RSM QUARTERLY SPOTLIGHT

HEALTH CARE

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Data powered by PitchBook
The upset presidential election victory of Donald J. Trump and the Republican hold of the House of Representatives and the Senate signal major changes ahead in both the federal government’s approach to growth and the Federal Reserve’s approach to monetary policy. Most evident will be a return of supply-side tax cuts, large operating fiscal deficits, and a move back toward more traditional monetary policies that, over time, should lead to higher short- and long-term interest rates.

Below we outline our views on the implications of a Trump presidency for economic growth and trade, in particular, with other issues considered at greater length online.

**Economic growth**

We anticipate that the Trump administration will attempt to achieve the economic equivalence of a strategic breakout with respect to the pace of economic growth. It will also seek significant reform of Dodd-Frank, which would be a boost for Wall Street, and move to inject private competition into the health care system. Because the GOP does not have veto-proof majority, the reform of regulation governing finance and health care will be quite challenging and difficult to obtain.

While there will likely be a faster pace of growth in the near term, uncertainty about the role and status of the United States in the global economy may combine to create longer-term issues that, ironically, act as a drag on growth.

**Trade**

In our estimation, the Trans-Pacific Partnership (TPP) represents a once-in-a-lifetime opportunity for the middle market to be given preference in a multilateral trade treaty. It would not be any surprise if the TPP quickly becomes the last major policy debate of the outgoing Obama administration. Given the outcome of the election, the upcoming lame-duck session of Congress represents likely the last opportunity for a number of years to pass multilateral trade policies that decisively favor the middle market.

It is here where the greatest risks lie. It is quite clear that Trump intends to slow down the pace of economic integration between the U.S. and its trade partners. More than half of all U.S. trade is with its North American partners, and is an important source of growth in the economy. To the extent that Trump either intends to, or can, renegotiate portions of NAFTA will define what appears to be neomercantilist policies that the new administration may adopt.

Because of the relative lack of substantial policy preferences set out by the Trump campaign, at the current time, it’s difficult to quantify the overall economic impact from what policies do emerge. It is safe to say that it is best to avoid starting trade wars, which are always popular at the outset but end up harming everyone over the long term.

For consideration of the implications of a Trump presidency on taxes, infrastructure, central bank policy and interest rates, click here.

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**OTHER RESOURCES**

**The Real Economy**

A monthly publication to help the middle market anticipate and address the unique issues and challenges facing their businesses and the industries in which they operate. We also release a Global Edition on a semi-annual basis that addresses issues affecting business on a global scale. Read more.
Coming to a crossroads

Just 10.9 percent of U.S. adults under the age of 65 were recorded as uninsured during the third quarter of 2016, according to the Gallup–Healthways Well-Being Index. That is the lowest uninsured rate reported in the nine years of the index’s tracking. It also serves as a useful juncture to assess the current state of the U.S. health care industry; in fact, breaking down that statistic leads to a complete chain of events both realized and unrealized that paint a picture of current practices and policies, and how they are evolving. For example, the crux of that insured population is its composition—the highest uninsured rates are still among adults between the ages of 18 to 25 and 26 to 34. These “young invincibles” simply do not sign up for insurance at a high enough frequency to balance out the droves of older, sicker people, or, at least, they don’t yet. The recent increase in premiums is hardly likely to encourage more to sign up. Whether or not the individual mandate may eventually mitigate the issue, insurers are leaving certain markets in the meantime, citing unexpected high costs. Perhaps equilibrium can be achieved in the next enrollment period, which began in November 2016, but even if the current trend reverses and more younger, healthier people sign up this fall and winter, many are set to lose current insurance plans next year due to insurers’ exits from marketplaces. Furthermore, in some markets where insured people are set to lose their coverage, there remain only a few or even just one remaining insurer. It remains to be seen how this attrition, rising premiums and lack of choice will play out, particularly in light of the current enrollment period. Volume growth is crucial for hospitals, but the quality of the volume matters more nowadays than in the past, particularly with the advent of bundled payment models.

Such issues with the insured and uninsured population speak to potentially even more significant developments across the industry. The swelling of the insured population as well as increasing costs in general are only further encouraging care providers to emphasize population health management. Key areas of focus on the consumer-facing side include outsourcing simple and basic post-care procedures to the realm of virtual care, in addition to providing readily available holistic measures and information to patients before and after visits. As for the back end, ramping up security efforts and streamlining payment platforms remain paramount concerns. Achieving greater efficiency in the accounting of payouts and billings goes beyond simply integrating systems in the case of an acquisition or updating legacy software packages, but also increasing visibility and accountability for both consumers and providers, especially given the ongoing push toward fee-for-value schema. The federal campaign to link 90 percent of Medicare payments to quality assurance programs and half to alternative payment models by 2018 is still pushing forward, after all, even if at least one recent survey has indicated that fewer than 25 percent of U.S. hospitals are on track to meet that goal. Beyond federal nudges, improving the health care consumer experience also further impels the alignment of care toward fee-for-value models, although that leads to further complexities than may at first be presumed. For instance, how to best align care delivery with compensation? Especially as bundled payments initiatives roll out, the importance of such programs and acts as the Quality Payment Program for Advanced Alternative Payment Models and the Medicare Access and CHIP Reauthorization Act (MACRA) becomes even clearer. More clearly tying providers’ payroll to specific episodes of care will not only help with adoption and implementation of fee-for-value programs but also may help differentiate hospitals and clinic systems in quality ratings and recruitment of personnel. That last is only growing in significance when it comes to cost management—as clinician shortages loom, care providers will find it ever more necessary to invest in improving recruiting and retention.

All in all, it remains a challenging, dynamic time for U.S. health care, particularly in the arena of absorbing more and more enrollees. From that development flows the interlocking issues of keeping costs down, adapting to more stringent quality ratings, relating care episodes to patient billings in a more transparent fashion, etc. It is a slow-paced yet unceasing evolution, prompting much consolidation and plenty of divestitures among businesses as they grapple with the entire array of challenges. In many ways, some of those challenges are still essentially the same as they ever were; in others, they are entirely new phenomena in the realm of U.S. health care. In short, the more things change, the more they remain the same.
Closed transactions' tally belies sentiment

In the third quarter of 2016, 211 mergers and acquisitions (M&A) within the health care sector were closed, with an aggregate value of $43.6 billion. Although as time goes on and more data is processed that deal count figure may rise, it does currently represent the lowest quarterly tally of activity in years. Total value does not—at $43.6 billion; it sits comfortably amid the median of the past two and a half years.

“We saw a downturn in all M&A activity in the first six months of the year, not just in health care, but across all industries,” says Andy Jenkins, partner in transaction advisory services at RSM US LLP. “But the investment bankers and clients that we speak to are all expecting Q4 to be busy. The downturn has not necessarily had anything to do with negative outlooks or deal dynamics, so it’s possible activity is slipping into the back half of the year.”

Ron Ellis, senior director with transaction advisory services at RSM US LLP, agrees: “There was a short period where we slowed down for the first time in years, but now it is set to pick up.” Ellis also states that caution is still apparent, with buyers eyeing reimbursement rate trends and carefully working through due diligence. The disparity between the anecdotal evidence and data is likely driven by timing, with the actual closing of transactions dispersing the perceived level of activity. As always, the intensity of M&A varies considerably by segment. Much attention has been paid to further development of holistic treatment models as a way to achieve greater efficiency, and accordingly, areas such as behavioral health are still enjoying plenty of interest.

“We have been doing a lot of behavioral health work in the past six months.” Chris Milligan, director of health care consulting at RSM US LLP, states. “One unique opportunity came from a client that asked us to go through extensive due diligence and provide training in order to see whether or not funding within the behavioral health space was worthwhile.” As there are a minimum number of actual, standalone mental or behavioral health hospitals that still exist, Milligan adds, opportunities exist for these clinics to work with hospitals that do not possess the resources to provide mental health services in an in-patient setting. And, apart from such sector–specific expansions and deals, a fair amount of acquisitive interest from foreign corporations is likely to remain in place. “It’s primarily health care businesses where reimbursement risk is lower,” Milligan states. Ellis concurs: “It’s a growth opportunity for Chinese investors, a way to diversify further.”
SPOTLIGHT: HOSPITALS AND IN-PATIENT SERVICES

**Health Care**

**Strong focus on efficiencies**

The fee-for-value model is not necessarily new to many hospitals. In fact, as many systems contend with increasing costs and clinician shortages, a focus on providing value over volume has already been apparent. Accordingly, many hospitals are cutting capacity, with the number of hospital beds dropping from over 900,000 in 1994 to nearly 787,000 in 2014, according to the American Hospital Association Trendwatch Chartbook 2016. Providers are looking to reduce in-patient stays, directing more patients to utilize out-patient services in an effort to stem the rise of more expensive care delivery and procedures. On the patient side, consumers are also looking to manage their spend, especially as employers and other insurance sponsors pass on more costs to plan participants.

Even as hospitals look to shift more services to be delivered in an out-patient setting, they are also scrutinizing the relative quality of their branches and affiliated clinics in light of oncoming bundled payment initiatives. As hospitals become more accountable for the cost and quality of care provided, with reimbursement rates dependent on ratings and savings, they may look to divest underperforming centers to not only improve overall results but also mitigate risk. Particularly as margin and cash flows are increasingly derived from Medicare patients, as opposed to commercial payers, hospitals are looking to ensure they are in compliance and are able to get bills covered by the federal government. The MACRA final rule is now available, and early findings indicate that although during the first year of its Merit-Based Incentive Payment System (MIPS) providers will not be evaluated on cost and resource use, and flexibilities remain, there are financial incentives down the road for providers to participate fully—even if said incentives kick in later, planning for their eventuality needs to occur now. Furthermore, quality measure benchmarks will be released soon, with historical Physician Quality Reporting System (PQRS) data used for 2017 in the meantime. In short, the emphasis on value-based care delivery models isn’t lessening anytime soon.

**Hospitals/in-patient services M&A deal flow**

<table>
<thead>
<tr>
<th>Year</th>
<th>Deal Value (SM)</th>
<th># of Deals Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>$1,083</td>
<td>26</td>
</tr>
<tr>
<td>2014</td>
<td>$5,176</td>
<td>24</td>
</tr>
<tr>
<td>2015</td>
<td>$4,908</td>
<td>27</td>
</tr>
<tr>
<td>2016</td>
<td>$3,385</td>
<td>19</td>
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**Hospitals/in-patient services M&A deal flow by year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Deal Value (SM)</th>
<th># of Deals Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>$3,632</td>
<td>97</td>
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<tr>
<td>2014</td>
<td>$5,314</td>
<td>82</td>
</tr>
<tr>
<td>2015</td>
<td>$7,769</td>
<td>152</td>
</tr>
<tr>
<td>2016*</td>
<td>$5,219</td>
<td>56</td>
</tr>
</tbody>
</table>

**Hospitals/in-patient services private equity deal flow by year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Deal Value (SM)</th>
<th># of Deals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$1.7</td>
<td>19</td>
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<tr>
<td>2009</td>
<td>$0.2</td>
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<tr>
<td>2010</td>
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<tr>
<td>2011</td>
<td>$4.6</td>
<td>34</td>
</tr>
<tr>
<td>2012</td>
<td>$5.1</td>
<td>17</td>
</tr>
<tr>
<td>2013</td>
<td>$5.1</td>
<td>13</td>
</tr>
<tr>
<td>2014</td>
<td>$2.8</td>
<td>23</td>
</tr>
<tr>
<td>2015</td>
<td>$4.5</td>
<td>31</td>
</tr>
<tr>
<td>2016*</td>
<td>$1.8</td>
<td>16</td>
</tr>
</tbody>
</table>

**Hospitals/in-patient services PE deal flow by type**

- Recap
- Platform Creation
- PE Growth/Expansion
- Add-on
- Buyout

*Source: PitchBook. *As of 9/30/2016
Health Care

PRIVATE EQUITY DEAL FLOW

Health care private equity deal flow by quarter

More of a cyclical decline

In general, private equity (PE) activity has been slowing within the United States, and health care is no exception. Fresh off of recent highs, the 103 transactions closed in the third quarter of 2016 did not represent as much of a plummet as it may seem at first glance, particularly if the final tally is revised upward slightly once all data has been tabulated. Rather, it represents more of a pause, particularly as deal value remained relatively healthy.

“All our PE clients are still hungry,” Jenkins says. “Capital raising has been strong. It’s hard to find the right deal given the competitive landscape, so some are intentionally halting their efforts.” He also notes that generalist funds’ activity can also sway quarterly tallies one way or the other. Companies within the lower middle market remain attractive to PE funds, particularly as their growth potential is necessarily higher but also predicated on a three- to five-year period, suiting PE cycles. In addition, as Jenkins notes, with more equity being deployed in transactions in general, the lower reaches of the middle market are attractive simply on a pricing basis.

“Multiples have been fairly consistent,” Ellis says. The buy-and-build strategy is still extremely prevalent, which can entail some inflation of multiples as platforms performing add-ons include synergies within ROI calculations that wouldn’t be reflected in historical financials. It’s worth noting, however, that while add-ons may account for the bulk of PE dealmaking still in such spaces, Jenkins has seen an increase in the number of sponsors backed by a group of wealthy investors interested in the space, without a formal fund structure. Health care still offers opportunities for diversification. Even as the buyout cycle winds down across the PE industry as a whole, it will likely remain one of the more attractive arenas for investors.

Health care add-on activity

Health care private equity deals (SB) by sector

Source: PitchBook

Source: PitchBook

*As of 9/30/2016
Selling stays flat

PE-backed selling remained flat for another quarter, leaving 2016 on pace to come in well below the level of 2015 activity—excepting a truly frenetic fourth quarter—in a return to the tallies observed in 2014. At this point, a number of factors are contributing to the slowdown in sales, apart from typical cyclicality and interruptions to the pipeline of worthwhile opportunities in the market. One of the primary factors is simply caution, likely inspired by the typical quality of businesses looking or willing to be sold. “A few years ago, we weren’t getting too many calls related to the sell-side health care quality of earnings analysis, but now, we are quite busy,” Ellis says. “It’s either cash-basis accounting businesses going up for sale, or companies that have performed many acquisitions that need a run-rate analysis before they themselves get taken into the market by investment banks.” Ellis states that the nature of the industry itself contributes to the level of sell-side work, as surgical centers, dental practices and more that operate on a cash basis often need to convert their numbers to an accrual accounting. “For instance, with the clinic model, if you had 20 facilities five years ago, and you added five every year since, you would need to show prospective buyers the current run-rate EBITDA based on that current number of clinics,” Ellis says. “Much of that kind of analysis has added to the reasons we’re more engaged by clients now on the sell side.”
IPO ACTIVITY

The IPO market remains marked by outliers

Largely owing to a continual trickle of debuts by pharmaceuticals and biotechnology companies, initial public offering (IPO) activity in the health care sector has been healthier than in many counterparts, especially technology. Yet it still remains marked by outliers by and large. The surge in capital raised in the third quarter of 2016 is attributable to drug-ingredient maker Patheon, which accounted for no less than $719 million, or nearly half of the total. Moreover, the total number of debuts still remains at the lower end of what was experienced in the past handful of years. There simply aren’t many compelling incentives to go public for many—for those that do have reason, the market isn’t necessarily foreboding right now, but rather still marked by uncertainty and volatility. Accordingly, it’s likeliest that the trickle of pharmaceuticals or biotechnology IPOs will continue, as indicated by examples in the IPO pipeline table below, which overall will still account for most of the health care sector’s showing when it comes to going public.

RECENT HEALTH CARE IPOS

<table>
<thead>
<tr>
<th>Company name</th>
<th>Sponsor(s)</th>
<th>Sector</th>
<th>Amount (SM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patheon</td>
<td>JLL Partners, Koninklijke DSM</td>
<td>Pharmaceuticals</td>
<td>$719</td>
</tr>
<tr>
<td>Medpace</td>
<td>Cinven</td>
<td>Laboratory Services</td>
<td>$174</td>
</tr>
<tr>
<td>Protagonist Therapeutics</td>
<td>Starfish Ventures, Foresite Capital Management</td>
<td>Biotechnology</td>
<td>$90</td>
</tr>
<tr>
<td>Audentes Therapeutics</td>
<td>Venrock, Rock Springs Capital, Redmile Group</td>
<td>Drug Discovery</td>
<td>$75</td>
</tr>
</tbody>
</table>

Source: PitchBook

HEALTH CARE IPO PIPELINE

<table>
<thead>
<tr>
<th>Company name</th>
<th>Sponsor(s)</th>
<th>Sector</th>
<th>Amount (SM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ra Pharmaceuticals</td>
<td>Morgenthaler, New Enterprise Associates, Novartis Venture Funds, Novo</td>
<td>Drug Discovery</td>
<td>$75.4</td>
</tr>
<tr>
<td>iRhythm Technologies</td>
<td>Kaiser Permanente Ventures, Norwest Venture Partners, New Leaf Venture Partners</td>
<td>Monitoring Equipment</td>
<td>$74.9</td>
</tr>
<tr>
<td>Thar Pharmaceuticals</td>
<td>Innovation Works</td>
<td>Biotechnology</td>
<td>$50</td>
</tr>
</tbody>
</table>

Source: PitchBook
PE firms have more incentives to stay active

Interestingly, PE’s portion of overall deal flow hit a remarkable 36 percent in the third quarter, the highest measure recorded since the start of 2013. As larger businesses take a breather after significant activity—much as hospitals are experiencing a lull of digestion after several quarters of elevated activity—smaller PE firms geared toward the middle market are still staying active. It’s not just that there remains a preponderance of capital for PE funds to put to work, but rather, their strategies are more resilient even in times of overall subdued deal-making as they target smaller companies and plan for longer holding periods. Hence, it’s not too surprising to see the relative proportion of PE funds’ activity remain elevated or even grow further over the next few quarters. If general M&A picks up considerably to close off the year, as is fairly common, it’s likelier that PE’s percentage remains elevated, yet not quite as high as it was in the third quarter.

SELECT HEALTH CARE Q3 2016 M&A/PE TRANSACTIONS

<table>
<thead>
<tr>
<th>Company name</th>
<th>Buyer</th>
<th>Sector</th>
<th>Amount (SM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sagent Pharmaceuticals</td>
<td>Nichi-Iko Pharmaceuticals</td>
<td>Pharmaceuticals</td>
<td>$750</td>
</tr>
<tr>
<td>Beaver-Visitec</td>
<td>TPG</td>
<td>Surgical Devices</td>
<td>$540</td>
</tr>
<tr>
<td>Cardon Outreach</td>
<td>MedData</td>
<td>Practice Management</td>
<td>$400</td>
</tr>
<tr>
<td>Advanced Cell Diagnostics</td>
<td>Bio-Technie</td>
<td>Biotechnology</td>
<td>$325</td>
</tr>
<tr>
<td>PTS Diagnostics</td>
<td>Sinocare</td>
<td>Diagnostic Equipment</td>
<td>$200</td>
</tr>
</tbody>
</table>

Source: PitchBook

*As of 9/30/2016
New debt-equity regulations provide favorable treatment to many private equity investments

In April 2016, the Treasury proposed broad and controversial debt-equity regulations designed to limit erosion of the United States corporate tax base. The final and temporary regulations issued Oct. 13, 2016, significantly improve upon the proposed regulations and place the focus squarely on certain areas in which the Treasury and the Internal Revenue Service (IRS) have viewed issuance of related party debt as inappropriate or abusive.

Under new regulations many related party debts issued by US C corporations could be characterized as equity, thereby eliminating the tax shield provided by interest deduction on the recharacterized debt. In general, the regulations apply only to debt issued by US C corporations, so most debt issued by flow through portfolio investments would be exempt from equity recharacterization. In addition, only debt issued to another corporation (and certain controlled partnerships) is subject to characterization, so debt issued to a private equity (PE) fund or related entity that is a partnership for tax purposes is also exempt. Another PE-favorable position exempts debt issued amongst commonly controlled US corporations where the common control is held through a partnership or other non-corporate entity.

As a result, a large number of small and midsized portfolio investments will be exempt from the rules, which is a favorable outcome. However, where the portfolio investment is a multinational group with multiple corporate entities and related party debt, the new regulations are likely to require consideration.

As always, the regulations include a number of exceptions to every rule, so consult your tax advisor to determine if and how the new rules will impact your investments.

Read more on the new debt-equity regulations and how they may impact your investments.

5 keys for a successful enterprise health record launch

An electronic health record (EHR) implementation project has consistently been a reason for intense anxiety for executives at many health care organizations. Consider the following five keys for a successful EHR launch:

1. Design for the future. Use this EHR implementation project as an opportunity to evaluate and redesign inefficient clinical and functional workflows in the current state. When devising the scope for this implementation, try to understand the current state first and design a system which enables the desired future state. Often an IT strategic roadmap would have been devised that looks out three to five years, and aligns with the organizational goals, with the EHR implementation as one of the projects that enables that organizational vision. Utilize this strategy throughout the planning, design and build phases of this project.

2. Embrace the standard. In recent years, most EHR vendors have aggressively documented the standard configuration settings as a guide to a successful implementation. These standards are developed by the vendors with learning from their applications utilized in the field. They take into account industry best practices when it comes to workflows and often encapsulate the system build that aligns with regulatory reporting needs.

3. Train for proficiency. Training once is almost never enough. What often works best is a classroom training coupled with established lab hours where the end users are able to practice using the system in a mocked up, real world environment. Additionally, the training and user performance should be monitored post-conversion. After implementation, it is prudent to plan for a 90-day checkpoint and provide supplemental education through trends in workflow discrepancies identified during this time period.

4. Test everything. While diligence in testing the system is important and can never be downplayed, a common mistake involves a lack of focus on the completeness of the testing. Too often we see what gets tested is only what is new with the project. It cannot be emphasized enough how the testing plan should include every component in unison that will be affecting the end users’ workflow post-conversion.

5. Invest in go-live support. Having at-the-elbow support resources for the users to help them through this transition will benefit all involved. An investment in resources in the units and on the floors supporting the end users will contribute to a quicker return to normal operating levels for the end users and reduces the risk of affecting patient outcomes and billing delays.

Visit www.rsmus.com for more popular insights.
The value of RSM’s middle-market leadership

Focusing on the middle market, RSM US provides integrated transaction advisory, tax, assurance and consulting services. Our work with 1,300 middle-market health care companies gives us a deep understanding of the key trends impacting the industry. In addition, we have performed due diligence on more than 1,700 deals in the past five years, over 350 of which were health care transactions. This in-depth knowledge provides our private equity and strategic buyer clients with industry-specific due diligence considerations.

The following list shows a detailed breakdown of the PitchBook industry codes for the health care industry.

5. HEALTH CARE

5.1 Devices and supplies
5.2 Services
5.3 Technology systems
5.4 Pharmaceuticals and biotechnology
5.5 Other health care