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HEALTHCARE TRANSACTIONS: CONSIDERATIONS FOR THE COMPLIANCE PROFESSIONAL

INTRODUCTION

Over the last several years—including 2018—the number of mergers, acquisitions, and joint ventures across the healthcare industry have increased as healthcare organizations have continued to re-invent themselves in the face of changes to reimbursement, technology, and government reform. Central to this re-inventing effort has been the pursuit of vertical integration strategies—such as accountable care organizations ("ACOs"), clinically integrated networks ("CINs"), and bundled payment models—to establish economies of scale, migrate into new territories, and improve the quality and outcome of patient care.

We believe there is a key role to be played by the compliance professional in the transaction process, whether their organization is planning an expansion (i.e., acting as the buyer) or is in the process of being acquired. The compliance professional can add significant value by looking for risks and opportunities to be addressed once a transaction closes in order to expedite the cohesiveness of the subsequent integration steps. For any areas of identified risk, the compliance professional can also perform necessary audit functions. For many organizations that are party to a transaction, however, their compliance professionals do not participate in the due diligence efforts of a transaction. Instead, the organization's office of general counsel is consulted on matters relating to risk or potential legal liabilities while the compliance professional focuses primarily on matters relating to internal policies and training. The content of chapter is therefore intended to provide the compliance professional the prerequisite background necessary for navigating the transaction process, mitigating any identified risks, and facilitating subsequent integration procedures.

COMMON TRANSACTION STRUCTURES

Transactions between healthcare organizations can be structured in the form of a stock sale, an asset sale, or a merger. Compliance professionals should have a basic understanding of the different types of transaction structure in order to adequately understand the risks and obligations of a subject transaction opportunity when compliance-related issues are found.

Stock Sale

A stock sale involves the sale of all, or a portion of, the ownership interests in a target entity to a buyer. In other words, a stock sale results in the transfer of ownership in the target entity while the target entity continues to possess the same assets and liabilities prior to the sale.

A stock sale is generally the simplest way to consummate a transaction as it requires fewer third-party approvals and instruments of transfer than an asset sale does. Unlike an asset sale, a stock sale does not require a separate conveyance of each individual asset that is acquired because the title of each asset lies within the target entity.

Barring any express indemnification obligations, the seller in a stock sale does not retain any of the target entity's liabilities. Thus, because these liabilities are transferred to the buyer in a stock sale, an agreed upon amount of reserve funds is generally incorporated into the purchase price to meet any unexpected financial obligations to which the buyer may be subject.

> ***Compliance Tip:*** *The compliance professional should keep in mind that under a stock sale, the liabilities of a target entity transfer from the seller to the buyer. Due diligence efforts should thus would include auditing contracts, claims, and other areas of risk.*

Asset Sale

An asset sale involves the sale of all, or a portion of, the assets and liabilities of a target entity. Rather than transferring the ownership securities of the target entity to the buyer (as is the case in a stock sale), the seller in an asset sale transfers the assets and liabilities of the target entity to the buyer via assignment and assumption agreements. Additionally, an asset sale allows the buyer to choose which assets of a target entity it will purchase from the seller.

Asset sales generally do not include the target's preexisting cash balances and accounts receivable ("A/R"). Any cash held by the target prior to the transaction is generally distributed to the sellers at the time of sale based on their proportional ownership percentages in the target. The prior target would then continue to collect on preexisting A/R balances and distribute any received collections to the prior owners as well. A buyer may sometimes acquire the A/R of a target entity but the acquisition of that A/R may result in the transfer of certain other risks. Thus, the acquisition of a target entity's A/R will generally be accompanied by purchasing representations and/or warranty insurance.

With the exception of capital lease obligations, the preexisting debt balances of a target entity are generally not assumed as part of an asset sale. Instead, any loans associated with those preexisting balances are closed at the time of the transaction and new loans are taken out by the buyer as appropriate.

For entities in the healthcare space, the buyer does not acquire the taxpayer identification number ("TIN") of the target entity in an asset sale and thus does not acquire any payor contracts that may be associated with the target.

> ***Compliance Tip:*** *The compliance professional should confirm that any valuations performed match the actual transaction executed. To the extent an asset sale does not involve 100% of a target entity's assets, the valuation of the target entity should be adjusted to account for any assets that are not acquired (e.g., cash, A/R) or any liabilities that are not assumed (e.g., working capital debt, capital lease obligations).*

Merger

In a negotiated merger, two separate entities combine to form a single entity. Unlike an asset sale or a stock sale, the seller in a merger does not directly transfer assets or ownership interests in a target entity to the buyer. Instead, the seller allows the target entity to be merged with the buyer. In the most common type of merger (also known as a "reverse triangular merger"), the buyer creates a new wholly-owned subsidiary (also known as a "merger sub") into which the target entity is absorbed. The merger sub is then dissolved post-transaction, leaving the original target as the surviving legal entity wholly owned by the buyer. Because mergers do not require consent from all existing shareholders of a target entity,

negotiated mergers are generally sought when the ownership of a target entity is comprised of diverse and/or individual shareholders.

Other Transaction Arrangements

Other common transaction arrangements within the healthcare space include joint ventures, affiliations, and subsidiaries.

A joint venture is an arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task, such as a new service line or business activity. In a typical joint venture, two entities share governance over a separate new entity and participate in an agreed upon level of profit- and risk-sharing in the separate entity.

The terms "affiliate" and "subsidiary" refer to the degree of ownership that a parent entity holds in another entity. An affiliation (sometimes referred to as an association) is an arrangement in which one party owns less than 50% of another party. Thus, an affiliate (or associate) company is generally an entity whose parent entity is the minority shareholder. In contrast, a subsidiary is an entity whose parent is the majority shareholder (i.e., owns more than 50% in the subject entity). Affiliations provide the most flexible structure for healthcare organizations and may be used to increase the footprint of an organization and to create referrals.

For any of the above transaction arrangements, the prices ultimately paid between the parties are determined through valuations of the subject arrangements. As discussed in further detail below, the valuation process of subject arrangement involves a combination of approaches and requires highly skilled valuation experts to determine the true value of a subject arrangement.

FAIR MARKET VALUE STANDARD

Any financial arrangement within the healthcare space that includes or entails a referral relationship between the parties must comply with the fair market value ("FMV") standard. FMV is a specific standard of value that adheres to assigned definitions in regulatory context—definitions that have been further translated by both the valuation community and by case law. FMV is defined by the Internal Revenue Code as:

> "…the price at which the 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 relevant facts."[1]

The federal Anti-Kickback Statute[2] and Physician Self-Referral Law[3]—also known as the Stark Law—impose additional limitations on the parameters of FMV for financial arrangements within the healthcare space. The primary purpose of the Anti-Kickback Statute is to protect patients and federal healthcare programs from fraud and abuse by ensuring that individuals or entities party to a subject financial arrangement do not receive any form of remuneration in return for inducing services payable under federal healthcare programs. The primary purpose of the Stark Law is to prevent the monopolization and overutilization—

[1] Rev. Rul. 59-60, 1959-1 C.B. 237—I.R.C. §2031 (Also §2512.) (Also Part II, §811(k), §1005, Regulations 105, §81.10.)
[2] 42 U.S.C §1320a-7b(b)
[3] 42 U.S.C §1395nn

which can lead to overinflated costs—of healthcare services by prohibiting the ability of a physician to refer patients to medical facilities in which the physician financial interest (e.g., ownership, structured compensation arrangement). Under these constraints, FMV is further defined as:

> "…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 agreement."

To comply with the FMV standard, the concluded value for a subject financial arrangement should fall within a range of values that would be paid by likely hypothetical buyers rather than a specific identified buyer.

COMMERCIAL REASONABLENESS STANDARD

The commercial reasonableness of any proposed transaction or financial arrangement involving physicians and hospitals is a critical standard that must be satisfied for the arrangement to withstand regulatory scrutiny. Many recent settlements relating to violations of the Stark Law and/or Anti-Kickback Statutes have originated from the failure to demonstrate the commercial reasonableness of a subject arrangement. In general, an assessment of commercial reasonableness examines whether a subject arrangement makes economic sense and is consistent with common practice.

Guidance within the Stark Law commentary offers definitional language surrounding the concept of commercial reasonableness. In a proposed ruling to Stark Law in 1998, DHHR defined commercial reasonableness as:

> "A sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals."

CMS additionally provided the following interpretation of commercial reasonableness in the preamble to the proposed Phase II regulations of Stark Law in 2004:

> "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 referrals."

Assessments of commercial reasonableness are conducted in accordance with the regulations of Stark Law, and with guidance from the Centers for Medicare and Medicaid Services ("CMS") and the U.S. Department of Health and Human Services ("DHHS"). In order for a prospective transaction or financial arrangement to be commercially reasonable, there must exist a business need, a clinical need, and a market need to justify the transaction or arrangement.

It should be noted that FMV and commercial reasonableness are separate and distinct considerations. FMV assesses the value of an arrangement in the absence of referrals while commercial reasonableness assesses whether the arrangement makes sense in the first place. It is possible for a subject arrangement

to meet FMV on a term-by-term comparison but still fail to be commercially reasonable given certain market conditions. Similarly, a transaction may be commercially reasonable but have payment terms that exceed FMV.

> ***Compliance Tip:*** *An assessment of commercial reasonableness should, at a minimum, address the following questions for a prospective transaction or arrangement:*
>
> - *Does the arrangement serve a rational clinical/business strategy in the absence of referrals?*
> - *Is the arrangement necessary for the parties to function?*
> - *Does the arrangement require the specific specialty of a physician?*
> - *Are time requirements of the arrangement defined and reasonable?*
> - *Is there an existing community need and/or quality concern to justify the arrangement?*
> - *Do there exist market conditions that could affect the reasonableness of the arrangement?*
> - *Does the arrangement duplicate any preexisting efforts?*

LEGAL PERSPECTIVE: FMV AND CASE LAW

As stated previously, the Income Approach is heavily reliant upon certain assumptions regarding the future operations of a subject company. Many of these assumptions—particularly ones that involve adjustments to historical and projected financial statements—have been scrutinized and challenged through litigation, including:

- Adjustments to revenue per case based on payor contracts that can only be secured by a specific buyer in a market;
- Projections of case volume growth without historical trends or adequate documentation to support the increase post-transaction;
- Projections of case volume in excess of existing capacity constraints without the corresponding capital and operating expenditures necessary to accommodate growth post-transaction;
- Removal of seemingly duplicative salaries and/or other expenses that are in fact necessary for operations post-transaction;
- Removal of seemingly discretionary expenses that will in fact be incurred post-transaction; and
- Failure to account for changes in owners' compensation post-transaction.

Challenges to the above concerns have been the focus of IRS cases as well as qui tam settlements with the Department of Health and Human Services' Office of the Inspector General. Some of the more notable cases frequently referenced in the context of transaction within the healthcare space are summarized below.

Derby et al v. Commissioner

In the case of Derby et al v. Commissioner, the U.S. Tax Court opined on: (i) the fair market value of intangible assets donated by more than a dozen physicians to a tax-exempt entity; (ii) whether the transfer of the intangible assets lacked donative intent; and (iii) whether the transfer had "dual character."

The case arose out of a 1994 transaction in which the member physicians of United Health Medical Group (the "UHMC Physicians") in Davis, California sold the assets of their medical group to Sutter Medical Foundation ("Sutter"). Although Sutter had offered the UHMC Physicians favorable compensation terms, it declined to offer cash consideration for the medical group's intangible assets out of concerns that: (i)

the payment would constitute a violation of the Anti-Kickback Statute; and that (ii) the payment would render the deal financially nonviable for Sutter, based on the post-acquisition projections for the medical group of the UHMC Physicians. The UHMC Physicians were advised by their counsel to instead donate the medical group's intangible assets to Sutter and take a charitable contribution deduction on their 1994 tax returns equal to the estimated FMV of those intangible assets. Based on an opinion developed by an independent valuation expert, the FMV of the intangible assets—and thus the deduction amount—was determined to be approximately $1.6 million. Following an audit and subsequent challenge of the deduction by the IRS, counsel for the UHMC Physicians retained a second valuation experts to opine on the FMV of the donated assets for the trial. Under this second opinion, which the UHMC Physicians relied upon for the trial, the FMV of the donated assets was determined to be approximately $2.5 million.

The Court ultimately accepted the IRS' conclusion that the UHMC Physicians taxpayers failed to show that the FMV of the assets acquired by Sutter exceeded the consideration received by the UHMC Physicians in exchange. In addition, the Court found fault with several aspects of the second FMV opinion, stating it did not properly the reflect transaction terms and employment agreements that were already in place at the time of the valuation. The aspects at fault were as follows:

1. The reliance upon national median physician compensation data instead of the actual compensation terms;
2. The lack of any allocation of intangible value to the personal goodwill of the UHMC Physicians;
3. The lack of any consideration for the absence of noncompetition agreements;
4. The lack of any consideration for other agreement terms in place at the time of the valuation, such as signing bonuses, guaranteed minimum compensation, and rights to participate in certain management committees; and
5. The lack of any consideration for the perceived greater professional autonomy granted by Sutter to the UHMC Physicians.

United States ex. rel. Singh v. Bradford Regional Medical Center

In the case of U.S. ex rel. Singh v. Bradford Regional Medical Center, the U.S. District Court for the Western District of Pennsylvania issued a significant False Claims Act Whistleblower Opinion. The lengthy opinion addressed the issue of whether a fixed payment can be deemed to "take into account" the volume or value of referrals for purposes of the Stark Law, and whether a fixed payment can violate the FMV standard even if a written opinion of FMV is obtained. The opinion also addressed issues concerning the burden of proof for establishing compliance with the Stark Law as well as requirements for an arrangement to be "set out in writing".

The 2011 case examined an arrangement between Bradford Regional Medical Center ("BRMC") and the medical practice of Drs. Peter Vaccaro and Kamran Saleh ("V&S"). Prior to 2001, V&S was a significant source of referrals to BRMC for nuclear camera services. In 2001, V&S entered into an equipment lease with General Electric ("GE") for a nuclear camera (the "GE Lease") and began performing the diagnostic services it had previously been referring to BRMC. In response, BRMC adopted a policy that threatened revocation of medical staff privileges for physicians who held competing financial interests with BRMC. To avoid losing their privileges, V&S entered into a sublease arrangement with BRMC for nuclear camera services. Under the arrangement, BRMC agreed to pay: (i) the monthly rent owed by V&S under the GE Lease; and (ii) an additional fixed monthly fee in exchange all other rights under the GE Lease and a noncompetition agreement from V&S. The fees paid by BRMC to V&S were based on the FMV opinion of a third-party appraiser who had been engaged by BRMC. In determining FMV, the appraiser compared

the revenue levels that BRMC could reasonably expect with the sublease arrangement in place to those that could be expected without the sublease arrangement in place. Thus, the FMV opinion was based upon the assumption that V&S would likely refer their nuclear services to BRMC so long as V&S did not have a financial incentive to refer those services elsewhere.

The Court ultimately held that the arrangement between V&S and BRMC constituted an "indirect financial relationship" under the Stark Law because the fixed payments "took into account" anticipated referrals from V&S. BRMC had argued that because the payments were fixed-fee in nature, were deemed to be commercially reasonable, and were not shown to exceed FMV, they did not incorporate referrals. BRMC further argued that the sublease arrangement qualified for protection under the Indirect Compensation Arrangement Exception because one of the requirements for invoking the exception is that the compensation must be set at FMV. The Court rejected these arguments by noting that: (i) the first required assessment of an indirect compensation arrangement under the Stark Law is whether that arrangement "takes into account" referrals; and that (ii) the FMV of the arrangement should not be considered unless and until a defendant raises to invoke an exception under the Stark Law. The Court additionally maintained that any compensation arrangement that "takes into account" anticipated referrals would "necessarily be greater than what would be paid by parties who are not in a position to refer business to each other", and thus would not reflect FMV.

United States ex Rel. Barbetta v. DaVita HealthCare Partners, Inc.

In October 2014, DaVita HealthCare Partners, Inc. ("DaVita") entered into a settlement agreement with the U.S. Department of Justice ("DOJ") to resolve allegations that were originally brought in a lawsuit against DaVita filed under the qui tam or whistleblower provisions of the Federal False Claims Act. As part of the settlement, DaVita agreed to pay $350 million to settle claims it violated the Federal False Claims Act, and $39 million in civil forfeitures tied to two specific transactions.

The allegations claimed that between March 2005 and February 2014, DaVita identified physicians or physician groups that had significant patient populations suffering renal disease and offered them lucrative opportunities to partner with DaVita by acquiring and/or selling interests in dialysis clinics to which their patients would be referred for dialysis treatment. The allegations claimed that in order to make the transactions financially attractive to potential physician partners, DaVita manipulated the financial models used to value the transactions, which resulted in the physicians paying less for their interests and realizing extraordinarily high returns on their investments. The allegations further claimed that DaVita sequentially ensured referrals of these patients to the clinics through a series of secondary agreements with the physicians that would have prevented the physicians from referring their patients to other dialysis providers.

As part of the settlement agreement, DaVita entered into a five-year corporate integrity agreement of the Office of the Inspector General to the Department of Health and Human Services. Under the agreement, DaVita was required to unwind and restructure several of its joint venture arrangements and appoint an independent monitor to review DaVita's prospective arrangements with other nephrologists and healthcare providers to ensure subsequent compliance with the Anti-Kickback Statute.

United States ex rel. Payne, et al v. Adventist Health System / Sunbelt, Inc.

In September 2015, Adventist Health System ("Adventist") entered into a settlement agreement with the DOJ and agreed to pay $115 million to resolve allegations that were originally brought in a lawsuit against Adventist filed under the whistleblower provisions of the False Claims Act. The allegations claimed that

Adventist submitted false claims to the Medicare and Medicaid programs for services rendered to patients referred by employed physicians who received bonuses based on a formula that improperly took into account the value of referrals from the physicians to Adventist. The allegations further claimed that Adventist submitted bills containing improper coding modifiers to Medicare and obtained greater reimbursement for these services than entitled.

United States ex rel. Reilly v. North Broward Hospital District

In September 2015, North Broward Hospital District ("NBHD") entered into a settlement agreement with the DOJ and agreed to pay $69.5 million to resolve allegations that were originally brought in a lawsuit against NBHD filed under the qui tam or whistleblower provisions of the False Claims Act. The allegations claimed that NBHD provided compensation to nine employed physicians based on their ability to generate patient referrals. NBHD tracked the value of the referrals and pressured physicians to increase referral volume when they decreased. The DOJ contended that these agreements violated the Stark Law and the False Claims Act.

VALUATION METHODOLOGIES

In the valuation of a subject financial arrangement, three different approaches may be employed to determine its FMV: (i) the Asset Approach, (ii) the Market Approach, and (iii) the Income Approach. While each of these approaches is initially considered, the nature and characteristics of the subject arrangement will indicate which approach, or approaches, is most applicable. Each of these approaches is described in further detail below.

Asset Approach

The Asset Approach is a general way of determining a value indication of a business, business ownership interest, security, or asset by using one or more methods based on the discrete cost of reproducing specific assets and liabilities. The asset approach assumes that a prudent investor would pay no more for a security or asset than the amount at which it could be replaced or reproduced. Under the Asset Approach, an appraisal of a subject company's tangible assets and identifiable intangible assets is performed. The total asset value of the subject company is then reduced by: (i) any liabilities that will be assumed by the hypothetical buyer, as well as (ii) any assets that will not transferred to the hypothetical buyer. The remainder represents the fair market value of the subject company.

Generally, the Asset Approach is assumed to represent a "floor" of value and provides an indication of value that is materially less than indications of value using the Income and Market Approaches. The value developed under the Asset Approach is thus thought to be the value of the assets that could be obtained for such assets if they were liquidated in the event of dissolution of a business entity. In general, the value of a going concern is determined by its ability to generate earnings rather than the value of its constituent assets. Thus, the Cost Approach generally carries little or no weight in comparison to the Income and Market Approaches. The difference between the values determined under the Asset Approach and the values determined under the Income and/or Market Approaches represents the subject company's unidentifiable intangible value—commonly referred to as the subject company's goodwill.

> ***Compliance Tip:*** *From a compliance perspective, the Asset Approach entails the least amount of exposure to unknown liabilities.*

Market Approach

The Market Approach is a general way of determining a value indication of a business, business ownership interest, security, or asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities or assets that have been sold. The Market Approach is based on the principle of substitution, which reflects the premise that an informed investor would pay no more for a security or asset than he/she would pay for another security or asset of equal utility.

There are two primary methods of the Market Approach: (i) the guideline company method and (ii) the comparable transaction method. The guideline company method derives an indication of value for a subject company based upon the prices for individual shares of publicly traded comparable companies as well as the market value of debt and other sources of capital. The comparable transaction method derives an indication of value for a subject company or arrangement based upon published pricing data from actual transactions of comparable companies or arrangements within a meaningful historical period. The pricing data is then converted to standardized fractions relative to a key financial metric of economic benefit for the acquired companies, such as revenue, EBITDA, net earnings, or book value. These fractions, known as valuation multiples, are then applied to the same financial metrics of the subject company to arrive at an indication of value for the subject company.

It is important to note that valuation multiples are intended to express a relationship, in the form of a single number, between a level of capital and a specific benefit stream that accrues to the providers of that capital. Thus, for a given valuation multiple to be meaningful, its underlying financial metric (i.e., the denominator in the fraction) must bear a logical relationship to the stakeholders in the level of capital that is being measured (i.e., the numerator in the fraction). For example, if a valuation multiple is sought for the total value of a company's invested capital, then the underlying financial metric must reflect a benefit stream that accrues to all stakeholders (i.e., both debt and equity holders) in the company's invested capital.

The market approach is considered the best way to determine the value of an entity. The market approach is based on a multiple of revenue, earnings, or some other factor that is consistent with what other buyers are paying for similar businesses.

> ***Compliance Tip:*** *When reviewing a valuation analysis developed under the Market Approach, the compliance professional should be aware of the following common issues:*
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> - *Not reviewing the subject entity's historical income statements for possible adjustments.*
> - *Relying upon publicly traded company multiples without adjusting the multiple for size (e.g., a subject company with $10 million in single-source revenue vs. a guideline company with $500 million in diversified revenue).*
> - *Relying upon private transaction multiples without a full understanding of the underlying terms of those transactions (e.g., not knowing whether debt was assumed).*
> - *Not reconciling the results of the Market Approach with the terms of the subject transaction (e.g., business enterprise value vs. the valuation of specific assets subject to acquisition).*

Income Approach

The Income Approach is a general way of determining a value indication of a business, business ownership interest, security, or asset by using one or more methods that convert anticipated economic benefits into

value. Under the Income Approach, value is measured as the present worth of anticipated future net cash flows generated by a business or asset. The discounted cash flow ("DCF") method, the most common form of the Income Approach, entails estimating a subject company's capacity to generate financial benefits to its investors over the life of the investment (which may be into perpetuity) and then discounting those projected benefits to present value at a rate consistent with the inherent level of risk in the company. The present values of those benefits are then summed to arrive at a current value for the company.

While the Income Approach is generally favored by valuation professionals, it relies heavily upon certain assumptions regarding future events and information that is subject to control of the parties and is often difficult to verify. Intangible assets are particularly difficult to measure under the Income Approach since valuation professionals are constrained from assigning value to any anticipated revenues that may directly or indirectly result from referrals. Moreover, the value of one identified intangible asset may already be partially assigned to another and thus may be overstated.

> ***Compliance Tip:*** *The use of the Income Approach carries the highest degree of compliance risk. Thus, the factual assumptions of an Income Approach valuation should be reviewed carefully to ensure they are realistic, and any conclusions should be corroborated—if possible—by the Cost and Market Approaches. This is consistent with IRS' instruction that the Income Approach "be used in determining the FMV of intangible assets of a business only if there is no better basis available for making the determination".*[4]

DUE DILIGENCE PHASE: OVERVIEW

The Due Diligence Phase is the process in which organizations explore new transaction opportunities and seek to mitigate any risks associated therein. Some of these risks may include incurring criminal and/or civil liabilities of an acquired company that is later found to be tainted by corruption or overpaying for a company due to misrepresentations of its revenue and/or profit streams. Additionally, there is the risk of incurring unexpected management costs associated with resolving issues that may arise post-transaction (i.e., it can be expensive, time-consuming, and distracting).

The ultimate goal of the Due Diligence Phase is to ferret out these and related issues that may halt or complicate a prospective transaction and establish the agreed upon price and terms of the prospective transaction. During this phase, a comprehensive assessment of the assets and liabilities in connection with the transaction is conducted. Reviews are also conducted across a variety of areas, including previous and pending litigation, financial results across prior years, independent audit opinions, background checks on executives and principals, scrutiny of government excluded parties lists, and verification of assets and property records. When new transactions are being considered, attorneys are typically the first to be included in discussions so that the legal interests of all involved parties are protected. The specific amount of due diligence required for a prospective transaction depends on the size of the acquired company, the complexity of the transaction, and the risks identified therein.[5]

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[4] Rev. Rul. 68-609, 1968-2 C.B. 327—I.R.C. §1001.

[5] For more information on due diligence, see:

- Compliance Issues in M&A: Performing Diligence on the Target's Ethics and Compliance Program, by M. Mannix and D. Black, The Complete Compliance and Ethics Manual (2017), Society of Corporate Compliance and Ethics.
- Mergers and Acquisitions Due Diligence in Health Care, by R. Kusserow. Journal of Health Care Compliance (November – December 2013); CCH and Aspen Publishers.

Since the goal of the Due Diligence Phase is for the acquisition team to be fully advised of any risks associated with a target company, it is essential that compliance professionals be included in the evaluation process to mitigate unanticipated regulatory liabilities. While legal and valuation professionals look at the conditions and components that are actually present, compliance professionals determine the conditions and components that *should be* present. The due diligence efforts provided by compliance professionals typically include a review of processes common to many healthcare organizations, including:

- Compliance and privacy training;
- Focus arrangements (i.e., agreements with referral sources);
- Sanction checks or verification that sanction screening has been taking place;
- Claims reviews;
- Data analysis of evaluation and management ("E&M") codes and relative value units ("RVUs");
- CMS contractor and payor inquiries;
- HIPAA Privacy incidents, breach notifications, and Office for Civil Rights ("OCR") inquiries;
- Hotline management;
- Disclosures and government investigations; and
- Comparable policies, procedures, templates and forms.

DUE DILIGENCE PHASE: QUALITY OF EARNINGS ANALYSIS

In the outset of the Due Diligence Phase of a prospective transaction, the parties will perform what is commonly referred to as quality of earnings ("QoE") analysis. The QoE analysis is conducted to ensure that the underlying metrics of a target company factually support any representations made by the company's management, including any expectations that the target entity will continue to perform as well as, or better than, its own historical trends once it is under new ownership. The principal areas of focus in a QoE analysis are listed below:

- Reimbursement
  - Reimbursement Status,
  - Fee for service vs. Capitation or Other Bundled Payment,
  - Payor Mix,
  - Government Reimbursement, and
  - Other Reimbursement.
- Volume
  - Specialty,
  - Competition,
  - Capacity of Facility and Equipment, and
  - Status of Physicians.
- Expenses
  - Physician Compensation,
  - Other outsourced agreements, and
  - Fixed/Variable Costs.
- Risk
  - Coding,
  - Relationships with Physicians,
  - Diversification,
  - Existence of non-competes, and
  - Competition
- Other
  - Working Capital Requirements
  - Capital Expenditures

Whenever a subject healthcare organization is sought for acquisition, an analysis of a target company's revenue cycle is performed. The revenue cycle can be thought of as the financial circulatory system of a healthcare organization in that it captures all of the administrative and clinical functions that relate to a patient account. The front end of the revenue cycle manages the patient-facing aspects, such as

- What Every Compliance Officer Should Know About M&A Due Diligence, by G. Brock, J. Gilbertson, V. Griggley, T. Kraemer, and K. Woo. Compliance Today (December 2008), Health Care Compliance Association.

scheduling, registration, authorization, and upfront collections. The back end of the revenue cycle manages the post-patient functions, including claims management, medical billing, and subsequent collections.

As part of the Due Diligence Phase, coding and medical necessity audits are performed on the target company to ensure that any medical services currently being provided are properly recorded and tracked and are in fact required. The transferability of any revenue contracts (e.g., payor contracts) already in place is also determined to assess the buyer's ability to continue billing under current contracts post-transaction.

> ***Compliance Tip:*** *The due diligence team should ensure that revenue of a target company is being properly and accurately measured. An overstatement of revenue will directly increase earnings of a company, which will result in an overstatement of value under the Income and Market Approaches.*

A closely held business may incur expenses that are not necessary for operations as part of an internal strategy (e.g., maximizing tax advantages). Some examples include the employment of family members with limited professional responsibility or rent expenses charged by a related holding company at rates in excess of FMV. Additionally, a business that operates as a subsidiary of a larger entity (e.g., an ancillary service line) may incur expenses that are allocated from the parent entity. Examples include management salaries, pro rata rent, professional services (e.g., legal, accounting), and overhead costs (e.g., utilities).

Because the value of a subject company is determined in part by the expenses it incurs, the Due Diligence Phase of a prospective transaction also includes a review of the target company's expenses to determine whether expenses are being properly reported, are necessary for operations, and are incurred at FMV, and whether any adjustments are warranted.

> ***Compliance Tip:*** *When reviewing the expenses of a target company, the due diligence team should assess whether leased office space, supply contracts, equipment lease and maintenance contracts, and other third-party agreements are transferable. The due diligence team should also ensure that all vendors are in fact real.*

DUE DILIGENCE PHASE: DATA-SHARING COMPLIANCE

Parties to a transaction face compliance risk anytime data is shared since the parties are subject to the Health Insurance Portability and Accountability Act ("HIPAA"), corresponding state laws as they relate to sharing protected health information ("PHI"), and federal antitrust laws as they relate to sharing reimbursement rates and compensation rates. To maintain compliance with these laws, parties to a transaction will generally engage an independent third party to review and facilitate certain sensitive information. Because these reviews involve PHI, the transaction parties will enter into nondisclosure agreements with the third-party reviewer.

Compliance Tip: *For any third-party review of data that containing PHI, the following agreements should be established between the parties:*

- *Engagement Letter*
- *Business Associates Agreement*
- *Nondisclosure Agreement*

Additionally, when determining if a prospective transaction makes financial sense, the buyer generally reviews how the financial operations of a target company (e.g., payor contracts, cost structure, etc.) would look under the buyer's operating structure. Because this pro forma data is proprietary in nature and may capture the value of potential referrals, sharing this information internally creates a high compliance risk.

Compliance Tip: *The due diligence team should ensure that members of the negotiating team do not have access to any pro forma model developed by the buyer that depicts profit/loss metrics post-transaction.*

LEGAL PERSPECTIVE: NONDISCLOSURE AGREEMENTS AND LETTERS OF INTENT

During the Due Diligence Phase, confidentiality or nondisclosure agreements ("NDAs") are established between the parties so that negotiations can move forward with the understanding that any information shared by the parties in connection with the prospective transaction is not disclosed to anyone outside of those involved in the transaction. During the Due Diligence Phase, the parties will prepare a list of any materials it wishes to review prior to moving forward. Because the restrictions that accompany NDAs can limit access to documentation, it is important for the parties to keep track of what is and is not obtained during this time. The parties may also establish additional agreements allowing the parties to conduct the reviews in connection with the following elements:

- Conditions of Assets
- Contracts
- Government Investigations
- Indemnifications
- Labor Issues
- Licensure and Certifications
- Liens on Assets
- Ongoing Litigation
- Representations and Warrantees

As the parties become more serious about the discovery process, a Letter of Intent ("LOI")—also known as a Memorandum of Understanding—is developed, which outlines the prospective terms and agreements between the parties. At this stage, project managers for the two parties will develop timelines for the desired steps in order to keep the process on task, control the discovery requests, and prevent disruption. A more tech-savvy organization may develop a tool that guides the parties through the discovery process and integration steps. Planning and collaboration are crucial during this stage to ensure that various departments do not duplicate tasks and that risks are properly assessed to mitigate interruption to the process as much as possible.

An NDA can perhaps be likened to a first date where two parties agree to discuss their similarities and differences while simultaneously agreeing to keep details of the date from their respective peer circles.

Similarly, the LOI can be likened to an engagement with a prenuptial (albeit without the public announcement and diamond investment). The LOI is when two parties commit to move forward with the relationship, find out what kind of debt each other has, outline the key terms of the process, and prepare for unfavorable outcomes.

DUE DILIGENCE PHASE: ASSESSING ETHICS CULTURE AND COMPLIANCE PROGRAMS

As compliance professionals have become acutely aware, the strength of a company's ethical culture is an important factor in how it is treated by government agencies, law enforcement, and regulators who oversee it. Even the Federal Sentencing Guidelines for Organizations ("FSGO") recognize that the ethical culture of a subject company can either positively or negatively impact the company's degree of fraud risk. Executive decision-making across the transaction space has thus increasingly begun take into consideration the ethical practices of target companies, including how they address regulatory challenges and how their management and employees prioritize integrity. These considerations are often measured in the form of an ethics culture assessment, which can provide the prospective buyer insight into the adequacy of a target company's regulatory and compliance programs, and potentially alert them to hidden acquisition costs.

> ***Compliance Tip:*** *A meaningful ethics culture assessment should focus on key themes derived from the best practices of companies that have successfully strengthened their ethical culture and managed their fraud risk.*

Additionally, the ability to assess the effectiveness of a target company's existing compliance programs can uncover otherwise hidden issues that may halt or change the transaction process. These assessments can also be used to identify more efficient practices that can be implemented for the target company.

In January 2017, the DHHS OIG hosted a roundtable of compliance professionals to discuss various methods for measuring the effectiveness of compliance programs. The roundtable aimed to solicit ideas for reviewing the standard elements of a compliance program and to assist healthcare organizations in measuring the effectiveness of their compliance programs. In March 2017, these ideas were compiled together and published as *Measuring Compliance Program Effectiveness—A Resource Guide* (the "Resource Guide"). The 52-page Resource Guide contains a list of survey questions and over 400 metrics that compliance professionals can use to assess performance across the seven standard elements that should be addressed under an organization's compliance program. These elements are:

- Standards, policies, and procedures;
- Compliance program administration;
- Screening and evaluation of employees, physicians, vendors, and other agents;
- Communication, education, and training on compliance issues;
- Monitoring, auditing, and internal reporting systems;
- Discipline for non-compliance; and
- Investigations and remedial measures.

Included in these seven elements are measurement options for organizations of different sizes, risk profiles, operational structures, industry segments, and resource levels. The purpose of the Resource Guide is to provide organizations with as many ideas as possible, be broad enough to help any type of organization, and let the organization choose which measurement options best suit its needs. Accordingly, the OIG notes that compliance professionals should not treat the Resource Guide as a "one

size fits all" checklist but should instead select metrics based on their organization's size, risk profile, resources, and industry segment.

> ***Compliance Tip:*** *The Resource Guide frequently recommends the use of surveys to learn about employee knowledge, understanding, and attitudes relating to various compliance issues. Survey results can provide valuable insight into the effectiveness of a target company's compliance programs and potentially uncover hidden surprises. To ensure legitimate and valuable results, surveys should be administered independently and preserve the anonymity of respondents. Moreover, if the survey results can be benchmarked against a sample size of organizations using identical measurements, the value of the survey increases.*

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