DUFF & PHELPS

Healthcare Services: Healthcare IT Services Insights

January 2015

Revenue Cycle Management Sector is Poised for Growth in 2015

Duff & Phelps' HCIT report last focused on Revenue Cycle Management (RCM) several issues ago. The fundamentals for growth for RCM technology and outsourced service companies are strong and improving as a result of factors including the evolution of reimbursement models and the long awaited conversion to ICD-10. The convergence of these trends in 2015 could increase M&A activity in the sector by stimulating acquisition interest from buyers while providing excellent financing or exit opportunities for owners of well-positioned RCM companies. Given this outlook, a fresh look at RCM is in order.

While the hospital market is well-penetrated by RCM systems, the existing infrastructure is aged. HIMSS Analytics estimates that the average RCM system is nine years old. Given that tenure, an upgrade cycle appears inevitable and many vendors have introduced new versions of their systems in anticipation. Healthcare providers and their IT budgets have been focused on implementing clinical systems to comply with Meaningful Use and attain subsidy dollars, and that will continue. CMS reports that as of December 1, 2014, 1,681 of the 5,011 hospitals eligible for Meaningful Use subsidies had attested to Stage 2, with more expected before the December 31, 2014, reporting deadline. However, even with the continued spending requirement for Meaningful Use compliance, the evolving changes in reimbursement models and other issues discussed below may also necessitate an increase in spending on RCM systems and outsourcing. In addition, in many instances providers have experienced reduced levels of uncompensated care as a result of ACA enrollments, creating incremental cash flow that can be used for investment in new RCM systems.

The shift from fee-for-service (FFS) to various fee-for-value (FFV) reimbursement models is underway and the disconnect between payments and value is beginning to be bridged, with important implications for RCM. FFV, which is the centerpiece of CMS' ACO program, includes payment models such as bundled payments, capitation, shared savings and other risk based contracts. It is also making inroads into the commercial insurance market. One example is the pilot program announced on December 15, 2014, by the renowned MD Anderson Cancer Center and UnitedHealth Group (NYSE:UNH). It is a bundled payment model for cancer patients that focuses on the quality of patient care and outcomes. This three year program will include eight different bundled prices for care including surgery, radiation and chemotherapy services. UnitedHealth launched a similar initiative in 2010 with five medical oncology groups which treated 810 cancer patients. A report recently published on this program indicated that cancer costs were cut by a third and quality was improved.

FFV moves reimbursement away from the quantity and cost of treatment to quality. The role of physicians and providers moves beyond treatment of disease to managing

Inside

Revenue Cycle Management Sector is Poised for Growth in 2015 (cont.)

population wellness. In order to manage the financial risk associated with FFV contracts, providers must have access to more granular data about the management of populations and outcomes, cost and performance. This further increases the need to collect quality data and use predictive analytics to estimate the future cost of care for a population based on demographics, not just past claims experience, across the delivery network. In a FFV environment, providers must manage utilization and understand what is reimbursed through the bundled payment versus individually. A premium will likely be placed on RCM systems with robust contract modelling analytics given the complexities of FFV reimbursement. It is unclear whether best-in-breed or end-to-end solutions will benefit most in this new environment, but clearly there is a need for RCM systems that are more interoperable with clinical systems.

Provider-side mergers and acquisitions have created increasingly larger hospital systems and integrated delivery networks that consist of inpatient and outpatient facilities. Providers must manage financial risk and reimbursement across these increasingly large networks of caregivers in disparate facilities which is very difficult to do with legacy systems that often have limited interoperability, making the case for system-wide uniformity compelling. For example, Cerner Corporation (NasdaqGS: CERN) recently reported that its client, Adventist Health, is replacing separate patient accounting systems in its 19 hospitals with one standard RCM platform in order to eliminate duplicative processes and streamline enterprise workflows.

The oft-extended conversion date for ICD-10 coding is now set for October 1, 2015. Of course, there is substantial speculation about whether this date will hold. Last year, with the industry moving toward an October 1, 2014 conversion date, an unexpected amendment to the April 2014 “Doc Fix” legislation extended the date by a year. Various physician groups recently lobbied Congress for an additional two year delay as part of the recently enacted “Cromnibus” bill funding the federal government into 2015, but ultimately, no such provision was included. Nonetheless, physicians are well represented in Congress and there will be plenty of opportunity to attempt another extension as part of the 2015 Doc Fix or other legislation.

Whenever it arrives, ICD-10 will have a profound impact on every part of the RCM chain. The conversion to ICD-10 will vastly increase the number of disease classification codes at a time when the supply of qualified coders is tight. Schedulers and registrars will need to understand ICD-10 codes to determine what is required for more targeted pre-authorizations from payers. Most obviously, the significant increase in codes will be a challenge to charge and additional CDI can be expected to be required to support coding. The bottom line impact will be felt in the business office as staff deals with payment delays and higher rejection and denial rates.

Finally, the increased popularity of Consumer Directed Health Plans also creates challenges for providers’ revenue cycle. According to America’s Health Insurance Plans (AHIP), out-of-pocket payments by insured patients are expected to reach $420 billion in 2015, up 68% over five years, in large part attributable to high-deductible health plans. Collecting from self-pay accounts can be more challenging than doing so from government or commercial payers. When self-pay was a small percentage of total billings it mattered much less than it does today.

The combination of these and other factors will likely drive revenue opportunities for system vendors and for outsourcers as well. According to RCM vendor Greenway Medical Technologies, the RCM function of approximately 70% of today’s healthcare practices is performed in-house. Black Book Market Research estimates that approximately $7.7 billion will be spent by providers on outsourced RCM services in 2014, growing to $9.9 billion by 2016, with end-to-end service providers driving this growth. Providers are increasingly outsourcing the RCM function, concluding that dealing with the complexity of RCM is far away from their core competencies and missions.

The ACA, by creating ACOs, has been a catalyst for FFV adoption. While the ACA is slated for attack by Congress in 2015, the drivers behind FFV are here to stay regardless of whether the ACA is repealed or amended. Costs must be controlled by changing the way care is delivered and reimbursement should reflect quality and value. RCM systems and services are a critical part of this new environment.

RCM Prognosis

- ☑ Aging Infrastructure
- ☑ FFV Reimbursement
- ☑ Provider Consolidation
- ☑ ICD-10
- ☑ High Deductible Plans

Five Questions with Dena Bengson, CEO and Co-Founder of Revenue Masters

San Diego, CA based Revenue Masters is a new entrant in the RCM software market. Founded in 2011 by RCM industry veteran Dena Bengson and her husband Rick, a software development executive, the company began marketing its cloud-based RCM software to hospitals and surgery centers in early 2014. Dena has more than 29 years of experience in the healthcare industry and over the past 12 years she has provided financial, operational and strategic product development services to 67 healthcare partners. She has spent much of her career implementing revenue cycle solutions, developing and expanding service line offerings, and improving performance management throughout the revenue cycle continuum.

Q. Dena, what inspired you and Rick to found Revenue Masters?

My entire career has been focused on the revenue side of healthcare. Working with hospitals and health systems nationwide, it was very apparent that due to dated software (or lack thereof), fractured processes and inefficiencies are the drivers resulting in decreased reimbursement.

What we saw in the revenue cycle management market was that after the claim was submitted, hospitals and health systems had to buy as many as six different software solutions to ensure the claim was priced and adjudicated correctly. These solutions are usually stitched together, clunky to use and dated with limited functionality and reporting. A provider might buy 4, 5, or 6 of these from one vendor or multiple vendors. So we created a single modern solution that is affordable, seamless and flexible - one tool with 6+ functions - called the RMReimbursement Accelerator™.

Healthcare providers' revenue cycle is extremely complex with many touch points and people involved across the organization. Hospitals and health systems are at risk daily of losing revenue due to the complexity and touch point, especially as it relates to accurate payer revenue collection, where inefficiency and outdated software are common.

Many hospitals and health systems are not able to afford various patient accounting modules due to shrinking revenue as well as the spending that has been focused on clinical outcomes and electronic health records. Our goal was simply to help providers achieve one hundred percent collectability. So we bundled all A/R functions - A/R, contract modeling, collection management and revenue analytics – into one affordable, streamlined solution. Healthcare providers of all sizes are able to standardize all key performance areas within their revenue cycle, improve their data analysis and ultimately increase their cash collections while reducing their costs. Rick had fifteen years of cloud software building knowledge and we put it all together.

Q. What are the unique capabilities and characteristics that differentiate Revenue Masters from other RCM software offerings?

We provide innovative and streamlined software that encompasses multiple revenue cycle needs, allowing providers to get paid faster and more accurately. This is offered at a price point which is roughly a third of the price of what other vendors charge for one module, making it available to many health providers who could not previously afford a product like this. Clients can purchase just cloud contract modeling to ensure accurate reimbursement or the full RMReimbursement Accelerator™ for the entire workflow after a claim is dropped. We also offer a unique payment recovery contingency service that is free to the provider and we give them a login to our software to give transparency to our entire collection process. They can then later subscribe to the software and collect on their own open balance accounts and identify their own underpayments.

Q. After three years of development, Revenue Masters launched sale of its revenue cycle software in March 2014. What has the uptake been? What is the market telling you about the product?

After pilot programs we are finding that clients are asking for implementations across all of their facilities as they are identifying new underpayments and love the ease of use. Small and medium size providers love the price as they could never afford even contract modeling before. Large providers love the increased productivity for each employee and the modern user interface and reporting versus their old system.

Q. As healthcare reimbursement moves away from fee-for-service to various fee-for-performance reimbursement models, what are the implications for the Revenue Cycle industry? How is Revenue Masters positioned to succeed in this new environment?

Revenue cycle systems and operational processes in place today are designed for Fee-For-Service and not Value-Based (VB) reimbursement. As healthcare enters its patient-centered, payment-bundled era, hospitals and physicians know there will be a shake-up. Hospitals and health systems are vertically integrating risk into their models, however it is unclear which reimbursement model or a combination thereof will dominate.

New innovative tools are needed to manage the components of the new value-based payment models. The more notable change will be adding tools that fit around the revenue cycle, specifically costs and reimbursement, will be necessary to achieve the goal of a profitable margin. The RMReimbursement Accelerator™ was built in anticipation of this change.

Revenue cycle will continue to remain a top-of-mind issue as healthcare reform plays out.

Q. Contract modelling and simulation likely will become an increasingly important RCM function in a fee-for-performance world. How will Revenue Masters handle contracts that provide for bundled payments, capitated payments and other reimbursement models based on outcomes and quality?

Agreed. Contract modeling and having the ability to analyze projected payer contract rates is crucial to ensure fiscal viability. If you are not checking every claim against complicated payer contracts, you are leaving money behind.

Reimbursement is one of the most challenging aspects facing hospital and health system administration. As payers migrate to ACO'ish reimbursement models so has Revenue Masters. One of the unique aspects of our robust contract modeling software is the ability to create customized calculators based on each payer's specific reimbursement rates and terms.

Five Questions with Dena Bengson, CEO and Co-Founder of Revenue Masters (cont.)

Clearly defining the episode and the duration of the episode is critical, as it will determine both reimbursement and contractual obligation. There are four bundled models comprised of various included services and excluded services and durations. Additionally, there are other value-based payment models being introduced. Having a tool to ensure you were paid appropriately to contracted agreement as well as run various proposed payment analysis is paramount to all healthcare institutions.

Our contract modeling software is dynamic. We have incorporated the flexibility to create customized, bundle specific reimbursement calculators that incorporate new sophisticated payment models. For example, we are able to model clear episodic triggers and endpoints that define what services are included in the single payment and what services for which the hospital or health system will receive additional payments for exclusions to the defined bundle.

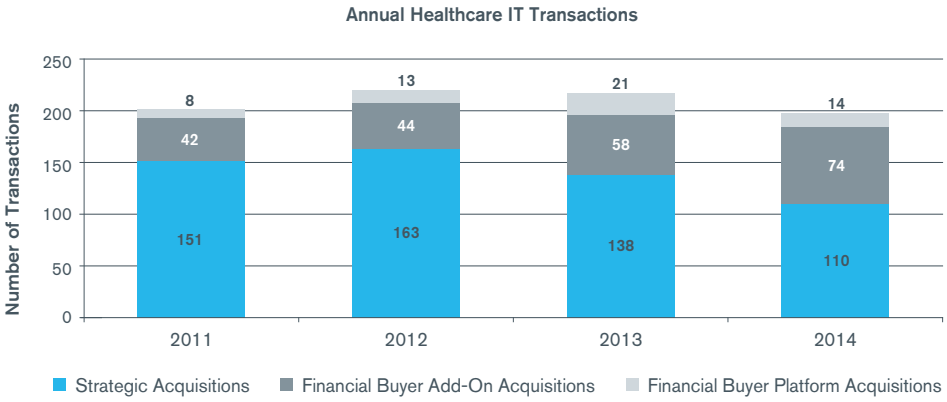
I recall the 90s when capitation and HMO payment models were introduced, providers struggled with profit margins. Providers are now faced with strategizing their fiscal viability with the transition from volume to value.

Thank you Dena Bengson for your insight into the RCM market.

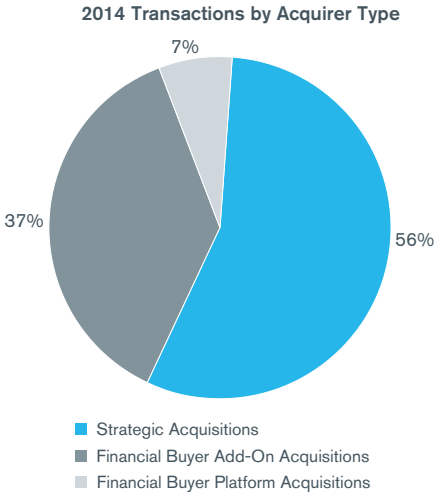
2014 M&A Activity

198 HCIT transactions were announced during 2014, compared to 217 transactions announced during 2013. Activity in the sector was supported by acquirers seeking solutions to address not only broad concerns surrounding electronic record integration and meaningful use, but also issues affecting the revenue cycle as reimbursement pressure and complexity of coding persists. Strategic buyers, including portfolio companies of financial investors, represented 93% of activity with new platform acquisitions by financial investors representing the remaining 7% of announced deals.

2014 Healthcare IT M&A Activity



Source: S&P Capital IQ



Healthcare M&A activity continues to thrive

Healthcare organizations from large provider networks to smaller physician practices have continued to struggle with issues of reimbursement and costs of technology and compliance implementation. In addition, the structural shifts resulting from the implementation of the ACA, as well as the cost pressure and shifting responsibilities between payer and providers are challenging the entire healthcare landscape. According to Black Book, in a recent study of hospital finance leaders polled on the status RCM upgrades, approximately 83% noted that their systems would become obsolete by 2016, indicating a looming need for additional investment in RCM systems and services.

Strategic acquirers headline the transaction activity with investments in RCM

In addition to private equity firms' investment in HCIT companies as both platform investments and add-ons, the second half of 2014 saw several large public companies including Team Health Holdings, Inc. (NYSE:TMH), Cognizant Technology Solutions Corporation (NasdaqGS:CTSH), Conifer Health Solutions, LLC (operating subsidiary of Tenet Healthcare Corp. (NYSE:THC)) and Optum, Inc. (operating subsidiary of UnitedHealth Group Incorporated (NYSE:UNH)) make strategic investments in RCM. An overview of these transactions can be found below.

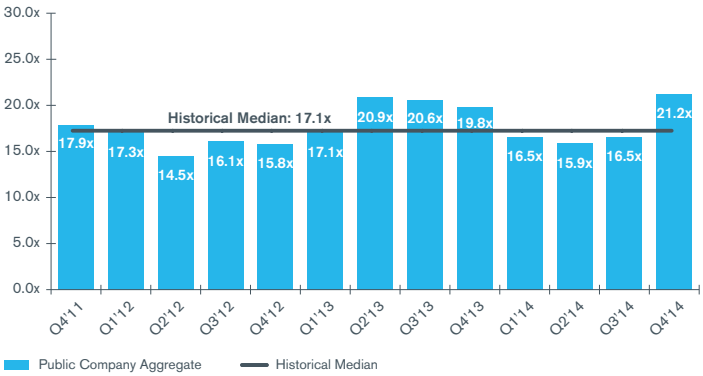
In September 2014, Optum announced the acquisition of MedSynergies, Inc., a provider of RCM and physician practice management solutions to health care organizations and physician practices, from Catholic Health Initiatives and FTV Capital for an undisclosed amount. According to the press release, the transaction is expected to enhance Optum's service offerings and provide "Optum with innovative physician practice management capabilities that complement and advance the company's focus on helping care providers improve patient care and outcomes and reduce health care costs." Larry Renfro, Optum's CEO, noted, "MedSynergies' capabilities fill out our revenue management offerings and enable us to now serve care providers across their care continuum from ambulatory and outpatient through inpatient and critical care services."

In October 2014, Conifer Health Solutions, a provider of business process management solutions for healthcare providers announced the acquisition of SPi Healthcare, a provider of revenue cycle management and physician billing services for an enterprise value of $235 million. Conifer expects the acquisition will enhance its already expansive services portfolio and solidify its position as a sole-source provider of RCM and value-based care solutions to healthcare providers. According to Stephen Mooney, Conifer's President and CEO, "We believe the combined organization will drive incremental growth for Conifer by creating an enhanced value proposition for physicians in a variety of care settings–including integrated delivery networks–that are seeking to improve their operational performance in the era of value-based care and other changes in healthcare delivery and financing."

In November 2014, Cognizant Technology Solutions, a global leader in information technology, consulting and business process services, completed the acquisition of TriZetto Corporation, a broad-based information technology solutions provider including RCM, for $2.7 billion in cash. According to the press release, Cognizant expects this acquisition to accelerate its market position and strategy of delivering innovative healthcare software and solutions to a wide range of healthcare clients. Francisco D'Souza, Cognizant's CEO, stated, "We are excited that the integrated portfolio of capabilities across technology and operations will uniquely position us to help clients drive higher levels of operational efficiency, while re-imagining care for the future."

2014 M&A Activity (cont.)

HCIT Index
Quarterly LTM EBITDA Multiples (Q4 2011 – Q4 2014)[1]



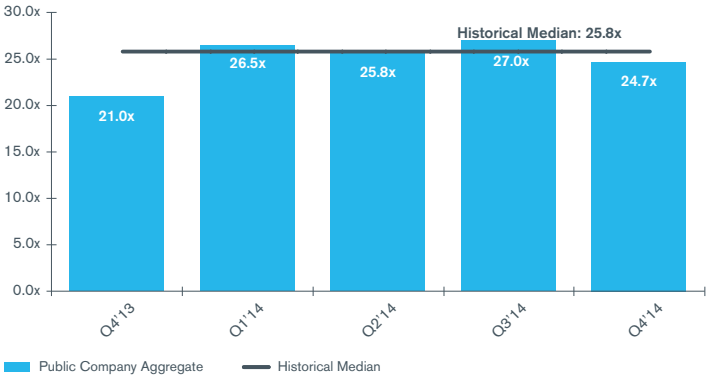
(1) EBITDA multiples greater than 100.0x are deemed not meaningful.

Multiples calculated based on the average daily LTM EBITDA multiple for the preceding fiscal quarter. As such, the multiples presented herein differ from the multiples presented elsewhere in this report.

One of the HCIT companies (MTBC) IPO'd in the second half of 2014.

Source: S&P Capital IQ

Consumer Driven Health and Wellness Index
Quarterly LTM EBITDA Multiples (Q4 2013 – Q4 2014)[2]



(2) EBITDA multiples greater than 100.0x are deemed not meaningful.

Multiples calculated based on the average daily LTM EBITDA multiple for the preceding fiscal quarter. As such, the multiples presented herein differ from the multiples presented elsewhere in this report.

Three of the CDHW companies (CSLT, EVDY and IMS) IPO'd during the first half of 2014 and two of the CDHW companies (CNXR and HQY) IPO'd during the second half of 2014.

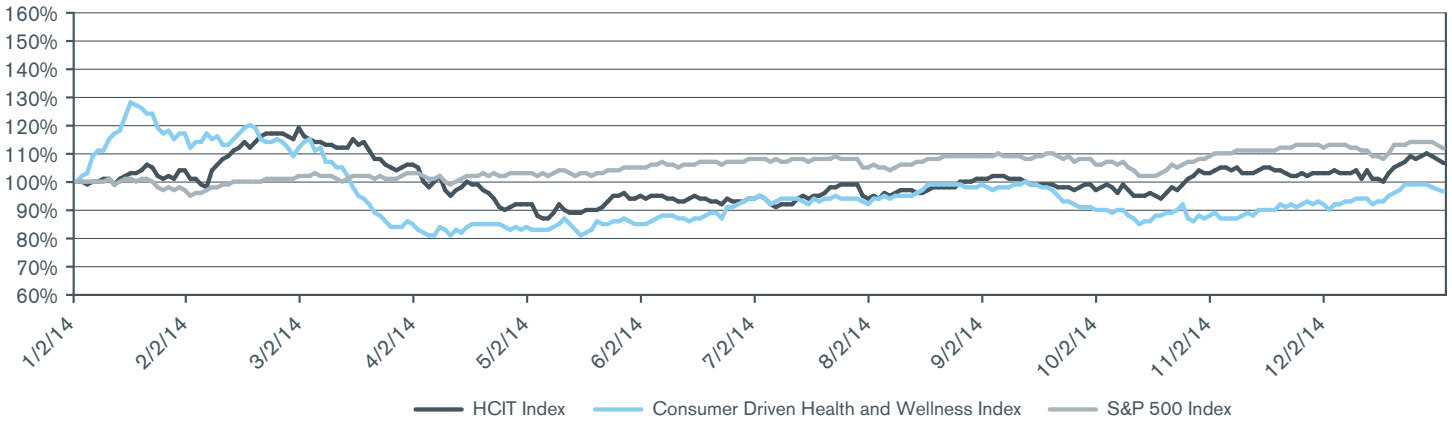
Source: S&P Capital IQ

Selected Publicly Traded Companies

Improving market conditions are driving IPO activity

Record highs set in the U.S. stock market, driven by low inflation and interest rates, a rise in consumer confidence and an increase in business spending, coupled with strong corporate earnings and a lack of alternative investment options, have fueled investor interest in IPOs. Several HCIT companies went public in 2014 including: Castlight Health, Inc. (NYSE:CSLT), Connecture, Inc. (NasdaqGM:CNXR), Everyday Health, Inc. (NYSE:EVDY), HealthEquity, Inc. (NasdaqGS:HQY), IMS Health Holdings, Inc. (NYSE:IMS) and Medical Transcription Billing, Corp. (NasdaqCM:MTBC). To end the year, on December 30, 2014, Inovalon Holdings, Inc., a cloud-based data analytics platform provider healthcare, filed an S-1 with the U.S. Securities and Exchange Commission for an IPO with a proposed offering amount of $500 million.

Stock Price Index
January 2, 2014 – December 31, 2014

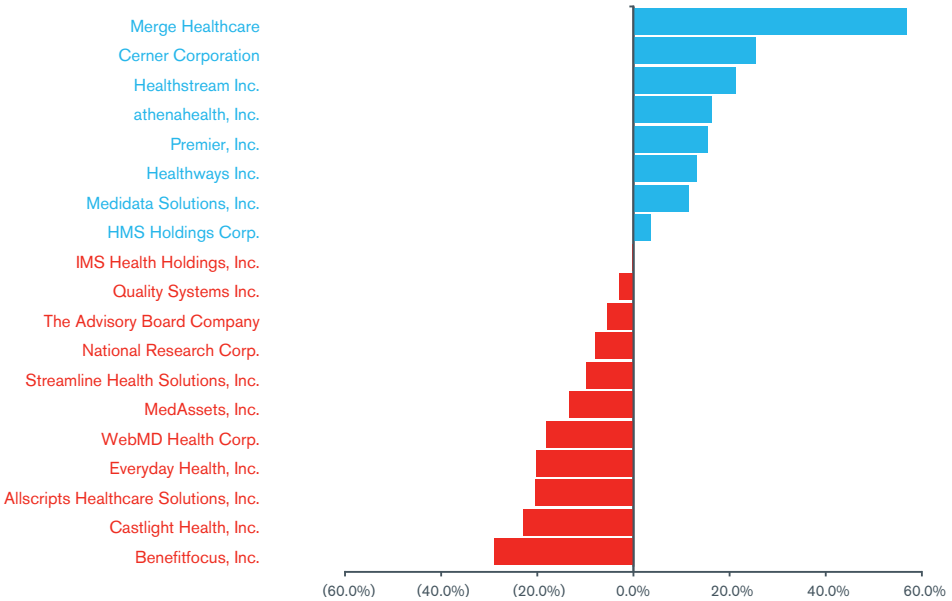


Source: S&P Capital IQ

Healthcare IT services companies underperformed the broader market. In 2014, both the HCIT and Consumer Driven Health and Wellness indices underperformed the S&P 500 index year-over-year. The HCIT index underperformed the S&P 500 by 5%, while the CDHW index underperformed the S&P 500 by 15%. In the second half of 2014, Merge Healthcare Incorporated (NasdaqGS:MRGE) was the leading performer in the HCIT index, gaining 56.8%, and Healthways (NasdaqGS:HWAY) was the leading performer in the CDHW index, gaining 13.3%.

Despite market performance, valuation multiples remain healthy. The median LTM EV/EBITDA multiple for the HCIT companies in the index increased 17.6% from 16.3x at 6/30/2014 to 19.2x at 12/31/2014. The median LTM EV/EBITDA multiple for CDHW companies decreased 8.7% from 26.4x at 6/30/2014 to 24.1x at 12/31/2014.

Stock Price Change
(June 30, 2014 – December 31, 2014)



Note: Excludes Medical Transcription Billing, Corp.; Connecture, Inc.; and HealthEquity, Inc. as each IPO'd in 2H2015
Source: S&P Capital IQ

Selected Publicly Traded Companies (cont.)

Company Name	Ticker	Price 12/31/14	% Change 6/30/14	LTM Multiples (as of 12/31/2014) Rev	LTM Multiples (as of 12/31/2014) EBITDA	LTM Multiples (as of 6/30/2014) Rev	LTM Multiples (as of 6/30/2014) EBITDA	Change in Multiples Rev	Change in Multiples EBITDA
HCIT[1]									
Allscripts Healthcare Solutions, Inc.	MDRX	$12.77	(20.4%)	2.1x	62.0x	2.5x	NM	(17.1%)	NA
athenahealth, Inc.	ATHN	145.70	16.4%	8.0x	95.3x	7.6x	82.7x	4.2%	15.2%
Cerner Corporation	CERN	64.66	25.4%	6.6x	24.8x	5.7x	21.8x	14.6%	14.1%
Computer Programs & Systems Inc.	CPSI	60.75	(4.5%)	3.1x	10.9x	3.3x	12.2x	(7.1%)	(10.8%)
Healthstream Inc.	HSTM	29.48	21.3%	4.3x	26.5x	4.0x	23.8x	6.7%	11.4%
HMS Holdings Corp.	HMSY	21.14	3.6%	4.3x	18.7x	4.0x	15.9x	7.3%	17.1%
MedAssets, Inc.	MDAS	19.76	(13.5%)	3.0x	10.1x	3.2x	10.7x	(5.8%)	(6.4%)
Medical Transcription Billing, Corp.	MTBC	2.34	NA	1.8x	NM	NA	NA	NA	NA
Medidata Solutions, Inc.	MDSO	47.75	11.5%	8.0x	NM	8.0x	90.4x	0.1%	NA
Merge Healthcare Incorporated	MRGE	3.56	56.8%	2.5x	14.0x	1.9x	16.7x	30.1%	(15.9%)
National Research Corp.	NRCI.B	35.97	(8.0%)	4.0x	12.3x	4.4x	13.8x	(8.4%)	(11.4%)
Premier, Inc.	PINC	33.53	15.6%	1.1x	3.1x	0.9x	2.4x	28.6%	32.1%
Quality Systems Inc.	QSII	15.59	(2.9%)	1.8x	19.7x	1.9x	13.8x	(8.0%)	42.6%
The Advisory Board Company	ABCO	48.98	(5.5%)	3.1x	32.3x	3.6x	33.0x	(12.8%)	(2.2%)
Mean			7.4%	3.8x	27.5x	3.9x	28.1x	(2.5%)	(2.3%)
Median			3.6%	3.1x	19.2x	3.6x	16.3x	(13.1%)	17.6%
Market Capitalization Weighted			13.7%	5.8x	33.1x	5.2x	31.2x	11.1%	6.3%
Consumer Driven Health and Wellness[2]									
Benefitfocus, Inc.	BNFT	$32.84	(28.9%)	6.4x	NM	9.9x	NM	(35.3%)	NA
Castlight Health, Inc.	CSLT	11.70	(23.0%)	NM	NM	NM	NM	NA	NA
Connecture, Inc.	CNXR	9.01	NA	2.6x	NM	NA	NA	NA	NA
Everyday Health, Inc.	EVDY	14.75	(20.2%)	2.5x	28.4x	4.7x	56.0x	(47.2%)	(49.4%)
HealthEquity, Inc.	HQY	25.45	NA	NM	NM	NA	NA	NA	NA
Healthways Inc.	HWAY	19.88	13.3%	1.3x	28.1x	1.3x	29.7x	3.3%	(5.7%)
IMS Health Holdings, Inc.	IMS	25.64	(0.2%)	4.6x	20.1x	5.0x	18.6x	(8.7%)	8.0%
Streamline Health Solutions, Inc.	STRM	4.33	(9.8%)	3.3x	NM	3.0x	NM	10.1%	NA
WebMD Health Corp.	WBMD	39.55	(18.1%)	3.0x	15.6x	3.7x	23.0x	(19.9%)	(32.1%)
Mean			(12.4%)	3.4x	23.0x	4.6x	31.8x	(26.5%)	(27.7%)
Median			(18.1%)	3.0x	24.1x	4.2x	26.4x	(29.5%)	(8.7%)
Market Capitalization Weighted			(7.3%)	3.5x	15.4x	4.6x	17.7x	(23.3%)	(12.9%)

Source: S&P Capital IQ

Note: Revenue multiples greater than 10.0x and EBITDA multiples greater than 100.0x are deemed not meaningful.

(1) One of the HCIT companies (MTBC) IPO'd during the second half of 2014.

(2) Three of the CDHW companies (CSLT, EVDY and IMS) IPO'd during the first half of 2014 and two of the CDHW companies (CNXR and HQY) IPO'd during the second half of 2014.

#1 Announced Fairness Opinions in the U.S. Over the Past Five Years

#3 U.S. Middle-Market M&A Advisor Over the Past Three Years

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Valuation and Corporate Finance Advisors

Source: Fairness opinion rankings calculated by number of deals from Thomson Financial Securities full years 2010 through 2014. M&A rankings calculated by number of deals from Thomson Financial Securities full years 2012 through 2014. Middle-market M&A deals < $200 million. Bankruptcy case ranking provided by The Deal Q3 2014 league table.

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