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managing risk in today's healthcare M&A transaction

Both buyers and targets in mergers and acquisitions face risk mitigation challenges with these transactions that require careful planning and execution to effectively address.

Healthcare mergers and acquisitions (M&A) activity is off to a very healthy start in 2016. As reported by *The Wall Street Journal*, merger activity in the healthcare industry rose 108 percent year over year in the first quarter of 2015, with health care being the busiest sector for M&A globally in the quarter and generating more than 25 percent of all U.S. M&A activity.^a The deal volume in the

second quarter slowed somewhat, with fewer big deals, but transactions involving long-term care, lab/MRI providers, and hospitals remained strong.

Looking at last summer's headlines, the beat went on: Anthem's proposed acquisition of Cigna, along with Aetna's deal for Humana, punctuated the relentless consolidation story. The combination of four of the nation's top five health plans illustrated just how furious and swift the merger wave is in our healthcare industry.

The robust merger activity is due to multiple factors: incentives under the Affordable Care Act (ACA) to provide efficient, high-quality care; tighter reimbursement rates and margins for hospitals and insurers; the flood of newly covered enrollees under Obamacare pushing providers to scale up; and the ACA's incentives to implement electronic health record systems and telemedicine, requiring access to additional capital.

Beyond customary business diligence, a merger in the healthcare arena must clear an array of federal

AT A GLANCE

Beyond customary business diligence, mergers in the healthcare arena must clear an array of federal and state regulatory hurdles and compliance risks that have grown more pronounced in recent years. Primary challenge are posed by:

- > Antitrust issues
- > Licensing and compliance practices
- > Data privacy and security
- > Payment and revenue stability
- > Cultural fit and post-merger integration

a. Mattioli, D., "M&A Deal Activity on Pace for Record Year," *The Wall Street Journal*, Aug. 10, 2015.

and state regulatory hurdles and compliance risks that have grown more pronounced in recent years. This new reality has made parties more cautious during the due diligence process. Regulatory issues or compliance red flags can cause significant delays or, in some instances, a scrapping of the deal. Yet with deft planning and execution, the vast majority of transactions—even the acquisition of a not-for-profit institution by a commercial entity—close without serious obstacles.

Success for health systems in this arena will depend on how adept they are in managing the five most important risk mitigation challenges facing dealmakers:

- > Antitrust issues
- > Licensing and compliance practices
- > Data privacy and security
- > Payment and revenue stability
- > Cultural fit and post-merger integration

Antitrust Issues

Health systems seeking to enhance patient care or reduce costs through acquisitions must carefully assess the antitrust risks of such opportunities, preferably early in the acquisition process. A deep analysis of antitrust concerns can help a buyer or seller vet potential partners and determine whether a transaction might invite too much regulatory scrutiny or incur undue delay or unexpected costs.

Two federal agencies are responsible for reviewing mergers: the Federal Trade Commission (FTC) and the Department of Justice (DOJ). For transactions reportable under the Hart-Scott-Rodino Act, the FTC and Antitrust Division of the DOJ will review the parties' agreement and documentation (e.g., relevant emails and board minutes) to ensure the transactions do not raise anticompetitive concerns. In seeking to prevent mergers that substantially lessen competition, the FTC also looks for transactions that will benefit consumers through improved quality, integrated care, or decreased costs.

In addition to federal agencies, states also may scrutinize a deal. For example, the Connecticut

legislature passed a law requiring parties to transactions that result in a "material change" to the business structure of a group practice to notify the attorney general's office in advance of closing. And Connecticut Governor Dannel Malloy issued an executive order in February 2016 imposing a moratorium on approvals of any hospital consolidation until a new task force could examine the merger approval process and the implications of the increasing consolidation of health systems in that state.

The following are some principal antitrust concerns that attract regulatory attention.

Large market shares. Antitrust issues emerge when consolidation involves a large percentage of the competing providers in a given market. As a rule, a 30 to 40 percent market share will undoubtedly raise antitrust concerns.

Market concentrations. Antitrust concerns arise when the number of providers in a given market goes from four to three, or three to two.

Anticompetitive effects. Collaboration that eliminates or reduces price competition or whose principal aim is to allow providers to gain increased leverage with payers can raise concerns. No longer may parties rely solely on claims of improved patient care and greater efficiency to justify consolidation. They also must show that the transaction will not adversely affect competition.

Most-favored-nation (MFN) clauses. Despite the general procompetitive effect of MFN clauses in lowering prices, scrutiny may occur when payers with a dominant market share require providers to agree to an MFN clause or a dominant provider network requires providers it contracts with to agree to such a clause. Such agreements might be construed as unfairly imposing higher costs on rivals or new entrants into the market.

Nonetheless, despite renewed scrutiny from the FTC and state regulators in recent years and the spate of scary headlines declaring open season on

healthcare mergers, the antitrust laws are not a barrier to bona fide efforts to improve care through integration or other means. Although a number of high-profile enforcement actions have resulted in settlements, and even the unwinding of mergers, the FTC reports that the vast majority of reported transactions under the Hart-Scott-Rodino Act—more than 96 percent in each of the past five years—have been allowed to proceed without further inquiry, and only a small fraction of proposed or consummated mergers have required additional investigation. If the FTC cannot close an investigation during the initial Hart-Scott-Rodino review period, it will require a “second request,” which involves more extensive discovery and scrutiny, and additional costs. For some not-for-profit entities, this action might signal the end of the deal, but that need not be the case for those willing to expend the resources to respond to the agency’s further inquiries.

In the end, the vast majority of transactions survive scrutiny if they are procompetitive or neutral, and if they have adequately prepared their arguments to overcome any unfavorable facts with evidence of tangible benefits to the community or toward patient outcomes. Although federal and state antitrust scrutiny is a demonstrable hurdle, it is manageable if the parties take the time to engage counsel early in the process to handle potential antitrust concerns proactively. On balance, hospital mergers generally fail or face great scrutiny based upon facts that evince large post-merger market shares, payer opposition to the deal, or an inability to prove the transaction would produce procompetitive effects and improved care that can be achieved only through a merger.

The exchange of current or future pricing information, which the buyer requires to be able to perform a proper valuation of the target entity,

Recent Antitrust Enforcement Actions: Lessons Learned

The Federal Trade Commission (FTC) monitors an increasing number of mergers involving healthcare providers, including deals involving hospitals, physicians, clinics, and surgery centers, and intervenes when they pose a threat to competition. Two recent enforcement actions that were upheld by federal appeals courts are noteworthy.

In *ProMedica Health System, Inc. v. Federal Trade Commission*, on April 22, 2014, the U.S. 6th Circuit Court of Appeals upheld the FTC’s decision requiring ProMedica Health System to divest its rival, St. Luke’s Hospital, because the merger would have given ProMedica undue leverage to demand higher rates from health plans.

In *St. Alphonsus Med. Ctr.- Nampa Inc. v. St. Luke’s Health Sys.*, the 9th Circuit affirmed on Feb. 10, 2015, the lower court’s ruling that the acquisition of Idaho’s largest independent physician practice group by the state’s dominant health system violated antitrust laws, given that the combined entity would have had the power to demand higher rates in the market for adult primary care services in the state’s second-largest city. The court did not find St. Luke’s quality-based efficiencies defense adequate to rebut a prima facie case that a merger would be anticompetitive.

The St. Luke’s Health System case provides important lessons for health systems to factor into their growth strategies and any merger-related litigation strategies:

- > The FTC may challenge even small acquisitions involving healthcare providers.
- > Future healthcare mergers must consider the likelihood that the relevant geographic market will not encompass nearby cities and healthcare hubs, but may be limited to smaller cities or regions.
- > Courts and the FTC weigh the reactions of insurers when defining product and geographic markets in the healthcare industry, focusing on the bargaining power that the combined entity would be able to leverage in negotiations with purchasers.
- > In-house counsel should remind deal-oriented employees to comply with well-documented best practices and antitrust guidelines to avoid having business language contained in internal documents and emails misconstrued in a merger challenge.
- > Market efficiencies must be verifiable, merger-specific (i.e., obtainable only through the merger), and negate the anticompetitive effects of the merger.

may pose an additional antitrust-related concern. The mere possibility of a merger generally cannot permit business rivals to freely exchange competitively sensitive information. Thus, with the buyer often conducting its own “black box analysis” of the target’s rates and financial data, parties should have in place certain safeguards to limit any potentially unlawful premerger behavior, including:

- > Standard confidentiality agreements for those parties and hired experts examining sensitive pricing data during due diligence
- > Limits regarding the individuals who will be privy to the sensitive pricing information, particularly ensuring that a rival’s pricing data are not sent to any managers directly responsible for contracting for the same services
- > An expert’s report on valuation and risk assessment, the conclusions from which can be delivered in general terms without breaking down the target’s price data by specific regions or benefits
- > A standing invitation allowing the target’s counsel to examine any valuation report before it is transmitted to the buyer’s executives to screen out any competitively sensitive details

Licensing and Compliance Issues

Healthcare acquisitions also are subject to myriad state and federal regulatory issues beyond antitrust concerns, including state licensing and permit requirements (including for employees), state corporate practice of medicine laws, antikickback statutes, the False Claims Act, and Stark law compliance regarding physician referral sources—not to mention any open environmental matters or related criminal investigations. In preparation for a potential transaction, sellers should perform a proactive audit of compliance with laws and state licensing requirements to close open violations or paperwork omissions before the process begins in earnest. Proper compliance in these areas evinces “good governance,” and loose controls can be a red flag of undiscovered violations or management risk.

An examination might reveal whether:

- > The target entity keeps documents concerning a history of reported incidents and accompanying compliance records and remediation efforts
- > The target can document that physician compensation arrangements adhere to fair market value
- > The target co-owns any entity with any physicians who might refer patients to such a provider

Due diligence in antikickback and Stark law compliance typically focuses on physician and system-based referral sources and whether an unlawful financial relationship exists that falls outside safe harbors and exceptions. With the trend of physicians becoming employees of hospitals, a buyer must determine whether a hospital’s payment arrangements with physicians are commercially reasonable and do not violate antikickback statutes, including looking into such things as:

- > Employment agreements for physicians
- > Physicians’ agreements with suppliers
- > Physicians’ ownership interests in imaging or service providers where patients are referred
- > Physician-owned entities that sell or arrange for the sale of implantable medical devices, particularly where physician owners condition hospital referrals on the purchase of devices from such entities
- > Lease terms or loans offered to physicians at below fair market value

Penalties for federal violations can be substantial. For example, in 2014, Halifax Health in Daytona, Fla., reached an \$85 million settlement with the DOJ over allegations that the hospital violated the Stark law by executing contracts with several oncologists in which an incentive bonus for the physicians improperly included the value of prescription drugs and tests billed to Medicare that the physicians ordered at Halifax.^b It should be noted that the Halifax enforcement was referred to the government by an internal

b. See DOJ, “Florida Hospital System Agrees to Pay the Government \$85 Million to Settle Allegations of Improper Financial Relationships With Referring Physicians,” news release, March 11, 2014.

whistleblower in accordance with the qui tam provisions of the False Claims Act—a fact that should not be lost on buyers and sellers evaluating the risks of noncompliance and how violations may come to light. Thus, during the due diligence process, noncompliant relationships should be examined carefully and remedied and, if appropriate after consultation with counsel, voluntarily disclosed to the appropriate regulatory agency to reduce potential penalties.

Beyond identifying red flags during the due diligence process, a buyer can mitigate certain compliance risks through contractual provisions, including the following.

Representations and warranties. A buyer concerned with compliance risk can negotiate a longer survival period for the representations and warranties and compliance with laws provisions, taking into account that the statute of limitations for breach of contract varies widely by state law.

Indemnification caps, baskets, and exclusions. Beyond the period of indemnification, the agreement typically includes limitations of liability on the seller's indemnification. Baskets are levels below which recovery may not be sought (e.g., the first \$50,000), while caps place a limit on the amount the seller is responsible for, typically tied to a percentage of the purchase price, with variances for different liabilities. A buyer and seller also might agree that certain liabilities are exempt from indemnification caps and baskets.

Holdbacks and escrow. To mitigate risk, parties also might designate an amount (e.g., 10 to 15 percent of the purchase price) to be placed with a third-party escrow agent, or otherwise “held back” by the buyer, to handle subsequent to closing adjustments and indemnification liabilities.

Earn-outs. To assuage a buyer's anxiety that it is overpaying, the parties might negotiate earn-outs that allow the buyer to withhold a portion of the price tied to the seller reaching future performance benchmarks. Care should be taken,

however, to structure earn-outs carefully to comply with healthcare laws.

Representations and warranties insurance. Buyers and sellers also may consider insurance on representations and warranties, which can provide an anxious buyer with an additional backstop and the seller with a cleaner exit on a deal.

Privacy, Data Security, and Technology

The 2014 headlines were dominated with news of retailer data breaches, but more recently, cyber-thieves have targeted health records (a prominent example being the theft of 80 million records from Anthem, the nation's second largest health insurer). Because financial institutions have bolstered their systems, healthcare entities now are seen as potentially soft targets, with hackers stealing valuable patient records to facilitate identity theft and medical fraud.

Despite the incentives to providers under the ACA to implement the “meaningful use” of electronic health records, a system is only as effective as the data security procedures in place. As such, a buyer should conduct a security audit of the target company of vital data security procedures, including protections regarding third-party contractor access to the system. Special care should be taken with financially strapped institutions, which, due to obvious budget constraints, may not have allocated enough resources for data security and may have latent cybersecurity risks.

Beyond cyberfraud, privacy issues also have been the focus of regulators. Buyers need to examine a seller's HIPAA compliance plans and business associate agreements, as well as subcontractor agreements, and the seller's privacy notices and breach protocols. Even if the buyer has a robust compliance program, the acquired entity's uneven HIPAA compliance may be a future institutional weakness in the new merged entity. Moreover, gaps in documentation, although not necessarily indicative of violations, may point to lagging compliance procedures and will not be

looked upon favorably by regulators investigating an incident in the future.

The following are additional privacy-related questions to ask:

- > What is the extent of employee privacy and security training?
- > What procedures are in place to limit authorized access to patient records?
- > What bring-your-own-device or remote-network-access procedures and protections does the provider have in place?
- > How is the provider employing encryption for protected health information as per the HIPAA Security Rule? Are data stored on laptops and other peripheral devices similarly encrypted?
- > Has the entity suffered any reported or unreported data security breaches or network intrusions? Did the entity comply with HIPAA and state law breach notification requirements to affected patients?
- > Are there any ongoing federal audits under the Health Information Technology for Economic and Clinical Health (HITECH) Act or similar state attorney general investigations over the loss of health data?
- > If the entity accepts credit cards from patients or other visitors, is it compliant with the Payment Card Industry Data Security Standard (PCI DSS), which is separate from the HIPAA Security Rule?

During negotiations, a buyer may mitigate privacy risks with contractual safeguards, such as a carve-out of data breaches from the contract's indemnification caps and an exclusion from liability for security incidents that predate the closing, being careful to define the contours of such limitation, as an existing data breach may not be discovered until after closing.

Beyond privacy and data security, the due diligence process also should examine whether the target's current IT capabilities might affect the deal value. The buyer should consider whether circumstances exist that might hinder the integration of the two parties' systems, such as the need to make significant post-sale IT

investments or resolve interoperability issues. Moreover, if the buyer forecasts efficiencies in eliminating duplicative software licenses and service agreements, counsel should examine existing license agreements to determine the licensee's scope of rights and whether the terms permit the new entity to use the software following a change of ownership.

Payment and Revenue Stability

A target entity's participation in government programs such as Medicare may affect a buyer's potential liability in an acquisition and may influence how the transaction is structured. Medicare payment is, of course, an indicator of an entity's past and future earnings, but buyers also should assess a target entity's billing and coding practices for ambiguities and overbilling. "Up-coding" inflates billings, muddies a valuation, and may subject the seller to potential liability for overbilling Medicare.

To be sure, due diligence also may show under-billing, which would change future earnings estimates. Medicare payments made to providers are subject to a year-end accounting and auditing under Medicare's Recovery Audit Program. This process becomes important during a merger because the buyer may become the assignee of the seller's Medicare provider number to ensure a steady flow of income during the transition following closing.

The federal government also may conduct audits into the seller's past billing practices and coding procedures long after the closing, potentially exposing the buyer to unknown successor liability. Often, the parties will contract for this risk through escrow, or use indemnity provisions, negotiating carefully with the duration of the indemnification clause (e.g., 36 months), particularly because a government investigation into past billings may take years.

As such, a buyer typically will perform due diligence into a seller's billing practices, looking for any procedures that run counter to U.S. Department of Health and Human Services

guidance and standards, differ greatly from traditional benchmarks, or show an inordinate volume of certain claims. A buyer also should examine whether the seller maintains robust controls (e.g., compliance officers, employee training, internal audits) and request that the seller clear current violations and alter procedures if ambiguities are uncovered.

Cultural Fit and Related Issues

Legal and financial concerns aside, a lack of cultural fit can be one of the biggest impediments to a healthcare merger. Despite what the numbers say, culture should be a driving force in selecting a partner, and the parties' positions should align on the answers to the following questions:

- > What is the reason for the merger? Does it provide mutual value for both parties?
- > Do the strategic priorities and core competencies match on both sides?
- > Is it the right time in the market to merge?
- > Is there a fit between the executives of the buyer and seller and consensus regarding shared governance and the business style of the new entity?

Ultimately, a combination may prove unsuccessful if any of the following circumstances exist:

- > The respective corporate cultures are incompatible.
- > The boards and executive teams clash on business styles and potential leadership choice.
- > The physicians are unwilling to coordinate clinical practices.
- > Board members or executives are unwilling to give up their seats or close redundant facilities.
- > The parties differ on long-term goals and future investments.

Although these concerns may sound “soft” compared with regulatory risks, such divides can quickly scuttle a deal. The executive teams therefore should gauge the degree of affinity with a face-to-face meeting early in the process. Even when a large health system is buying a failing entity, a merger should always be a mutual partnership—and never be a hostile takeover.

Poised for Future Performance

After the financials have been thoroughly scrutinized and all the due diligence has been done, it is good to consider the future performance goals of the entity targeted for acquisition and what adjustments might become necessary in the near term. Here are some questions to address at this stage:

- > Does the target have the strategic tools necessary to continue whatever success it may have enjoyed in the past?
- > Can the target move toward integrated care and improved patient outcomes and thereby grow its market share and remain a competitive player in its sector?
- > Is the target tracking patient outcomes by medical condition to measure whether updated practices have achieved new objectives?
- > Is the target tracking the actual cost of care per medical condition to measure ways to reduce waste and improve outcomes?

Cultural differences or local political considerations can emerge when a for-profit entity is seeking to acquire a not-for-profit or religious hospital. At the outset, the transaction teams should identify non-negotiable terms such as maintenance of certain community services (e.g., obstetrics or emergency care services) or a historic level of charity care.

Beyond the need to maintain certain community health services, a not-for-profit institution also may have ethical or religious directives that must be honored by the new entity, or its real estate might be encumbered by covenants limiting commercial uses on hospital grounds. Often, the state attorney general will review closely community hospital conversions to gauge the merger's impact on the community and the merger's effect on the institution's charitable purposes.

Even when interests align, a merger should take into account employee relations and legal compliance concerns. These concerns include:

- > Resources required to transition staff
- > The impact on employee morale and retaining and attracting talent
- > Obligations under union contracts
- > Remediation of any labor law issues, such as discrimination, wage claims, COBRA

obligations, WARN Act requirements, underfunded pensions, and severance payments

Working on the culture fit doesn't end with the closing. Post-closing governance and the continuing role of the transition teams ensure that management remains passionate about the coupling, even in the face of post-deal hiccups.

Final Valuation Consideration

In the end, the buyer also must determine whether the deal is a good value and makes financial sense in today's new healthcare market. To this end, the buyer must identify the metrics it will use to gauge the likely future financial performance of the target.

In a dynamic reimbursement and financial environment—such as the current change from fee-for-service to value-based payments or population health—the historic financial

performance and market share of a target is not a reliable basis for predicting future performance. Thus, the traditional “quality of earnings” evaluation by buyers takes on added importance and complexity.

Taking a wider view, buyers should develop a thesis on how the particular sector and segment is likely to evolve in the future and how the entity targeted for acquisition is positioned to take advantage of those trends. ■

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