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Understanding US Private Equity Healthcare Provider Transactions

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Introduction

Author's note: The author wishes to thank Holly Buckley, Geoffrey Cockrell, and Adam Rogers for their detailed review of this report. Any inaccuracies remain my own.

Over the past decade or so, healthcare provider practices have grown to be one of the most prominent private equity investment areas. In the past five years, healthcare services deals, the majority of which are provider deals, accounted for over 70% of all US private equity healthcare buyouts and over 10% of all US private equity buyouts (including add-ons). Like other key private equity buy-and-build playgrounds ranging from registered investment advisors (RIAs) to auto repair shops, the healthcare provider landscape is highly fragmented, with thousands of small, privately owned businesses. This creates attractive opportunities to employ the private equity playbook, leveraging multiple arbitrage and economies of scale to generate returns. However, the complex regulatory and reimbursement frameworks in which healthcare services businesses operate mean that private equity healthcare services transactions are unique among other private equity deals in many important ways.

This report provides a comprehensive orientation to the range of regulatory and financial nuances that private equity firms and private equity-backed platforms must consider when undertaking healthcare practice transactions. It aims to identify and explain the reasoning behind the most common practices in the industry, as well as to unpack the relevant legal and regulatory frameworks and address their implications for due diligence and platform growth. Understanding these transaction considerations is essential for strategic decision making in growing a private equity-backed healthcare services business, because they can have a profound impact on risk, revenue, and geographic expansion. For this reason, we hope this note will be a valuable resource for deal professionals looking to understand the nuances of executing healthcare provider transactions and for allocators seeking insight into the key risks and considerations that need to be addressed.

Regulatory frameworks

Corporate practice of medicine

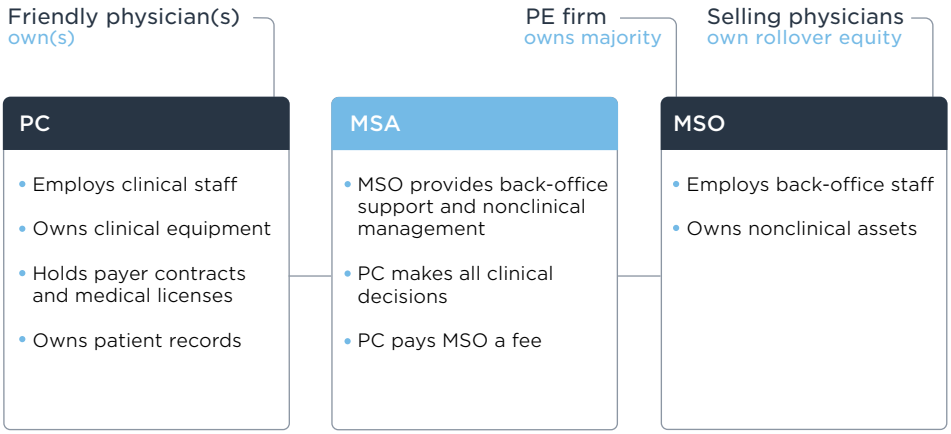
The most important regulatory issue governing US private equity healthcare services transactions is a body of law known as "corporate practice of medicine," or CPOM, laws. These are enacted—or derived from case law—and enforced at the state level. "Corporate practice" means ownership of a medical practice, employment of physicians, or influence—formal or de facto—over clinical decision making. Clinical decision making includes physician (and often clinical staff) hiring, diagnosis, and treatment decisions, but depending on the state, it can also include other factors such as equipment and supply purchases. Put simply, a state that prohibits CPOM generally requires that medical practices be solely physician owned and forbids any corporate structure that would allow non-physicians (laypeople or entities) to influence clinical decision making.

The majority of states prohibit CPOM, although how narrowly or widely "corporate practice" is defined and the ways restrictions are enforced varies. New York, New Jersey, Washington, Texas, and California are among the states with the strictest CPOM prohibition regimes. By contrast, states such as Ohio and Virginia permit the corporate practice of medicine, and several other states, such as Kentucky, have a CPOM prohibition law but do not regularly enforce it. There are equivalent laws relating to dentistry and optometry, and some states also prohibit the corporate practice of physical therapy and/or psychology. Additionally, CPOM laws in many states apply to veterinary medicine. In the analysis that follows, we focus on human medicine, but the same general principles apply to other practice types.

Because of CPOM restrictions, in most cases, private equity firms cannot purchase medical practices directly. Instead, they must form a management services organization (MSO) that is separate from the professional corporation or limited liability company (PC). That is, they split all the administrative and back-office operations of the practice into a separate, nonclinical entity (the MSO), while all clinical functions remain with the physician-owned PC. Generally, the PC must be fully physician owned and employ the selling physicians, thus incurring their compensation, benefits, and malpractice costs. Entity-level licenses needed to operate the medical practice, payer contracts and associated liabilities, and patient records also reside with the PC. The MSO is the entity that the private equity firm will own. It acquires the practice's nonclinical assets, employs all nonclinical support staff, and provides back-office support such as information technology (IT) services, human resources and payroll, and administration. The MSO's economic value is created by a fee paid by the PC to the MSO.[1] This fee and the corresponding services that the MSO will provide to the PC are set out in a management service agreement (MSA).

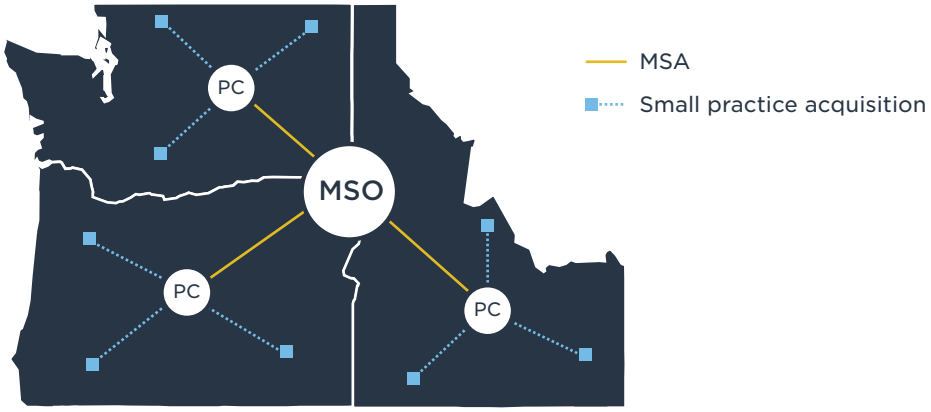
1: Some practices also choose to form a physician-owned MSO independent of a private equity sponsor or other non-physician corporate owner. This can provide an attractive way for independent practices to combine into a single enterprise, thereby fueling growth while centralizing back-office operations.

MSO structure



Even though some states allow CPOM, most private equity purchases of a healthcare provider platform, regardless of location, involve the creation of an MSO. This is because growth strategies for these platforms usually involve regional, if not national, expansion. It is also possible to combine a directly owned practice in a state that allows CPOM with an MSO structure under a single entity, although this can sometimes become unwieldy. Once a firm has established an MSO platform, it will look to acquire additional practices via the MSO. According to J. Matthew Owens, Partner at Arnold & Porter, practice roll-ups can be structured as a hub-and-spoke model, wherein a single MSO contracts with many PCs, or as a series of affiliated "sister" MSOs established on a state-by-state or regional basis, each with several PCs.[2] In smaller asset purchase deals that do not cross state lines, selling physicians can be absorbed as employees into an existing PC affiliated with the MSO.

Hypothetical regional MSO structure



2: J. Matthew Owens, telephone interview with Rebecca Springer, September 21, 2021.

Fee splitting

Regulations that prohibit fee splitting are closely related to CPOM laws, which prevent licensed medical professionals from sharing medical service fees in connection with the referral of a patient. These provisions are found in many states with varying degrees of stringency. For instance, New York is known for its robust fee-splitting prohibition. The primary implication of New York's regulation is that fees paid by the PC to the MSO may not be calculated as a percentage of—or be otherwise tied to—the PC's revenue. As a result, most New York MSO fees are fixed at fair market value. The fixed fee can be adjusted to reflect changes in service levels. In practice, this does not adversely affect the profitability of MSOs in states that prohibit fee splitting, but it does require that deal professionals pay careful attention to how the MSO fee is structured. We discuss this in greater depth below.

Federal Anti-Kickback Statute and The Stark Law

The federal Anti-Kickback Statute (AKS) and the Physician Self-Referral, or Stark, Law are two regulations intended to prevent the overutilization or misuse of Medicare and Medicaid funds that can arise when financial incentives are connected to patient referrals. Some states also layer additional, more stringent restrictions on top of these federal statutes. Under these regulations, medical practices cannot pay doctors to refer patients to them, cannot pay laypeople to bring patients to them, and cannot use financial incentives to lure patients into treatment.

Although the laws are related, some key differences exist. AKS is a criminal statute that prohibits exchanging anything of value for the referral of medical services reimbursable by any federal healthcare program. Under AKS, the referral can be made by anyone, not just a physician. The Stark Law, on the other hand, is a set of US civil laws that forbid compensation for referrals for Medicare or Medicaid if the referral is made by a physician to a designated health service in which the physician or their family member has a financial interest. Designated health services are specifically defined by the Centers for Medicare & Medicaid Services (CMS) and include labs, physical and occupational therapy providers, and a range of other ancillary or supportive medical services.[3]

AKS is an intent-based statute, which means prosecutors must prove that the involved parties intended to induce referrals while knowing that doing so was wrongful, while Stark is a strict liability statute, meaning that violations are prosecutable regardless of intent.[4] The practical effect of these differences is that Stark violations—many of them unintentional and benign—are much more common, while AKS is typically used as a backstop to prosecute fraudulent schemes that have nevertheless slipped through the Stark safe harbors.[5]

3: "Physician Self Referral," CMS, March 16, 2021.
4: "Buying, Selling, Merging and Valuation: Regulatory Issues," Foley & Lardner, Chris Rossman, October 2007.
5: "Stark Law and Anti-Kickback Statute Reform: Six Key Insights for Private Equity Healthcare Affiliations," McGuireWoods, January 7, 2021.

Anti-Kickback Statute	Physician Self-Referral (Stark) Law
Criminal statute: Violation requires intent	Strict liability: Violation does not require intent
Prohibits compensation for the referral of medical services that are reimbursable by any federal healthcare program	Prohibits compensation for referrals by physicians for "designated health services" if the physician or their family member has a financial interest in the service and it is reimbursable by Medicare or Medicaid
Often used as a backstop to prosecute bad-faith schemes	Benign violations can be addressed through voluntary self-disclosure

Private equity firms frequently discover and must self-report potential Stark violations in the existing compensation structures of practices they are looking to purchase. Adam J. Rogers, Partner at McDermott Will & Emery, gives an example of a common pitfall in gastroenterology: Many well-run practices do not know that PillCam, a common procedure in which a patient swallows a tiny, encapsulated camera, is a designated health service under Stark. If a gastroenterologist refers patients for a PillCam procedure internally and the gastroenterologist's compensation is tied to the revenue the practice receives from that physician's PillCam "referrals," this would be a potential Stark violation. Identifying Stark violations is an important part of due diligence, both for identifying historic liabilities and for ensuring the PC is able to perform at the same levels once the noncompliance is corrected. However, financial penalties for Stark violations that are self-reported through the Stark Law Self-Referrals Disclosure Protocol, and in which there was no bad conduct, tend to settle for cents on the dollar, according to Rogers.[6]

Moreover, due to the volume of voluntary Stark disclosure filings (CMS is currently several years backlogged, according to Rogers), CMS recently finalized revisions to AKS and Stark that clarify numerous definitions and exemptions, with the aim of reducing the range of non-abusive practices that nevertheless ran afoul of these laws. These updates should reduce the number of self-disclosures that private equity firms need to make when they discover potential Stark discrepancies during the pre-purchase due diligence process. One of the most noteworthy amendments was a greater allowance for referrals within value-based care (VBC) programs, which typically rely on close coordination among providers with different specialties treating the same population in order to improve patient outcomes.[7] Private equity firms have been increasingly investing in VBC providers as this payment model has gained traction with providers, payers, and policymakers.

6: Adam Rogers, telephone interview with Rebecca Springer, September 23, 2021.
7: "Fraud and Abuse Rules Part III: New Value-Based Arrangement Protections," McGuireWoods, January 20, 2021.

Another noteworthy amendment provides greater freedom for hospitals and large health systems to donate (provide freely or at a cost below fair market value) electronic health record (EHR) systems and cybersecurity tools to affiliated physician practices.[8] Without this safe harbor, the donation could be considered financial remuneration for any referrals made by the practice physicians to the hospital. Due to legislative mandates under the Affordable Care Act, the growth of VBC models, and patient demand, healthcare providers have an acute need to improve the user friendliness, interoperability, and decision-supporting analytics capabilities of their EHR platforms. And cybersecurity has emerged as a major area of concern for hospitals due to underinvestment in digital infrastructure and the highly sensitive nature of patient data.

By contrast, AKS violations are less frequent. For example, in 2019, the private equity firm Riordan, Lewis & Haden and its portfolio company Patient Care America (PCA), a compounding pharmacy, settled with the Department of Justice for $21 million after it was found that PCA had knowingly used an illegal referral scheme, hiring outside marketers to solicit patients and paying them on commission.[9] Some medical specialties are more prone to referral-related AKS violations than others. For instance, according to Sandra Zervoudakis, Managing Director at Mertz Taggart, many independent addiction treatment centers have historically used commission-based third-party marketers. A related violation, also historically common in addiction treatment settings, is the waiver of patient copays or other fees such as room and board for residential and/or outpatient programs, which amounts to compensating patients to induce them to receive treatment, according to Zervoudakis.[10] Private equity firms must be vigilant in due diligence to ensure they buy a practice with neither AKS liabilities nor significant revenue based on illegal practices.

Another AKS violation that occasionally occurs involves overpayment for a practice to which a selling physician will refer post-closing. This can happen when, as is common, a selling physician becomes an employee of the buyer and the purchasing entity treats patients in multiple specialties. This is typically more of an issue for hospitals as buyers, because hospitals offer a variety of services that frequently refer to each other. In a recent violation, Prime Healthcare, a for-profit, not private equity-backed health system, intentionally overpaid for a cardiology practice in expectation of referrals from the practice to one of its hospitals. Prime, its CEO, and the cardiology practice owner settled for $37.5 million.[11] By contrast, it is relatively uncommon for private equity acquirers to run afoul of AKS in this way, as private equity firms tend to build single-specialty platforms that are unlikely to refer to themselves. However, some practice types do lend themselves to cross-specialty acquisitions. For instance, some private equity-backed Autism applied behavioral analysis (ABA) providers have

8: "Fraud and Abuse Rules Part II: Amended EHR and New Cybersecurity Donation Safe Harbors and Exceptions," McGuireWoods, January 12, 2021.
9: "Healthcare Enforcement Quarterly Roundup Q4 2019," Jason B. Caron, et al., National Law Review, February 7, 2020.
10: Sandra Zervoudakis, telephone interview with Rebecca Springer, August 26, 2021.
11: "Prime Healthcare, Reddy Part of $37.5 Million Settlement Over Alleged Kickbacks," Modern Healthcare, Tara Bannow, July 19, 2021.

purchased physical, occupational, and/or speech therapy providers. Where there is risk of an AKS violation in the context of a transaction, the law requires that the purchase price be at fair market value. In some cases, an auction is sufficient to establish this; in others, an additional third-party valuation may be advisable.

Earnouts present a final potential issue for compliance with both AKS and Stark regulations. Earnouts have become increasingly popular in private equity healthcare transactions, particularly during COVID-19, because they allow firms to de-risk the purchase of practices that have recently been or are still exposed to the effects of the pandemic. Again, hospitals and multi-specialty groups are at risk of violating AKS and/or Stark if they provide revenue-based earnouts to sellers who stay on as employees after the acquisition and may refer internally. Single-specialty platforms, wherein physicians do not refer internally, generally avoid this risk. The logic is that physicians who have revenue-based earnout agreements after selling a practice and becoming employees of the buyer would be indirectly compensating themselves by making internal referrals, because those referrals increase the practice's revenue. A Stark violation would require referral of a designated health service. Firms can avoid an AKS or Stark violation by structuring earnouts in relation to other performance-related goals that do not take into account referral volume or the resulting revenue, such as recruiting other physicians to join a platform.

Practice licenses and patient record retention laws

States require medical practitioners to hold various licenses. In some cases, these can be difficult or time consuming to obtain. In addition to medical practice licenses, depending on the specialty, licenses may be required for laboratories, prescription drug dispensation, handling radioactive materials or biomedical waste, the use of lasers, and so on.[12] In a stock purchase transaction, these licenses are usually transferred automatically from the seller to the buyer; smaller asset purchases may require a new license or third-party consent for the transfer of licenses.

Medical practices are generally required by state law to securely retain and provide access to patient records for a set period, usually five to 10 years. Patient records are usually purchased along with a practice, but this does not necessarily release the seller from the record retention requirement. To circumvent this, deal parties enter into a custodianship agreement, which obligates the buyer to hold and provide access to patient records on the seller's behalf.[13]

12: "Client Alert: Practical Considerations in the Purchase and Sale of Physician Practices," Shumaker, Erin S. Aebel and Kathleen M. Bickelhaupt, April 11, 2019.
13: "Q&A: You're Selling Your Practice – What About the Medical Records?" Health Law Observer, Christina Burke, September 18, 2019.

Commercial and government payer contracts

Commercial payers

Most private equity-backed healthcare providers bill the majority of their revenue via commercial insurance. Insurance companies, or payers, contract with individual physicians or practices to establish in-network reimbursement rates. Contracted rates vary by state and, to a lesser extent, among different physician-payer contracts. They are usually renegotiated every three to five years and often include built-in annual increases. Commercial payer rates are generally higher than government (Medicare or Medicaid) rates and are also a desirable revenue stream because of the multiyear contract duration.

When a private equity firm initially purchases a platform practice by creating an MSO, the affiliated PC simply retains its existing payer contracts. However, the vast majority of private equity healthcare transactions are add-ons; that is, they involve an existing private equity-backed MSO platform as the buyer and a smaller practice as the seller. In this case, a key question is whether the seller's existing payer contracts will be continued. Alternatively, the buyer can cancel the seller's payer contracts and add physicians from the selling practice to the platform's existing contracts.

In most cases, private equity-backed platforms opt for the latter. This is because the seller's contract may carry liabilities, such as past overpayments for services that the payer will later seek to recoup or billing irregularities that could lead to contract suspension or malpractice penalties. These liabilities are rare but potentially catastrophic: Overpayment can result in millions of dollars in unanticipated expenses, while the loss or suspension of an important payer contract due to fraudulent billing can slash revenue and rupture existing patient relationships. Overpayment-related liabilities can also take years to emerge after a transaction closes. Additionally, as platforms grow and increase density (market share) in a given state, they can sometimes secure more-favorable reimbursement rates with commercial payers.

There are some cases in which it makes sense for a private equity-backed platform to preserve the payer contracts of an acquired practice. Because commercial payer contracts are often state specific, a platform entering a new state for the first time via an add-on will often keep the payer contracts of the acquisition. In this case, the acquired practice with its contracts are kept intact and become the new state PC. Another occurs if the practice being added on has secured significantly better reimbursement rates than the platform in one or more of its payer contracts. However, according to Rogers, this opportunity to benefit from rate differentials has diminished over time as payers have adopted contract language and policies that limit the ability of the provider to decide which contract it will use going forward.[14] Finally, in some cases, the process to assign an existing buyer's payer contract to a new location (the purchased practice) can be lengthy, thus necessitating at least temporary retention of the seller's contract(s) to avoid a loss of revenue.

14: Adam Rogers, telephone interview with Rebecca Springer, September 23, 2021.

Medicare and Medicaid

Analogous to private payer contracts, medical practices must maintain provider agreements with Medicare and/or Medicaid to receive reimbursements through these programs. As with commercial payer contracts, private equity-backed platforms typically rely on their existing Medicare provider agreements and do not acquire new agreements in add-on transactions. This involves either rejecting automatic assignment of the seller's provider number in an asset purchase transaction, or, in a stock purchase, terminating the seller's provider agreement, which would otherwise be transferred to the buyer.[15]

For most healthcare platforms, Medicaid is a less important reimbursement source than Medicare and is generally less desirable as a revenue source due to lower reimbursement rates and state-by-state variation. However, it can be important to certain platforms depending on the target patient population. Unlike Medicare, which is federally administered, Medicaid is administered by states according to broad federal guidelines. These variations can add layers of complexity when building a platform across state lines. In general, the treatment of Medicaid provider agreements in transactions is comparable to the treatment of Medicare agreements, but there are some significant state-level variations in the criteria for transferring a Medicaid number without interruption to billing and in the treatment of successor liability.[16] Additionally, states have discretion to decide which services are covered under their own Medicaid programs, subject to federal guidelines. For instance, many states either do not cover or provide limited coverage for behavioral health treatment under Medicaid. Additionally, the majority of Medicaid recipients are enrolled with a Managed Care Organization (MCO). MCOs contract with states to provide Medicaid services in exchange for a flat per-patient fee and can determine whether to admit providers to their networks, thereby introducing further uncertainty in growing a platform.

Other transaction considerations

Healthcare provider acquisitions—indeed, all acquisitions—may be structured as asset purchases or stock (equity) purchases. If the selling entity is an LLC partnership, the choice is between selling the partnership's assets and selling the partners' ownership interests. Several factors weigh into this consideration.

In the current climate of high competition for attractive assets, the most significant factors in deciding between an asset and stock sale are often transaction speed and limiting complexity. Sellers tend to prioritize efficient transactions; offering this can nudge a firm's offer into the lead in a competitive process. According to Holly Buckley, Partner and Healthcare Department Chair at McGuireWoods, and Geoffrey C. Cockrell, Partner

15: "Mergers and Acquisitions in the Healthcare Industry: Medicare and Medicaid Change of Ownership Rules," Reed Smith, Karl A. Thallner, November 9, 2016.
16: Ibid.

and Private Equity Group Chair at McGuireWoods, for all but the smallest acquisitions—those under $50 million or so—prioritizing efficiency usually necessitates structuring the transaction as a stock sale. This is because asset sales require a more complicated and time-consuming process that includes securing third-party consents to move contracts, credentialing providers, fulfilling government change of ownership requirements, and so on.[17] As many firms push to decrease hold times and integration costs and grow platforms more rapidly, private equity firms have become more disciplined in focusing less on add-on acquisitions of small or single-site practices, instead preferring to purchase smaller aggregators. When an asset purchase is pursued, it is almost always of a small practice in a state where the platform already has sufficient payer contracts. In these instances, the aim is to simplify due diligence by reducing or eliminating the possibility of historical liabilities being carried over from seller to buyer, according to Buckley and Cockrell. All of this analysis is complicated by some states' regulatory restrictions on the structure of entities and ownership of professional entities employing physicians or dentists.[18]

Advantages of an asset purchase	Advantages of a stock (equity) purchase
More efficient for smaller transactions	More efficient for larger transactions
Tax advantageous to buyer	Tax advantageous to seller
Reduces or eliminates buyer liability for historical seller overpayment, regulatory violations, and so on	Option to preserve payer contracts (for example, if establishing a new state PC)
	Requires fewer third-party consents, provider credentialing, government approvals, and so on

Tax considerations are another set of factors that sometimes play into the decision of how to structure a transaction. In general, asset purchases are tax advantageous to buyers, while stock sales are often tax advantageous to sellers. This is because in an asset purchase, assets are acquired at a stepped-up tax basis (the cash purchase price), which results in post-closing tax benefits to the buyer through depreciation deductions over time and the ability to deliver that benefit to a subsequent buyer. The effect on the seller will depend on the tax characteristics of the seller entity. If the seller entity is a flow-through tax entity, the impact on the seller is often modest. However, if the entity is a C-Corp, an asset sale could subject the seller to double taxation on the proceeds (one at the C-Corp level and again when the proceeds are distributed to the seller). The opposite is true for stock sales: The buyer foregoes the basis step-up and may inherit a more problematic tax structure going forward. Sellers, on the other hand, are taxed at the capital gains rate—rather than via a mix of capital gains and ordinary tax—on the proceeds of a stock sale and can avoid double

17: Holly Buckley and Geoffrey Cockrell, telephone interview with Rebecca Springer, October 8, 2021.
18: Ibid.

taxation in the case of a C-Corp. Again, in the current deal environment, private equity firms are likely to acquiesce to the more seller-friendly transaction structure (stock sale) in order to win competitive deals.

Finally, deal participants must also consider the increasingly important role of representations and warranty insurance (RWI) in healthcare transactions. According to Buckley and Cockrell, RWI materially changes the risk exposure to a seller. A traditional, non-RWI deal will have significant exposure to the seller for historical liabilities and other breaches of representations in the purchase agreement, with exposure ranging from around 10% to 100% of the purchase price in some situations. This exposure is secured by an escrow of 5% to 10% of the purchase price. By contrast, an RWI deal shifts most of that exposure to an insurance policy, with the seller's exposure effectively being zero (other than fraud) or limited to a small escrow of around 1% of the purchase price to offset a portion of the RWI policy deductible. Because sellers of high-quality assets currently enjoy significant market power, they are often successful in securing the reduced liability of a deal with RWI. Over the past decade, private equity firms have increasingly turned to RWI as an alternative to holdbacks and indemnity escrows that can speed and/or simplify transactions. RWI underwriting is particularly complex in healthcare relative to other industries because of the intricacies of billing and coding—irregularities that can be costly or have high magnitude/low probability risks that are difficult to resolve—but insurers have become increasingly comfortable with underwriting this risk, and prices have accordingly fallen.[19]

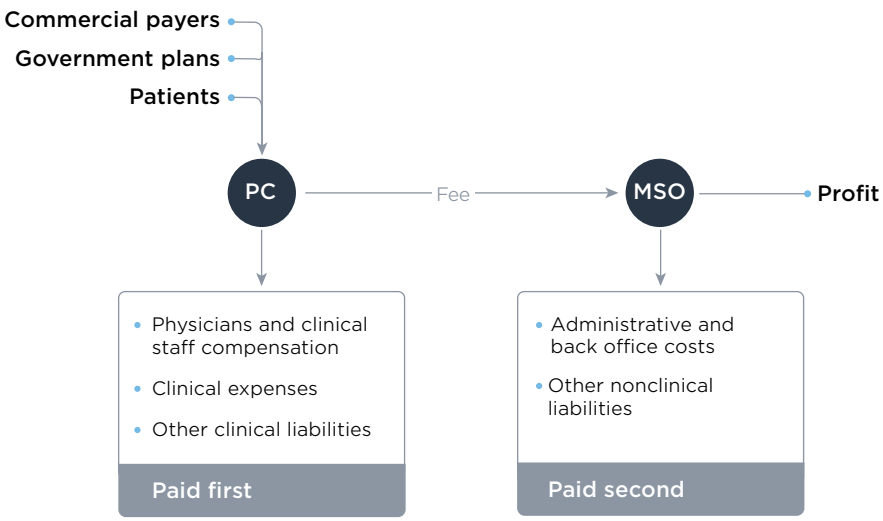
MSO creation and fee structures

According to Owens, in many cases, the seller creates the MSO as part of the private equity purchase transaction, often in the days leading up to closing. This involves creating the MSO, transferring nonclinical assets to it, and determining the go-forward ownership structure of the PC. The PC will typically be owned by one physician, though multiple physician-owners are also possible. That physician may be one of the selling physicians or another affiliate of the private equity sponsor; it is only important that they are aligned with the vision of the new MSO owners.[20]

The relationship between the PC and MSO is laid out in the MSA. MSO fees and services are included in a long-term lease agreement, usually 10 to 15 years in duration, with provisions for automatic renewal. In most states, the PC may be kept "friendly" or "captive" to the MSO via a stock transfer restriction, or succession planning agreement, which allows the MSO to ensure that there will continue to be a qualified, licensed physician to own the PC. In some states, chiefly New York, transfer restrictions and similar provisions are prohibited. According to Rogers, in these cases, PC-MSO alignment can be strengthened through financial means, including forfeiture provisions or liquidated damages fees, which would be triggered upon termination of the MSA or other conduct that adversely affects the viability of the MSO before a certain period of time.[21]

19: "Driving the Deal Podcast: The Evolving Role of Insurance in Private Equity Investments," McDermott Will & Emery, Kristian A. Werling, April 21, 2021.
20: J. Matthew Owens, telephone interview with Rebecca Springer, September 21, 2021.
21: Adam Rogers, telephone interview with Rebecca Springer, September 23, 2021.

MSO cash flows



According to Rogers, because the private equity firm owns the MSO, not the PC, the value of the acquisition comes from the MSO fee. The structure and amount of the fee paid by the PC to the MSO is a focal point for these investments—not just from a business perspective but also because of the need to comply with applicable laws, including fee-splitting prohibitions. An improperly structured MSO fee can create regulatory risk and become a material diligence issue when financing or exiting an investment. Often, MSO fees cannot be structured as a percentage of profits. For example, in New York, parties generally elect to set fixed MSO fees due to a prohibition on tying the fees to the amount received by providers.[22]

This poses a logical follow-up question: How can private equity firms capture value creation within the practice—such as through operational improvements, growth of the practice, or a more favorable reimbursement—if the MSO fee is not tied to revenue or profitability? Because the fee is set at fair market value, the parties can revisit the fee level periodically to adjust it as the business grows. It is important not to adjust the fee too frequently to avoid the appearance of implicitly tying it to revenue, and, although not required, it is generally advisable to also secure a third-party valuation to show that the fee is at fair market value.

Physician compensation and valuing a practice

The valuation of a physician practice, like other businesses, is usually expressed as a multiple of EBITDA. Because the value of a physician practice resides primarily in the skill, reputations, and patient relationships of the physicians themselves, in acquisitions of physician-owned practices, the physician-seller(s) usually continue to work at the practice after the deal closes. As a result, a physician compensation reduction model is applied to determine the valuation of the practice. Owens explains this with a hypothetical example. Say a physician-owned practice has 10 physician-owners with equal shares and $20 million EBITDA—$2 million EBITDA is attributable to each of the 10 owners. Following its sale to a private equity-

22: Adam Rogers, telephone interview with Rebecca Springer, September 23, 2021.

backed platform, each of the 10 physician-owners will be employed by the PC at a salary of $1 million annually. The compensation reduction for each physician is $1 million, or $10 million in total. This total reduction represents $10 million of residual EBITDA in the practice. From there, a multiple will be applied—say 10x. The MSO valuation (purchase price) is therefore $100 million.[23]

In addition, provider transactions commonly feature rollover equity, which can vary but is typically around 30%. In the example above, if 30% of this purchase price is in the form of rollover equity, then the 10 physician-owners each receive $7 million cash from the purchase and a 3% stake—worth $3 million—in the MSO.

Conclusion

Healthcare provider transactions are unique among private equity deals in their regulatory and technical complexity. Working with experienced lawyers and transaction service providers to carefully perform due diligence on potential corporate practice, fraud and abuse, payer contract, transaction structure, and physician compensation issues is essential to avoid unforeseen costs or revenue loss and to strategically plan geographical expansion. Moreover, this landscape is fluid, as changes to federal and state regulations can have a significant effect on private equity strategy, especially in areas such as Medicare reimbursement and VBC. We will continue to track these important transaction considerations as they evolve.

23: J. Matthew Owens, telephone interview with Rebecca Springer, September 21, 2021.