Presentation Topics

- Healthcare Merger and Acquisition Overview
- Due Diligence Phase
- Pre-Acquisition Planning Phase
- Post-Acquisition Integration Phase
- The Consequences

CHS to sell off home health, hospice division for $128 million

WellCare to acquire Care1st Health Plan Arizona in $157 million deal

Kindred sells off 12 hospitals

Ardent Health and LHP Hospital Group to merge

UMass Memorial Health to merge Clinton, HealthAlliance hospitals

RCCH HealthCare acquires Ascension hospitals in Washington State, Ohio

Quest Diagnostics Completes Acquisition of Solstas Lab Partners

Palmetto Health purchases Sumter-based Tuomey Healthcare System

Community Health Systems sells off 4 rural hospitals to Curae Health

Pfizer buys cancer drugmaker

CRH Healthcare buys Patient's First urgent care network

Duke LifePoint takes over two North Carolina hospitals from Tenet

Barnabas Health, Robert Wood Johnson Health system complete merger

EmblemHealth, Northwell form agreement for shared-risk

RegionalCare Hospital Partners and Capella Healthcare to merge

Arizona's Gilbert Hospital, Florence Hospital at Anthem merge

CHS subsidiary acquires majority stake in Indiana University Health La Porte, Knox hospitals

LifePoint Health completes Providence Hospitals takeover

Jefferson continues merger blitz, will partner with Kennedy Health in NJ

Peconic Bay Medical Center joins newly rebranded Northwell Health System

Jefferson, Aria Health make spring merger plans official

Shire, Baxalta to merge in $32 billion big-pharma deal

LifePoint buys struggling St. Francis Hospital in Georgia

Kindred acquires in-home healthcare operations from Arkansas Health Department for $39 million

St. Joseph Health, Santa Rosa Memorial Hospital, UCSF Benioff Children's Hospitals partner to expand pediatric services

TeamHealth acquires Tri-City Emergency Medical Group operations

Kindred Healthcare, Select Medical Holdings complete swap of long-term acute care hospitals

Wellcare Health Plans acquires Advicare's Medicaid business

Aetna, Texas Health Resources establish a jointly owned health plan

AmSurg buys Jandee Anesthesiology Partners

Memorial Hermann to purchase Memorial Hermann Northeast Hospital

Northwell Health, Davita join forces

Post Acute Medical nabs HealthSouth Rehabilitation Hospital

Behavioral health orgs Centerstone, Seven Counties to forge $310 million affiliation

Ventas sells 36 skilled nursing facilities to Kindred for $700 million

HCA will sell its Oklahoma hospitals for $750 million

HCA to take over 14 urgent care centers in Las Vegas

Walgreens will buy Rite Aid in a deal worth $17.2 billion

Tenet forms JV with Baptist Health System in Alabama, merges 5 hospitals

Baptist Health South Florida, Bethesda to merge after 24-month transition

Northside Hospital, Gwinnett Medical Center to merge in Georgia

Tennova Healthcare adds 4 hospitals in Tennessee

True Health Diagnostics buys Health Diagnostics Laboratory for $37.1 million

Capella Healthcare sold for $900 million

Ascension to buy 4 central Tennessee hospitals

Cardinal Health wraps major drug group buy

NYU Langone grabs Long Island's Huntington Medical Group

Cabell Huntington Hospital to acquire St. Mary's in West Virginia

Providence Health and St. Joseph Health merge

Family Care Partners acquire Wagener Medical Center as part of further expansion efforts

CHS acquires Physicians' Specialty Hospital in Arkansas

NYU Langone grabs Long Island's Huntington Medical Group

CVS buys Target's pharmacy biz

HealthSouth buys Reliant

Acadia Healthcare will buy Highland

Rite Aid, Walgreens to sell 865 stores to Fred's Pharmacy

Tenet wraps up sale of Atlanta-area WellStar hospitals

Larkin Community Hospital acquired Hollywood Pavilion Hospital and Hollywood Hills Nursing Home for $24.6 million

HealthSouth buys Reliant

Prime donates Glendora Community Hospital to nonprofit Prime Foundation

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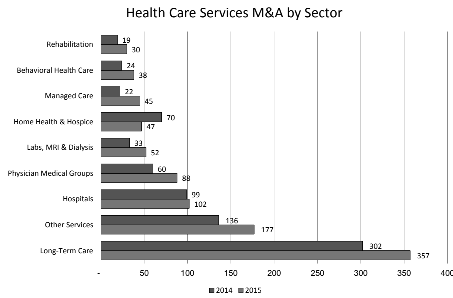
Current Market Dynamics



Source: The Health Care Acquisition Report, Twenty-Second Edition, 2016 by Irving Levin Associates, Inc.

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Common Healthcare Transaction Structures

- Asset Acquisition – only assume agreed assets and liabilities
- Stock Acquisition
- Merger
- Member Substitution

Transaction Risks

The main risks are:

1. Acquiring a company that is tainted by corruption, and therefore assuming criminal and civil liability;
2. Paying too much for the acquired company or business, to the extent that part of the revenue and/or profit is based on corrupt behavior, and is therefore not sustainable; and
3. Risk to reputation of the buyer. In addition, there is the risk associated with the drain on management of resolving any issue along these lines that does show up. It can be expensive, time consuming, and distracting.

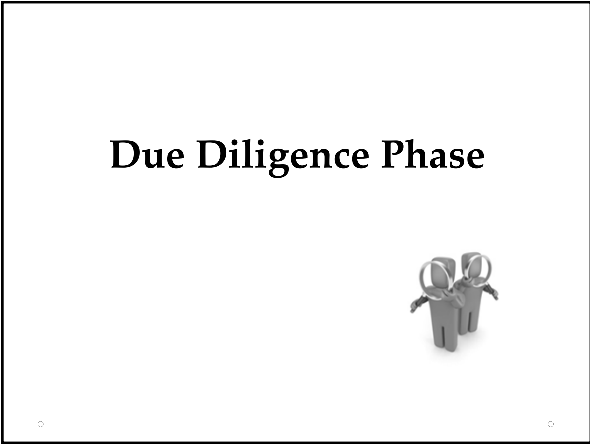
Different Perspectives

Attorneys and Valuation professionals look at what's there.

Compliance looks at what should be there (unanticipated regulatory liabilities).

The Goal of due diligence for an *acquisition* team is to be fully advised of all the legal (and compliance) risks of the *target*. This is rarely possible.

Additional protection in the form of *warranties*: can cover the compliance program and areas of regulatory risk specific to the target.



What is Due Diligence?

The purpose of due diligence:

- Assess the risks
- Adjust the value and terms of the agreement
- Decide how much to hold in reserve
- Amount of Due Diligence depends on the size of the acquired company and the risk

Due Diligence Considerations - Legal

- The Legal Perspective
  - Contracts
  - Evaluating relationships with "health care professions" – processes involving focused arrangements
  - Labor issues - HR/Employee matters including benefits, contractors
  - Any allegations of violation of law and the resolution
  - Ongoing litigation
  - Government investigations
  - Liens on assets
  - Conditions of assets
  - Licensure and certification
  - Representations and warrantees
  - Indemnification

Due Diligence Considerations - Valuation

- The Valuation Perspective
  - Structure of the Transaction (asset vs. equity, what is included?)
  - Historical and ongoing risks
  - Historical and forecasted financial statements (income statements, balance sheets, etc.)
  - Tax returns and other IRS documents
  - Payor mix data
  - Assets
  - Indebtedness
  - Regulatory issues, refunds, etc.
  - Volume/production reports
  - Referral sources
  - Current and go-forward agreements
  - Potential problem areas such as goodwill, non-competes and other intangibles

Fair Market Value Standard(s) of Value

Fair Market Value — Tax Purposes, Seller Advisory, Management Decision-Making

- *"…the price at which the property would change hands between a willing seller and a willing buyer neither being under any compulsion to buy or to sell and both having reasonable knowledge of relevant facts."* Revenue Ruling 59-60

Fair Market Value — Regulatory Stark and Anti-Kickback Statute Requirements

- "means *the value in arm's-length transactions, consistent with the general market value. General market value 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 party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement* ***who are not otherwise in a position to generate business for the other party*** *on the date of acquisition of the asset or at the time of the service agreement."* § 411.351 42 CFR

Fair Value — Financial Reporting

- *"Price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date."* ASC 820 (fka SFAS 157)

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Fair Market Value - Business Analysis

ATTRIBUTE	RELEVANT COMPONENTS
Reimbursement	(A) Reimbursement Status, (B) Fee for service vs. Capitation or Other Bundled Payment, (C) Payor Mix, (D) Governmental Reimbursement and (E) Other Reimbursement
Volume	(A) Specialty, (B) Competition, (C) Capacity of Facility and Equipment and (D) Status of Physicians
Expenses	(A) Physician Compensation, (B) Other outsourced agreements and (C) Fixed/Variable
Risk	(A) Coding, (B) Relationships with Physicians, (C) Diversification, (D) Existence of non-competes and (E) Competition
Other	Working Capital and Capital Expenditures

Due Diligence Considerations - Compliance

- The Compliance Perspective
  - Document review of Policy and Procedure differences to determine integration changes
  - Billing Reviews
  - Training documentation
  - Review Coding, denials, audits, payor mix
  - Relationships with health care professionals (*focused arrangements* – those in position to influence the volume and/or value of business for the target
- Assessing the Target's Compliance Program

Focus of Compliance Due Diligence

Regardless of the deal structure, "compliance" review needs to focus on:

- Identification of the underlying risks inherent in the type of business conducted by the target
- Review and assessment of the effectiveness of the target's compliance program as a tool to prevent and detect misconduct in those risk areas.

Regulatory due diligence more complicated in health care

Hui Chen's Four "Factors"

DOJ Criminal Division Compliance Counsel and Fraud Section Chief recommends review of the following when assessing the effectiveness of a compliance program:

1. Does the compliance program demonstrate thoughtful design?
2. How operational is the program (not a paper program)?
3. How well do stakeholders communicate with each other?
4. How well is the program resourced?

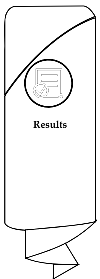
https://www.youtube.com/watch?v=pRTGZmmbc5o&feature=youtu.be

(November 13, 2015, NYU School of Law)

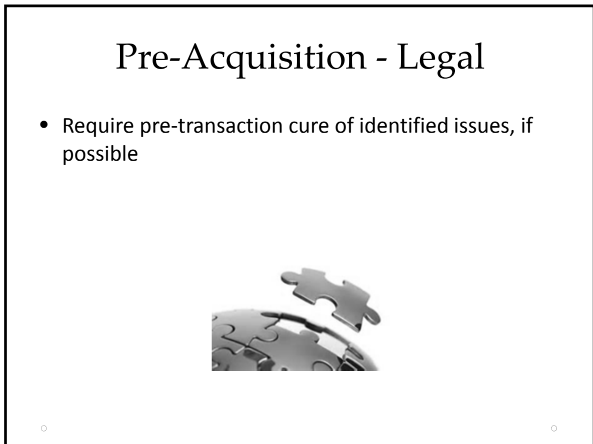
Steps to Assess the Compliance Program

- Review the oversight and operational structure of the compliance program
- Review the actual operation of the compliance program
- Review the periodic evaluation of the compliance program's effectiveness

Summary of (effectiveness) results



- Striving to fulfill its mission of detecting, deterring, and preventing instances of fraud, waste, and abuse, the [Company Name] Compliance Department, the Executive Compliance Committee and the Board of Directors , continues to evaluate and improve the performance of its Compliance Program.
- **[Reviewer] concluded that [Company]'s Compliance Program would likely be determined "effective," if reviewed by [the DOJ or other governmental agencies].**
- The program would likely qualify as a mitigating factor, reducing culpability in the sanction or penalty phase of a government action associated with an area in which the Compliance Program is demonstratively providing coverage/oversight.



Pre-Acquisition – Valuation

- Review go-forward compensation and any other services agreements (i.e. management agreements), if applicable. Make any necessary changes to valuation analysis.
- Final review of agreements
- Evaluate commercial reasonableness
- Finalize valuation

Commercial Reasonableness

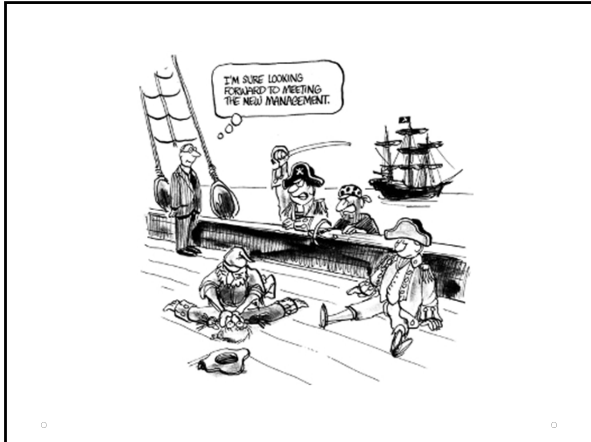
- Evaluation of Commercial Reasonableness
  - In 1998, the Center for Medicare Services ("CMS"), in its Stark proposed rule, clarified "commercially reasonable" to mean that an arrangement appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals."[3] In the preamble to the Stark Phase II interim final rule, CMS further stated that "an arrangement will be considered 'commercially reasonable' in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential designated health services ("DHS") referrals."[4]
  - In determining whether a financial transaction is commercially reasonable, it is important to understand whether the relationship will allow the organization to accomplish its strategic operational, and/or financial objectives. Whereas a fair market value analysis may focus on the compensation components of the transaction, a commercial reasonableness analysis must be larger in scope, to include the overall terms and circumstances of the arrangement. When determining commercial reasonableness, one should ask whether the overall deal makes sense to the purchaser of services (in the absence of referrals) and whether there is a legitimate business propose for the arrangement.

[3] 63 Fed. Reg. (Jan. 9, 1998), p. 1700.
[4] 69 Fed. Reg. (Mar. 26, 2004), p. 16093.

Pre-Acquisition - Compliance

- Map out who will lead process changes and train project managers on what is needed
- Develop tools to map processes against regulations, policies, procedures.
- Rank risks into high, med, low
- Determine resources needed to drive integration

Post-Acquisition Integration Phase



Post-Acquisition - Legal

- Successor liability – liability for obligations not specifically assumed
- Contractual
- Medicare
- Common Law
- Statutory
- Stock transactions – liability for obligations intended to be excluded

Successor Liability

Medicare Standards and Certifications

§ 489.18 Change of ownership or leasing: Effect on provider agreement.

(a) What constitutes change of ownership -

(1) Partnership. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law, constitutes change of ownership.

(2) Unincorporated sole proprietorship. Transfer of title and property to another party constitutes change of ownership.

(3) Corporation. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(4) Leasing. The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

(b) Notice to CMS. A provider who is contemplating or negotiating a change of ownership must notify CMS.

(c) Assignment of agreement. When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

Successor Liability

Change of ownership (“**CHOW**”) - CHOWs "are officially defined and governed by 42 C.F.R. § 489.18 and State Operations Manual (Pub. 100- 07), Chapter 3, §§ 3210-3210.5.C. The Regional Office generally makes the final determination as to whether a CHOW has in fact occurred." Medicare Program Integrity Manual (Pub. 100- 08), Chapter 15, § 15.7.7.1, (Rev. 423, Issued: 6-01-12, Effective: 07-02-12, Implementation: 07-02-12).

For program participants that have Health Benefit Agreements or Provider Agreements with the Medicare program (hospital, SNF, HHA, hospice, CORF, OTPT/SP providers and CMHC), a CHOW is important because it must be determined who the responsible party is under the agreement.

CMS has similar concerns with respect to participating suppliers that have category-specific agreements with the Secretary (RHC, ASC, and FQHCs) or that must file cost reports (e.g., ESRD facilities).

For other supplier types (i.e., supplier types without agreements or cost report requirements (e.g., PXR)), the CHOW process is generally to ensure compliance with the statutory requirement for ownership disclosure and to ensure that the program has current, accurate records regarding such participants.

Successor Liability

CHOW and 42 CFR 18(d)

(d) Conditions that apply to assigned agreements. An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Compliance with applicable health and safety standards.

(3) Compliance with the ownership and financial interest disclosure requirements of part 420, subpart C, of this chapter.

(4) Compliance with civil rights requirements set forth in 45 CFR parts 80, 84, and 90..

Successor Liability

What does that mean?

Medicare sanctions and penalties are assigned to the new owner unless the following applies:

- The new owner is not responsible for money owed to the Federal Government due to a determination that the previous owner is personally guilty of fraud as long as the purchase is incorporated as a new and separate corporation.

Relying on Representations and Warrantees

Regardless of deal structure, the basic transaction documents typically contain representations and warranties of the buyer and the seller to one another, which set forth the basic assurances of a party that certain facts are true and may be relied upon when entering into the transaction.

Seller representations and warranties will usually address the following substantive areas:

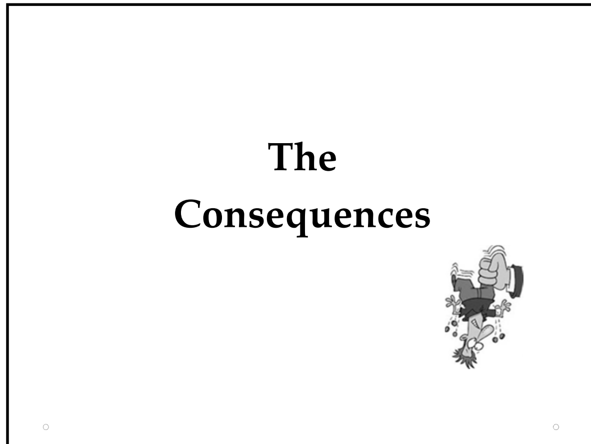
- Due organization of the seller and its legal authority to consummate the transaction
- Compliance with laws and permits
- Good and marketable title to the seller's assets, free and clear of liens
- Any required third-party consents to consummate the transaction
- The physical condition of the fixed assets and the overall adequacy of the assets to run the business
- The liabilities of the seller
- Accounts receiv1able, inventory, and other current assets
- The accuracy of the seller's financial statements and its financial condition
- Tax, intellectual property, environmental, ERISA, and employment matters
- Litigation matters
- Material contracts
- Real property matters
- Broker's fees

Post-Acquisition - Valuation

- Conduct purchase price allocation, if requested
- Periodic review of service agreements

Post-Acquisition - Compliance

- Set up weekly calls with each department or functional group
- Look for best practices between the organizations
- Use tools to track discussions on process changes
- Expect a loss of expertise and history
- Look at manual and automated processes
- Document discussions, corrective actions needed, barriers and timelines
- Determine risks/exposure, overpayments
- Standardize policies, procedures, training through integration
- Standardize disciplinary actions and other processes that involve other functional departments
- Develop an ongoing audit work plan that looks at focus arrangements and coding/billing



The Consequences

qui tam Court Case: US vs. Bradford Regional Medical Center and V&S, LLC

Background
- Lease Agreement between Hospital and Physician-owned LLC.
- Valuation of Lease Payment included Non-compete
- Other cross-payment arrangements (Billing, etc.)

Issues
- Original Appraiser not involved in case
- Appraisal was not deemed credible by the court
- Court determined the Non-compete value included referrals and therefore was a Stark violation
- Lack of adherence to the agreement
- Lengthy negotiations and changing deal structure

On November 2010, Bradford was ordered to pay $2.75 million plus $600,00 in relator attorney fees to settle claims it violated the Stark Law.

qui tam Court Case: US vs. Tuomey

Background
- Exclusive, 10 yr. term w/ a 3-year non-compete
- Base Salary + Productivity Bonus + Incentive Bonus based upon qualitative factors + other payments
- Total comp exceeded collections
- Full-time benefits for part-time services

Issues
- Opinion Shopping
- Blind reliance on valuation opinion
- Submitted a total of 21,730 tainted Medicare claims

On October 3, 2013 , Tuomey was ordered to pay $237 million in fines for violations of the False Claims Act. On October 16, 2015, the Department of Justice announced a settlement in the amount of $72.4 million.

qui tam Court Case: Barbetta vs. DaVita

Background

- Sales of shares of existing dialysis centers below FMV
- Purchases of physician-owned dialysis centers above FMV
- De novo joint ventures that made little to no economic sense apart from the purchase of the physician's patient referrals

Issues

- Manipulation of financial models by analysts that were provided to outside appraisers
- Only obtained valuations when purchasing 100 percent of a partner's interest in a jointly-owned center
- Requirement of medical director agreements with non-compete provisions to secure referrals
- Suppression of valuation not supporting deal price

On October 22,2014, the Department of Justice announced a settlement in the amount of $350 million to resolve claims that DaVita violated the False Claims Act.

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qui tam Court Case: Simmons v. Meridian

Background

- Relator alleged Meridian violated anti-kickback statute by paying physicians for referrals to Treasure Coast Surgery Center, LLC.
- Relator alleged Meridian paid existing physician owners above FMV for its 60% ownership but charged referring physicians a discounted amount to purchase minority interests
- Relator was the former office manager of Treasure Coast.

Issues

- Recruiting efforts and ownership offers appeared in part to be based on physicians' case volume.
- Appearance of conflict of interest throughout the negotiations between Meridian and physicians
- Medical directors were hired despite lack of need

In September 2014, Treasure Coast agreed to a settlement to pay $5.1 million to resolve claims that it had violated the False Claims Act.

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qui tam Court Case: Barker v. Columbus Regional and Tidwell

Background

- Columbus Regional Health System purchased Tidwell Cancer Treatment Center July15, 2010.
- Relator alleged purchase price was in excess of fair market value and was not commercially reasonable in the absence of referrals.
- Relator alleged purchase was not in response to a community need.
- Case brought by an individual, Richard Barker, who was the top administrator at John B. Amos Cancer Center.

Issues

- Valuation analysis was only a DCF calculation titled "Discussion Documents" identified as preliminary draft. No narrative was provided.
- Report completed for St. Francis, not Columbus Regional Health System
- Analysis did not account for the known outdated equipment in DCF CapEx
- Physician competence and ability to practice medicine at an acceptable level had been identified as an issue by Columbus Regional oncologists.
- Market for new radiation therapy patients was mostly stagnant

In September 2015, Columbus Regional agreed to a settlement to pay up to $35 million to resolve claims that it had violated the False Claims Act. In addition, the medical director, Dr. Andrew Pippas, agreed to pay $425,000 to settle claims against him.

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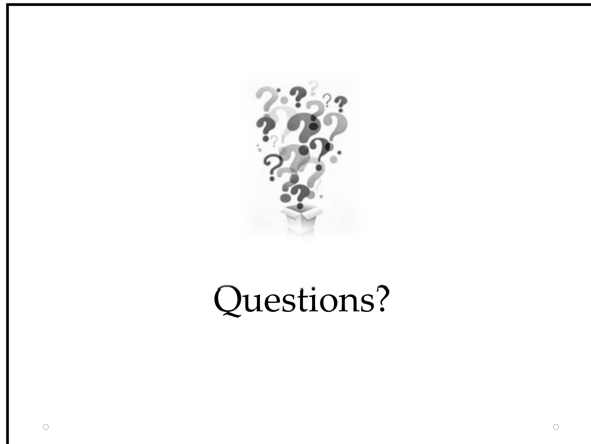

Questions?

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