CONSOLIDATION AND CONFLICT IN THE HEALTH CARE INDUSTRY

By Viggo Boserup, Esq.

The health care industry has experienced a significant increase in consolidations among providers of facilities and services alike. From drugs to devices to service providers, 2014 saw the largest consolidation within the health care industry in the past 20 years. These consolidations were spurred primarily by two distinct factors in the market.

The first is the reduction of reimbursements from both insurers and governmental agencies. Both 2013 and 2014 saw some of the most dramatic reductions in Medicare and Medicare-related reimbursements to service providers.

The second factor is the effect of health care reform requiring a redesign of the clinical delivery system. The Affordable Care Act (ACA) represents a transition from fee-for-service reimbursement to a results-based reimbursement. It is no longer about how many services a provider can provide, but the quality of those services, often referred to as "population health."

Mergers have been utilized to accommodate the foregoing two factors by realigning services to achieve greater scale of operations, an improvement in quality of care and/or enhanced access to care. Variations on mergers with these goals in mind include strategic partnerships and shared-service agreements essentially consisting of purchasing networks.

These changes all bring greater opportunity for conflict. They include *contractual disputes* over purchase price adjustments, valuations due to earn-out provisions, representations and warranties and countless other contractual provisions contained in the governing documents. Likewise, *non-contractual disputes* will arise out of the natural friction occurring in any combination of two previously independent companies.

Contractual Disputes

Dispute resolution should be addressed in the acquisition agreement itself, and the arbitration clause in that agreement should be crafted with greater care than is typically the case. Parties should attempt to incorporate the rules of arbitration providers specifically designed for arbitration in order to avoid the ambiguity inherent in references to statutes designed for civil litigation. The number of arbitrators and the possibility of appellate review should also be considered.

Given the unknowns created by these changes, it is possible that buyers in such transactions may insist upon earn-out provisions in which final numbers are dependent upon future revenue or profit. The earn-out portion of any transaction may constitute a significant portion of the purchase price and thus is a likely source of future conflict.

Non-Contractual Disputes

The mix of new bosses, new co-workers and changed goals will create its own set of pressures with which we have had prior experience. The shift to the emphasis on population health under the ACA, however, places most providers in uncharted territory. They will be creating goals and metrics for values that have little, if any, historical bases. This uncertainty should cause parties to seriously consider the need for compromise in the form of negotiation or mediation.

The volume of consolidations in health care will apparently continue to increase. The conflicts inherent in any mixture of entities and cultures, as well as the conflicts likely to arise from the redesign of the clinical delivery system, will also continue to rise in number. Contract disputes should be dealt with through a thoughtfully articulated dispute resolution process set forth in the governing documents themselves. Other disputes likely to arise are common to the workplace and lend themselves to other existing processes, including early negotiation and mediation. ■

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