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assessing the value in transactions involving multi-provider networks

A health system's efforts in deploying strategic network initiatives will be effective only to the extent that its leaders understand the unique factors affecting the economics of multi-provider networks.

AT A GLANCE

When seeking to determine the financial value of a multi-provider network, hospital finance executives should address the following considerations:

- > Revenue projections
- > Shared savings revenue risk
- > Distribution of profits
- > Cost structure
- > Working capital requirements

As payers continue to turn toward new payment methods, many healthcare providers are embracing some form of value-based payment model, such as accountable care, bundled payments, or shared savings/shared risk arrangements. The first step often involves the development of an entity to bring independent physicians in a community together to contract with governmental and commercial payers on these arrangements, often (but not always) alongside a local health system and its employed physicians. These new entities are most commonly called clinically integrated networks (CINs), accountable care organizations (ACOs), physician-hospital organization (PHOs), or independent practice associations (IPAs).^a They are referred to more generally in this article as multi-provider networks (MPNs).

Within these structures, otherwise independent parties work together to govern the entity, design care initiatives, improve data and information sharing, measure quality outcomes, and garner rewards from payers for managing quality and cost, while complying with antitrust regulations surrounding arrangements between independent providers.

Much attention has been given in the literature to the strategic imperative to create MPNs and to the mechanics for doing so. Over the past five years, hundreds of MPNs have sprung up in markets across the country. As one might expect in a rapidly consolidating market, transactions involving MPNs are becoming increasingly common. Consider the following typical examples:

- > A hospital decides to acquire all or part of the ownership interest in an existing MPN instead of developing its own entity.
- > A health system seeks to expand an existing CIN by acquiring or partnering with another MPN.

a. The Federal Trade Commission and the Centers for Medicare & Medicaid Services have specific definitions for the terms *clinically integrated network* and *accountable care organization*, but these terms have been adopted by the healthcare industry to refer to the function of these organizations.

- > One of two health systems that have decided to merge holds ownership interest in an MPN.
- > A hospital or provider group contracts with an MPN for care management, leadership, and analytic support services to achieve shared savings goals.

Although health systems clearly gain value from MPNs, their finance leaders nonetheless should thoroughly evaluate each opportunity and potential transaction on its own merits. Finance leaders can best deploy strategic network initiatives if they understand the unique considerations and drivers that affect the economics of MPNs.

Important considerations include the fair market value (FMV) requirement of the Stark Law, the Anti-Kickback Statute, and other regulations that establish that any such transaction involving a referring physician must be based on FMV.

Two currents run throughout any assessment of the financial value of an MPN. First, its revenues are produced, at least in part, by reducing spending under shared savings contracts rather than through patient service fees. Second, there often is no cash generated in the early stages of an MPN, because shared savings revenue is based upon performance and calculated by the payer or payers at the end of specified periods. Together, these issues make for

unique challenges in determining the financial value of an MPN, including making revenue projections, assessing shared savings revenue risk, determining how profits should be distributed, and understanding the cost structure and working capital requirements.

Revenue Projections

Several factors unique to MPNs affect revenue projections.

Total years of contract revenue. Shared savings contracts have a limited lifespan. An MPN’s potential for shared savings revenue is not perpetual; no organization can cut spending 4 percent every year in perpetuity, for example. The margin of savings potential generally diminishes each year, even if the MPN’s total number of beneficiaries increases. Once an entity reaches optimal or achievable efficiencies and care quality, the opportunity for shared savings revenue will theoretically end. When preparing a business plan, financial projections, or a valuation, finance leaders should consider how many years the organization will be able to generate “revenues” from reduced spending. This time frame is unlikely to exceed two contract periods. If adding beneficiaries is part of the plan, finance leaders also should consider the extent to which the MPN will be able to expand its population base and establish new contracts or business models.

Projected provider base and attributed beneficiaries. This projection requires caution. For example, if an organization is contemplating involvement with an MPN that projects 10 percent annual increases in its provider base over an initial five-year period, finance leaders should take a close look at the provider population in the MPN’s geographic area. Is it realistic to assume the MPN will recruit 90 percent of the providers in the region? What about 40 percent? Is the MPN competing with similar organizations for attributed beneficiaries? Because attributions are based mainly on primary care physicians, the MPN’s ability to increase attributed beneficiaries will depend on the primary care provider base.

The Valuation Lens

Three standard valuation approaches can be used to gauge the value of a multi-provider network:

- > The income approach, which describes the value of the anticipated income stream that the business can reasonably be expected to produce and distribute to shareholders
- > The market approach, which measures value based on prices paid in the marketplace for similar assets and business enterprises
- > The cost approach, which estimates the fair market value of the assets (both tangible and intangible) that constitute the business—often seen as the cost to a buyer to recreate the business

Each valuation approach is applicable to varying degrees in different situations; the valuation conclusion is formulated by comparing the results of the income, market, and cost approaches and their respective risks, benefits, and applicability.

Projected savings. Assuming the MPN will generate shared savings revenues, finance leaders should carefully consider whether the savings projected by management are achievable. Projections that imply room to cut at least 30 percent of healthcare spending are a red flag. Is there really that much waste in the local health system? Is it realistic to think that the MPN can reduce spending per beneficiary by even 5 percent annually for three consecutive years?

Shared Savings Revenue Risk

An MPN runs a risk of generating *zero* revenue (or sustaining losses) in a given contract period, even if some savings is generated. The MPN financial projections are based on achieving a certain level of shared savings. However, the projections must take into account provisions in many ACO contracts (such as those under the Medicare Shared Savings Program [MSSP]) requiring that a minimum savings threshold and certain quality measures be achieved before any achieved savings are shared with the MPN.

To evaluate the risk associated with shared savings contract revenue, finance leaders should develop multiple projected scenarios (i.e., best case, base case, and worst case) using the same rate of return (or discount rate). They also might consider scenarios using a higher rate of return (or discount rate) to account for the increased risk of shared savings contract revenue.

Distribution of Profits

Distribution of profits is important in determining the value of an MPN. These networks vary considerably in how much of their earnings are distributed to participating physicians. Many distribution models leave little or nothing for distribution to the owners.

If an ACO contracting entity earns shared savings revenue and realizes net profit, but distributes 90 percent of that amount to participating physicians, there will be little cash available to investors (e.g., the health system, hospital, physician owners). Although the MPN may have

Only Half of ACOs Achieved Savings in First Year

Of the 114 accountable care organizations (ACOs) that participated in the Medicare Shared Savings Program (MSSP) in 2012, only about half (60 ACOs) generated first-year savings. Of those 60, approximately half (32 ACOs) generated sufficient savings to hit the minimum savings threshold (MSR) necessary to share in savings. In other words, about a quarter of the MSSP ACOs that started in 2012 ended up sharing in savings.

For the 106 ACOs that started the MSSP in 2013, more than half (58 ACOs) generated first-year savings, but only 20 hit the MSR threshold necessary to share in savings.

Source: Centers for Medicare & Medicaid Services, Data.CMS.gov: Shared Savings Program Accountable Care Organizations (ACO) PUF, May 2015.

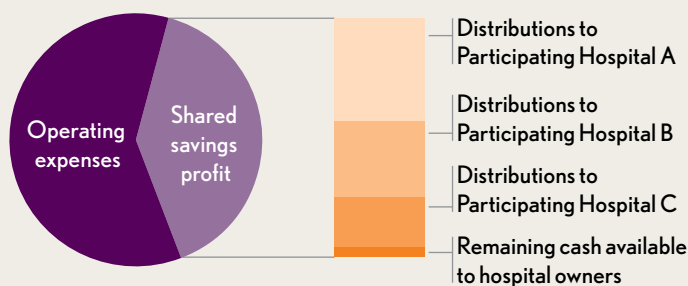
little value to the owners or buyers in terms of profitability, it may still have strategic value.

The exhibit below represents a hospital network that has created a joint venture for purposes of care management and participating in shared savings contracts. As part of the operating arrangement, almost all profits are distributed to each participating hospital based on number of attributed beneficiaries and savings achieved. Very little cash is left for equity owners.

For equity owners to obtain a more commensurable share of the profits, the MPN must have cash remaining after distributions to participating

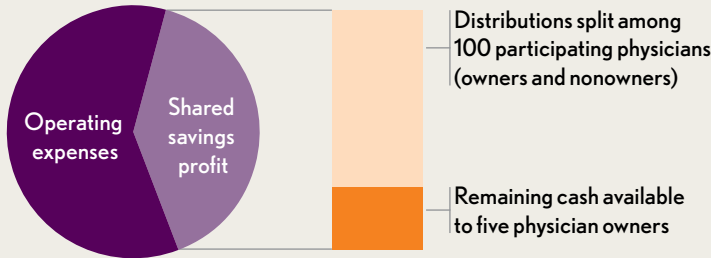
**SAMPLE SHARED SAVINGS ALLOCATION:
LITTLE PROFIT ALLOCATED TO OWNERS**

Shared Savings Revenue Allocation



**SAMPLE SHARED SAVINGS ALLOCATION:
30 PERCENT OF PROFIT ALLOCATED TO OWNERS**

Shared Savings Revenue Allocation



providers. The exhibit above represents an independent practice association (IPA) consisting of 100 physicians, all of whom participate in the shared savings contracts, but with only five founding physicians being equity owners. To create an incentive for participation while also enhancing the value of the entity, the IPA distributes 70 percent of the shared savings profits among participating physicians and leaves 30 percent available to the five owners.

Cost Structure

No single MPN is exactly like the next. Each entity tends to have unique complexities, and some may outsource a number of core services. Understanding the complete financial picture requires having a clear idea of the cost of all features that must be in place to reduce spending per beneficiary. These costs include:

- > IT infrastructure and ongoing analytic support
- > Staffing (including management, analytics, IT, administration, and care coordinators)
- > Office space, utilities and maintenance, and other miscellaneous operating expenses necessary for provision of the services
- > Financial and performance reporting

It is important to understand how the MPN will implement these features both during the start-up phase and when the MPN matures. In a new market, determining the levels of activities and costs required to achieve the targeted results

can be difficult, especially given that MPNs can differ significantly in their specific goals.

Because proper financial analysis and valuation require validating the projected expenses of the MPN, finance leaders can benefit from becoming familiar with the strategies and effective cost structures being pursued by similarly structured healthcare organizations and other MPNs.

Working Capital Requirements

MPNs with traditional shared savings contracts must maintain much higher working capital balances as a percentage of expenses, compared with standard healthcare providers. For example, MSSP shared savings revenues are recorded as a receivable for which cash will be collected six to seven months *after* the end of the calendar year in which services were provided—making for rather unusual balance sheet projections.

Healthcare providers are familiar with managing and aging accounts receivable (A/R) over 30 to 150 days, and they maintain working capital accordingly. MPNs can experience an average of 365 days in A/R.

Understanding the timing of cash payments from payers is critical. It's important not to understate the average days in A/R, as doing so can artificially inflate cash flows. An understatement will make it appear that the MPN will generate cash to cover expenses significantly earlier than it actually will, resulting in a valuation that is significantly higher than it should be.

MPNs with No Cash Flow

Many MPNs do not generate cash to support a traditional valuation based on a discounted cash flow analysis. This situation may occur for the following reasons:

- > All shared savings income is contractually required to be distributed to participating providers.
- > The MPN has not yet entered into any shared savings contracts.
- > The business purposes of the MPN do not include entering into shared savings contracts

(for example, an IPA designed to deploy the messenger model).^b

Nevertheless, significant resources are involved in developing an MPN. Tangible and intangible assets commonly associated with MPNs include:

- > Fixed assets (e.g., furniture, fixtures, and office equipment; computer hardware and software)
- > Workforce in place
- > Contracts—particularly shared savings contracts
- > Developed processes (e.g., policies and procedures, care management protocols, analytics algorithms)
- > Organizational development
- > Physician networks

Not all of these assets will be seen with every MPN. For example, in some cases, an MPN may manage shared savings contracts on behalf of a sister organization that manages the physician network.

When looking at valuation for a “build versus buy” analysis, care should be taken not to simply calculate the costs incurred by the MPN in question. Rather, the actual assets should be identified to provide a basis for evaluating the costs an entity would likely incur in an attempt to duplicate those assets.

What the Financial Statements Do Not Reveal

Financial statements may not capture the whole picture. Debt obligations often are not obvious on the balance sheet, for example, or unique cash transfers between sister companies may be in place to support working capital. MPNs may receive services or operational support from a parent or sister company for which no expense is recorded on the income statements.

Start-up companies and entities that are developed as part of two or more related organizations

b. In the messenger model, a payer will make an offer to a network that is then communicated to all of the network’s participating providers. If an insufficient number of providers individually accept the offer, the payer will improve the offer. This process continues until an agreement is reached, with the network acting only as communicating agent and not as a negotiator.

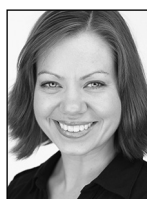
can be especially challenging. It is critical to understand contractual and other relationships between the related entities.

An Evolving Landscape

As CMS and commercial payers change their value-based contracting programs and offer new options, business models will adapt to them. The change in market conditions and business models may cause some value drivers to become critically important and create an increased need for caution with respect to others. For example, payers may advance a larger portion of expected shared savings upfront to ease cash flow issues. Or they may change their definition of *value*, which may ultimately change the economics for a particular organization.

In any case, to effectively deploy strategic initiatives related to shared savings contracts involving an MPN, or to successfully negotiate a transaction with an MPN, it is critical to understand the business model, the means by which value is driven to the owners (as opposed to the participants), and the MPN’s areas of greatest exposure to risk. ■

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