VMG's Health Care Transactions and M&A Report: 2016 Trends and 2017 Expectations

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Health care M&A activity continued its half-decade long growth trend in 2016. Though the dollar value of total deals decreased relative to 2015 due to a spike in managed care megadeals in 2015, when excluding 2015, the dollar value of deals has continued to increase annually since 2012. The increase in both volume and value of health care M&A activity is driven by changing technology, an aging population, an increase in the number of insured people through the Patient Protection and Affordable Care Act (ACA), and the implementation of value-based payments and alternative payment models. Taken together, these factors have driven providers to consolidate in an effort to take advantage of the economies of scale necessary to meet the goals of the "triple aim," namely, increase service offerings and access to care, decrease cost, and improve the quality of care.

Leveraging VMG's expertise as a leading provider of transaction health care valuation services, this article examines 2016 trends and 2017 expectations across seven prominent health care verticals. An overarching factor shaping the near-term future of health care M&A activity will be the effect of any changes to the ACA in 2017. While buyers tend to proceed cautiously in the face of uncertainty, large regulatory changes affecting health care providers has historically been accompanied by an increase in M&A activity.

Ambulatory Surgery Centers

The total number of Medicare-certified ambulatory surgery centers (ASCs) in the United States grew at a compound annual growth rate of 1.1%, increasing from 5,135 ASCs in 2010 to 5,496 ASCs in 2016.[1] The ASC industry continues to remain highly fragmented with approximately 72% of freestanding ASCs being independently owned and operated. The remaining 28% of the ASC industry is controlled by large players, including United Surgical Partners, Inc., AmSurg Corp., Surgical Care Affiliates, Inc., HCA Holdings, Inc., Surgery Partners, and other multi-site operators.

In 2016, VMG observed a decrease in valuation multiples with median total invested capital (TIC) to trailing twelve month (TTM) earnings before interest, taxes, depreciation, and amortization (EBITDA) (TIC/TTM EBITDA) declining from 6.7x in 2015 to 6.5x in 2016. Despite the decline in median multiples, over the same period, we observed a wider dispersion in TIC/EBITDA multiples with the top transaction multiples (i.e., those in the 75th percentile and above) increasing from greater than 7.2x in 2015 to greater than 7.8x in 2016.

Table 1: VMG Observed ASC Multiples

TIC / EBITDA	2014	2015	2016
25th Percentile	5.9x	5.7x	5.0x
Median	7.0x	6.7x	6.5x
75th Percentile	9.1x	7.2x	7.8x

On November 1, 2016, the Centers for Medicare and Medicaid Services (CMS) released the 2017 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center payment system policy changes and payment rates final rule. Based on the final rule, ASC payment rates will increase by 1.65% in 2017. Beginning January 1, 2017, CMS began implementing its site neutral policy. The goal of the policy is to stop paying hospital off-campus facilities the same reimbursement rates as hospital outpatient departments (HOPD). For ASCs which are billed as HOPDs, the change could cut reimbursement rates by up to 50.0%. Facilities affected under this policy include facilities located more than 250 yards from a hospital's campus that began serving patients after November 1, 2015 and were previously billing Medicare as an HOPD.

The trend of consolidation and mega-transactions continued in 2016, following the 2015 merger of Tenet Healthcare Corporation and United Surgical Partners, Inc. Two of the three publicly-traded ASC companies were involved in megadeals in 2016.

Envision Healthcare Holdings, Inc. merged with AmSurg Corp. on December 2, 2016 in an all-stock deal that valued the combined entity at an implied total enterprise value (TEV) to TTM EBITDA multiple of 10.0x.[2] Additionally, Optum (a subsidiary of UnitedHealth Group) announced the acquisition of Surgical Care Affiliates, Inc. (SCA) on January 9, 2017 for approximately $2.35 billion consideration paid to shareholders. The acquisition is expected to close in the first half of 2017.

VMG expects the consolidation trends to continue in 2017 as ASCs seek to guard themselves from increasing reimbursement, regulatory, and competitive risk and as health systems and insurers aim to defend market share and diversify operations. Driving these factors is the health care industry's continued push to provide services in lower cost outpatient settings. We expect hospitals and health systems to continue direct participation in the ASC industry through either outright acquisitions or indirect participation via a joint venture (JV) arrangement with ASC management companies and/or local physicians. VMG expects ASC multiples to trend neutral to favorable in 2017 due to continued high demand and favorable economic variables for ASCs.

Diagnostic Imaging Centers

The diagnostic imaging market is highly fragmented with the top twenty operators accounting for approximately 13.5% of the total centers. RadNet, Inc. is the largest single operator, controlling 306 of the approximately 6,816 total diagnostic imaging centers (IMCs). In 2016, VMG observed a decrease in median TIC/TTM EBITDA multiples from 4.7x in 2015 to 4.6x in 2016.

Table 2: VMG Observed IMC Multiples

TIC / EBITDA	2014	2015	2016
25th Percentile	4.3x	4.0x	3.5x
Median	4.7x	4.7x	4.6x
75th Percentile	5.6x	5.6x	5.3x

Physician alignment with hospitals has impacted referral volume to unaffiliated and independent IMCs. Many hospitals are now pursuing transactions of IMCs after having already acquired and aligned with the referring physician groups (for example, large orthopedic groups). The IMCs are often secondary targets and might be acquired several months later, after referral patterns have shifted. The continued physician alignment trend has tempered actual and anticipated volume growth in unaffiliated IMCs and has impacted valuation multiples. Subsequently, operators are increasingly pursuing health system JV relationships in an effort to reduce competition with the health systems.

Since the passage of the Deficit Reduction Act of 2005, there have been significant reimbursement cuts for IMCs. The reimbursement cuts have targeted perceived over-utilization and cuts have been structured to incentivize upgrading equipment by providing lower reimbursement to older, technologically outdated scanners. For example, in 2017, IMCs not meeting computed tomography (CT) scanner standards will have technical reimbursement reduced by approximately 15%[1]. Estimates range from $20,000 to $150,000 to upgrade older CT equipment and up to $500,000 to replace CT equipment. Similar cuts are proposed for x-ray machines providing analog (i.e., film-based) or computed (i.e., cassette-based) imaging. The cumulative result is a dampening of cash flow returns to IMC investors as both operating expense and capital expense, as a percentage of revenue, increase.

CMS provided the 2017 OPPS final rule which increased reimbursement slightly for most modalities with the exception of magnetic resonance imaging (MRI). Reimbursement declines for MRI were primarily due to the restructuring of imaging ambulatory payment classifications payable under the OPPS. IMCs that are structured as HOPDs (and which remain HOPDs after the implementation of the site neutral policies discussed in the Physician Services section) will experience a rate increase of 1.65%. Additionally, as discussed in the Physician Services section, the CMS site neutral policies could reduce reimbursement by up to 50% for HOPDs located more than 250 yards from a hospital's campus that began serving patients after November 1, 2015 and which currently bill Medicare as an HOPD.

In March 2016, Fujian Thai Hot Investment Co. completed its $102.5 million acquisition of a 51.5% stake in Alliance Healthcare Services, Inc. (consideration paid to shareholders). The transaction resulted in implied TEV/TTM Revenue and TEV/TTM EBITDA multiples of 1.7x and 6.5x, respectively.[3]

VMG expects another slow year in IMC M&A volume as operators opt to pursue strategic partnerships and JV relationships with health systems in lieu of outright acquisitions. We expect transaction multiples to trend neutral in 2017 on lower total volume.

Physician Services

The annual volume of physician services (PS) transactions has been impacted by large regulatory changes (i.e., the passage of the ACA in 2010 and the passage of MACRA in 2015). Physicians are increasingly opting to align into larger groups, adopt the accountable care organization (ACO) model, or align with health systems rather than face the burden and expense of increased regulatory and data reporting requirements alone.

On April 14, 2015, the Senate passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which permanently removed the sustainable growth rate (SGR) formula from the determination of the conversion factor under the Medicare Physician Fee Schedule (MPFS). The SGR formula has been replaced with fixed 0.5% annual increases through 2019. Therefore, under MACRA, the conversion factor will increase 0.5% annually from 2015 to 2019. After 2019, physician payments under the MPFS will remain flat through 2025. During this time period, individual physicians can achieve payment increases through participation in either the Merit-based Incentive Payment System (MIPS), which will be developed by the Secretary of Health and Human Services, or an alternative payment model (APM).

The MIPS supersedes three legacy CMS programs: Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier. Depending on the provider's

participation level, payment adjustments in the first year will range from negative 4.0% to positive 4.0%. The range will increase annually to approximately negative 9.0% to positive 9.0% by 2022. Providers opting the Advanced APM route will have the potential for a lump sum incentive payment of 5% annually from 2019 to 2024. The following models are approved as Advanced APMs by CMS for 2017:

- Next Generation ACO Model
- Comprehensive Primary Care Plus Model
- Medicare Shared Savings Program Tracks 2 and 3
- Comprehensive End-Stage Renal Disease Care Model (Large dialysis organizations and non-large dialysis organizations two-sided risk arrangements)
- New participation models have been planned for 2018

VMG expects another year of high transaction activity as physicians and physician groups seek alignment in order to avoid penalties from MACRA's data reporting requirements. We expect the move to value-based reimbursement and alternative payment models to drive transaction activity higher in 2017. Additionally, any major regulatory changes to the ACA in 2017 will likely drive increased M&A activity, as regulatory changes have historically driven the physician services market.

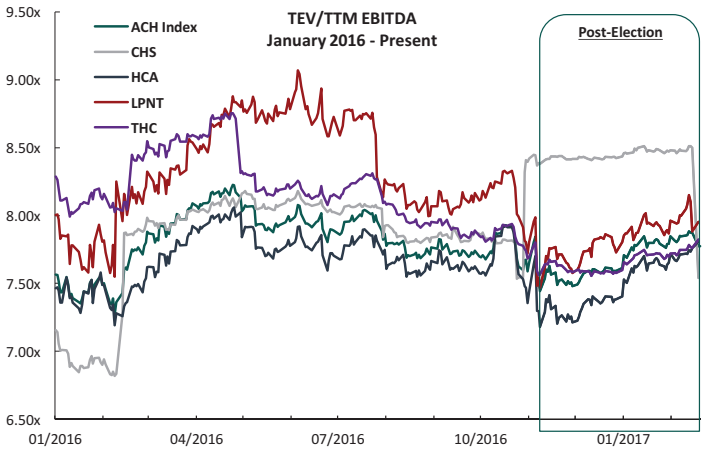
Acute Care Hospitals

As of 2016, there were approximately 4,725 general acute care hospitals (ACHs) in the United States excluding specialty hospitals. The total number of hospitals has remained relatively flat over the past 13 years, increasing slightly from 4,567 in 2003 to 4,725 in 2016.[1,4] In 2015, spending on hospital services accounted for the largest percentage of total personal health expenditures. During 2015, total expenditures on hospital services were approximately $1.036 trillion or approximately 32.3% of total national personal health care expenditures. Total hospital spending has increased 4.7% compounded annually from $902.7 billion in 2012 to $1.036 trillion in 2015.[1] The growth in hospital spending has accounted for a significant portion of growth in total national health care expenditures in recent years.

The VMG ACH Index consists of Community Health Systems, Inc. (CHS), HCA Holdings, Inc. (HCA), LifePoint Health, Inc. (LPNT), and Tenet Healthcare Corporation (THC). The VMG ACH Index ended 2016 with a TEV/TTM EBITDA multiple of 7.6x. Individually, CHS ended 2016 at 8.4x; HCA ended 2016 at 7.4x; LPNT ended 2016 at 7.7x; and THC ended 2016 at 7.6x. Quorum Health Corporation (QHC) is not included in the VMG ACH Index as the company did not start trading on the New York Stock Exchange until April 2016.

Several public for-profit health systems have been divesting a sizable amount of hospital assets in order to reduce debt. In April 2016, CHS completed its spin-off of 38 hospitals into a new public company, QHC, for approximately $1.2 billion in net proceeds. In March 2016, THC closed its sale of five Atlanta hospitals to nonprofit WellStar Health System, Inc. resulting in an enterprise value of $661 million.[3] In October 2016, HCA announced it was selling Oklahoma University Medical Center to University Hospitals for $750 million; the deal had an implied TEV/TTM Revenue multiple of 0.8x and TEV/TTM EBITDA

Table 3: VMG Index of Acute Care Hospitals



Source: S&P Capital IQ

Multiple of 7.2x.[5] Finally, in November 2016, CHS announced it was selling Spokane Washington Hospital Company, LLC to nonprofit MultiCare Health System, Inc. for $425 million.[3]

The divesting trend for ACHs isn't over yet. Trevor Fetter, the CEO of THC, has publicly stated plans to reduce portfolio risk by divesting non-core facilities. CHS announced plans to divest 25 hospitals in its 4th Quarter 2016 earnings call on February 21, 2017, and has publicly stated that CHS is focused on trying to receive around 10x TEV/TTM EBITDA on the facilities they are divesting. As mentioned above, CHS divested close to 40 hospitals in 2016 alone.

There was significant consolidation activity in 2016 as well. In October 2016, Dignity Health and Catholic Health Initiatives announced they are in merger talks. If completed, the merger would create the nation's largest not-for-profit hospital company. In May, Capella Healthcare, Inc. and RegionalCare Hospital Partners Inc. completed a merger of the two companies. The combined entity has 16 health systems in 12 states with approximately $1.7 billion in revenue. In October, Ardent Health Services and LHP Hospital Group, Inc. announced plans for a merger that would create one of the largest privately owned for-profit hospital operators in the United States.

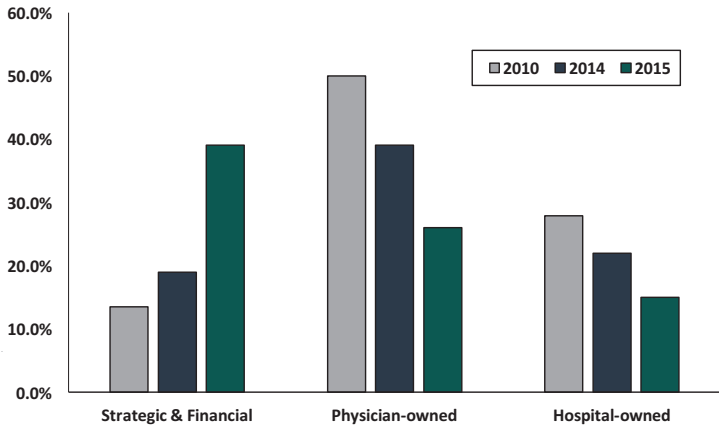
On August 2, 2016, CMS released the FY 2017 Inpatient Prospective Payment System (IPPS) policy changes and payment rates final rule. Based on the final rule, IPPS payment rates will increase by 0.95% in 2017. CMS also removed the Two-Midnight Rule's negative (0.2%) reimbursement adjustment for 2017 after years of opposition by ACHs. Additionally, total Disproportionate Share Hospital Payments, which are payments made by state Medicaid programs to qualifying hospitals who serve a large number of uninsured and Medicaid individuals, will decrease by approximately $400 million in 2017.[1]

For 2017, VMG expects a continued high level of ACH M&A activity as well as other strategic alignments, including JVs and joint operating agreements, as hospitals and health systems emphasize providing coordinated, cost-effective care. VMG expects multiples to trend neutral as large operators continue to divest non-core entities and mid-size operators continue to consolidate.

Urgent Care Centers

The urgent care industry has witnessed a surge of strategic and financial ownership in recent years. Since 2010, the percentage of urgent care centers (UCCs) owned by strategic and financial investors increased from 14% of total center ownership in 2010 to 39% of total center ownership in 2015. During the same time period, UCCs owned by physicians and hospitals decreased from 78% of total center ownership to 41% of total center ownership.[6] Data for 2016 is not available at the writing of this article, but we expect 2016 to report similar trends as observed for 2015.

Table 4: Ownership of Urgent Care Centers



Source: Urgent Care Association of America

Driving the strategic and financial interest in UCCs is the perceived potential for positive cash flow generation through expansion of an existing platform and/or operational changes. Thriving UCCs are generally able to provide cash flow returns to strategic and financial investors due to either 1) high levels of volume in underserved markets or 2) leverage of mid-level providers relative to physician providers. Many financial investors are acquiring physician-owned and operated UCCs and implementing a staffing model more heavily reliant on lower cost mid-level providers. State laws regulate the amount of physician oversight required in individual UCCs.

There were several large UCC transactions in 2015. In March 2015, post-acute provider Select Medical Corp. and private equity firm Welsh, Carson, Anderson & Stowe (WCAS) announced they were entering into a JV, acquiring Concentra Inc. and its 300 UCCs from Humana Inc. for a purchase price of $1.055 billion and an implied TEV/TTM Revenue multiple of 1.1x.[3] In April 2015, UnitedHealth Group's subsidiary, Optum, announced it was acquiring MedExpress and its 141 UCCs from private equity firms General Atlantic, Sequoia Capital, and Highmark Capital for $1.5 billion.[3] In May 2015, private equity firm ABRY Partners, LLC announced it was acquiring FastMed and its 87 UCCs from private equity firm Comvest Partners.

Following the M&A boom of 2015, transaction activity slowed in 2016 due to buyers' need to digest recent UCC purchases. However, strategic and financial buyers remained relatively active. In January 2016, United Surgical Partners International, a JV between Tenet Healthcare Corporation and WCAS, announced it was acquiring CareSpot Express and its 35 urgent care centers from WCAS. In August 2016, private equity firm Revelstoke Capital Partners, LLC announced it was acquiring Fast Pace Urgent Care and its 36 urgent care centers from private equity group Shore Capital Partners.

Urgent care centers are reimbursed by Medicare according to the MPFS. On November 2, 2016, CMS released the FY 2017 MPFS payment and policy changes final rule and increased the MPFS conversion factor by approximately 0.24% in 2017.

VMG expects continued expansion in the UCC industry in 2017 driven by the health care industry's continued push to lower-cost outpatient settings and increased consumer demand for cheap, convenient access to care. We expect an increase in volume of UCC patients due to the ACA creating newly insured patients every year, many without a primary care provider. Despite the growth in the UCC industry, M&A transaction volume is expected to stay below 2015 levels as buyers continue to digest acquisitions and expand on previously acquired platforms. VMG expects UCC multiples to trend neutral to favorable in 2017 due to high demand and low supply of mature entities.

Freestanding Emergency Departments

The two classifications of freestanding emergency departments (FSEDs) are hospital-based off-campus emergency departments (Hospital-Based ED) and independent freestanding emergency departments (Independent ED). Hospital-Based EDs are hospital-run and must be located within 35 miles of the affiliated hospital, integrated with the affiliated hospital, adhere to Medicare Conditions of Participation, be licensed by the state, meet the requirements of 24-hour per day operations, and must comply with the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA requires all who come to an emergency room to be treated regardless of insurance status or ability to pay. Independent EDs, on the other hand, do not have an affiliation to a hospital, are not recognized by CMS as emergency departments, are not reimbursed by Medicare, and therefore have no obligation to comply with EMTALA.[7]

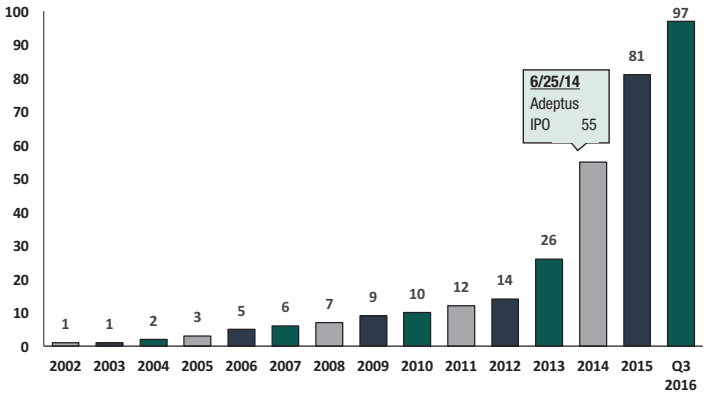
Independent ED operators have been leading the growth in FSEDs by rapidly opening Independent EDs primarily in states with no Certificate of Need (CON) requirements and where FSEDs are permissible. For example, as of 2010, the state of Texas had no Independent EDs. As of 2015, Texas had 156 Independent EDs, approximately 90% of the 172 Independent EDs in the U.S., with the majority of the remaining 10% located in fellow non-CON states Arizona and Colorado.[4]

Regulatory scrutiny of FSEDs has increased recently with the growth of the industry. The Medicare Payment Advisory Commission (MedPAC) has recommended adding modifiers flagging FSEDs' claims, asserting that FSEDs benefit from an exemption to the site-neutral payment law. There has been criticism

claiming patients mistake FSEDs for urgent care centers and can end up with a bill as much as ten times higher than the same service performed in an urgent care setting. Additionally, there have been claims that Independent ED operators benefit from the EMTALA exemption, as well as claims that Independent EDs purposely place facilities in ZIP codes where it is less likely to serve uninsured patients.

Adeptus Health Inc. (Adeptus), the largest U.S. operator of FSEDs, grew from one FSED in 2002 to 97 FSEDs in Q3 2016. The inability of Independent EDs to accept Medicare, Medicaid, or Tricare has proven to be an issue for operators such as Adeptus, who is witnessing significant commercial volume declines in the company's Independent ED markets. In order to gain access to government payer volumes, in 2016 Adeptus built several micro-hospitals to convert their Independent EDs into Hospital-Based EDs. In another strategy to convert Independent EDs into Hospital-Based EDs, Adeptus entered into multiple JV agreements with health systems. These strategies have led to a heavy drain on Adeptus' capital resources. As a result, Adeptus' stock price decreased from a high of $120.88 on August 4, 2015 to $7.64 on December 30, 2016.

Table 5: Growth in Adeptus' Freestanding EDs



Source: Adeptus S-1 Filing

Hospital-Based EDs are reimbursed under the Hospital Outpatient Prospective Payment System (OPPS). Based on the FY 2017 OPPS final rule, the OPPS payment rates will increase by 1.65% in 2017. Additionally, CMS has exempted Hospital-Based EDs from the site-neutral payment rule to ensure access to care. As mentioned previously, Independent EDs are not eligible for reimbursement from Medicare.

VMG expects FSED M&A to slow in 2017 as regulatory scrutiny increases and patient education on FSEDs' high pricing compared to urgent care centers continues to pose a risk to volume, revenue, and cash collection for FSED operators. We expect valuation multiples to trend lower as the aforementioned risks are digested by buyers. With the difficulties surrounding government payer volume for Independent EDs, VMG expects de novo Independent EDs to slow down in 2017 as well.

Post-Acute Care

Post-acute care facility types include skilled nursing facilities (SNF), long-term acute care hospitals (LTACH), inpatient rehabilitation facilities (IRF), home health agencies (HHA) and hospice agencies (HSPA). The number of Medicare certified post-acute facilities in the United States is published by MedPAC annually. The 2017 MedPAC report has not been released yet. As such, we are relying on the 2016 MedPAC report, which is based on 2014 data.

The number of Medicare certified IRFs decreased from 1,221 in 2004 to 1,177 in 2014. The decline during this time period is attributable to the reimplementation of the 75% rule in 2004. The 75% rule required that 75% of patients admitted to an IRF have a primary diagnosis that falls within 13 distinct high acuity diagnostic categories. Even though the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) lowered the 75% threshold to 60%, the effects of the rule still resulted in a large decrease in IRF volume, particularly by limiting the number of hip and knee replacement patients who could be treated at an IRF. It should be noted that the number of Medicare certified IRFs increased 1.4% from 1,161 in 2013 to 1,177 in 2014.

The number of Medicare certified LTACHs increased 8.6% compounded annually from 100 in 1990 to 373 in 2006, which resulted in a significant increase in Medicare spending. As a result, Congress passed the MMSEA, which imposed a moratorium on new LTACHs from 2007 to 2010. The moratorium was extended by the ACA to December 2012, but included exemptions for LTACHs that were given Certificates of Need. The moratorium on LTACHs was reinstated by the SGR Reform Act for a three-year period from April 1, 2014 to September 30, 2017.

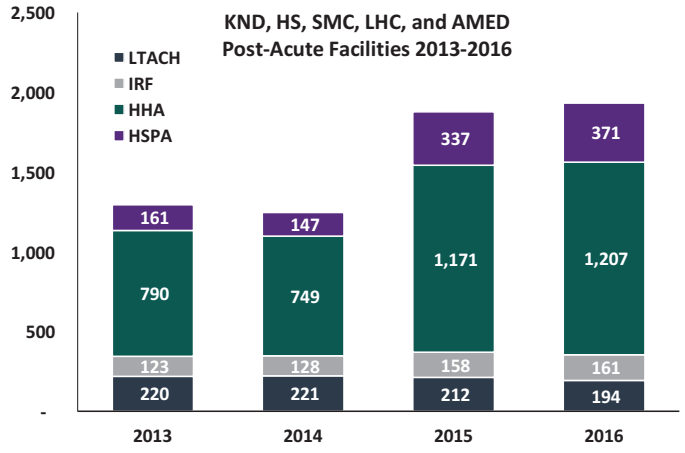
The number of Medicare certified HHAs increased 4.5% compounded annually from 7,528 in 2000 to 11,453 in 2010. CMS imposed a moratorium on new HHA enrollment on the Chicago, Dallas, Detroit, Houston, Miami-Dade, and Fort Lauderdale areas effective July 2013, determining these areas to have a high risk of fraud. The moratorium has since been expanded to include all of Florida, Illinois, Michigan, and Texas. As a result, the growth in the number of HHAs has slowed, increasing just 2.1% compounded annually from 12,199 in 2011 to 12,461 in 2014.

The number of HSPAs increased 1.7% compounded annually from 3,250 in 2000 to 4,092 in 2014. During the same time period, the number of Medicare hospice beneficiaries increased 6.7% compounded annually to approximately 1.3 million beneficiaries in 2014.

With the capital costs and regulatory pressure on LTACHs and IRFs, as well as the continued shift toward lower cost outpatient settings, M&A volume for HHAs and HSPAs has increased. This trend can be seen in the portfolios of public post-acute providers Kindred Healthcare (KND), HealthSouth (HS), Select Medical Corp. (SMC), LHC Group (LHC), and Amedisys, Inc. (AMED). Of facilities owned by these companies from 2013 to 2016, the total number of LTACHs has decreased (11.8%), the total number of IRFs has increased (30.9%), the total number of

HHAs has increased (52.8%), and the total number of HSPAs has increased (130.4%).

Table 6: Public Post-Acute Providers



Kindred acquired 74 HHAs and seven HSPAs from the Arkansas Department of Health in June 2016 for $39 million and an implied TEV/TTM Revenue multiple of 0.7x.[3] Kindred also acquired several more HHAs and HSPAs throughout the year. In February 2016, Amedisys acquired Associated Home Care and its eight HHAs for $38.1 million, of which $10.1 million is contingent on 5-year EBITDA thresholds, and an implied TEV/TTM Revenue multiple of 0.95x. Amedisys acquired three other HHAs in 2016.[3] In March 2016, Compassus, Inc. acquired the majority of Genesis Healthcare, Inc.'s HHA and HSPA operations for $84 million, with an implied TEV/TTM EBITDA multiple of 9.3x.[3] Finally, in January 2017, Almost Family Inc. completed its acquisition of an 80% interest in CHS' 74 home health and 15 hospice locations for $128 million and an implied TEV/TTM EBITDA multiple of approximately 6.5x (including full run-rate synergies).

Private equity buyers were active as well with Blue Wolf Capital Partners LLC acquiring National Home Health Care Corp. in March 2016 for $103 million[3] and acquiring Great Lakes Caring Home Health and Hospice in November 2016. Bain Capital Private Equity virtually built a home health platform overnight, acquiring Epic Health Services, Inc. in December 2016 for $950 million[3] and Pediatric Services of America, Inc. in January 2017.

Through 2016, CMS released the final Prospective Payment System (PPS) payment and policy changes for each of the post-acute verticals. CMS increased the LTACH PPS standard federal payment rate by 1.75%, increased the IRF base reimbursement rate by 1.49%, increased the HHA payment rate by 2.5%, and increased the HSPA payment rate by 2.1% for 2017.

Given the capital requirements and regulatory pressure on LTACHs and IRFs, VMG expects M&A volume in post-acute to continue to focus on HHAs and HSPAs. The fragmented status of both the HHA and HSPA industries has left plenty of room for continued consolidation. Value-based payment and alternative payment models will continue to pressure health systems to reduce hospital readmissions and direct patients to more cost-effective settings across the post-acute vertical.

Conclusion

Driven by regulatory changes, VMG expects the health care industry as a whole to continue the push towards increasing service offerings, decreasing cost while improving quality, and taking advantage of economies of scale. The decision by health care entities to enter into transactions of any size will be one that is heavily scrutinized by regulators and stakeholders. Federal and state statutes generally provide that pricing in health care transactions should consider the Fair Market Value (FMV) of the transferred business or asset. Along with hiring an experienced health care transaction attorney, securing an experienced health care financial advisor to perform a fair market value analysis can be a critical part of the due diligence process for any transaction. ◆

Sources

1 Center for Medicare and Medicaid Services
2 Envision Healthcare Corporation's Presentation at 35th Annual JP Morgan Healthcare Conference
3 S&P Capital IQ
4 Medicare Payment Advisory Commission
5 Irving Levin and Associates, *The Health Care M&A Report*
6 Urgent Care Association of America, *2016 Benchmarking Report*
7 Catherine Gutierrez, Rachel A. Lindor, Olesya Baker, David Cutler and Jeremiah D. Schuur; State Regulation of Freestanding Emergency Departments Varies Widely, Affecting Location, Growth, and Services Provided; *Health Affairs* 35, no.10 (2016): 1857-1866; doi: 10.1377/hlthaff.2016.0412