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# Let the Buyer Beware: The Need for HIPAA Risk Analysis in Healthcare M&A Transactions

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Healthcare mergers, acquisitions, and joint venture partnerships have surged in recent years, driven by increasing opportunities to innovate, improve quality, and reduce costs. The advancement of new business models and consolidated platforms also has played an important part in the surge.

Over the last decade, strategic acquirers and private equity investors have integrated thousands of Health Insurance Portability and Accountability Act (HIPAA) covered entities and business associates into their portfolios. Through these experiences, they have become much better educated on the regulatory and reputational risks counterparties bring as a result of a privacy or security breach.

In 2021, the number of healthcare data breaches hit an all-time high, impacting 45 million people.[1] Ransomware attacks also doubled in 2021, with healthcare among the hardest hit industries.[2] Reading about these attacks in the daily headlines, investors often think "that won't happen to us"—until it does. Any investor who has lived through a nightmare breach scenario within its portfolio is all too familiar with the associated costs, business disruption, and potential regulatory scrutiny.

## Past Breaches May Cause Future Liabilities

In addition to future cyberattacks and privacy breaches, buyers need to be concerned about liabilities they may be assuming as a result of the seller's non-compliance with HIPAA or failure to exercise the required duty of care in cybersecurity practices. It is not uncommon that breaches go undetected and unreported for months or even years, and thus they may not be identified in the due diligence process.

While the seller will typically be responsible for a breach prior to closing, determining and proving when a breach first occurred is often not straightforward, even with the support of expensive forensic experts. If the breach was ongoing and unidentified for some time after the purchase, it becomes even more complicated. Additionally, federal and state regulatory actions and civil lawsuits typically follow for years after a breach, with the buyer left managing an expensive and distracting situation. Failures of the past may weigh heavily on the organization's future growth trajectory.

Organizations that enter into joint ventures, make minority investments, or establish business partnerships also should take note of potential privacy and security liabilities and business ramifications that may occur from a counterparty's failure to comply with HIPAA or from its lack of due care in cyber risk management. Companies that partner with organizations that are responsible for safeguarding protected health information (PHI) should assess and limit their exposures in the event the other party fails to implement reasonable and appropriate security and privacy practices.

## Review the Counterparty's Risk Analysis as Part of Due Diligence

For many years, HIPAA compliance and cybersecurity were only worthy of cursory levels of diligence in healthcare transactions. However, today's investors (in particular, private equity) and their attorneys are devoting more time and resources to this area. A preventable breach associated with HIPAA failures could be a non-starter for future acquirers and therefore might significantly reduce the value of the company at a future exit. As such, investors now have a stronger appetite to invest in diligence at the same levels they are accustomed to with other traditional categories such as financial, insurance, and intellectual property.

Comprehensive HIPAA compliance and cybersecurity diligence must include a thorough review of the organization's security risk analysis. It must determine whether the risk analysis is up to date and if it complies with the Office for Civil Rights' (OCR's)[3] Guidance on Risk Analysis Requirements under the HIPAA Security Rule.[4] Demonstration of an accurate and thorough risk analysis is critical for several reasons:

1. During an OCR investigation of a breach, one of the first things the assigned investigator will ask to review is the organization's risk analysis. A failure to conduct an enterprise-wide risk analysis of all of the organization's information assets according to the OCR Guidance is *the most common deficiency* resulting in a civil money penalty or settlement. Failure to perform an adequate risk analysis is cited in 89% of these cases.[5] Recent OCR enforcement actions support that its focus on compliance with the risk analysis requirement is not going away.[6]
2. As can be inferred from the above, what most healthcare organizations call a risk analysis does not meet OCR's standards. This is true even for larger organizations, which are more complex and for whom the bar is set even higher.[7]

3. A risk analysis is the only method by which the organization—and the acquirer—can truly know what actual cybersecurity risks exist for that particular organization. A risk analysis is not simply completing a controls checklist. Rather, it evaluates the specific vulnerabilities and threats to the organization's information systems, as well as the controls in place and how well they mitigate risks. By reviewing the risk analysis, the buyer can understand what risks exist and at what level, and determine whether, based on its risk tolerance level, it will need to reduce those risks further. The buyer can work with its diligence consultant to estimate the cost and level of effort involved to reduce these risks and therefore have better visibility into how much capital investment in the security program is required. As a result, the buyer will have a better sense of the true acquisition cost of the target.

## Does the Risk Analysis Meet Regulatory Standards?

A risk analysis must meet OCR's definition and standards to be of any value. Make sure that (a) the review of the risk analysis receives particular attention in the compliance and cybersecurity due diligence process, and (b) the reviewer of the risk analysis is an expert in this area. A generalist cybersecurity firm, accounting firm, or other non-HIPAA Security Rule expert will often not have the expertise required to make this determination.

Healthcare leaders are increasingly seeking the advice of counsel when it comes to risk analysis diligence along with the broader HIPAA diligence process. Many healthcare transaction attorneys will, in turn, ask one of their healthcare and privacy security partners to assist in this area or leverage a third-party healthcare cybersecurity consultant to perform the detailed review and produce a findings and observations report.

## Include Satisfaction of 45 C.F.R. § 164.308(a)(1)(ii)(A) in Seller Representations and Warranties

Requiring representations and warranties related to HIPAA compliance along with other regulatory requirements may not be a new concept. What is new, however, is an emerging trend to specifically include representations of compliance with 45 C.F.R. § 164.308(a)(1)(ii)(A) of the HIPAA Security Rule—i.e., performance of a risk analysis. We would go further and suggest that the representations should include specifying that the risk analysis complies with the OCR guidance document previously referenced. Why is this so important? Attesting that the organization complies with HIPAA is broad, vague, and open to interpretation. It is highly likely that many organizations that paid substantial fines thought they had performed a risk analysis correctly but did not. With risk analysis failure leading the reasons for regulatory enforcement, calling out that it must have been done following OCR guidance may provide more protection for the buyer or third-party partner.

Healthcare leaders are encouraged to consult with their attorneys as to whether they should require specific representations and warranties from the seller or partner related to their performance of a security risk analysis that meets OCR standards as stated in its guidance. Attorneys can advise on whether the buyer can seek recourse from the seller if the organization incurs future damages resulting from regulatory actions or lawsuits that occur as a result of a risk analysis failure.

## Addressing Lack of, or Inadequate, Risk Analysis

It is quite common to discover through diligence that the target or partner has not performed an adequate security risk analysis that meets OCR's standards. Typical failures of risk analysis include (1) it has not been performed recently, (2) it does not include all of the organization's information assets used to create, receive, maintain, or transmit electronic PHI, or (3) it does not address reasonably anticipated threats and vulnerabilities. Additionally, the organization may have failed to respond to the high and critical risks that emerged from the analysis (known as the risk management plan).

As discussed, failure to perform a risk analysis creates a risk of a potentially substantial liability for the company or partnership. In this case, there are several approaches to help reduce risk:

1. **Require that a risk analysis be performed by the seller (or in case of a joint venture, the partner) as a closing condition.** While this may be the optimal approach from a risk perspective, it also could delay the transaction. The ability to accomplish the risk analysis quickly will largely depend on the scope, the availability of the target's resources, and the capability of the assessor to move quickly. Clearwater consultants have completed a risk analysis in less than 30 days. A typical practice would be to create the follow-up risk management plan post-closing.
2. **Require a risk analysis as a Post-Closing Covenant.** This might be a common and adequate approach in partnership agreements, minority investments, or other transactions where the seller or partner maintains control of the organization. This approach may also be more practical when timing and resources are less flexible, and when other areas of HIPAA and cybersecurity diligence provide reasonable levels of comfort that the organization has strong controls in place but has not yet gone through the process of assessing them against risks that are relevant for its organization.
3. **Buyer performs risk analysis post-closing.** In this case, the buyer is acquiring control of the company, and it can opt to perform the risk analysis after closing and should do so as soon as possible. The buyer must be comfortable with accepting the regulatory risk and the fact that until it performs the risk analysis, it will not truly know the potential risks to the confidentially, integrity, and availability of patient data and the organization's information systems. Performing an OCR-quality risk analysis carries a material cost. The buyer may wish to seek a reduction in the purchase price or request other compensation. Note that there may be additional costs associated with responding to high or critical risks, but those will not be known until after the risk analysis is complete—a further argument for performing the risk analysis before closing.

## Reps and Warranties Insurance Trend: OCR-Quality Risk Analysis Required to Underwrite Claims Due to HIPAA Violations

The highly complex regulatory environment in healthcare, along with growing concerns about patient privacy and safety, result in a large number of potential future liabilities that neither party wants to be responsible for. As a result, negotiation over reps and warranties can be one of the most arduous and lengthy parts of the deal-making process. Reps and warranties insurance can solve this issue by protecting buyers from future liabilities. The use of this insurance has become increasingly common in healthcare transactions with private equity firms. We have noticed several trends emerging regarding reps and warranties insurance:

1. **Underwriters are requiring more comprehensive HIPAA and cybersecurity diligence.** Insurers are expecting that the buyer is using a qualified expert to perform an extensive amount of HIPAA diligence as part of its overall diligence efforts.
2. **Risk analysis specifically required to avoid exclusions.** Some insurers are going as far as to specifically require that a HIPAA risk analysis is performed prior to underwriting liabilities related to HIPAA compliance.
3. **Underwriters are relying on the risk analysis as a key input in determining coverage.** In addition to ensuring the risk analysis has not only been completed but also performed correctly, the insurer wants to know what high and critical risks exist and may rely on them to justify further exclusions or limits to the coverage.

## Conclusion

While the COVID-19 pandemic slowed the pace of healthcare mergers and acquisitions initially, M&A activity surged in 2021 and the trend is expected to continue this year.[8] Fueled by the increase in cyberattacks and damages incurred with their portfolio companies and joint ventures, investors are expected to place increased emphasis on the execution of strong diligence of HIPAA compliance and cybersecurity practices as new deals develop. Risk analysis should take center stage as one of the most important components of compliance with the HIPAA Security Rule. If the target or partner has not performed a risk analysis that meets regulatory standards, it should take action to eliminate the deficiency by performing the risk analysis as soon as possible. Risk analysis reps and warranties can help protect buyers from counterparty failures, as can reps and warranties insurance. Knowledgeable underwriters will often require the insured party attests that it has not only complied with HIPAA, but that it also has performed an OCR-quality risk analysis.

Transaction attorneys play a vital role in developing the right approach and strategy. Clearwater can help conduct HIPAA compliance and cybersecurity diligence, and if necessary, perform a risk analysis on a timeline that helps achieve transaction objectives.

**Endnotes**

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# Physicians in Practice: Ways to Align and Remain Independent

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Over the past several years, the rising trend in physician practice acquisitions is well documented and continues to climb. The latest study from the Physicians Advocacy Institute (PAI) reported that hospitals nationwide acquired approximately 8,000 additional practices from July 2016 to January 2018.[1] The percentage of hospital-owned practices increased by more than 70 percent over the entire study period from July 2012 to January 2018.[2]

PAI also conducted a study on COVID-19's impact on physician practice acquisition and employment from January 1, 2019, to January 1, 2021. The study found **only 30 percent of physicians in the United States practiced medicine independently** at the beginning of 2021, and hospital systems or other corporate entities employ 70 percent of U.S. physicians.[3] When we first published this article in 2019, there were signals in the marketplace indicating independent practices were poised to return. At the 2018 MGMA annual conference, a group of physicians shared some of the unintended consequences—higher costs, physician disengagement, flat or declining outcomes[4]—of the acquisition influx and predicted that independent practices might make a comeback.

However, in the aftermath of 2020 lockdowns and consumer hesitation to use health care services, many physicians thought COVID-19 would see the end of independent physician practices. According to a survey Merritt Hawkins conducted for The Physicians Foundation, **59 percent of physicians agreed COVID-19 would reduce independent physician practices**.[5] Although only 8 percent of physicians closed their practices because of the pandemic, there is significant concern more will follow suit.

But is employment the only option to keep physician practices alive?

We're here to remind you that employment isn't the only option when pursuing alignment between physicians and partnering entities. Depending on the situation, the structures described below may offer a similar upside to employment or acquisition without the same unintended consequences or risks.

Let's take a look at the options available outside of employment that independent practices and partnering entities can leverage to align for better outcomes.

## Professional Services Agreement

For over a decade, our team has crafted and negotiated professional services agreements (PSAs) for physician enterprises of all sizes. Our (infamous) PSA white paper performs a deep dive into the many options available to those pursuing this model.[6] Back in 2012, when groups like accountable care organizations (ACOs) were still considered unicorns, *Becker's Hospital Review* also wrote about the increase in PSAs as a viable option for systems and practices.[7] Today, our team is observing steady, if not increasing, PSA activity and interest, and we'd like to remind you of the various types of PSAs, as well as provide some tips for those pursuing them.

The categories below represent general guidelines for the various types of PSA models, but agreements do not need to fit rigidly within each. We often work with clients who mix and match different components of each model to develop a solution that works best for their goals and market. Think of a PSA like a pizza: most can agree on the base ingredients, but different types of sauces, toppings, and crusts produce a delicious creation uniquely suited for each person (except maybe sardines).

- **Traditional PSA |** A traditional PSA is a contract, typically between a hospital or health system and a practice, for professional services reimbursed using a rate per wRVU generated. The hospital or health system assumes ownership of the practice support structure by employing staff, managing billing and revenue cycle functions, and overseeing leadership and governance related to the practice team. The PSA providers are aligned with the network but do not face the same oversight as their employed colleagues.
- **Global Payment PSA |** The contract for professional services is similar to the traditional PSA except for the rate per wRVU, which encompasses both provider compensation and benefits cost. The global payment also includes fixed and variable overhead expenses for the practice. Both parties collaborate to manage annual budgets and strategy through a management committee, and the practice retains control of its entity and support staff.
- **Practice Management Arrangement |** The partnering entity employs the providers within this arrangement, but the practice's legal entity is maintained. The practice continues

to manage its staff, which are not employed by the hospital, through a separate management services agreement, and the practice receives a fair market value (FMV) fee for the services. This model is essentially the inverse of the traditional PSA.

» **Carve-Out PSA |** The professional services within this model can be carved out based on practice location, subspecialty, or providers that fall within the agreement. For example, a gastroenterology (GI) group can align with a hospital to provide only endoscopy services. Related administrative costs are carved out, and the hospital reimburses them separately at an FMV rate.

» **Hybrid Arrangements |** Continuing with the pizza topping analogy, hybrid PSA arrangements allow both parties to mix and match the toppings. Any component from the previous models, such as medical directorships, quality incentive payments, compensation guarantees, and several payment or management services methodologies, can be leveraged in a hybrid model.

While there may be numerous ways to execute a PSA, compliance is one critical requirement. Compensation or professional service terms should meet FMV standards and be commercially reasonable, and the overall agreement should not violate any federal or state regulations (i.e., Stark, Anti-Kickback). As with any agreement, we recommend both parties work with legal counsel to execute the contract.

## Clinical Co-Management Agreement

If PSAs feel too close to employment, partnering entities and practices might consider clinical co-management agreements (CCMAs) as a more moderate and attractive strategy. Unlike PSAs, the alignment mechanisms in CCMAs do not involve contracts for professional services or management of practice support structures. CCMAs typically focus on a collaborative effort between individual providers and partner leadership to achieve a predefined set of performance outcomes for a hospital service line.

We view these arrangements as a win-win for both parties to accomplish shared goals, often related to quality and the shift to value-based initiatives. CCMAs continue to mitigate a hospital's financial investment and limit any lost autonomy for independent providers.

While there are several structures around which to build a CCMA, all of these arrangements will include fees for the management services provided and a specific set of measurable outcomes for the CCMA entity to monitor and achieve. Fees often include a base rate, typically paid hourly and evaluated using an FMV calculation for administrative services within that specialty and an incentive rate for exceeding the outcomes within the agreement.

The descriptions below are for the various CCMA structures. Read our white paper for more detailed information on the formation, execution, and benefits of CCMAs.[8]

» **Traditional CCMA |** A management agreement exists between a physician practice entity and the hospital. The contracted management services relate to a specific service line. This model is common when one practice aligns with the hospital as that does not require the creation of a separate entity.

» **CCMA with New Entity |** This model involves creating a new professional corporation (PC) or limited liability corporation (LLC). The new entity administers management services and receives compensation for those services at fair market value. The agreement is between the client (i.e., a private practice) and the new entity, and typically there are multiple practices engaged with the new entity for those management services.

» **Joint Venture CCMA |** A physician or group of physicians and the hospital create a jointly-owned new entity to administer management services. This CCMA model is less common because the joint venture is subject to more regulation and a longer implementation timeline. Because the hospital and physician(s) own the entity, this type of CCMA is more permanent.

» **Joint Oversight CCMA |** Separate management agreements may exist between the hospital and physicians involved in this type of CCMA. Additionally, a formal oversight committee comprised of representatives from all parties manages the performance of the CCMA goals.

It is important to note that PSAs and CCMAs are not the only ways for independent practitioners to partner with hospitals, health systems, or other corporate entities. Joining managed care networks or ACOs (no longer unicorns!), setting up call coverage or medical directorship agreements, and creating or using management services organizations (MSOs) represent additional strategies for consideration among providers who want to align and remain independent.

Acquisition will not necessarily slow down or become less relevant in healthcare. Still, it is imperative for those who want to grow their provider network or expand the reach of their practice to be mindful of the alignment options outside of acquisition, particularly those who may be dissuaded by some of its more negative factors.

Coker Group works with physician groups to develop customized healthcare business solutions. Our advisors have the experience and creativity to find the right solution for any market. You can learn more about Coker's work in alignment strategy and physician services at cokergroup.com and contact us to speak with one of our experienced consultants.

**Endnotes**

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# Representation and Warranty Insurance in Health Care Transactions

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## Overview of Representation and Warranty Insurance

Representation and warranty insurance (R&W Insurance) is an increasingly popular type of insurance policy that is purchased in connection with private company mergers and acquisitions. A standard acquisition agreement will contain representations and warranties made by the seller about the target company, and such representations and warranties are usually heavily negotiated by the parties. The seller generally agrees to indemnify the buyer (subject to certain limitations) for breaches of such representations and warranties. The seller's indemnification obligation has historically been (and sometimes still is) backed by a portion of the purchase price payable at the closing being held back or held in escrow for a specific period of time. The emerging use of R&W Insurance is modifying this traditional indemnification structure. R&W Insurance provides protection against financial losses for certain unknown and unintentional breaches of the representations and warranties in the acquisition agreement. The American Bar Association's 2021 Private Target M&A Deal Points Study (the 2021 Deal Points Study), which analyzed the acquisition agreements of publicly available transactions from the year 2020 and the first calendar quarter of 2021 involving private companies, indicated that the percentage of acquisition agreements expressly referencing R&W Insurance increased from 29% in the 2017 study to 52% in the 2019 study to 65% in the 2021 Deal Points Study.

R&W Insurance is available to both buyers and sellers in a transaction. Under a buy-side policy, the buyer would look directly to the insurer for coverage for breaches of the seller's representations and warranties. Under a sell-side policy, the insurer would reimburse the seller for indemnification claims paid by the seller to the buyer. The use of buy-side R&W Insurance policies has far outpaced the use of sell-side R&W Insurance policies. The 2021 Deal Points Study indicated that 95% of the acquisition agreements that referenced R&W Insurance provided that the buyer would acquire the R&W Insurance policy. The other 5% of acquisition agreements did not specify which party would acquire the R&W Insurance policy. None of the acquisition agreements provided that the seller would acquire the R&W Insurance policy.

R&W Insurance can benefit a buyer in a variety of ways. For example, a buyer can purchase R&W Insurance to cover higher amounts than the cap that the seller is willing to accept, and with longer survival periods. Additionally, if recovery against the seller(s) is expected to be difficult (e.g., because there are several sellers, foreign sellers, or financially distressed sellers), R&W Insurance can provide an alternative, streamlined mechanism for recovery. R&W Insurance can also make a buyer's bid more attractive in an auction process by reducing the amount of the purchase price that is held back or held in escrow. It can also help preserve relationships by mitigating the need for a buyer to pursue claims against management sellers who will remain in place as management personnel following the closing of a transaction.

R&W Insurance can benefit sellers in a variety of ways as well. As previously mentioned, R&W Insurance can be used to eliminate or reduce the portion of the purchase price that is held back or held in escrow, which allows a greater portion of the purchase price to be distributed to the sellers right away at closing. The 2021 M&A Deal Terms Study by SRS Acquiom found a stark difference in escrow sizes between transactions with R&W Insurance and transactions without R&W Insurance—a majority of deals with R&W Insurance had an escrow amount that was 0.5% or less of transaction value, while transactions without R&W Insurance had an escrow amount hovering in the traditional range of 10% to 15% of transaction value. A R&W Insurance policy can also protect passive sellers and provide a "clean" exit for sellers, with fewer contingent liabilities, which is particularly beneficial for private equity companies or venture capital funds at the end of their life cycle. In addition, with a R&W Insurance policy, the seller may feel more comfortable giving more fulsome or broad representations and warranties, which could lead to a faster negotiation of the acquisition agreement and lower legal costs for all parties.

## Process and Cost

To begin the process of obtaining a R&W Insurance policy, either the buyer or the seller approaches an insurance broker (e.g., AON, Lockton, Marsh, Willis, or Woodruff Sawyer) to solicit quotes from insurers. The insurer generally will provide an initial "non-binding indication" or "NBIL" and will then undergo an underwriting and due diligence process. The insurer will want to review the data site for the transaction, the due diligence report prepared by the buyer, and the key transaction documents, including the acquisition agreement and the disclosure schedules. Once the insurer completes its diligence process, the insurer and the party seeking the R&W Insurance policy

will negotiate the specific terms of the policy. The party seeking a R&W Insurance policy should plan on actively negotiating the policy and should begin such negotiation early in the process. While carriers may not be open to negotiating certain provisions and the insurance market may influence the success of the negotiations, the party may be able to obtain more favorable provisions by negotiating the provisions early in the process. There are standard exclusions under R&W Insurance policies, including, for example, with respect to covenant breaches, purchase price adjustments, pension underfunding/withdrawal, or breaches of representations and warranties of which the buyer had knowledge, and there may also be specific exclusions based on the insurer's due diligence. The party seeking the R&W Insurance policy should plan on exclusions wherever there are diligence gaps or specifically identified diligence risks, but because the policies are not bound until either the signing or the closing of the transaction, there is the possibility of removing such exclusions with additional diligence. However, because additional diligence raises legal costs and requires more time, the decision to seek removal of exclusions will be transaction-dependent.

The insurer charges a premium to issue the policy, which generally is paid up front and is usually 2% to 4% of the coverage limits, and an underwriting fee. There may also be an insurance broker fee. The deductible or retention amount of a R&W Insurance policy is typically based on a percentage of the transaction value (e.g., 1% of the transaction value) and often correlates to the size of the indemnification escrow or holdback amount. As discussed below, the cost of obtaining a R&W Insurance policy for a health care transaction was inflated at the end of 2021 due to the state of the market.

## Health Care Transactions

Historically, obtaining a R&W Insurance policy for health care transactions (and, in particular, for health care provider transactions, as opposed to adjacent industries such as health care technology or life sciences) was challenging. Insurers did not want to assume the risk for violations of health regulatory laws, including with respect to Medicare and Medicaid billing and reimbursement practices (False Claims Act violations), Anti-Kickback Statutes and the Stark Law. Insurers would categorically exclude these types of health care compliance-related representations and warranties from coverage, making R&W Insurance policies of little value for health care provider transactions. In 2014, there were only one or two insurers providing R&W Insurance for transactions involving health care providers. Accordingly, the use of R&W Insurance for these types of transactions has lagged behind other industries.

Several factors have led to the expansion of R&W Insurance in health care transactions, including a growing demand for R&W Insurance products for health care transactions, partially due to the increased involvement of private equity firms in health care acquisitions; insurer's improved ability to perform efficient health regulatory due diligence; and the relative stability of the health care industry, despite general times of unpredictability or unprecedented disaster.

There are many more insurers willing to provide R&W Insurance for health care transactions than in the past. Currently, there are approximately seven to nine insurers that can underwrite a health care provider deal. Insurance broker AON indicated that it has brokered R&W Insurance on more than 75 health care provider transactions since 2015. As depicted on the table below, whether an insurer is willing to underwrite a health care provider transaction is based on a number of considerations, including provider type, size of provider and scope of operations, government payer exposure, availability of audited financial statements, and compliance history.

**Provider Characteristics**

| | | |
|---|---|---|
| » Consolidated (one-location) billing operations<br>» Limited number of health care services provided (i.e., small number of CPT codes billed)<br>» Capitated-rate billing model (fee/month) | » Bills sent from up to three locations<br>» Health care services performed in the field<br>» Cost report-based billing | » More than three locations billing government insurance<br>» Many different services provided (i.e., high variation in number of CPT codes billed)<br>» Fee-for-service billing model<br>» Multiple billing models (e.g., cost report and fee-for-service) |
| **← Easier to Underwrite** | | **Harder to Underwrite →** |
| » Medicare/Medicaid Health Maintenance Organizations<br>» Accountable Care Organizations<br>» Benefit Management Companies<br>» Specialist Providers, such as:<br>  » Radiology / Medical Imaging<br>  » Durable Medical Equipment<br>  » Labs<br>  » Physical Therapy<br>  » Single Specialty Physician | » Home Health / Hospice<br>» Urgent Care<br>» Physician Practices<br>» Multi-Specialty / Ancillary<br>» Nursing Homes<br>» Hospitals (one to three locations) | » Large Integrated Hospital and Health Systems (e.g., more than three hospitals)<br>» Multi-State Providers |

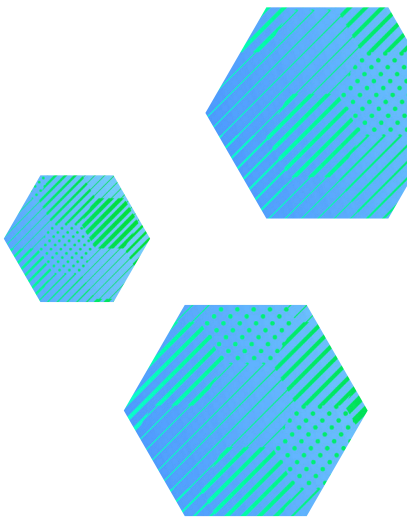
**Example Provider Types**

In order to underwrite a health care provider transaction, insurers expect to conduct fulsome diligence on health care regulatory matters. Insurers will typically perform diligence with respect to financial arrangements and referral sources; employment, physician and independent contractor arrangements; real estate leases; sales and marketing activities; the compliance program and internal and external compliance audits; privacy and data security compliance, including compliance with HIPAA; payer contracts; and corporate practice of medicine.

## 2021 Issues and 2022 Outlook

In 2021, the issues with obtaining R&W Insurance related to bandwidth, as it was a record-breaking year for mergers and acquisitions. The challenges varied by industry, but the health care industry was particularly impacted. Towards the end of 2021, insurers were able to cherry-pick the transactions they wanted to underwrite and, accordingly, steered away from health care provider transactions involving increased health regulatory due diligence and risk. Additionally, parties who obtained R&W Insurance for health care transactions in the last quarter of 2021 paid significantly higher premiums than usual.

As we have moved into the new year, the R&W Insurance market has reset, and pricing has begun to return to more normalized rates. However, pricing for health care transactions is not resetting as quickly as other industries. Premiums for transactions involving complicated health care providers still appear to be around 6% of the coverage limits, and, in general, premiums for health care provider deals are expected to stay in the range of 4% to 6% of coverage limits. As 2022 progresses, parties to health care transactions should be prepared for tightening of the R&W Insurance market if mergers and acquisitions have another record year. R&W Insurance has increased in popularity in private company mergers and acquisitions over the past decade, and its usage in health care transaction is only expected to rise. As private equity companies continue to pursue health care transactions and the volume of health care transactions in general continues to increase, R&W Insurance may become entrenched in health care transactions like it has in many other industries. Both buyers and sellers should consider whether a R&W Insurance policy could be beneficial on their next health care transaction.



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# 2022 Outlook: Physician Practice Industry

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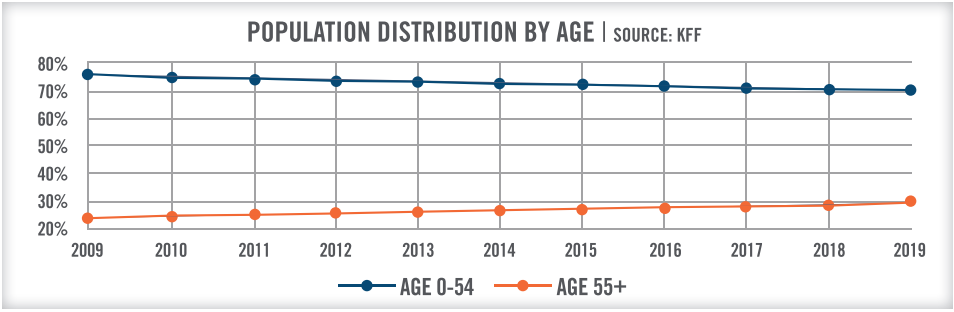
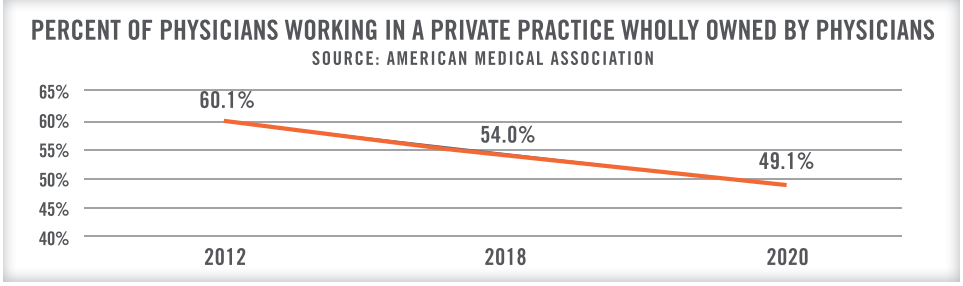
## Overview of the Physician Practice Industry

With slightly over one million active physicians in the United States, IHS Markit Ltd. projects a total physician shortage between 54,100 and 139,000 physicians by year 2033. Demand for physicians is expected to continue growing faster than supply, with the primary drivers for demand being population growth and the aging of the population.

This problem is further compounded by the large portion of physician workforce that is also nearing retirement age. COVID-19 added additional strain on physicians, further accelerating the retirement of some physicians as they faced personal health risks and declining income due to loss of revenue and higher costs to acquire supplies such as personal protective equipment. Of 3,500 doctors surveyed by The Physicians Foundation between July 15 and July 26, 2020, 8 percent of physicians have closed their practices as a result of COVID-19, and 72 percent of physicians have experienced a reduction in income due to COVID-19.[1] Even before COVID-19, reimbursement pressure and need for capital to acquire new technology, such as electronic health records and telemedicine software, have led physicians to sell their practices and become employees of larger organizations. According to the AMA, 2020 was the first year in which less than half of patient care physicians worked in a practice wholly owned by physicians.[2]

For many years, physician practice acquisitions were completed by hospitals and health systems as they sought to develop strong physician relationships that allowed them to provide specialized care and increase their market share. Hospitals also found a need to employ physicians as retiring independent physicians left gaps in care in rural areas. From an independent physician's perspective, government and insurer payment policies have favored larger health systems, which put them at a competitive disadvantage. Many of these practices were struggling due to administrative and regulatory burdens such as measuring and reporting quality metrics and needing to implement capital intensive electronic health record systems. Combined



with reimbursement cuts to certain specialties, failure to maintain reporting and minimum quality goals also resulted in reimbursement penalties. Independent physicians were also dealing with a change in consumer expectations, which include the need for convenience, use of technology for scheduling appointments, rapid test results on mobile devices, virtual communication, and use of telemedicine. Furthermore, younger physicians usually have high student loan burdens and seek financial stability and work-life balance. These trends have all contributed to physicians seeking to be employed instead of pursuing private practice.

Hospitals have not been the only ones acquiring medical practices. Non-traditional industry participants like insurance/health plans, private equity firms, large employers (*e.g.*, Amazon and Apple), and Medicare Advantage-focused providers have also started investing in physician practices, causing an arms race in securing the services of healthcare providers. These non-traditional players still provide benefits including access to capital, reduced administrative burdens, practice management services, and contracting leverage, but they can offer other benefits too, such as potential equity payouts or the ability to innovate and influence new models of care and technology.

## Transactions and Consolidation Within the Industry by "Non–Traditional" Participants

### Insurance Companies

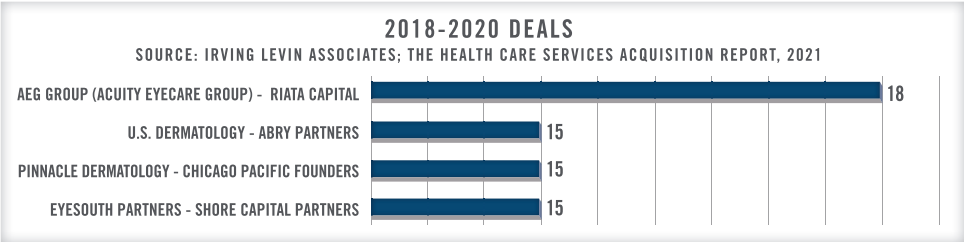
Insurance companies and health plans have been acquiring physician practices as a way to vertically integrate. The motivations behind these transactions are different than the acquisitions made by health systems and are primarily driven by goals of controlling spending, lowering cost, and increasing quality through managing care and reducing costly/wasteful utilization. Furthermore, these transactions highlight the need for health data to further optimize care and impact health outcomes.

- In 2018, UnitedHealth Group's Optum division acquired DaVita Medical Group for $4.34 billion. DaVita Medical Group operated nearly 300 medical clinics that provided primary and specialist care to approximately 1.7 million patients per year. As a result of this transaction, Optum became the largest single employer of doctors in the U.S. Optum's CEO David Wichmann stated, "OptumCare entered 2021 with over 50,000 physicians and 1,400 clinics. Over the course of this year, we expect to grow our employed and affiliated physicians by at least 10,000." In March 2021, Atrius and Optum signed a definitive agreement that would add 715 physicians to Optum. In addition to acquiring medical groups, Optum announced it would acquire Change Healthcare in a $13 billion deal that would further advance its data analytics capabilities.
- In 2018, Anthem acquired Aspire Health, the largest non-hospice community-based palliative care provider. Aspire Health uses proprietary predictive clinical and claims-based patient algorithms to identify patients with a serious illness who may benefit from additional support. Advanced illness programs have been shown to reduce hospitalization, decrease costs, and improve patient satisfaction. This highlights the desire for health plans to acquire technologies that other clinical provider platforms are able to leverage.
- Humana teamed up with private equity firms TPG Capital and Welsh, Carson, Anderson & Stowe in 2018 to acquire and combine Curo Health Services and Kindred Healthcare to create the largest hospice operator in the United States. Humana had stated that it anticipates robust data sharing between Humana and Kindred at Home to help yield improved analytics and predictive modeling.[3]
- Centene purchased Community Medical Group in 2018, a physician group that served over 70,000 Medicaid, Medicare Advantage and ACA Insurance Marketplace consumers in Florida. Community Medical Group is the leading at-risk provider in Miami-Dade County with a demonstrated ability to generate medical cost savings. This acquisition provides a platform to expand this model of care across Florida. At the end of 2020, Centene completed its acquisition of Apixio, a data analytics platform, which can extract patient data from physician notes, medical charts, and other documents and translate the information into clinical and administrative guidance.

### Private Equity

In the early 1990s, physician practice management companies (PPMCs) grew quickly as the industry saw the need for consolidation in order to achieve economies of scale as well as the size necessary to negotiate managed care contracts. As physicians began looking for partners with capital and organizational expertise, PPMCs aggressively acquired single and multi-specialty groups and offered a way for physicians to remain independent from hospitals. At the peak, there were over 39 publicly traded PPMCs, with companies such as MedPartners, PhyCor, and FPA Medical Management having thousands of affiliated physicians. Due to the unsustainable prices being paid for acquisitions, followed by underperforming assets, PPMCs collapsed as quick as they rose, with eight of the ten largest publicly traded PPMCs declaring bankruptcy by 2002. Nearly two decades later, many of the challenges that PPMCs attempted to solve still exist and have grown in complexity. As a result, we are now experiencing the second generation of PPMCs. The industry remains highly fragmented, and projected healthcare spending is expected to continue increasing. Similar to the early 1990s, private equity activity has ramped up quickly. In 2014, only 10 percent of physician medical group deals were done by private equity firms, which has since grown to 72 percent in 2020. This proportion of private equity transactions seems likely to continue as the amount of private equity capital available for investment has approached nearly $1.9 trillion globally.[4]

What started as a consolidation of practices focused on hospital-based specialties such as emergency medicine, radiology, and anesthesiology, has since moved on to medical specialties such as ophthalmology and dermatology, which generate more reimbursement from private insurance and out-of-pocket payments, rather than government payers. Between 2018-2020, the most active private equity backed platform companies were focused on these two specialties.




| YEAR | PRACTICE/MSO | PRIVATE EQUITY PARTNER |
|---|---|---|
| 2022 | SOUTHERN ORTHOPAEDIC SURGEONS | FFL PARTNERS |
| 2021 | RESURGENS ORTHOPAEDICS | WELSH, CARSON, ANDERSON & STOWE |
| 2021 | BLUEGRASS ORTHOPAEDICS | TRIVEST PARTNERS |
| 2020 | ADULT GASTROENTEROLOGY ASSOCIATES | WAUD CAPITAL PARTNERS |
| 2020 | MISSISSIPPI SPORTS MEDICINE/U.S. ORTHOPEDIC PARTNERS | FFL PARTNERS/TG THURSTON GROUP |
| 2020 | GASTRO ONE | WEBSTER EQUITY PARTNERS |
| 2020 | PINNACLE GI PARTNERS | H.I.G. GROWTH PARTNERS |
| 2020 | SOLARIS HEALTH | LEE EQUITY PARTNERS |
| 2019 | ORTHOPAEDIC & NEUROSURGERY SPECIALISTS/SPIRE ORTHOPEDIC PARTNERS | KOHLBERG & COMPANY |
| 2019 | BEACON ORTHOPAEDICS & SPORTS MEDICINE/ORTHO ALLIANCE | REVELSTOKE CAPITAL PARTNERS |
| 2019 | PEAK GASTROENTEROLOGY ASSOCIATES | VARSITY HEALTHCARE PARTNERS |
| 2018 | ORTHOBETHESDA | ATLANTIC STREET CAPITAL |
| 2018 | CENTRAL OHIO UROLOGY GROUP | NEW MAINSTREAM CAPITAL |
| 2018 | NEW JERSEY UROLOGY | J.W. CHILDS ASSOCIATES |
| 2018 | ATLANTA GASTROENTEROLOGY ASSOCIATES | FRAZIER HEALTHCARE PARTNERS |
| 2017 | THE ORTHOPAEDIC INSTITUTE/ORTHOPEDIC CARE PARTNERS | VARSITY HEALTHCARE PARTNERS |

Private equity firms are now shifting to medical specialties such as orthopedics, gastroenterology, and urology, which can generate ancillary revenue from ambulatory surgery centers, medical imaging, pharmacy, pathology, physical therapy, and durable medical equipment. Furthermore, trends suggest continued growth in these specialties, such as earlier colorectal screenings and a generation that desires to maintain an active lifestyle later into life. The number of total joint surgeries continues to increase as advances in technologies and surgical procedures have allowed these surgeries to be performed on an outpatient basis and in freestanding ambulatory surgery centers.

### Independent Physician Groups

In a 2019 survey conducted by McKinsey & Company, 79 percent of small independent practices and 67 percent of large independent practices cited autonomy as a top factor in selecting their current practice model.[5] The main challenges faced by independent physicians are clinical integration, increasing administrative burden, and the need for negotiating power. One option for a solo practitioner or small practice is to join a larger physician-owned medical group which usually brings stronger brand awareness, economies of scale, and the resources to manage the administrative tasks associated with running a practice.

Another alternative for independent physicians is to form and/or join an independent physician association (IPA). An IPA is a separate business entity owned by a network of physician practices with the goal of using its size and scale to reduce overhead and negotiate managed care contracts. Physicians who join an IPA are still able to operate independently from other members of the IPA. IPAs may still face challenges as it is difficult to gain cooperation from large numbers of physicians. Some payers will compensate IPAs through capitated contracts, which puts the financial risk on the IPA. Under these contracts, an IPA receives a flat per member, per month payment regardless of the how much a patient utilizes healthcare services. If these risks are not properly managed, IPAs can incur significant losses.

The need for capital still exists for IPAs, which is evident in recent IPA transactions. The partnership between Altais and Brown and Toland highlights the market demand for robust practice management platforms that provide advanced data tools. With health systems and medical groups looking to expand their networks, there will be continued transaction activity in this space.

| YEAR | IPA | PROVIDERS | ACQUIRER |
|---|---|---|---|
| 2019 | ACCOUNTABLE HEALTH CARE IPA | 1,150 PHYSICIANS | APOLLO MEDICAL HOLDINGS |
| 2020 | BROWN AND TOLAND | 2,700 PHYSICIANS | ALTAIS |
| 2020 | CAL CARE IPA, LOS ANGELES MEDICAL CENTER IPA, VANTAGE MEDICAL GROUP | 10,000 PROVIDER (COMBINED) | PROSPECT MEDICAL SYSTEMS |
| 2021 | OMNI IPA MEDICAL GROUP, INC. | 400 PHYSICIANS | P3 HEALTH PARTNERS |

### Large Employers

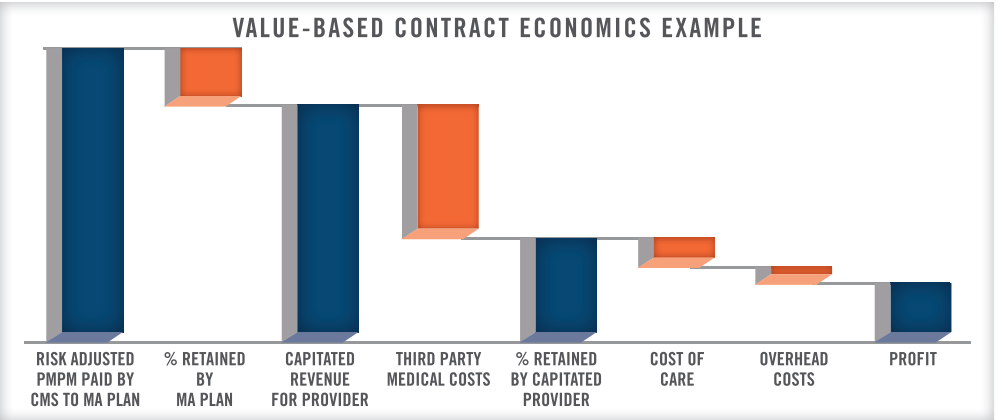
Nearly 50 percent of Americans are covered under an employer sponsored health plan, with 84 percent of large firms being self-funded.[6] With employers focusing on reducing costs and improving employee satisfaction, there is a strong incentive for employers to provide access to convenient and high-quality healthcare to drive better clinical and financial results. Increased employee wellness through preventative healthcare can further reduce loss of employee work hours. Large companies have started exploring different models to ensure their employees have access to high-quality healthcare.

- In 2018, Apple launched two primary care clinics called AC Wellness near its headquarters. Additionally, Apple has offered on-site health clinics operated by Crossover Health to its employees which integrate wellness benefits with tech-enabled services to increase access to care and decrease healthcare spending.
- In 2019, General Motors entered into a direct-to-employer, risk-based arrangement with Henry Ford Health System called ConnectedCare. Some of the employee benefits include same-day appointments with primary care physicians, telehealth options, and an exclusive phone line for GM beneficiaries.[7]
- Amazon announced it would continue partnering with Crossover Health to launch "neighborhood health centers" where its employees can access "full-spectrum acute, chronic, and preventive primary care, same-day pediatrics, prescriptions, vaccinations, behavioral health services, physical therapy, health coaching, and care navigation for specialty referrals and diagnostic services." The neighborhood health centers provide services to over 115,000 Amazon workers and their dependents with 75 percent of Amazon employees being located within 10 miles of one of the neighborhood health centers.[8] To further increase access to healthcare services, Amazon also offers a virtual health service benefit called Amazon Care. What was originally launched as a way for Amazon to help decrease the cost of insuring its own employees has since been offered to other employers across the country under a pay-by-usage model. This pay-by-usage model reduces the upfront commitment and cost for employers where other telemedicine providers may charge a per member per month fee. Amazon Care has the potential to disrupt the telemedicine market not only as a result of this payment model, but because of its strong brand and consumer loyalty, as well the convenience it provides to patients by leveraging its suite of services (e.g., filling prescriptions through Amazon Pharmacy and the ability to make appointments through Amazon Alexa enabled devices).

### Medicare Advantage Focused Providers

With the continued increase in population eligible for Medicare/Medicare Advantage, certain providers such as Cano Health (NYSE: CANO), Agilon Health (NYSE: AGL), Oak Street Health (NYSE: OSH), and CareMax (NASDAQ: CMAX) have focused on providing care to this segment of the population. These companies provide care through globally capitated or full-risk contracts and receive a pre-negotiated per member, per month payment. Through use of their technology-powered population health platforms, these companies are rewarded for furthering the "triple aims" of improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare services.

While the companies outlined above are focused on healthcare for seniors, they are a part of the greater "physician enablement" market which also includes companies such as VillageMD, Privia Health (NASDAQ: PRVA), Aledade, ChenMed, P3 HealthPartners (NASDAQ: PIII), ApolloMed (NASDAQ: AMEH), and Skylight Health Group (TSXV: SLHG). Though each of these companies have slightly different models and serve different populations, they all share a similar vision of providing physicians with the tools and technology necessary for succeeding in value-based care.



| COMPANY | TEV/LTM TOTAL REVENUE[8] | TEV/NTM TOTAL REVENUE[9] | TEV[9] | LIVES, MEMBERS, PATIENTS[10] | TEV/LIVES |
|---|---|---|---|---|---|
| CANO HEALTH | 1.58X | 0.94X | $2,308,450,447 | 210,663 | $10,958 |
| AGILON HEALTH | 3.25X | 2.33X | $5,501,797,913 | 236,500 | $23,263 |
| OAK STREET HEALTH | 3.30X | 2.08X | $4,242,217,238 | 131,500 | $32,260 |
| CAREMAX | 2.60X | 1.03X | $578,576,707 | 40,400 | $14,321 |
| PRIVIA HEALTH | 2.15X | 1.82X | $1,941,138,058 | 760,000 | $2,554 |
| P3 HEALTH PARTNERS | 0.49X | 0.37X | $284,017,083 | 95,000 | $2,990 |
| APOLLOMED | 2.99X | 2.56X | $2,260,673,109 | 1,100,000 | $2,055 |
| SKYLIGHT HEALTH GROUP | 2.03X | 1.37X | $62,994,789 | 13,000 | $4,846 |

## Transaction Structures

### Health Systems

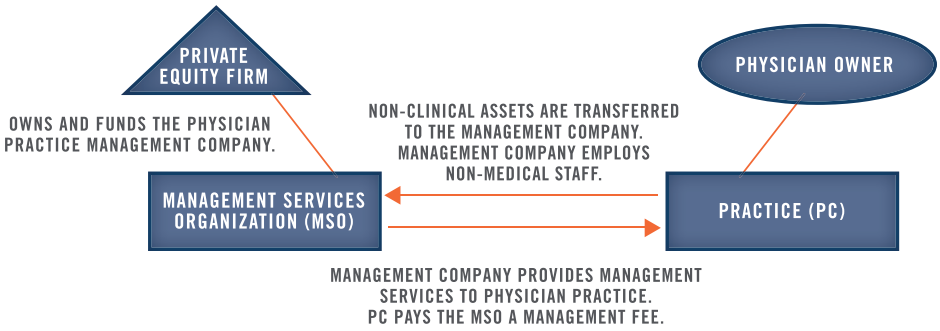
In most physician practice transactions, health systems acquire tangible and intangible assets of a practice and subsequently enter into an employment/professional services arrangement with the physicians. Physicians generally receive a base salary with the opportunity to earn production-based compensation (commonly measured based on work relative value units) which must be consistent with fair market value. While this provides physicians with stable compensation and the ability to focus on patient care, they are precluded from having equity in the practice entity and therefore are not able to benefit from any growth of the business. In recent years, hospital-employed physicians have been offered investment opportunities in ambulatory surgery centers that are co-owned by their hospital employer. On April 26, 2021, the U.S. Department of Health and Human Services Office of Inspector General issued a favorable advisory opinion regarding the investment in a new ambulatory surgery center that would be owned jointly by a health system, management company, and various physician investors employed by the health system. Though less common, these types of arrangements can be structured to be compliant with federal and state laws.

### Private Equity

Private equity firms are prohibited from owning physician practices in many states due to corporate practice of medicine (CPOM) laws. Therefore, these transactions typically involve the private equity firm establishing a PPMC which acquires the non-clinical assets, business functions, and ancillary services of a medical group. These medical groups are often large "platform" practices that have a substantial market share and a strong reputation. Subsequently, the PPMC provides management services to the medical practice, owned by licensed physicians, in exchange for a fair market value management fee.

Shareholder physicians receive an upfront cash payment as well as rollover equity in the PPMC. This helps align the interest of the shareholder physicians as it allows for the prospect of a future payout when the private equity firm sells to another buyer (usually after five to ten years). The shareholder physicians generally pay for their equity interest by taking a 20 percent to 30 percent cut in their compensation. The private equity firm then grows the value of the medical group by acquiring additional small and solo practices or "add-on" practices to merge with the larger "platform" practice.

Private equity firms benefit in being less constrained by the legal and regulatory requirements compared to health systems, but they still need to be cognizant of CPOM laws, fee splitting, and anti-kickback laws. An overview of these regulations is discussed in the following section.



## Legal Aspect of These Transactions

CPOM laws prohibit non-physicians from owning or controlling physician practices or employing physicians. While each state has its own laws, they can generally be categorized as either "strong" or "weak." In "strong" states, non-professional corporations cannot hire physicians without meeting a specific exception set forth in the CPOM laws. "Weak" states may allow non-professional corporations such as hospitals to employ physicians if the licensed physicians maintain actual control over clinical decision-making. While CPOM laws may dictate how a physician practice transaction is structured, investors must also be aware of various fraud and abuse laws that may impact the structure of certain compensation arrangements such as managements fees.

The prohibition on fee splitting is aimed at situations where a healthcare professional splits part of the professional fee from treating a referred patient with the source of the referral. This is relevant to PPMC arrangements as it may require that a management fee between the PPMC and the professional practice be structured as a fixed fee instead of a percentage of revenue. Furthermore, it's important that these management fees are consistent with fair market value. Unlike health systems that must ensure acquisitions and compensation arrangements with physicians are consistent with fair market value, private equity firms are primarily concerned with making sure their management arrangements are structured to be compliant with state and federal anti-kickback laws.

Lastly, when evaluating a potential transaction, a buyer may require certain data to perform its due diligence and understand the financial impacts of the transaction. Buyers and sellers should be aware of federal antitrust laws that prevent the parties from freely sharing agreements with third party payers.

## Summary

The physician practice industry has experienced significant changes over recent years and faces a growing list of challenges surrounding increasing administrative burden and continued reimbursement pressures. At the same time, there is a shortage of physicians while demand continues to increase. To be able to continue focusing on caring for their patients, physicians have realized the need to partner with other organizations, whether it be with other independent physicians or entities such as private equity investors. HealthCare Appraisers has significant experience in providing valuation and consulting services for physician practice transactions. Given the continually changing regulatory environment, it's important to rely on an appraiser who understands the details of these types of transactions.

**Endnotes**

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