# Weighing the Probabilities: Transactions Involving ACOs and Other Multi-Provider Networks

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As payers continue to turn towards new payment methods, many health care providers are embracing some form of value-based payment model, such as accountable care, bundled payments, or shared savings/risk arrangements. Although they have been around in various forms for many years, hundreds of multi-provider networks (MPNs) have sprung up in markets across the country to help facilitate these new payment models.

These types of entities include clinically integrated networks (CINs), accountable care organizations (ACOs), physician-hospital organizations (PHOs), and independent physician associations (IPAs).[1] ACOs, specifically, are defined as MPNs that participate in the Medicare Shared Savings Program (MSSP) to further the "triple aims" of health care reform—improving care delivery, improving health, and reducing growth in costs. Generally, MPNs are legal entities under which groups of physicians, hospitals, and other health care providers collaborate to provide coordinated, high quality care to patients at a cost lower than their peers.

Due to continued consolidation in the health care industry and the shift toward value-based payment models, transactions involving MPNs are becoming increasingly common. While MPNs can provide significant value, they present unusual challenges for health care attorneys and appraisers tasked with ensuring compliance with the health care fraud and abuse laws. This article provides sufficient introduction to MPN entities and transactions to provide a framework for understanding related valuation issues, and then addresses key valuation concepts in relation to MPN appraisals and transactions, and specifically those involving relatively mature MPNs.

## Types of Entities and Business Structure

MPN entities may take a wide variety of forms and structures. Key structural elements, all inter-connected, include the MPN's ownership, its revenue streams, the services it provides, and the provider distribution model for shared savings achieved by the entity, if any.

### Ownership

The MPN's ownership fundamentally impacts the other structural elements, particularly the provider distribution model.

In *100% hospital-owned* MPNs:

- Participating providers are affiliated with the health system, and may or may not be employed by them.
- Participating physician providers have no ownership interest in the MPN, but typically receive a portion of shared saving profits as defined by a provider distribution model.
- Hospital-employed providers may not receive distributions directly, and may instead have a portion of their compensation arrangement contingent upon achieving MPN-relevant quality metrics (quality incentives).

In *100% physician-owned* MPNs:

- Participating physicians may all be owners, or a mixture of owners and non-owners.
- Where all participating physicians are owners, there may not be a provider distribution model in place—distribution will be directly determined by ownership. Even if there is, it may not have been reviewed from a fair market value (FMV) perspective because it is simply an alternative method of allocating owner distributions.
- Even in situations where some of the participating physicians are non-owners there may not need to be a provider distribution model in place, as the services provided by the MPN (e.g. payer contracting, quality reporting, care management, etc.) may by themselves make participation worthwhile.

In *hospital-physician joint venture* MPNs:

- The MPN is owned by one or more health systems in partnership with physicians, either individually or as a group.
- The MPN may or may not allow physician participants who are not owners.
- These arrangements can either be planned as a joint venture, or may evolve from the conversion of a 100% hospital or physician-owned MPN to a joint venture model.

In *for-profit joint venture* MPNs:

- A for-profit company with specific expertise in payer contracting, care management, and/or information technology may own all or part of the MPN in partnership with the health care providers.
- These for-profit companies may be private equity or venture capital-backed or a subsidiary of a larger for-profit organization, and may become involved at formation, or through acquisition of all or part of an existing MPN.

- For example, a 100% for-profit owned MPN will typically negotiate contractual relationships with payers, charge a fee to participating providers for services provided, and make distributions to participating providers based on a provider distribution model.

### Sources of Revenue

MPN revenue streams may include payer contracts, participant dues, fees, and gain-sharing arrangements.

***Payer Contracts.*** MPNs are fundamentally payer contracting entities, and most of their revenue typically comes from these contracts. An MPN's contracts may include the MSSP, in which case it is an ACO, and/or managed care and commercial contracts with shared savings components designed to further incentivize higher quality and lower cost care.

Under shared savings arrangements, MPNs receive a portion of the total cost savings they generate through effective care management. Shared savings payments are highly variable year-to-year, sometimes resulting in no payments during a performance period. As a result, properly "risk-adjusting" this revenue is a key consideration in valuation. Some MPN contracts may also include per member per month (PMPM) payments for care management or coordination services provided by the MPN.

***Participant Dues.*** MPNs typically charge both their physician and hospital/health system participants dues, usually for the value of the services provided by the MPN rather than for the ability to participate in the shared savings profits. Dues may be a fixed amount that is consistent from year to year, or may vary (i.e. to cover the MPN's operating budget). Dues for participating owners and non-owners or for primary care and specialist physicians may differ. New participants may also have to pay application or initiation fees.

***Other Revenue Sources.*** Other potential MPN revenue streams include:

*Health information exchange (HIE) fees:* Some MPNs have their own electronic medical record (EMR) systems that are used by their participants, and may charge non-member providers a fee to use these systems.

*Gain-sharing arrangements:* Some MPNs may also participate in a variety of gain-sharing arrangements with payers on behalf of their participants or with health systems to reduce medically unnecessary items/services.

### Services Provided

The services provided by ACOs usually fit the following categories:

- Payer contracting
- Care management and/or coordination
- Data analytics and quality reporting
- Information technology and infrastructure

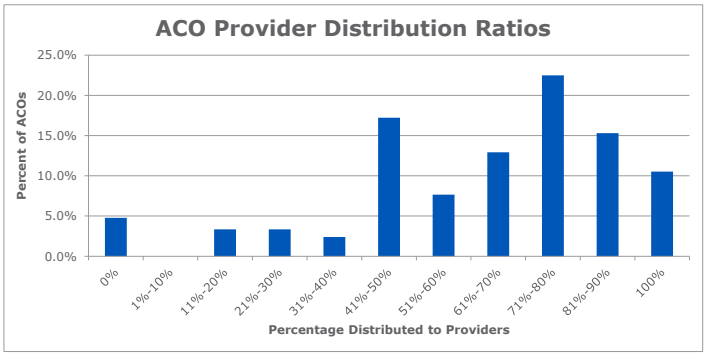
These services may be provided by employees of the MPN, one or more of the MPN's owners, or through contracts with external vendors. The provision of outsourced services is a fast-growing market, with services provided by many private equity and venture-backed entities.

### Provider Distribution Models

Most MPNs have provider distribution models that specify how any profits or realized savings are to be distributed among participating providers. This is typically, though not always, considered an expense of the MPN for valuation purposes. Distributed amounts vary significantly, from 100% allocated to providers to 100% retained by the MPN, and are significantly influenced by the ownership structure and participant dues.

- For example, a 100% physician-owned MPN may not have a provider distribution policy and can divide 100% of the profits pro rata based on ownership.
- Likewise, an MPN with a dues policy requiring participants to collectively pay annual fees equal to the MPN's budgeted operating expenses may comfortably allocate 100% of any profits to the participants based on a formula.

Further, the amount allocated to each individual provider can vary based on a number of factors, including ownership, attribution, specialty, and quality scores. Most ACOs (MPNs that have MSSP contracts) publicly disclose the percentage of their shared savings that are distributed to providers. Based on our research on 209 ACOs that disclose their distribution methodology, distribution formulas vary widely, from 100% allocated to providers (including hospitals/health systems) to 100% retained by the ACO. The average percentage distributed to providers is currently 65.65%, and the 25th and 75th percentiles range from 50% to 81.6%.




*Source: Websites for 209 ACOs that disclose their distribution percentages.*

Due to the wide variation, a detailed study that considers the specific characteristics of the MPN is required to assess the FMV of a particular provider distribution model. Our focus in this article is MPN transactions, which will account for the post-transaction provider distribution model.

## Types of Transactions and Rationale

MPN transactions usually fit into the same broad categories as other health care transactions, but there are unique considerations and rationales specific to MPNs for each transaction type.

### 100% Acquisitions

Traditional 100% business enterprise acquisitions most commonly involve an existing MPN acquiring full ownership of another MPN, which may be hospital and/or physician-owned, to expand its network. The MPNs involved may also benefit from combining the different services provided by the two entities, from shifting one of the populations to an entity that has a more proven track record of success, or from optimizing the combined population relative to their respective payer contracts.

Another form of 100% acquisition may occur when a hospital, health system, or large physician group acquires an existing MPN to expand its physician network and/or improve its internal population health management capabilities.

In both these cases the transaction may be the result of a health system acquiring or merging with another hospital or health system that has an MPN.

### Joint Ventures

Some joint venture MPNs result from a hospital/health system, large physician group, or for-profit company purchasing a partial interest in an existing MPN.

For hospitals and health systems, the rationale for partnering with physicians is that physician-sponsored ACOs are typically more successful, indicating that physician ownership may create more incentive for physicians to change behaviors in desirable ways. Physician ownership can also serve to more tightly align the participant providers with the health system.

For physicians, the rationale for partnering with a hospital or health system is that the health system has access to resources that the physicians may not, including capital, data and analytics, and human resources. Partnering with a low-cost hospital or health system may therefore have a positive impact on the performance of the MPN.

### Minority Interest Buy-in/Buyout

MPNs with physician ownership routinely need to facilitate the buy-in and buyout of physician owner-participants. The price for these transactions is typically set annually or bi-annually. The valuation typically considers the impact of lack of control and marketability on the minority interest.

## Valuation Concepts

It is important for attorneys to understand certain key valuation concepts when they are reviewing and assessing the reasonableness and accuracy of an appraiser's work.

### Approaches to Valuation

Ownership interests in MPNs are valued using the same three approaches commonly used to value any asset:

***Cost Approach:*** The anticipated cost to replicate the assets of the business.

***Market Approach:*** Comparisons to transactions involving similar businesses.

***Income Approach:*** The present value of future economic benefits generated by the business.

Each of the three traditional valuation approaches presents unique challenges when applied to MPNs.

- The Cost Approach is difficult to apply, and may not result in a reliable indication of value, due to the fact that the majority of MPN assets are intangible in nature. For early stage or struggling MPNs, this approach may be the only option.
- The Market Approach is also difficult to apply due to comparability issues (no two MPNs are alike) and a lack of reliable market data. Transaction data related to managed care and/or care management organizations can be used as a proxy.
- The Income Approach can also be difficult to apply due to the fact that MPN revenues and profits typically experience significant fluctuation from year to year and many have operated at a loss historically.

However, if future shared savings payments are properly probability-adjusted, reliable results can be generated using a traditional discounted cash flow model (Income Approach) in most situations.

## Key Valuation Review Considerations

The Income Approach, which is likely to be the primary valuation method utilized to value a mature MPN, involves projecting the future revenue and expenses of the MPN and discounting the resulting cash flows to present value using an appropriate risk-adjusted discount rate.

### Probability-Adjusting Shared Savings

Developing reasonable revenue projections from the MPN's payer contracts is the single most important aspect of an MPN valuation. Generally, revenue from these contracts is a function of the following:

- The number of participants, and ultimately, the number of assigned beneficiaries
- The number and structure of payer contracts that generate shared savings, PMPM, and any other type of revenue
- The expected success of the MPN relative to the contract terms

Assessing the expected success of an MPN is both extremely important and extremely subjective since shared savings payments are inherently uncertain. Under the MSSP, for example, an ACO that meets its minimum savings rate (MSR) is entitled to a percentage of the total savings below its financial benchmark, which typically amounts to millions of dollars annually. Meanwhile, an ACO that misses its MSR by $1 is entitled to absolutely nothing.

This payment structure makes MPNs dissimilar from other health care organizations and the uncertainty forces the valuator to make probability adjustments to the projected shared savings revenue.

| Summary of Historical Results Under the MSSP | 2013 | 2014 | 2015 |
|---|---|---|---|
| Total Beneficiaries in MSSP | 3,675,263 | 5,329,831 | 7,270,233 |
| Beneficiaries Attributed to Successful ACOs | 935,484 | 1,388,006 | 2,077,175 |
| Success Rate | 25.5% | 26.0% | 28.6% |
| Total Eligible Savings (e.g. achieved by successful ACOs) | $ 694,914,091 | $ 806,207,621 | $ 1,390,761,430 |
| Total Shared Savings | $ 311,922,221 | $ 341,246,303 | $ 645,543,866 |
| Shared Savings Percentage | 44.9% | 42.3% | 46.4% |
| Shared Savings per Beneficiary, Successful ACOs | $ 333.43 | $ 245.85 | $ 310.78 |
| Shared Savings per Beneficiary, All ACOs | $ 84.87 | $ 64.03 | $ 88.79 |

*Source: Historical MSSP results data published by CMS.*

As a result, revenue projections should be thought of in terms of "probability-adjusted" revenue rather than discrete projections. There are several general methods for assessing the expected success (e.g. making probability-adjustments) under each payer contract:

- Probability weighting: This methodology involves assuming some level of success and applying a probability factor, which is highly subjective.
- Increasing the discount rate: Another alternative is to assume some level of success with the revenue projections and increase the discount rate to account for the risk of failure. This is also a highly subjective approach.
- Option modeling: Shared savings models are effectively "put" options, where the MPN agrees to provide health care services at an agreed upon cost and is entitled to some portion of the savings if the costs are lower. While complex from a mathematical standpoint, option modeling significantly reduces the subjectivity involved in probability-adjusting revenue.

For the MSSP specifically, historical aggregate shared savings per beneficiary is a good starting point benchmark for assessing the reasonableness of the valuators probability-adjusted revenue projections. As indicated in the table above, the MSSP's aggregate shared savings per beneficiary[2] has historically ranged from $64 to $89.

If a valuator projects probability-adjusted revenue under the MSSP that is substantially different from this range, they should have a strong rationale, which may include:

- Strong historical results and a demonstrated ability to reduce costs while improving quality
- Significant investments in information technology and care management capabilities that are likely to aid in achieving cost reductions
- Anomalies in the historical results that have hurt performance
- A history of low costs relative to regional benchmarks, as the MSSP is moving toward a model that will eventually weight the benchmark 70% to regionally adjusted costs and 30% to historical results.

Historical data related to commercial contracts is not publicly available. However, most of these contracts share structural similarities with the MSSP, and the MSSP data published by CMS can be utilized as a proxy when analyzing most commercial contracts.

### Other MPN-Specific Factors

Projecting shared savings, and the required probability adjustments, are the most unique and analytically challenging component of an MPN valuation. Other MPN-specific factors include:

- Participant dues, which are generally a function of the projected growth in participants; these projections should be assessed for reasonableness.
- Expenses, which consist of a mixture of variable and fixed expenses and should reflect the required cost to support the projected growth.
- Provider distributions that should reflect the anticipated post-transaction model relative to the projected operating results.
- The discount rate, which should incorporate all of the risk factors of a typical valuation, with the added burden of also being appropriate relative to the MPN's stage of development and the revenue projection methodology utilized in the appraisal.

## Key Takeaways

MPNs are complex entities, from their many aliases and wide range of ownership structures, to the ambiguity between provider distribution models and owner distributions, to the complexity of their revenue generating payer contracts. As a result, it is important for attorneys and appraisers alike to be thoroughly familiar with the subtleties and complexities of these entities when providing support and ensuring compliance in MPN-related transactions.

1 The Federal Trade Commission (FTC) and the Centers for Medicare & Medicaid Services (CMS) have specific definitions for the terms "Clinically Integrated Network" and "Accountable Care Organization," respectively. However, these terms have been adopted by the health care industry to refer to the function of these organizations.

2 Aggregate MSSP shared savings divided by total beneficiaries in the program.

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