QUARTER 3 2019

FMVantage Point™

HealthCare Appraisers' Industry Insight

QUARTERLY INDUSTRY INSIGHTS

AT A GLANCE

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Monitoring Industry Activity from Quarter 3 of 2019

As part of our ongoing monitoring of developments in the healthcare industry, HealthCare Appraisers follows reports from publicly-traded health systems, physician services providers, ambulatory surgical center management companies, and other healthcare service providers. The following paragraphs are important valuation-related takeaways from recent earnings calls and conference presentations, as well as supporting quotes[1] from publicly-traded operators.

INCREASE IN DENIALS FROM PAYORS

Payors appeared more aggressive in their denials of charges from acute care and long-term care hospitals in the third quarter. While denials are always part of the back and forth between payors and providers, many of the largest hospital owners/operators reported an increase in denials from payors, and indicated that these denials negatively impacted their financial results. Specific instances discussed relate to classification as in-patient versus observation, although the trend of increased denials applied to a wide range of hospital charges. Going forward, it will be interesting to see if denial activity normalizes or remains elevated, especially as payors become more active in encouraging their members to use certain care sites.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *INCREASE IN DENIALS FROM PAYORS*

STEVE FILTON – CFO OF UNIVERSAL HEALTH SERVICES

"I think we're seeing some more aggressive behavior on the part of our payors, and we saw an elevated level of denials in the quarter...I would say that probably the most common area of denials on the acute side is over the issue of in-patient status versus observation. So it's really not so much an issue of whether a patient belongs in the hospital as it is an issue of whether they should be categorized as an inpatient or an observation patient. Obviously, as an inpatient, they would merit a higher reimbursement."

WILLIAM RUTHERFORD – CFO OF HCA HEALTHCARE, INC.

"Denials [are] a challenge for the industry that we spend a considerable amount of time and effort appealing and making a clinical case, and we have seen that activity increase."

THOMAS AARON – CFO OF COMMUNITY HEALTH SYSTEMS, INC.

"We saw an uptick in denials in the third quarter and we will look into specifically what's happening there and address our processes and see what we can do to improve that."

[1] *All quotes have been adapted from transcripts provided by S&P Capital IQ.*

MANY PERSPECTIVES ON THE SHIFT TO VALUE-BASED CARE

Payors continue to focus on steering patients to settings with lower cost of care through a variety of mechanisms. One large payor indicated that more than 20 percent of its medical spend could be shifted into a lower cost setting such as an ambulatory surgery center or outpatient imaging facility, and identified billions of dollars in savings that could be achieved by ensuring that patients see high performing providers, as defined by UnitedHealthcare in the quote below. This payor also announced a partnership with a telemedicine company that will provide access to telemedicine for 15 million of its commercially-insured members. In addition to shifting clinical care to lower cost settings, payors have invested in technology to help reduce readmissions by helping physicians get patients into the optimal post-acute care setting. There are reports by a large ASC operator of payor willingness to negotiate higher reimbursement rates, sometimes prior to the existing contract expiring, to help drive increased volume to the ASC as opposed to a hospital setting.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *THE SHIFT TO VALUE BASED CARE*

DIRK MCMAHON – CEO OF UNITEDHEALTHCARE

"There is considerable excess spending on care delivered in suboptimal, high-cost settings that can and should be provided in higher-quality, consumer-responsive and more cost-effective sites. In our commercial business alone, we see opportunity to shift well more than 20 percent of our medical spend to these more effective sites. For example, there is a significant opportunity for more hip and knee replacement procedures to be performed in ambulatory centers, with those settings often having a 50 percent cost advantage over traditional settings and with fully comparable, if not better, safety and quality. Similarly, we are better optimizing the settings for delivery of imaging procedures, and we're beginning to provide significant savings by enabling specialty drugs to be administered through alternate sites. We are rapidly expanding this approach to additional high-cost services that would be part of our site of service efforts by the end of this year. We expect these efforts to deliver $1.5 billion in savings in 2020 for our customers. The data on affordability and access is also clear with respect to high-performing physicians and health systems. We know high-performing providers, as measured by health outcomes and adherence to scientific, evidence-based medicine, provide care for people at 7 percent lower total costs. Across our businesses, this is a $9 billion annual savings opportunity."

"There is also significant potential to better transition patients from acute to post-acute care settings. Over the past year, we've deployed new technology that analyzes millions of data points to help physicians arrive at the specific care setting that's optimal for an individual's unique circumstance. On average, we realize nearly a 10 percent reduction in unnecessary readmissions by selecting the most appropriate clinical setting for the unique needs of the patient."

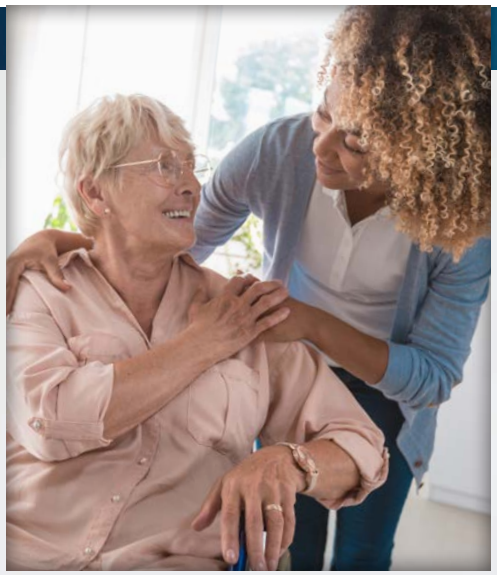
WAYNE DEVEYDT – CEO OF SURGERY PARTNERS, INC.

"it's always our preference, as we said, to first partner with the payor on the right market structure. But if that's not available to us, we know there [are] many providers and health systems out there that would like to partner with us as well. And we continue to try to partner with those that want to be a value play in the market. But under any scenario, our rates go up. I will tell you, pretty much across-the-board as we look at our book and as we're going through these negotiations, we can either partner with a health system and have meaningful rate increases or we can partner with the payor and have meaningful rate increases."

JASON GOREVIC – CEO OF TELEDOC HEALTH, INC.

"In the third quarter, we saw the greatest population expansion in the company's history as more than 17 million people gained access to Teladoc. This significant increase was driven by our entrenched distribution footprint across channels, in particular, the accelerated momentum in health plans. The largest population onboarded was UnitedHealthcare's 15 million commercial members. This marks the first and only fully integrated virtual care offering within the United experience, as highlighted by their recent press release."

LARGE HOME HEALTH PROVIDERS SEE AN OPPORTUNITY TO GAIN MARKET SHARE DUE TO DISRUPTION FROM PDGM MODEL



The largest home health providers in the country see potential opportunities to gain market share as a result of disruption to smaller providers who may struggle with the implementation of the new Patient Driven Groupings Model ("PDGM") payment system. The PDGM will take effect January 1, 2020 and increases the number of payment groupings from 153 under the old system to 432 under the new system. Properly coding and billing under the new system will require a significant investment of time and resources for all providers. While the larger operators with scale and specific departments dedicated to implementing the necessary changes should be able to accomplish a relatively smooth transition, smaller providers could struggle operationally due to the disruption and incremental expenses associated with implementation. As a result, large providers believe there could be an opportunity to acquire struggling agencies at lower prices, or gain market share by hiring away providers and gaining referral resources. The recent implementation of a similar payment model in the skilled nursing facility space has led to many layoffs due to a decrease in utilization[2], and there has been significant consolidation in the skilled nursing market in 2019. Many home health operators expect a similar impact to the home health industry once PDGM is implemented, with significant disruption and consolidation starting in the second quarter of 2020.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *DISRUPTION FROM PDGM*

APRIL ANTHONY – CEO OF ENCOMPASS HEALTH CORPORATION

"I think this change just further complicates the environment for the small providers and for those who lack a sophisticated technology solution to help their clinicians manage through it. So, we do think that there is going to be disruption. To my earlier point, I think that we will probably see that disruption really begin to take hold in the second quarter [of 2020], if you look at the timing of the decrease in the RAP (Request for Anticipated Payment) payment amount, if you look at what I think will probably be some challenges on the part of the intermediaries to even process PDGM claims in the first few weeks out of the gate. We think by early April time frame, there are going to be some agencies that are really feeling the pain of all of this and there will likely be buying opportunities that will be cost-effective. Similarly there will be opportunities to take market share where folks are either just going out of business, or they've got enough issues around their business that we wouldn't be interested in buying it, but we may be able to step in and support the patients in that community, the referral sources in that community, as well as hire some of those caregivers. So, I think it's going to be a little bit of both, but I do think the disruption to small-scale providers is going to be pretty significant. We'll see it hit pretty hard beginning in the second quarter [of 2020]."

KEITH MYERS – CEO OF LHC GROUP, INC.

"One last point on PDGM, and it's a big one for our organization. We see these changes as a real opportunity for growth. We've read of some providers already laying off therapists and cutting back on other clinical staff. We are instead opening onboarding and training centers across the country in anticipation of this growth to ensure that we have the clinicians necessary to continue to deliver on our high standards of quality care...To put a finer point on how much consolidation we are expecting, I will highlight a recent article in the Home Health Care News that cited numerous industry sources predicting that PDGM and the elimination of the RAP alone will lead to the closure of over 30 percent of existing home health agencies."

[2] *https://homehealthcarenews.com/2019/10/pdpm-aftermath-offers-glimpse-of-home-health-therapy-changes-to-come/?itm_source=parsely-api*

DISCUSSIONS ON VALUATION MULTIPLES

There were several discussions of valuation multiples in the marketplace for various types of healthcare providers. In particular, valuation multiples for hospitals with positive EBITDA margins were cited as ranging from 9.5x to 11.0x EBITDA, which is fairly consistent with what HealthCare Appraisers observes in the marketplace for profitable hospitals.[5] Outpatient imaging center valuation multiples were reported to range from 4.0x to 5.0x EBITDA in markets where there is one dominant provider, with higher valuation multiples for imaging centers in markets that remain fragmented.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *VALUATION MULTIPLES*

THOMAS AARON – CFO OF COMMUNITY HEALTH SYSTEMS, INC.

"So the dynamic that we've seen through the '17, '18, and '19 divestitures are that these are hospitals with slightly higher EBITDA margins. When you look at the EBITDA multiples, those are more in the typical range you might see, 9.5x to 11x."

HOWARD BERGER – CEO OF RADNET, INC.

"On the acquisition front, the environment for M&A continues to present us with tuck-in acquisition opportunities, where we can add centers into our existing regional operations at attractive multiples of between 4x and 5x EBITDA. While we have seen multiples expand to higher levels for acquisitions of larger regional platforms outside our core markets, targets in our markets generally do not have many options when it comes to alternative buyers."

PROVIDERS OF OUTPATIENT SURGICAL SERVICES ARE EXCITED ABOUT THE OPPORTUNITIES IN ORTHOPEDICS AND CARDIOVASCULAR

CMS has recently removed a variety of procedures from the inpatient-only list, including total hip replacements, spinal procedures, and certain anesthesia services.[4] Removal from this list enables these procedures to be performed in a hospital outpatient department and is often viewed as a first step toward enabling them to be performed in an ambulatory surgical center. The removal of these procedures from the inpatient-only list, as well as the addition of total knee replacements and multiple cardiac procedures to the ASC covered procedures list, further highlights the accelerating shift from the inpatient to the outpatient setting for surgical procedures. A large operator of ASCs indicated it is actively seeking physician partners specializing in these procedures for equity syndication to take advantage of this shift. Similarly, a large payor cited the surgical procedures currently performed in an inpatient setting that could be performed in an outpatient setting as a major opportunity to reduce medical spend. These factors, coupled with CMS's broad shift toward site neutral payment practices, have helped drive strong growth in complex surgical procedure volume for many outpatient surgical services providers.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *OPPORTUNITIES IN ORTHOPEDICS AND CARDIOVASCULAR*

WAYNE DEVEYDT – CEO OF SURGERY PARTNERS, INC.

"Year-to-date, we've done approximately 800 total joint [procedures] in our ambulatory surgery centers, which is double our total at this point last year. There are physicians around the country that are doing anywhere from 500 to 1,000 total joint procedures a year, which gives you an idea of the size of the opportunity. These are mostly Medicare cases, and generally located in high retirement communities...And so we're going to continue to build those relationships with those physicians, and we're looking at syndicating in order to attract these physicians to our centers."

ANDREW WITTY – CEO OF OPTUM HEALTH

"...if you look at Q3 [2019] over a year prior, our cardiovascular operations were up 13 percent, our spine procedures up 14 percent and total joint procedures up 39 percent year-over-year in our ASC division."

WAYNE DEVEYDT – CEO OF SURGERY PARTNERS, INC.

"And finally, total hip replacements, 6 spinal surgical procedures and certain anesthesia services were removed from the Medicare inpatient-only list making these procedures eligible to be paid by Medicare in the hospital outpatient setting in addition to the hospital inpatient setting in 2020. As with total knees, which was first removed from the inpatient-only list in 2018, we believe this move could signal additional near-term and long-term opportunities for our facilities to better serve the Medicare population."

[3] *https://www.stout.com/en/insights/industry-update/healthcare-services-life-sciences-industry-update-q3-2019*
[4] *https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0*
[5] *https://healthcareappraisers.com/current-trends-in-hospital-transactions-2019/*

EDITOR

DANIEL I. LEVIN, CFA, ASA

DLEVIN@HCFMV.COM | 303.566.3177

Daniel I. Levin, CFA, ASA is a manager in the Firm's Denver office where he specializes in a wide variety of healthcare business and compensation valuation assignments. Mr. Levin's business valuation experience includes valuing hospitals, health systems, dialysis clinics, imaging centers, ambulatory surgery centers, physical therapy clinics, urgent care clinics and physician practices in connection with a wide range of transactions. Prior to joining HealthCare Appraisers in 2016, Mr. Levin was an Equity Research Associate performing industry research and investment analysis on publicly-traded healthcare companies. Mr. Levin graduated summa cum laude from Florida Atlantic University in 2013, and has been a CFA charterholder since September 2017.

ASSISTANT EDITOR

NICHOLAS J. JANIGA, ASA

NJANIGA@HCFMV.COM | 303.566.3173

Nicholas J. Janiga, ASA is a partner in HealthCare Appraisers' Denver office, where he leads the firm's business valuation and capital equipment valuation service lines. He has been providing his clients analysis and consultation in business valuation, litigation support, intellectual property and healthcare provider compensation relationships since 2006. His experience includes working with healthcare organizations, attorneys, administrators, providers, developers, consultants, investment bankers, and private equity groups in connection with transactions in the healthcare industry. Many of the transactions he analyzes involve Stark, Anti-Kickback, IRC 501(c)(3), and/or other regulatory implications, which requires analysis of fair market value and the determination of commercial reasonableness. He also has experience providing expert testimony in deposition and trial settings.