the number of hours required, the amount of preparation needed in advance of delivering a program or service, or the distance from the HCP's location to where the service will be provided.

We have described how to go beyond relying exclusively upon compensation data by adjusting for the demand of an activity using HCP perceptions expressed directly or inferred from choices made in a conjoint approach. Which approach to use depends largely on the materiality of the program addressed and the breadth and variation of the services being valued.

Ensuring that payments to HCPs are at FMV is only one piece of ensuring compliance with anti-kickback statutes, as indicated by the compliance review checklist (see Table 3, pg. 14). Regulators may also scrutinize the commercial reasonableness of an arrangement with HCPs, whether an arrangement provides rewards for the volume or value of referrals or business generated, and whether the aggregate amount paid to any one HCP in a given year is excessive.

Payments for Data

Payments for health care data are growing in importance due to the increased use of data by manufacturers and health care systems to drive design, development, pricing, marketing of products and services, and the increasing focus by public payers and

Table 3. Compliance Checklist

Compliance Review Checklist: Payments to HCPs
■ Is the HCP's background appropriate for the activity and payment amount?
■ Are regional differences captured?
■ Is the intensity and specific requirements of the activity reflected in the payment?
■ Does the arrangement provide implicit or explicit incentives or rewards for referral volume or value?
■ Are the aggregate payments to an individual HCP or individual entity reasonable?
■ Are data sources used to estimate the FMV credible?
■ Is the methodology for estimating the FMV consistent and transparent?
■ Is the rationale for payments at the higher or lower end of a FMV range supportable and documented?

insurers on outcomes-driven health care. Hospitals, physician practices, pharmacies, and other entities collect vast amounts of data on treatment patterns, patient outcomes, and product usage in their ordinary course of business. This data is a valuable source of market intelligence for manufacturers and providers; however, payments received for the data are subject to scrutiny under anti-kickback, pricing, and other statutes.

Determining the FMV of data is often challenging due to the uniqueness of a given data set and the variety of data-driven products and services that may be associated with a data set. We will describe an approach we have used to value a variety of data products from one such provider.

Contracts for data services often include an initiation cost or setup fee for the work of tailoring a data set or product offering to a customer's needs, along with an annual subscription-type fee for the data or product itself. The FMV of the setup fee can be estimated using a Cost Approach, as the uniqueness of a given data set implies that unique activities and/or levels of resources may be needed to create it. Finding market data to support direct estimation of the setup fee is likely not possible. The fee for the data itself is addressed via a Market Approach, as we will describe later.

In applying the Cost Approach to estimate the FMV of the setup fee, if the organization has captured historical information, we consider the average and range of resources it has incurred per customer to on-board similar customers. This can inform projections of the resources that would be needed to on-board a given customer. The resource estimates are typically a range of hours by job title and reflect the variability across customers to on-board them for a given service, e.g., based on the complexity of the required data set, whether multiple data sources need to be integrated, the number of organizational touchpoints involved, and other factors. Care needs to be taken to allocate the resources on a per-data set or per-product basis for activities that support multiple products or customers.

The total cost for setup is based on the required resources and the fully loaded salary of each resource, as supported by industry compensation benchmarks. Finally, a Fair Margin is applied to the total cost based on the observed margins of comparable public companies.

Turning to the FMV analysis of the data itself, a Market Approach is typically used. If similar data products are available from several providers, the FMV of the data can be supported by the prices others charge for comparable products. Often though, the prices charged by other data providers are not publicly reported or their products are not similar enough to be considered comparable.

As an alternative, information from a survey of "data buyers" can support application of the Market Approach by measuring buyers' likelihood to purchase depending on price and other characteristics. The survey can present hypothetical data sets and product offerings that vary in the types of data, geographic/patient/specialty coverage of the data sets, frequency of updates, and other characteristics that differentiate products and providers.

From their responses, the willingness-to-pay of each buyer for various products is estimated. Willingness-to-pay is a measure of the likelihood that a buyer will purchase a data product at a given price and reflects both how well the product meets the buyer's needs and other alternatives the buyer may have, either through another data product or provider, or by addressing the need internally or through other means. The final step is to estimate the FMV for each product based on a willingness-to-pay estimate for the market that is aggregated across survey respondents.

The combination of the Cost Approach for the setup fee and a survey-based Market Approach for the data product or subscription provides the support needed to justify the FMV pricing for unique data products. Additionally, the conjoint measurement approach mentioned in the preceding section can be used to provide robust support for FMV pricing of data products that vary along a broader and deeper spectrum.

So, Are You Paying Fair Market Value?

In this discussion we have highlighted FMV considerations when pursuing or reviewing business and service transactions. FMV principles apply across the broad spectrum of health care transactions, but since no two transactions are alike, facts and circumstances must be considered. Whenever possible, more than one valuation approach should be used. An experienced and independent third party can facilitate the evaluation process and help lend confidence to your FMV conclusions. ♦

What Every Seasoned Transactional Health Care Lawyer Should Know about Key Regulatory Elements of a Health Care Transaction, All Parts (Intermediate)

Health care transactions are replete in complex regulatory issues. Transactional health care lawyers, of course, need to be versed in issues from antitrust to employee benefits, but they also need to understand the unique regulatory landscape of the health care industry. This landscape is driven by complex laws such as the Stark Law, the Anti-Kickback Statute and the Health Insurance Portability and Accountability Act, to name just a few.

Each part of this five-part webinar series will focus on a significant substantive component of a health care transaction. The series will include a part on negotiating indemnification provisions and their significance.

Part I: Antitrust Issues, Agency Enforcement, and Risk Mitigation Strategies

Part II: Addressing Privacy and Security in Health Care Acquisitions

Part III: Mergers and Acquisitions—Employee Benefits Issues to Consider

Part IV: Indemnification Issues in Health Care Transactions

Part V: Common Regulatory Pitfalls in Acquisitions—the Stark Law, AKS, and FCA

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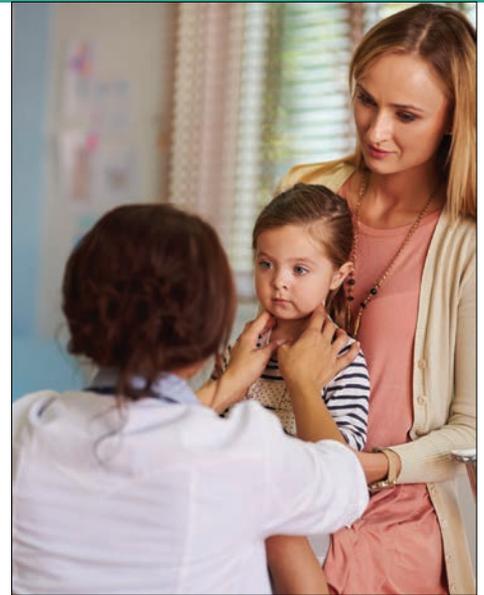
Putting Physician Practices on the Exam Table: How Comprehensive Due Diligence Brings Value for All Parties to an Acquisition

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Most physician practices haven't been built and operated with a clear focus on someday being acquired; rather, attention has been on serving patients and providing strong cash returns for the partners, and understandably so.

But with reimbursement changes, technology demands, regulatory compliance requirements, and other factors in the rapidly changing health care landscape, physician practices are increasingly considering strategic alternatives. It is also becoming increasingly clear that the established ways of operating can create a bumpy road when it comes to negotiating and closing a deal.

Cash-basis accounting, less-than-robust data collection, custom-tailored compensation practices, and outdated cybersecurity setups, among other factors, can all result in concerns for potential buyers and surprises for practice owners when the acquirers conduct their due diligence. Valuations calculated by potential acquirers can be far lower than practice owners expected. Discoveries during due diligence, such as uncorrected compliance issues, can even cause a potential transaction to fall apart.

For potential acquirers, particularly those with few—if any—physician practice acquisitions under their belts, the key to success is a due diligence process that goes beyond the traditional financial and tax diligence and explores issues like compliance and coding, cybersecurity, physician compensation and turnover, and integration costs. Having this information in hand will allow valuation professionals to calculate more realistic values.

For practice owners, the critical factor is planning and preparation—identifying the ducks that are paddling in circles and getting them moving all in a row—before ever exploring the transaction marketplace. The goal is to provide sellers with a realistic idea of what the practice is currently worth, and what it

could be worth if problems discovered ahead of time can be corrected. The fewer the surprises, the more likely both parties will be satisfied and the deal will close.

So how do both parties do that? The critical step is reviewing all facets of the practice—preferably conducted by an outside independent firm that can provide a cohesive, comprehensive picture of things as they are and the steps needed to get the practice ready for a buyer's evaluation. The outside firm should have expertise in accounting and finance, coding and compliance, cybersecurity, practice management, and valuation to be able to provide a complete view.

This article provides guidance on what should occur during a thorough diligence process. Tax considerations must also be taken into account, but those are outside the scope of this article.

Financial Due Diligence

A basic element of financial due diligence is analyzing the quality of earnings and assets, which includes a number of key considerations:

» **Converting to accrual-basis financial statements.** Many physician practices have been set up on a cash-basis accounting system. Revenue is recognized when cash comes in and expenses are recognized when payment goes out. That worked fine when the key considerations for owners were cash to be distributed and tax efficiency. But cash-basis accounting fails to give potential buyers a clear picture of the revenues generated and expenses incurred by the practice on a month-by-month basis during the previous 12 months

Merger and Acquisition (M&A) Marketplace

The past several years have witnessed hospitals and health systems actively acquiring physician practices. The targets of these acquisitions were typically primary care and internal medicine physicians and specialists, like cardiologists and surgeons, who complement the hospital and health system's continuity of care goals.

Financial buyers are also involved in consolidating certain hospital-based specialties. These consolidated practice management companies contract with hospitals and health systems

to provide in-hospital services. Anesthesia and hospitalist groups are examples of acquisition targets in this area.

More recently, single specialty practices whose patients are less likely to require hospitalization as part of their treatment—such as dermatologists, occupational medicine physicians, and cosmetic surgeons—are being targeted by financial buyers in practice consolidation (“roll-up”) deals, with the primary drivers being the creation of synergies and other economies of scale and increasing the ability to negotiate with payers and vendors.

and prior fiscal year, the basis on which most buyers want to evaluate the practice's earnings and cash flows.

For example, an unusually busy month for a physician 14 months ago may not have been reimbursed until three months later, providing a distorted view of the doctor's productivity in the trailing 12 months. Or a practice may routinely pre-pay bills in December to reduce tax liability for the current year, distorting expenses for the following year. Or the practice might be processing payroll every two weeks, so pay periods likely will not line up with month-end.

The consultant will normalize earnings for the trailing 12 months and prior fiscal year—providing an accrual-basis equivalent—and will present a calculation of EBITDA (earnings before interest, taxes, depreciation and amortization), which is a standard metric potential buyers use as a proxy for cash flow.

» **Properly classifying expenses.** The normalization analysis will identify such things as expense items that should have been classified as capital outlays or expenses, such as owner car mileage or other travel costs charged to the business that should have been classified as personal expenses. These reclassifications also contribute to computing an accurate EBITDA, which, for example, would increase once personal expenses are removed from the calculation.

» **Determining revenue run-rate and the value of accounts receivable.** The consultant will request detailed transaction-level data from the physician practice management system of all activity, principally claims and payments. Revenue run-rate reports will be generated using a variety of filters that show such things as revenue and payments after revenue by date of service, physician/provider, location, payer, and billing code.

This analysis provides insight into the quality of earnings. Accounts receivable will be evaluated for collectability, and corresponding adjustments will be made to both the net accounts receivable balances and normalized net revenue for the periods analyzed. Having robust data available for this analysis from an up-to-date electronic health records system that is integrated with the patient billing/practice management system is important; without it, a buyer may not feel it can get proper insight into the practice's revenue and productivity.

» **Determining working capital.** The transaction-level data of accounts receivable and collections is also used to establish one of

the key drivers of a working capital “peg,” which is a prediction of working capital to be delivered by the practice at transaction close. Since the working capital payment impacts the cash the owners receive at close or through post-close working capital adjustment mechanisms in the purchase agreement, disputes in this area can stall the deal process or lead to unexpected adjustments to cash proceeds from the transaction. The consultant will be looking for evidence that collections are not being accelerated or expense payments are not being delayed as a way of reducing apparent working capital. It is important that the targeted working capital be reflective of the way that the practice has historically run, without any attempt by the practice to “game” the system for a more favorable outcome. Once in negotiations, it is a good practice to clearly establish in the purchase agreement how the working capital “peg” will be defined to minimize the risk of post-closing working capital disputes between the selling practice and buyer.

» **Assessing professional liability historical exposures and costs.** Does the practice have any professional liability matters pending, and, if so, what are the potential liabilities? Has “tail” coverage been purchased to address incidents involving physicians who have since left the practice or for unreported claims under professional liability insurance policies? Is insurance coverage appropriate, and have costs been run through the financial statements on a consistent basis? This analysis provides insight into the quality of earnings from the standpoint of assessing the possible understatement of recorded professional liability expense and the likelihood of off-balance sheet professional liability exposures (i.e., unrecorded liabilities).

» **Compensation.** Practices often have a variety of ways to compensate physicians. Partners, for example, may receive distributions, which would not be included in financial statements as expenses but as equity transactions. After a deal closes, however, partners will become employees, paid with salaries likely to be different from what they previously received or what was previously recorded as compensation expense. How have physician incentives been calculated and paid? The normalized physician compensation and benefits expense for the historical periods analyzed has to be adjusted to account for these issues so that buyers will have a clear picture of what their physician compensation and benefit expense is likely to be in future periods (discussed further in Compliance and Coding below).

» **Assets.** What is the value of equipment, facilities, and IT systems? What are the expected costs of replacing them as well as expected costs of implementation and training practice staff related to new IT systems? (Discussed further in Valuation below.)

While reliable financial statements that are normalized to reflect the trailing 12 months of EBITDA are a critical baseline for determining value, there are a number of other factors involved in projecting future cash flows, which is what potential buyers really care about. The balance of this article examines other aspects of a comprehensive review.

Compliance and Coding

With increased government enforcement attention to physician practice acquisitions and physician compensation, a critical part of a practice review is compliance. Compliance issues left unaddressed present a far more serious threat to a deal than financial issues, which have a better potential of being resolved through negotiations on deal value and structure. An unresolved compliance issue can create uncertain financial and reputational liability for a potential acquirer, and may even cause the buyer to back away from a deal.

Many practices undergoing a due diligence review are surprised to learn that their existing compliance and coding processes were not robust enough to meet a potential buyer's scrutiny. Many haven't developed or implemented the required compliance plan. Early warning provides the opportunity to address these issues before expending time and money in an acquisition process. Areas a consultant would explore include:

» **Physician compensation.** The internal compensation formula determining how practice earnings are divided among physician-owners will be considered for compliance with regulations surrounding in-practice ancillary services. Incentive elements of the existing compensation formula will also be assessed. When practices are acquired, physician-owners become employees. Since part of their previous compensation may have been in the form of a profit-split, distributions, or dividends, an evaluation needs to be made to determine the fair market value (FMV) of compensation, lest there has been or could be a compliance issue. In transactions involving a party in a position to refer patients to the other party, post-transaction compensation is required by federal regulations to be at FMV (discussed further in Valuation below). In the absence of a potential patient referral relationship, buyers will propose an employment arrangement with compensation that may or may not correspond to the previous system. Regardless of the type of buyer, it's important to understand the existing compensation structure for compliance and its impact on seller expectations.

» **Productivity.** A standard way of looking at physician productivity is by calculating relative value units associated with actual services provided, or "wRVU," which measure the volume of work expended by a physician in treating patients. A reviewer should look deeper to determine whether over-coding is contributing to inflated wRVUs. The review should also examine whether the services of mid-level providers are being billed to

a physician's provider number, which would inflate physician wRVUs, as well as create a potential compliance issue.

» **Coding.** A review of a sample number of charts for each provider should be conducted to provide insight into coding practices. Under-coding may demonstrate that the practice owners risk leaving money on the table on a purchase price, while over-coding may result in a reduction of revenue in a normalized financial statement. Both pose the risk of a compliance issue and the potential need for the practice to self-disclose to the government.

Cybersecurity

As news about cybersecurity breaches continues, potential purchasers may want assurance that a practice's digital data is secure. Many practice owners are surprised to learn that their cybersecurity processes are not up to standards. Consultants will be looking for that assurance in several areas, including:

» **Credit card payments.** All businesses accepting credit cards for payment must comply with the Payment Card Industry Data Security Standard, better known as PCI. Companies found not to be in compliance can be fined by the entity they use to process their credit card transactions, but more importantly, leave themselves more open to a data breach. A cybersecurity consultant will be looking, at a minimum, for an indication that the practice has a handle on its credit card security obligations.

» **Information security policy.** HIPAA requires that security safeguards be specified, documented, and communicated to staff. The consultant will be looking to see if a plan has been created and what safeguards the plan calls for.

» **HIPAA.** The key items are whether the practice has completed an annual risk assessment as required by law and is prepared to explain any unaddressed high risks noted in the assessment.

» **Service providers.** Many practices employ vendors for IT support. Is there a contract that calls for the IT service provider to set up the IT environment in a secure way? Contracts with other vendors, such as an internet service provider, may also be examined.

» **The cloud.** Does the practice use cloud-based services, such as Dropbox, to transmit sensitive information? The consultant will be looking for an inventory of which items are transmitted over the cloud, how sensitive they are, and which services are used.

Having proper documentation may be enough to satisfy a buyer. In the absence of documentation for these items, the buyer may want to have an audit conducted of the practice's cybersecurity set-up.

If the potential buyer is an organization with established cybersecurity processes, it may be less concerned about the current state of cybersecurity since it likely plans to apply its own program to the acquired practice. While this is understandable, it can leave the acquirer liable for the costs of a previous breach discovered only after the deal closes, so many buyers will still conduct due diligence in this area.

Ability to Compete

No practice is an island. Consultants looking at prospects for a practice will be asking the following questions (and more), aimed at assessing the ability of the practice to compete:

- » Who are the competitors? Have they been expanding or contracting? Has a physician needs assessment been conducted for the service area?
- » What services do those practices offer? How do they compare with the practice undergoing diligence? What are the service opportunities for the service area?
- » What is the geographic area from which the practice could realistically draw? Has the practice fully penetrated this market?
- » Are facilities, equipment, and IT systems up-to-date? How will the status of those assets affect the patient experience and the future choices patients make about what practice to use?
- » How strong is the leadership team at the practice? How well do they manage the business and the people in it? What is the employee and physician/mid-level provider turnover rate?

Consideration of the practice's strengths, weaknesses, opportunities, and threats from competition is an important part of the valuation process discussed in the next section.

Valuation

With information from a comprehensive due diligence process in hand prior to entering into negotiations, a valuation expert will have the ability to calculate a value much closer to market realities than if a valuation is conducted as a stand-alone process. From a practical standpoint, there are a few considerations that, if agreed upon up front by the negotiating parties and their advisors, can streamline the valuation process:

- » **The valuation date.** A formal business valuation results in a value as of a specific point in time and is based on information known or knowable at that date. Although it's generally not necessary for the valuation date to coincide with the transaction close, the risk of an outdated valuation increases as time passes. In physician practice deals, factors such as the departure of a physician from the practice, opening a new location (or closing an existing one), and unanticipated cuts in Medicare reimbursement can occur in the months between initial valuation and close, prompting the need for a valuation update to ensure the ultimate transaction price reflects the value at the date of close.
- » **What will be included in the contemplated sale?** Physician practices vary greatly in size and complexity, and many offer services beyond the traditional physician-patient

Practical Tip

Many practice management systems can produce zip code reports to facilitate the patient geographic draw area analysis.

consultation. Practice-owned procedure suites, imaging equipment and services and labs are just a few examples. It's important that a valuation mirror the anticipated transaction as closely as possible to avoid surprises or adjustments for assets and/or business lines not included in the transaction (often referred to as "carve-outs").

- » **Post-transaction physician compensation structure.** As previously mentioned, depending on the type of buyer, post-transaction physician compensation will be required to be at FMV. The related regulations also require that compensation be commercially reasonable and determined without consideration of the volume or value of referrals that may be generated between the parties. Many buyers choose to have an independent, third-party assessment of compensation FMV. Because the post-transaction physician compensation impacts the valuation of the practice, using the same firm to perform the physician compensation FMV facilitates the practice valuation process and ensures the valuations mirror the final agreements used to close the deal.
- » **The standard of value.** It may seem that "value" would not require a formal definition, but this concept is critical in the valuation process. FMV is the most commonly used standard of value. In other transactions, the standard of value is often "strategic value" or "synergistic value." The primary difference between the two is that FMV is determined by looking at the market value of a practice for a pool of buyers and sellers, while strategic or synergistic value looks at the value to a specific buyer and/or seller. Although a comprehensive discussion of health care regulations impacting physician practice acquisitions is outside the scope of this article, it should be noted that transactions between parties in a position to refer patients for designated health services are required to be at fair market value. Also, buyers bringing synergies to the deal, even though not constrained by these regulatory requirements, may choose to transact at FMV.

While deal-makers tend to speak of purchase price in terms of EBITDA multiples, a formal valuation process will include consideration of the three commonly-accepted approaches to valuation: the asset approach, the income approach, and the market approach.

- » **The asset approach** focuses on the seller's balance sheet. Any adjustments or relevant information discovered through the financial due diligence process are incorporated into the analysis. Assets that will not be transferred to the buyer are adjusted to allow reconciliation to the purchase price. However, it's important that the seller understands that their total value of the deal includes both the retained assets and the price to be received at closing.
- » In applying the **income approach**, the true picture of the trailing 12-months of EBITDA is an important input to the valuation process. However, the income approach is more closely focused on an investor's expectation of future earnings in the form of cash flow. Although some equate EBITDA with

cash flow, due to the impact of taxes and the need to replace depreciating assets, it is unlikely that EBITDA will equal cash flow in the long term.

Income measures for the trailing 12 months are often used as a basis for a projection of future earnings (cash flow) considering known or knowable factors, such as pending changes in the competitive landscape and reimbursement, as well as potential capital expenditure requirements for purchasers, such as EHR, cybersecurity, equipment, facilities and other areas. The discounted cash flow method under the income approach is especially useful in assessing the impact of post-transaction changes in physician compensation, a new service offering, turnover in physicians or mid-level providers, the impacts of income taxation, anticipated capital expenditures, and other factors. The application of EBITDA multiples, a method under the market approach, does not lend itself to the fine-tuning of the valuation for anticipated capital expenditures.

» Two primary methods of valuation are used within the **market approach**, and both use the trailing 12-month EBITDA. Often, the EBITDA is “normalized” by adding back unusual or non-recurring expenses or other items in an attempt to adjust the figure to reflect ongoing earning expectations. It is typical for the buyer and seller to have some negotiation around whether the add-backs are appropriate. For high-growth entities, forward-looking EBITDA may also be used to avoid any negative impacts from start-up costs over the trailing 12-month period. The guideline transaction method uses available data on the valuation multiples involved in similar deals and applies those multiples, adjusted as necessary, to the earnings fundamentals of the subject practice. For physician practices, publicly-available information is limited. However, a private-equity firm buyer may have in-house deal multiples that would be relevant. The guideline public company method uses valuation multiples derived from the public markets; this information is only available for certain physician specialties.

The valuation professional reconciles the results from the various methods and computes a value. Generally, the asset approach will provide a “floor” value, excluding intangible value that may be captured by the other methods. At this time it is important to recall the importance of defining a standard of value; fair market value would not include synergistic value specific to a particular buyer. However, as previously mentioned, a buyer not subject to the fair market value standard may choose to pay the seller a price at a higher synergistic value, which could include intangible value relating to the synergies of the deal.

From a practical standpoint, physicians often feel their practice is worth more than the available pool of buyers is willing to pay. A key reason for this is the tendency for physician practices to continually pay out all residual profit (cash flow) to its physician-owners. It would be difficult for any buyer to justify paying a large purchase price for a physician practice and subsequently continuing to zero out cash flow by continuing that practice, with no profits for the new owner.

Although the immediate financial gain may not be as spectacular as expected, and the post-transaction compensation not as significant as hoped, practice acquisition may still be a very attractive option for physicians. The combined physician entity is generally in a better position and has more resources to contract with payers and vendors, can achieve economies of scale in administration and information technology needs, may relieve the physician’s burden of dealing with coding and compliance issues, and has the resources to ensure effective governance. A formal valuation process conducted sooner, rather than later, may help manage expectations and facilitate the acquisition process.

Integration Costs Post-Close

There are two types of buyers when it comes to post-close integration issues and their impact on purchase prices. Corporate buyers often have established systems for accounting, compliance, cybersecurity and other areas and plan to integrate the acquired practice into those systems, so the current state of systems at an acquired practice may matter less to them. As a result, practices with less-than-current systems may be penalized less by corporate buyers on purchase price for post-integration costs. Some private equity acquirers with a portfolio of practices may also have established best practices that they will introduce to a newly acquired practice.

Other private equity firms may not have those best practices in place. An important part of their evaluation of a practice for acquisition is the amount of investment they will have to make to update systems, which will in turn affect how much they are willing to pay. Practices looking to be acquired would be well-advised to have their consultant evaluate those costs so that the owners may have a realistic idea of what a purchase price is likely to be.

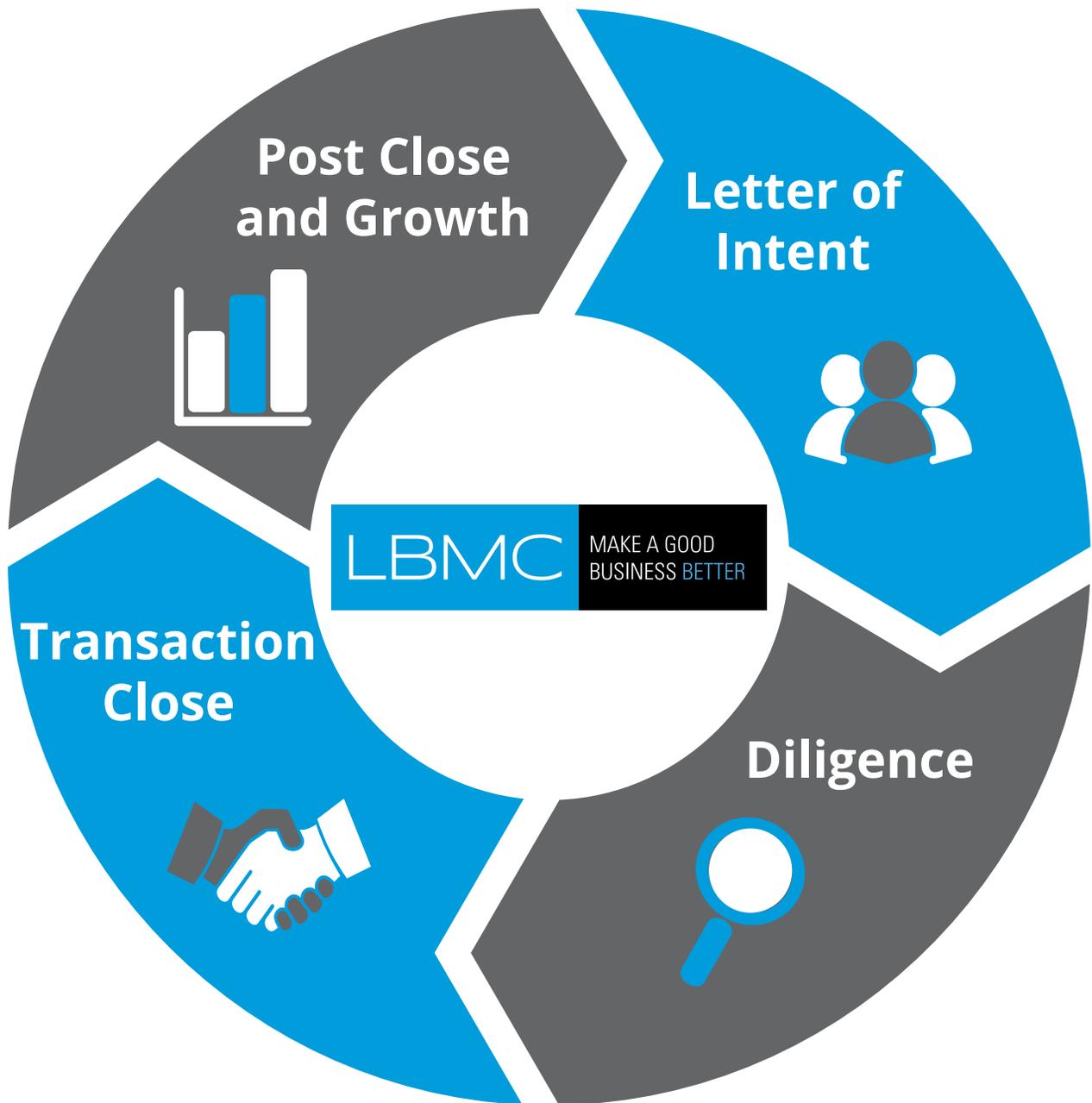
Conclusion

For a buyer, a thorough due diligence process that goes beyond financial diligence is essential for computing a proposed purchase price that makes sense and avoiding unpleasant surprises post-close.

For current owners, a thorough review prior to entering the M&A marketplace will require an investment, but the dividends can be enormous. With a clear understanding of the real value of their practice, owners can avoid disappointment based on unrealistic expectations, or worse, leaving money on the table.

For both parties, having complete information in hand will increase the likelihood of the deal actually closing and minimize the time, money, and emotional energy expended in the process. Using one professional services firm can streamline the transaction process from pre-Letter of Intent to transaction close, offering efficiencies for the buyer and seller with requests for documents and establishment of one data room. At LBMC, we use a dedicated, multi-disciplinary team approach to each transaction to ensure communication of significant factors along the transaction timeline. ♦

Transaction Cycle



Transaction Timeline





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Healthcare Valuation & Consulting Services

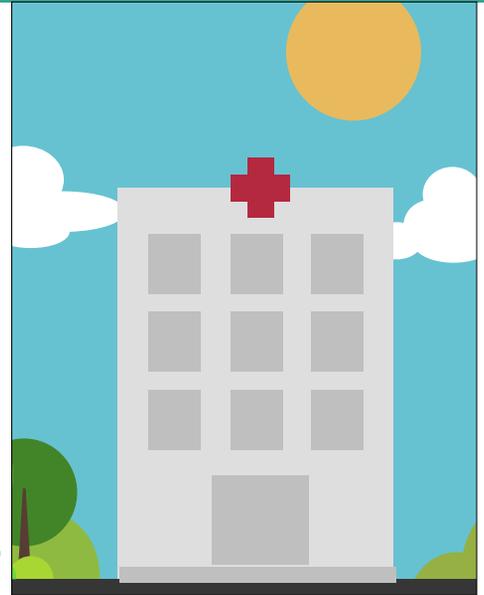
- Enterprise and equity valuations
- Fairness and solvency opinions
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- Personal property valuations
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Valuations & Fairness Opinions a Useful Tool in Distressed Hospital Transactions

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Health care reform dramatically changed the manner in which health systems deliver care to patients and are reimbursed for services. As hospital boards review their institution's competitive position in a post-health care reform world, particularly those overseeing community hospitals, many consider the option of selling to a strategic partner. Deciding to sell a community hospital will be the most scrutinized decision a board makes. Engaging a financial advisor to perform a valuation or fairness opinion will be a valuable exercise as the board evaluates various alternatives and defends its decision to hospital stakeholders and regulators.

Background

Impact of Health Care Reform on Hospitals

The passage of the Patient Protection and Affordable Care Act (ACA) in March 2010 meant significant change for hospitals. While the ACA provides patients with greater access to insurance, which can benefit hospitals through lower levels of uncompensated care, it also challenges these institutions to adapt to new payment models.

Traditionally, hospitals have been compensated on a fee-for-service basis which rewards the quantity of medical care and tests provided. The ACA introduced new payment models that focus on quality, such as the Hospital Value-Based Purchasing Program and the Hospital Readmissions Reduction Program. Under these new programs, hospitals are rewarded with increased reimbursement for achieving certain quality metrics and penalized with lower reimbursement for negative outcomes (e.g., excess patient readmissions). Funding for value-based purchasing is generated by withholding a percentage of Medicare payments.^{1,2}

Alternative payment models, such as Accountable Care Organizations (ACOs) and bundled payment arrangements, are another cornerstone of health reform. ACOs involve collaboration between hospitals and physicians to improve the quality of

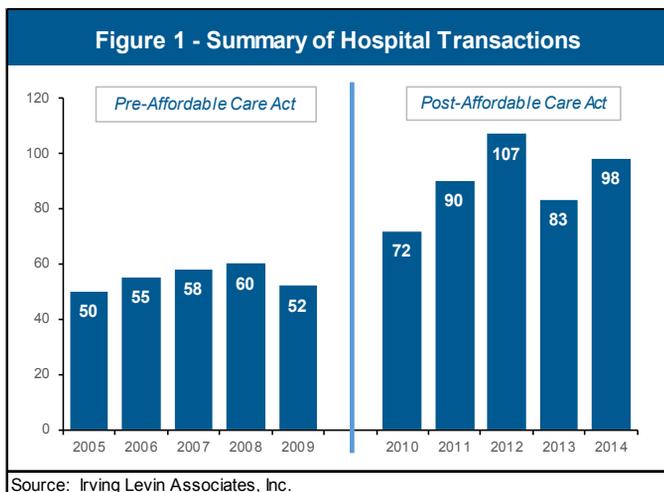
care for a population of patients while reducing costs. Participants in these alternative payment models can benefit financially by sharing in resulting savings. Thriving in an environment of value-based and alternative payment models requires hospitals to make significant investment in data analytics and technology, most prominently costly electronic health record (EHR) systems. Large health systems have the expertise and capital to make these investments, but community hospitals often lack these resources and may struggle to remain competitive.

Hospital M&A Activity

The challenges and costs of health care reform, coupled with maintaining aging facilities, declining reimbursement, rising wages, and the shift of care from an inpatient (hospital) setting to a lower cost outpatient setting can create financial distress for many community hospitals. As distressed hospitals face these headwinds, many determine that a sale to a larger health system is an attractive option.

As data from Irving Levin demonstrates (see Figure 1), hospital transactions have increased substantially since the ACA was passed into law. A sale to a larger health system or for-profit hospital operator can provide a range of benefits to a community hospital, including: access to capital markets to fund necessary investments in facilities and technology; greater negotiating power with payers and vendors; additional clinical expertise; and the resources to recruit new physicians to the community.

Hospitals play an important role in local economies and are often one of the largest employers in the communities they serve. The decision to sell a distressed community hospital can be a politically charged event that will be heavily scrutinized by stakeholders, the local business community, regulatory authorities, and creditors. There will be significant pressure on the board to defend its decision process and to "get it right." When a board begins contemplating a sale, it should retain experienced legal



counsel and an investment banker to assist it in evaluating strategic options. Separately engaging an independent financial advisor to perform a valuation of the hospital early in this process can be another valuable tool as the board explores its options.

Benefits of a Hospital Valuation

Duties of the Board

Nonprofit board members are fiduciaries of a hospital and are entrusted with the oversight of its charitable mission. Specific duties of the board include:

- » Duty of Care: Board members must be active in overseeing the hospital's affairs and be informed about decisions for which the board is responsible. Board members must question information that appears to be incomplete or lacking in validity.
- » Duty of Loyalty: Board members must put their duty to the hospital ahead of any personal interests.
- » Duty of Obedience: Board members have a duty to adhere to the hospital's charitable mission.³

State Attorney General Oversight

In most states, the state attorney general (AG) has the authority to review and approve transactions involving charitable assets. State AGs are becoming increasingly active in their reviews, particularly in hospital transactions involving a nonprofit seller and a for-profit buyer. State AGs and other regulators are primarily concerned that 1) the board performs its fiduciary duty in evaluating the transaction and any possible alternatives, and 2) the transaction is in the interest of the community. The preservation of the availability of health care services in the community and ensuring that the converting nonprofit receives at least Fair Market Value for its charitable assets are often focus areas of an AG review.⁴

Valuations performed for hospital boards contemplating strategic alternatives are often performed under a Fair Market Value standard. Fair Market Value is commonly defined as "the price at

which property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of the relevant facts."⁵ Fair Market Value is commonly described as representing an arm's-length price, negotiated without undue stress, and excluding consideration of any buyer-specific synergies.

Most board members lack experience with hospital transactions. Accordingly, it is common practice, and good business sense, for a board to engage a financial advisor to perform a valuation to better inform itself as it decides between strategic options, including the evaluation of potential purchase offers. Boards may also commission a fairness opinion to help it further evaluate a proposed transaction prior to a board vote. Valuations and fairness opinions help the hospital board demonstrate to the State AG that it has met its Duty of Care and received Fair Market Value for the sale of charitable assets.

Constructively Fraudulent Transfer Claims

In situations where the hospital may be insolvent at the time of sale, or may become insolvent as a result of the transaction, creditors may request that a trustee pursue claims that the transaction represented a constructively fraudulent transfer. Section 548(a)(1)(B) of the Bankruptcy Code, which deals with constructively fraudulent transfers, allows a trustee to void property transfers made by the debtor within two years of the filing if the debtor 1) "received less than reasonably equivalent value" in exchange for the transfer and 2) was insolvent on the date of transfer or became insolvent as a result of the transfer.⁶

In distressed hospital transactions, both the buyer and seller run the risk of having a transaction voided if a constructively fraudulent transfer claim is upheld. In many circumstances, a contemporaneously prepared Fair Market Value opinion can help the parties to the transaction demonstrate that the sales price represented adequate consideration at the time of the transaction, as well as assist in demonstrating that reasonably equivalent value was exchanged by the parties.

Hospital Valuations and Fairness Opinions

What is a Valuation?

A valuation is an independent and unbiased opinion of an asset's value presented either as a point estimate or a range. Hospital valuations should consider the three principle approaches to valuation: 1) the Income Approach, 2) the Market Approach, and 3) the Asset Approach. Determining the valuation approach or combination of approaches most appropriate for a hospital is largely dependent on the facts and circumstances, but such determination generally hinges on a hospital's ability to generate positive future cash flows from operations. The Income and Market Approaches are commonly used to value hospitals expected to continue as cash-flow producing going-concerns. When hospitals are expecting to sustain losses or when the application of the Income or Market Approach results in a value below the value of a hospital's net assets, the Asset Approach may be most appropriate.

Figure 2 - Publicly-Traded Hospitals and Health Systems Multiples

As of December 31, 2015		
Company Name	Ticker	EV / Revenue Multiple
1 Community Health Systems, Inc.	CYH	1.05x
2 HCA Holdings, Inc.	HCA	1.49x
3 LifePoint Health, Inc.	LPNT	1.02x
4 Tenet Healthcare Corp.	THC	1.06x
5 Universal Health Services Inc.	UHS	1.73x
6 Average		1.27x
7 Median		1.06x

Source: S&P Capital IQ, Inc.
EV = Enterprise Value

Income Approach

The Income Approach is based on the financial theory that a hospital’s value is equal to the present value of its anticipated future earnings. There are two common forms of the Income Approach: 1) single-period capitalization and 2) multiple period discounting. The Discounted Cash Flow Method (DCF), a multiple period discounting model, is commonly used in hospital valuations because it provides the flexibility to explicitly incorporate expected changes in financial performance.

To perform a DCF analysis, a financial advisor will work with hospital executives to independently develop a multi-year cash flow projection that reflects changes in reimbursement, patient volumes, expense ratios, as well as necessary capital investments and changes in working capital. The financial advisor will develop a risk-adjusted rate of return to calculate the present value of the projected cash flows. The board should review management’s forecast to ensure that it reflects the best available information at the time and the financial results can reasonably be attained. A valuation based on “hockey stick” projections is diminished in its usefulness as a tool to evaluate proposed transactions.

Market Approach

The Market Approach involves researching stock sales of publicly-traded hospitals (Guideline Public Company Method) or hospital acquisitions (Merger & Acquisition Method) and using this transaction data to calculate valuation multiples. Data on sales of shares of publicly-traded hospitals and hospital acquisitions is available from various published sources. Figure 2 presents revenue valuation multiples derived from trades of stock of five publicly-traded acute care hospitals.

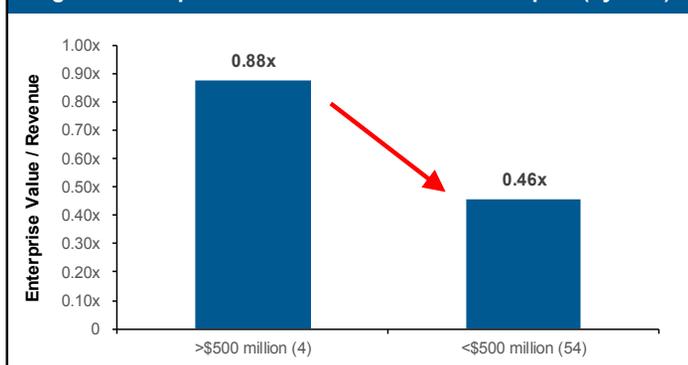
Many incorrectly believe that a hospital’s value can be determined by blindly applying an average market multiple. Without further analysis, this simplistic approach will likely result in a distorted estimate of value. The publicly-traded hospitals identified in Figure 2 operate dozens to hundreds of hospitals in different regions and markets, can access capital markets to fund growth, and have the economies of scale to produce strong profit margins. Investors are typically willing to pay a premium for these advantages.

Figures 3 and 4 present revenue multiples for hospitals acquired between 2012 and 2014 segmented by size and earnings before interest, taxes, depreciation and amortization (EBITDA) margin. As this chart demonstrates, all else being equal, investors will typically pay higher multiples for larger, well-diversified hospitals than for smaller community hospitals. Similarly, investors will pay a higher revenue multiple for hospitals with greater profit margins. An experienced financial advisor will analyze the risk and growth profile of the hospital relative to the market comparables and adjust the valuation multiple that is being applied as appropriate.

Asset Approach

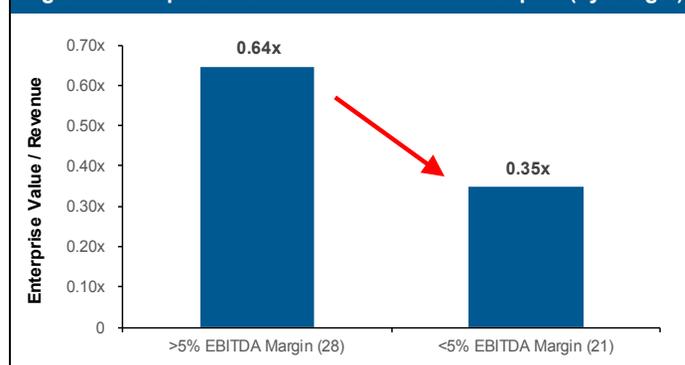
For severely distressed hospitals, the Income and Market Approaches can result in a valuation below the net value of the hospital’s tangible and working capital assets. In these circumstances, the value of the hospital is equal to the Fair Market Value of its component assets, net of the value of its liabilities. When the Asset Approach is applied, tangible asset appraisers

Figure 3 - Hospital Transactions: Revenue Multiples (by Size)



Source: S&P Capital IQ, Inc. and Irving Levin Associates, Inc.
For illustrative purposes only. Includes transactions between 2012 and 2014 segmented by size based on dollars of revenue. The number in parentheses represents the number of transactions included in that metric.

Figure 4 - Hospital Transactions: Revenue Multiples (by Margin)



Source: S&P Capital IQ, Inc. and Irving Levin Associates, Inc.
For illustrative purposes only. Includes transactions between 2012 and 2014 segmented by EBITDA margin. The number in parentheses represents the number of transactions included in that metric.

may be retained as real estate and medical equipment are typically the hospital's most significant assets.

Reconciliation of Valuation Approaches

One or a combination of the three valuation approaches may be applied in a hospital valuation. When multiple methods are applied, the financial advisor will assess the relative strengths and weaknesses of each approach and conclude on a point estimate of value or a range.

What is a Fairness Opinion?

A fairness opinion is an opinion that the consideration received in a transaction is fair, from a financial point of view. Fairness opinions incorporate a valuation analysis and the presentation of a range of reasonable values, but also include an analysis of the consideration to be received in a particular transaction. For a transaction to be financially fair, the consideration does not have to represent the highest or best possible price, only a fair price that falls within the presented range of values. Importantly, fairness opinions do not opine on the non-financial benefits of proceeding with the proposed transaction; the process leading to the transaction; the proposed transaction relative to any alternative transactions; legal or regulatory considerations; or the underlying business rationale for the transaction. Nor do they provide a recommendation as to how the board should vote on the transaction. Only the financial aspects of a transaction are contemplated in a fairness opinion.

Summary

A Fair Market Value opinion can be a critical exercise prior to the board initiating a sales process or during its evaluation of offers from potential acquirers. Because a fairness opinion involves the review of a specific transaction, these analyses are usually limited to situations in which the board has narrowed a sales

process to a primary buyer. Whether the board determines that it wants to commission a valuation, fairness opinion, or both, it is crucial that the financial advisor hired is independent with regards to the transaction. While it is common for the board's investment banker to provide a fairness opinion on a deal they helped negotiate, their independence may come into question if they earn a success fee upon closing. Hiring an independent financial advisor in addition to an investment banker may provide an extra level of transparency and protection.

Conclusion

The pressures of health care reform are expected to continue to encourage consolidation among community hospitals for the foreseeable future. The decision to sell a hospital will be one that is controversial and heavily scrutinized by regulators and stakeholders. Along with hiring an experienced health care deal attorney and investment banker, engaging a financial advisor to perform an independent valuation or fairness opinion will aid the board in defending its decision and demonstrate that it has met its fiduciary duties. ♦

Endnotes

- 1 CMS Fact Sheets, Hospital Value-Based Purchasing Program. Baltimore: 2013, Web. Mar. 2013.
- 2 CMS, Readmissions Reduction Program. Baltimore: 2016, Web. 15 Jan. 2016, 26 Jan. 2016.
- 3 Davidson, Paul S. and Rica Murdock, Tara. "Legal Duties and Avoiding Liability: A Nonprofit Board Member Primer." *Trustee Magazine* 10 Jun. 2013. Web. 30 Jan. 2016.
- 4 Zall, Richard J. and Kinsella, Brian J. "Going Private: Navigating State Review of Nonprofit Hospital Conversions." *AHLA Connections* Aug. 2013.
- 5 Revenue Ruling 59-60, 1959-1 C.B. 237; Treasury Regs. §20.2031-1(b) and §25.2512-1.
- 6 11 U.S.C. § 548(a)(1)(B)

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Acknowledging the Possible: When Affiliations Go Bad

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In the airline industry, safety gains have reduced the rate of crashes such that the number of fatal crashes annually has fallen even as air traffic has grown. This success has not, however, been repeated in the world of hospital mergers. For example:

- » Approximately half of the parties involved in a hospital merger—namely, those on the “sell” side—are inexperienced in such transactions due to lack of prior merger experience.
- » Hospitals may lack the tools they need to effectively handle a merger transaction. In some states, current consolidation deters or precludes the most experienced “buy” side entities from pursuing affiliates for strategic and/or anti-trust reasons.
- » The current regulatory, compliance, and operating environment for hospital mergers is becoming increasingly complex and risky for merger participants.

Reducing the Risks of a Merger Misadventure

It is vital to ensure that the hospital and its partner share a compelling and enduring strategic rationale for the merger. A decision to affiliate should only be made after careful evaluation of alternative strategic options and a Board’s consensus selection of a preferred affiliation partner, structure, and proposal as the best vehicle for achieving the organization’s strategic objectives.

At the outset of exploring strategic options, it is essential to understand that there are no risk-free strategic options for hospitals. Continued independence will subject the organization to ongoing “execution risk” that is likely to grow more acute given payment reductions, the growing prevalence of high deductible health plans, increasing consumerism, value-based purchasing, and the challenges of population health-based payment forced by the industry. The decision to affiliate is often driven by a desire to reduce stand-alone execution risk. However, affiliating introduces “partner risk,” which can be mitigated at the outset by:

- » Selecting a strategically aligned partner via a competitive process (in most instances);
- » Designing a structure customized to the organization’s strategic objectives; and
- » Negotiating contractually enforceable terms.

Once you have selected your preferred partner, defined the affiliation structure, and negotiated key terms and contractual commitments, it is critical to ensure that the merged entity has effective leadership that inspires buy-in and trust. Rigorous and effective post-affiliation execution should include:

- » Focusing on early wins to avoid a zero-sum merger where any party’s benefit is balanced exactly by the losses of the other party.
- » Tracking key performance indicators to create or strengthen a culture of accountability.
- » Ensuring that stakeholders receive thoughtful and proactive communication early and often.
- » Proactively studying the cultures of the organizations to identify and address areas that will require particular care and nurturing to avoid dysfunction.

The Consequences of a Bad Marriage

Deciding to walk away before an affiliation is finalized is not a worst case outcome. In fact, a far worse scenario would be to enter into an affiliation that does not create compelling strategic alignment or durably address organizational needs and constraints. It is important to avoid wishful thinking about the risks of a stand-alone strategy or the cost savings of a merger. Because most

mergers fail to generate the cost savings envisioned, the parties should identify other compelling rationales for the affiliation.

The costs and disruption from consummating an ill-conceived merger can be devastating to an organization’s finances, reputation, and strategic position. The organization’s standing with physicians and future potential partners may be harmed. A leader of an academic medical center that exited a failed merger once commented on the magnitude of the costs by rhetorically asking, “Have you ever seen a divorce that was cheaper than the wedding?”

Case Studies: Divorces Done Cheap and Not So Cheap

Regional Medical Center. RMC is a high-performing regional referral center that joined a five-hospital system centered in a mid-size MSA approximately 60 minutes away. Through the affiliation, RMC sought to realize procurement efficiencies; reduce cost of capital via the system-obligated group; provide opportunities for staff education and sharing of best practices; and improve provider recruitment. After five years, the system was requiring RMC to more tightly integrate and surrender key reserve powers held by the RMC Board due to enactment of the Sarbanes-Oxley reforms. RMC staff realized that best practices within the system often originated from RMC. Increasingly, RMC staff was asked to share their successes with other system affiliates, which, while flattering, raised the question of the value the system provided for RMC. RMC had significant debt capacity and a strong stand-alone credit profile. After five years in the system, RMC exercised its (unique) unilateral option to exit the system and refinanced its debt outside of the system-obligated group. Today, RMC remains a high performing, independent organization, while still participating in many system initiatives as an independent affiliate.

Key Factors: Stroudwater advised on RMC’s affiliation and dis-affiliation. RMC was a strong, high performing organization for which the five-hospital system failed to provide the sought-after benefits. RMC also had a unilateral, no-cause exit option that was exercised when the rules of engagement with the system were going to change. Most systems will not grant such an unlimited exit provision to an affiliate, preferring to limit the exit option in duration and for specified, limited causes.

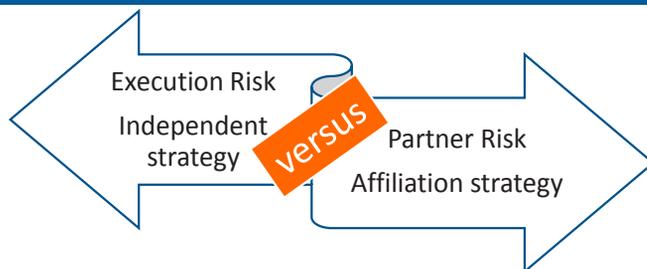
Jones Health System. JHS was formed via the creation of a Joint Operating Agreement (JOA) between two proximate community hospitals, Memorial Hospital (MH) and Green Hospital (GH). A large non-profit health system was retained to manage the new health system. As both members had weak balance sheets and anemic cash flows, JHS was undercapitalized from inception. Leadership from MH was elevated to lead JHS. When early wins at both MH and GH proved elusive because of difficult market conditions and the recession, relations between the two members deteriorated. If MH received a significant investment, for example, key stakeholders at GH believed those resources were diverted from their facility. JHS leadership focused on building MH into its own referral hub, but GH physicians saw their true referral partner as the tertiary hub 60 minutes away. The end-of-year true-up required by the JOA compelled the member that experienced less loss to ship funds to the member that lost more as a “due to” on their balance sheet going forward. That arrangement proved toxic to Board functioning, and the two camps dug in.

Key Factors: JHS retained Stroudwater to define a path forward for JHS and its members. Given the distrust engendered and JHS’s weak financial condition, it became clear that JHS was unworkable without an affiliate. Dissolving the JOA and allowing MH and GH to go their separate ways was also unworkable, as the costs of dissolving JHS, the weakened financial state of MH

Weighing Execution Risk & Partner Risk



What is the best strategy to achieve our client’s mission and vision?



How do you minimize “partner risk”?

- Design a well-structured affiliation process with clear objectives
- Require local input or local membership on governing board
- Involve key stakeholders from the beginning and emphasize communication
- Codify partner commitments in an enforceable contract
- **Make potential partners earn the right to be your partner**

and GH, market conditions, and the need to recreate system infrastructure independently at both MH and GH would sink both members. A new partner was needed to recapitalize MH and GH, separately or together. After conducting an affiliation process that required the blessing of JHS, MH, GH, and the non-profit manager, JHS was dissolved; MH and GH affiliated, separately, with a new partner. The instability of JOAs, the limitations of management arrangements for undercapitalized hospitals, and the need for early wins and leadership that earns buy-in and trust are key takeaways from the JHS saga.

Smith Medical Center. SMC is a community hospital located in a college town approximately 75 minutes from its academic referral partner. Approximately 15 years earlier, SMC folded its entire medical staff into a multi-specialty group (MSG) owned by its academic referral partner and formed a joint operating agreement (JOA) with the MSG. The JOA called for SMC and MSG to (i) eliminate duplicate service offerings for efficiency gains, (ii) collaborate on care coordination to achieve quality and cost objectives, and (iii) share in the revenue and costs of providing these services locally. For 10 years, the JOA worked well, sustaining a stable, high quality medical community with the annual operating performance of SMC and MSG tracking parallel to allow for a non-controversial end-of-year financial true-up as spelled out in the JOA. However, approximately five years ago, changes in reimbursement and utilization trends began to adversely impact SMC. The state passed a hospital tax to help fund its Medicaid program, further eroding SMC's financial performance. After being downgraded several times, SMC and the academic referral parent of MSG replaced the JOA and made the academic referral partner the sole member of SMC.

Key Factors: Stroudwater advised SMC on its strategic options when it was searching for an alternative to replace the JOA. The end-of-year true-up and workings of a JOA made it unstable and vulnerable to changes in the relative performance of its members. Ultimately, SMC found a more durable and sustainable affiliation structure with its academic referral partner but without the benefit of comparing multiple options side-by-side and introducing competition into the selection of a permanent partner. While the JOA was selected initially because it fostered collaboration without much loss of control at SMC, turning over the entire medical staff to another entity ensured de facto loss of control. The termination provisions of the JOA also effectively precluded SMC's ability to compare alternative partnering options.

What Risks Are Different for Mergers in 2016 and Beyond?

A significant risk factor for hospitals contemplating an affiliation in 2016 and beyond is the growing likelihood of an eventual change of control at the partner level. Mergers between multi-billion-dollar non-profit and for-profit systems indicate that greater scale does not protect against a downstream change of control. Affiliation terms should be negotiated with this probability in mind.

The durability and sustainability of any partner's strategic vision are likely to face significant stress as a result of forces

that are roiling the industry and most markets. The impact of mergers on health care costs continues to receive scrutiny by regulators. In addition, anti-trust matters have become a larger factor in more contemplated mergers.

Hospitals vetting merger partners should continue to closely examine strategic alignment, cultural fit, and how the proposed merger addresses organizational needs and constraints around access to capital, scale, and access to expertise and management systems. In addition to those areas of investigation, it is vital to vet how well potential partners demonstrate value through quality and efficiency. Does the partner have a track record of exporting higher value performance to affiliates? It is also critical to engage partners around how they attribute value within global budgeting and/or risk sharing arrangements. Is value attribution well-defined and transparent? How does the partner attribute covered lives within the system? Will the affiliate's investment in an aligned primary care base be treated as a revenue center or a cost center by the affiliate? And does the affiliate have the expertise, systems and resources, and demonstrated value proposition to succeed in a full population health payment environment?

Preparing for the Worst

When developing the architecture of a merger through the final negotiations of the definitive agreements, it is essential to include provisions that will provide a road map and define how key issues will be handled. There is no way to envision all eventualities, but some of the most important topics for consideration include:

- » Exit Provisions: Unilateral, duration, and for what cause(s).
- » True-up at Termination: Provisions for accounting for cash flow losses, investments (net of depreciation), assumption of debt and operating cash generated locally, and any break-up fees.
- » Timing: Notice of termination should ensure the affiliate has adequate time to transition and retains access to critical resources/services at fair cost for a reasonable period of time.
- » Delegation of Authority: Once notice of termination is provided, affiliate assumes operational authority to implement operational improvements.
- » Access To and Use of Consultants: Once notice of termination is provided, affiliate retains access and use of all consultant studies procured during affiliation.
- » Replacement Partner Selection: Once notice of termination is received, decision rights regarding finding a replacement partner in advance of termination date are held solely by affiliate.

There are no risk-free options, and a failed affiliation post-consummation is a messy and costly affair. Regardless of your chosen path, the case studies and findings presented in this article can help to prevent worst-case scenarios, keeping your hospital on the safest possible "flight path" toward achieving your strategic objectives. ♦

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