The Anatomy of Private Equity Investment in Health Care Services

AMERICAN BAR ASSOCIATION
BUSINESS LAW SECTION ANNUAL MEETING
HEALTH CARE AND LIFE SCIENCES COMMITTEE PANEL
SEPTEMBER 13, 2019

Moderator:
Ari J. Markenson, J.D., M.P.H., Partner, Co-Chair, Health Care and Life Sciences Industry Group, Winston & Strawn, LLP

Panelists:
Will FitzSimons, Senior Managing Director, Equity and M&A Practice, Gallagher
Angela Humphreys, Member, Chair, Healthcare Practice Group, Bass, Berry & Sims PLC
Lisa T. Nix, Shareholder & Practice Leader, Transaction Advisory Services, LMBC
Jon Pritti, Managing Director - Healthcare Group and Head of the Healthcare IT practice, Houlihan Lokey
Materials –


2. Humphreys, A. Want to Buy an “Ology”? Six Things to Know Before You Buy a Physician Practice.


Private equity has had an overwhelmingly positive impact on healthcare. But after a decade of reinvention in the industry – with no sign of letup – even those interested in finding new ways to deliver care show signs of change fatigue.

In this environment, critics wedded to the status quo are blaming PE for needed changes they don't like.

In parts of the industry, it is almost an article of faith to question whether PE investment is good for patients. In particular, two recent publications in dermatology have sparked media coverage that drew great attention to this point of view.

A recent article in the New York Times highlighted a paper published on the website of the Journal of the American Academy of Dermatology, bashing PE’s investment in dermatology practices. The JAAD paper suggested that private equity often buys outlier practices that share its focus on profits.

A Viewpoint article published in January by JAMA Dermatology suggested “risks to the specialty” from consolidation of dermatology practices that are “commoditizing the treatment of skin disease.” This article also raised the specter of PE investment leading to pressure to drive referrals of other services that violate healthcare laws and regulations.

What the authors of these papers are missing, however, is the positive impact of the enhanced compliance profiles and clinical protocols that PE firms bring to the physician practices they acquire.

Standardizing practices based on evidence-based protocols improves treatment levels and reduces errors. If standardization is commoditizing treatment, then I would guess many patients would appreciate commoditizing.

And of course, they overlook the signature benefit of PE investment: gaining a capital partner who will invest the resources necessary to grow the practice and enable physicians to focus on their highest and best use – practicing medicine.

PE firms are answerable to their investors, so they have every interest in ensuring the company they want to invest in is strong and in compliance. They bring a laser focus to compliance through a robust due diligence process that includes:

- a quality-of-earnings analysis to probe the ways a physician practice generates revenue and ensure the practice’s business model is proper and sustainable;
- an in-depth billing and coding audit to support this analysis; and
- a thorough review by experienced attorneys of the practice’s legal arrangements, especially with physicians. Physician arrangements are subject to federal civil and criminal laws that prohibit providing financial incentives to physicians for patient referrals.

The due diligence process can result in repayments to government health programs, such as Medicare and Medicaid, if technical violations are discovered.
Moreover, the vigilance of investors doesn’t end with closing.

Compliance issues that are identified during due diligence are corrected on a go-forward basis, and this is monitored by leadership and the board.

In addition, PE firms often establish medical advisory boards at their platform companies to advise physicians on the best clinical protocols to optimize patient care.

These strategies bring an enhanced level of sophistication and best practices to stand-alone physician practice groups.

An investment by a private equity firm provides a practice with much-needed capital, a significantly stronger compliance program and the collective knowledge of the physicians across its sister practices, enabling physicians to focus on patients instead of the business of the practice.

Despite what you may have read, that is a good thing.
1. Corporate Practice of Medicine
Although somewhat antiquated, the majority of states still have a prohibition on the corporate practice of medicine. This results in a private equity firm acquiror having to set up a “friendly physician” model with a management services agreement and securities transfer restriction agreement. If done properly, the private equity firm may be able to consolidate for both financial reporting and tax purposes.

2. Fee Splitting
Depending on state law, the management fee payable under a management services agreement may or may not be based on a percentage of revenue. Alternative fee structures include a fixed fee or fee based on a multiple of costs. Fees should be adjusted no more than annually and only on a prospective basis.

3. Earn-outs
Can you pay an earn-out? Although there are structures that can be implemented to provide for contingent payments based on certain metrics, care should be taken in structuring such payments based on the facts and circumstances of each individual situation.

4. Physician Noncompetes
Although noncompetes are generally favored in connection with a sale of a business, noncompetes in connection with ongoing employment of physicians post-sale can present issues. Arizona, California, Oregon and Texas, among others, all have specific restrictions on the enforcement of noncompetes in connection with physician employment. This necessitates careful drafting and risk mitigation.

5. Labs & Rollover Equity
Does your platform have a lab? Is the lab operated through a group practice? Any physician who has rollover equity in the platform parent who refers government program business to a lab may need to do so through a lab contained in the physician’s group practice in order to meet the Stark Law in-office ancillary services exception.

6. Platform Expansion
So, you have a great platform with great payor contracts. Can you use that platform to expand across multiple states? Maybe, maybe not. Some states require that the practice entity be domiciled in that state. Other states only permit the use of certain types of entities. California, for example, only permits the use of a California professional corporation. Some states also require all or some of the physician owners to be licensed in and/or a resident of the state.

Although every physician specialty has its own set of regulatory issues, the above issues present themselves in transactions across specialties. Addressing these issues prior to an LOI or indication of interest will help to keep your physician practice management transactions on track. If you have questions or need assistance with any upcoming physician practice management transactions, click here for a list of Bass, Berry & Sims Healthcare Private Equity attorneys.

About Bass, Berry & Sims’ Healthcare Private Equity Practice
With over 200 attorneys in its nationally recognized healthcare industry practice, Bass, Berry & Sims represents clients in more than 30 healthcare industry sectors. We regularly assist private equity firms and healthcare portfolio companies in finding creative and pragmatic, business-oriented solutions while navigating the unique healthcare regulatory, M&A and business environment.

To learn more about our team, industry experience and value add, click here.
The Philosophy for Investing in Urology: 5 Key Regulatory Risks

In the wave of physician practice management transactions, urology is poised to be one of the next hot sectors. In addition to the issues to consider in connection with any physician practice transaction, below we discuss five key regulatory risks to consider when investing in a urology practice.

1. IMRT and Utilization Rates

Intensity-modulated radiation therapy (IMRT) is a common treatment for cancer, including prostate cancer. Several studies have documented that urologists with an ownership stake in the IMRT are more likely to treat patients with IMRT than urologists without ownership. These studies have led to additional focus on all financial relationships with the urologists, necessitating thorough diligence to ensure compliance with the federal Stark Law and state self-referral laws. When evaluating urology practices, it is important to closely review and analyze the financial relationships between the referring urologist and the entity providing IMRT services, whether that be the practice itself or a third-party radiation therapy provider.

2. Other Financial Relationships

As a referral source to various healthcare facilities and a specialist practitioner that receives referrals from other practitioners, diligence should include close examination of any financial relationship between them to ensure those relationships are structured to comply with applicable fraud and abuse laws. In addition, increased regulatory attention has been placed on physician relationships with industry vendors, including pharmaceutical and medical device manufacturers. It will be important to identify and vet any such relationships, even if the practice itself is not involved, because of secondary impact to an investment if any of the practitioners are implicated in a noncompliant relationship.

3. Medical Necessity

As recent False Claim Act lawsuits demonstrate, medical necessity is not sheltered as being within the realm of professional medical judgment. A number of recent lawsuits focused on lack of medical necessity as the primary basis for a claim being false. In part due to the findings referenced above regarding potential overutilization of IMRT, it is important to ensure that the medical necessity for these services is well documented; in particular, because there are other, less expensive treatment options. Moreover, with increasing program integrity efforts from both commercial and government programs, documentation that supports medical necessity for all services – not just IMRT – is critical to being able to respond to audit requests and retain collections for services billed. Support of medical necessity for services and treatment is also an important issue in a value-based care system.
4. Billing and Coding

Today, incorrect billing to federal healthcare programs, whether intentional or not, potentially creates an obligation to promptly repay. Moreover, as payment mechanisms evolve it is becoming more complicated to bill for urology services - to ensure services within a bundled payment are not separately billed and navigate the rules of numerous different payors. As a result, it is incredibly important to evaluate the integrity of medical records and billing and coding before investing in a urology practice. That evaluation should include a representative sample of claims, including high-risk ancillary services, even if the revenue for these ancillary services is proportionally small. Investors should engage with an expert on how to properly code for urology, IMRT and other ancillary services to evaluate the sample and verify that there have not been any overpayments. Key issues to examine include the following: documentation; sudden changes in practice patterns (utilization rates); physician extenders (up-to-date credentials and proper scope of practice for midlevels); and upcoding (and undercoding).

5. ASCs

Urologists perform many procedures in ambulatory surgery centers (ASCs) and may use an ASC as an extension of their practices. They also may have ownership in an ASC, either individually or through their group practice or another entity. ASCs increase the attractiveness of investing in urology groups because of the efficiency of the ASC model and potential profitability. Because urologists are referral sources to the ASC, their relationships with ASCs fall within the purview of the federal Anti-Kickback Statute and similar state laws. As a result, any ASC relationships should be carefully considered to ensure the relationships fall within a safe harbor or otherwise present low risk.

About Bass, Berry & Sims’ Healthcare Private Equity Practice

Although there are issues to consider when investing in any physician practice, an investment in certain specialties such as urology present unique regulatory risks. With over 200 attorneys in its nationally recognized healthcare industry practice, Bass, Berry & Sims represents clients in more than 30 healthcare industry sectors. We regularly assist private equity firms and healthcare portfolio companies in finding creative and pragmatic, business-oriented solutions while navigating the unique healthcare regulatory, M&A and business environment.

To learn more about our team, industry experience and value-add, click here.

Authors:

**Angela Humphreys**
615-742-7852
ahumphreys@bassberry.com

**Danielle Sloane**
615-742-7763
dsloane@bassberry.com

**Ryan D. Thomas**
615-742-7765
rthomas@bassberry.com
Spring cleaning season has arrived! This time of year serves as the perfect opportunity to revisit your portfolio company’s healthcare compliance. The complex and ever-changing healthcare regulatory and enforcement environment, including increased focus on the role of private equity firms in their portfolio companies, make compliance a top priority for private equity firms investing in healthcare companies. The best way to limit your exposure as a private equity firm is to avoid a compliance misstep in the first place. Additionally, an effective and robust compliance program for your portfolio healthcare company makes it much more attractive to potential buyers and helps you avoid an unexpected and costly investigation or valuation hit down the road. Use this spring checklist to assess whether your portfolio company’s “house” is in order.

Confirm the portfolio company’s compliance programs are established and up to industry standards.

1. Is there an appropriate “tone at the top” and compliance culture?  
   YES  NO

2. Are the organizational leadership and board adequately **informed and knowledgeable** of the key regulatory risks impacting the portfolio company, including mandatory compliance training on an annual basis?  
   Lack of knowledge of the law and compliance risks is not a defense in a government investigation.  
   YES  NO

3. Are **up-to-date policies and procedures** in place, clearly identifiable, and being followed?  
   Do these policies and procedures address the appropriate risk areas for the particular healthcare company?  
   YES  NO

4. Is there a robust internal audit process that **assesses and addresses risk areas** on a regular basis? Has there been a recent audit of coding or other areas of high compliance sensitivity (including HIPAA)?  
   YES  NO

5. Is the portfolio company following obligations to **report and refund overpayments, Stark violations or similar obligations** relating to federal healthcare programs? **Don’t wait for a potential buyer to discover this (or other compliance issues) in due diligence.**  
   YES  NO
Identify the private equity firm’s role and risk profile in the portfolio company’s overall organizational structure.

1. What roles are your managers or operating partners filling in the portfolio company? Consider potential exposure that may be created for the private equity firm as a result of operating partners playing dual roles as strategic advisors, directors and/or officers of the portfolio company given their affiliation with the private equity firm.

2. How involved are you in the hiring of executives for the portfolio company and directly overseeing these executive officers? Consider the perception of setting performance metrics or expectations based on growing federal healthcare program business.

3. Are you directly facilitating or implementing new business programs at the portfolio company that involve revenue growth from federal healthcare program business? Seek regulatory guidance on the front end before implementing new programs that potentially implicate federal and state laws.

4. Do you have appropriate company and fund level insurance programs?

Ensure that attorney-client privilege protects both the private equity firm as well as the portfolio company.

1. When legal counsel is engaged, who is named in the engagement letter as the actual client? Should the engagement of outside counsel cover both the private equity firm and the portfolio company?

2. If the portfolio company has separate counsel and receives advice that needs to be shared with the private equity firm, are appropriate measures taken to avoid a possible waiver of the attorney-client privilege?

3. Is outside counsel being included in all communications between management and the board, including in board meetings, on sensitive issues in order to preserve the attorney-client privilege?

Keeping up with the ever-changing tangle of complex regulations is tough, and having a robust compliance program to protect your firm and your portfolio has never been more important.

With over 180 attorneys in its nationally recognized healthcare industry practice, Bass, Berry & Sims represents clients in more than 30 healthcare industry sectors. We regularly assist private equity firms and healthcare portfolio companies in finding creative and pragmatic, business-oriented solutions while navigating the unique healthcare regulatory, M&A and business environment.

To learn more about our team, industry experience and value-add, click here.
Regulatory Due Diligence: Putting it in a Box – Regulatory and Enforcement Issues

• Common Regulatory/Enforcement Issues to Address in Due Diligence
  o Reimbursement/Claims Issues
  o Internal Audits
  o External Audits
  o Regulatory Investigations
  o Criminal / Civil Litigation
  o Licensure/Inspection Issues
  o Citations/Deficiencies

• Excluded Individuals - The proverbial - “low hanging fruit”
  o This is a black and white issue where a Buyer can’t accept liability. The issue is generally an easy issue for a Seller to prevent in its operations. Determining the monetary exposure involved is not always simple where reimbursement is not directly attributable to the excluded individual
  o Issue - if the Seller has not been checking, how far back do you go in diligence?

• Do I want to know?
  o There are certain inherent risks in digging too deep. However, if you don’t dig enough as a Buyer you can end up inheriting things you never intended to.
  o 60 Day Overpayment Rule - Reporting obligation lies with which party – buyer/seller?

• If you find something, framing the risks involved in what you have found, becomes very important. The Buyer has to look as issues, such as -
  o Single provider entity vs. multiple providers
  o Single jurisdiction vs. multiple jurisdictions
  o Single provider vs. integrated provider
  o What % of revenue does the business unit affected contribute to the overall enterprise?
  o Can the business unit be separated out?
  o The Regulatory violation itself -
    ▪ Significance
    ▪ Business risks
      • Examples
        o Violation results in major financial loss (e.g. core structure violates AKS and must be abandoned)
        o Violation results in payment of small fine (e.g. local health department inspection report not posted)
      • Impact
        o Price adjustment?
        o Correction as condition of closing?
  o Developing Additional Diligence
  o Reviewing regulatory correspondence
  o Reviewing internal audit/review findings
Regulatory Due Diligence:
Putting it in a Box – Regulatory and Enforcement Issues

- Interviews with compliance personnel
- Interview with in-house and outside counsel
- Direct discussions with regulators
- Direct discussions with prosecutorial agencies
- Additional document requests –
  - Litigation, settlement agreements, subpoenas, investigations, CMPs – actual or threatened
- Compliance program
- Internal reviews, investigations
- Regulatory surveys, inspections and reviews

- **Battle of the Consultants/Advisors from Buyer/Seller**
  - They can have differing views on –
    - whether or not liability exists
    - the extent of problem or the dollars involved
    - the ultimate risk of enforcement
    - the amount that the government might settle for
  - Possible solutions include –
    - Tie-breakers – a counsel or consultant that both parties can agree on
    - Threshold indemnities
      - If issue ultimately cost >X, seller pays everything over X
    - Threshold escrows
      - A dollar amount that both parties can agree is at risk

- **Good Diligence Should Directly Relate to the Purchase Agreement**
  - Indemnity provisions
  - Content of reps. and warranties
  - Careful attention to survival periods
  - Necessity of escrow of purchase proceeds
I. Sample Health Care Regulatory Diligence Requests

(a). Litigation and Compliance

(1). List and description of all pending, threatened and concluded claim, litigation, arbitration, mediation and administrative proceedings involving the Company that relate to the applicability of, or compliance with, Health Care Laws that is or was pending, threatened or resolved within the last three years.

(2). For each such claim or proceeding, provide a description of the amount of damages or other relief sought, the status of the claim or proceeding, the amount of insurance coverage applicable, whether any insurer has disclaimed coverage with respect thereto, the court or tribunal in which such claim or proceeding is pending, and whether any claim for punitive or exemplary damages has been made.

(3). Schedule of all consent decrees, judgments, settlements and other dispositions of any legal, arbitration or administrative proceeding pursuant to which the Company has continuing or contingent obligations.

(4). Correspondence between the Company or the Company’s attorneys and auditors regarding threatened or pending litigation, claims or assessments related to Health Care Laws.

(5). Copies of regulatory surveys and inspections and related plans of corrections for the last three years and related correspondence.

(6). Correspondence with any Governmental Entity relating to the applicability of, or compliance with, Health Care Laws.

(7). A listing of site-specific governmental or contracted audit activity for the current year.

(8). Documents concerning alleged or actual contract violations by the Company that relate to the applicability of, or compliance with, Health Care Laws.

(9). Description of all investigations, inquiries or allegations of any Governmental Entity pending or threatened against the Company prior to the date hereof.

(10). Copy of all corporate compliance plans for the Company, its policies and procedures, and all updates and amendments thereto (including, without limitation, the Company’s policies and procedures for credentialing employees and reviewing employees for inclusion on a state or federal list of excluded providers). List of all complaints or inquiries made under such plans, policies and procedures during the past three years.

(11). A description of the Company’s employee concern reporting process.

(12). A list and description of the Company’s Sentinel and reportable events during the past two years.

(13). Opinions or other assessments of a Company’s attorneys concerning the potential effects of any Health Care Laws on the operations of the Company, or any proposed or pending change in any Health Care Laws.
Organizational chart of the Company’s compliance department, copies of minutes of the Company’s compliance committee meetings during the past year.

Copies of internal compliance audit templates for the Company and a description of the Company’s compliance audit procedure and follow-up action plan.

Results of the Company’s internal compliance audit or review for the past two years and the schedule for the Companies’ internal compliance audit or review for the current year.

Copies of any reports filed with any Governmental Entity or agency during the last three years (including, without limitation, cost reports), and copies of all correspondence to and from any Governmental Entity.

Description of any allegation or claim that a Company is acting in violation of any law, regulation, ordinance or other requirement of any Governmental Entity. Copies of all notices, reports, and correspondence with respect to any of the foregoing.

Certification documents and other documents that relate to the Company’s eligibility to participate in state and federal health care programs (including, without limitation, CMS 855A forms filed in the last five years).

Documents relating to any pending or threatened decertification or civil monetary penalties or other regulatory sanctions for the Company.

All other documents relating to a Company’s past, current or future compliance with Health Care Laws.

(b). **Contracts and Agreements**

All contracts or commitments to enter into contracts pertaining to the operation of the Company relating to any of the following: third party payor, medical director, physicians, nurses, ambulance, laboratory, optometry, ophthalmology, hospice, infusion therapy, respite care, nutrition, dental, pharmacy, x-ray, psychology, psychiatrist, physical, speech, occupational and respiratory therapy, dialysis, oxygen, podiatrist, audiology, and durable medical equipment.

All documents relating to the Company sent to or received from federal or state intermediaries for the Medicare, Medicaid, TRICARE and any other governmental programs during the last three years.

Contracts for the production or supply by the Company of goods or services.

Joint venture or partnership agreements.

Corporate Integrity Agreements.

A list of all employment contracts, independent contractor agreements, or other binding arrangements affecting employment rights of any person, to which the Company is a party.

Copies of the Company’s agreements with a medical director and any other physician.

Copies of current contracts with any vendors not otherwise requested herein.
Any and all agreements, arrangements or understandings with individuals or entities who have or may refer patients to the Company, e.g., hospitals, nursing homes, doctors, etc.

II. **Sample Health Care Representations and Warranties**

(a). **General - Health Care Laws Compliance**

The Company nor, to the knowledge of the Company, any of its respective members, managers, shareholders, directors, officers, employees or agents or persons who are or who are required to be licensed, certified, registered or who are otherwise qualified to provide health care or personal care-related professional services to, or on behalf of, the Company in their capacity as such is in violation of any Legal Requirement applicable to the Company, including, all federal and state Healthcare Laws.

(b). **General - No Health Care Investigations**

Neither the Company nor, to the knowledge of the Company, any of its respective members, managers, shareholders, directors, officers, employees, agents or professional personnel: (i) has received written notice from any Governmental Body that (A) alleges any noncompliance or that the Company is under investigation, or the subject of an inquiry by any such governmental body for such alleged noncompliance with any Healthcare Law or (B) alleges any non-compliance that is likely to result in a fine or assessment that can be reasonably determined or estimated or in a cease and desist order, or the suspension, revocation or material limitation or restriction of any governmental authorization or (ii) has entered into any agreement or settlement with any governmental body with respect to its non-compliance with, or violation of, any Healthcare Law.

(c). **General – Filing of all Health Care Governmental Filings**

The Company has timely filed all regulatory reports, schedules, statements, documents, filings, submissions, forms, registrations and other documents, together with any amendments required to be made with respect thereto, that it was required to file with any Governmental Body, including state health and insurance regulatory authorities and any applicable federal regulatory authorities, and all such filings are complete and accurate in all material respects.

(d). **Specific - No Health Care Fraud and Abuse Issues**

None of the Company, nor any of its respective members, managers, shareholders, directors, officers, employees, or agents or to the Company’s knowledge, any of the professional personnel or the predecessors to any of the Company in respect of any business to which the Company succeeded: (1) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Body or any other Person; (2) has been the defendant in any qui tam/False Claims Act litigation; (3) has been served with or received any search warrant, subpoena, civil investigative demand or contact letter by or from any federal or state enforcement agency or governmental body; (4) has been convicted, investigated for or charged with (i) any offense relating to the delivery of an item or service under a payment program, (ii) any offense under any laws, regulations or Legal Requirements relating to patient neglect or abuse in connection with the delivery of a healthcare item or service, (iii) any offense under any laws, regulations or Legal Requirements relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a healthcare item or service or with respect to any act or omission in a payment program, (iv) any laws, regulations or Legal Requirements relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a healthcare item or service or with respect to any act or omission in a payment program, (v) any related or similar
violation of any Legal Requirements or other offenses; (5) has been subject to any order of, or any criminal, civil or administrative fine or penalty imposed by, any governmental body with respect to any payment program; or (6) has engaged in any activity that constitutes or could reasonably be expected to constitute a violation of any Legal Requirement (including any Healthcare Law), including the following as applicable to any particular Governmental Program: knowingly and willfully making or causing to be made a false statement or representation of fact in any application for any benefit or payment; knowingly and willfully making or causing to be made any false statement or representation of fact for use in determining rights to any benefit or payment; failing to disclose knowledge by a claimant of the occurrence of any event affecting the initial or continued right to any benefit or payment on its own behalf or on behalf of another, with intent to fraudulently secure such benefit or payment; and knowingly and willfully soliciting or receiving any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind or offering to pay or receive such remuneration (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item of service for which payment may be made in whole or in part by any Governmental Program, or (B) in return for purchasing, leasing, or ordering or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made, in whole or in part, by any governmental program.

(e). Specific - No Exclusions or professional actions

Neither the Company nor any member, manager, shareholder, director or officer thereof nor, to the knowledge of the Company, any of the professional personnel or any current or former employee of the Company has at any time been suspended or excluded or, to the knowledge of the Company, threatened to be suspended or excluded from participation in the governmental programs. The Company screen all employees, prior to employment, against the List of Excluded Individuals and Entities maintained by the Office of Inspector General for the U.S. Department of Health & Human Services and the Excluded Parties List System maintained by the General Services Administration and require all subcontractors who furnish professional personnel to any of the Company to conduct such screening prior to the commencement of services for or on behalf of any of the Company and no suspended or excluded individuals have provided services for or on behalf of any of the Company. To the knowledge of the Company, there are no inquiries, investigation or monitoring of activities of any licensed, registered, or certified professional personnel employed by, credentialed or privileged by, or otherwise affiliated with or engaged by the Company pending or, to the knowledge of the Company, threatened by any state professional board or agency charged with regulating the professional activities of health care practitioners.

(f). Specific – No CMPs/Convictions

Neither the Company nor, any of their respective members, managers, shareholders, directors, officers, employees, agents or to the Company’s knowledge, any of the professional personnel: (i) has been assessed a civil money penalty under Section 1128A of the Social Security Act or any regulations promulgated thereunder, (ii) has been convicted of any criminal offense relating to the delivery of any item or service under a Governmental Program relating to the unlawful manufacture, distribution, prescription, or dispensing of a prescription drug or a controlled substance, or (iii) is a party or subject to any action or proceeding concerning any of the matters described above in the preceding clauses (i) and (ii).

(g). Specific – No False Claims

The Company has not submitted to any payment program any false or fraudulent claim for payment. There
are no reports required to be filed by the Company in order to be paid under any payment program for services rendered, except for reports not yet due. All payment program reports and claims filed or required to be filed by or on behalf of the Company have been timely filed and are complete and accurate in all material respects. Such reports and claims properly claim and disclose all information and other items to be disclosed for the periods covered thereby. The Company have paid, repaid, allowed to be offset or caused to be paid all known and undisputed refunds, overpayments, discounts or adjustments. There is no pending, concluded or, to the knowledge of the Company, threatened Legal Proceeding with respect to any prior reports or billings or otherwise relating to the Company’ participation in any payment program. No payment program has imposed a fine, penalty or other sanction on the Company.

(h). Specific – No Investigations, audits, etc.

The Company meets the conditions for participation in, and is in good standing with respect to, each payment program. There is no pending, concluded or, to the knowledge of the Company, threatened: (i) investigation, audit, claim review, of the U.S. Department of Health and Human Services or any federal or state agency, board or contractor, or other action pending or threatened which may result in a revocation, suspension, termination, probation, restriction, limitation, or non-renewal of any Governmental Authorization, or result in exclusion of the Company or any employee or agent of the Company, or professional personnel from any payment program; (ii) validation review, program integrity review or reimbursement audit; (iii) voluntary disclosure by the Company to the Office of the Inspector General of the United States Department of Health and Human Services, a Medicare fiscal intermediary, a State Medicaid program or any other Governmental Body of a potential overpayment matter other than refunds processed in the ordinary course of business; or (iv) health care survey report related to licensure or certification (including an annual or biannual Medicare or Medicaid certification survey report) that includes any statement of deficiencies pertaining to the Company that will not be fully corrected prior to the Closing.

(i). Specific – Compliance Policies and Procedures

The Company has implemented policies, procedures and/or programs designed to encourage its agents and employees are in compliance within all Healthcare Laws, including laws, regulations, directives and opinions of Governmental Bodies relating to advertising, licensing, marketing and sales practices.

(j). Diligence – Provided All Survey/Inspection Reports

The Company has delivered to XXX complete and correct copies of (i) all audit or inspection reports received by the Company from any Governmental Body for the last three (3) years prior to the date hereof and all written responses thereto made by the Company (ii) all inspection reports provided to the Company by any Governmental Body for the last three (3) years prior to the date hereof and (iii) all correspondence relating to any investigation by any Governmental Body for the last three (3) years prior to the date hereof.

(k). Diligence – Provision of all Provider Numbers

Schedule XXX sets forth a list of (i) the Medicare program (Title XVIII of the Social Security Act), including Medicare Advantage program, the Medicaid program (Title XIX of the Social Security Act), the TRICARE program (10 U.S.C. §§ 1071, et seq.), and any other federal, state or local governmental health care program in which the Company participate and any non-Governmental Program third-party payors with which

Ari J Markenson, Partner
Co-Chair, Health Care and Life Sciences Industry Group, Winston & Strawn, LLP
the Company have a contract to provide services and to receive payment therefor. Except as set forth on Schedule XXX, no payment program has either terminated its relationship or given notice of such termination with the Company, or has given notice that it intends to materially reduce the aggregate value of its annual transactions with the Company, taken as a whole.

III. Sample Definition of “Health Care Laws”

“Healthcare Laws” means all laws, rules, regulations, codes, ordinances, orders, decrees, judgments, injunctions, notices or binding agreements issued, promulgated or entered into by any Governmental Entity, relating in any way to: (i) the business or operation of the Company as a “XXX”; (ii) the provision of, or payment for, health care services, items or supplies; (iii) billing, coding or submission of health care claims for reimbursement; (iv) health care fraud and abuse, including but not limited to the following statutes, as amended and in effect from time to time, and any successor statutes thereto and the regulations promulgated thereunder, 42 U.S.C. §1320a-7b(b) (“Anti-Kickback Law”), the other provisions of 42 U.S.C. §1320a-7b, 42 U.S.C. §1395nn (“Stark Law”), 31 U.S.C. §3729 et seq. (“False Claims Act”), 42 U.S.C. §1320a-7a (“Civil Monetary Penalty Law”), 18 U.S.C. §1347 and the regulations promulgated pursuant to such statutes; (v) Medicare Regulations and Medicaid Regulations; (vi) all statutes and regulations applicable to Government Healthcare programs established under Titles V, XX, and XXI of the Social Security Act; (vii) all statutes and regulations pertaining to TRICARE; (viii) CLIA; (ix) HIPAA, its related regulations, and other federal and state privacy laws, regulations, guidelines, and industry guidelines (x) all state laws relating to fee splitting, professional practice, or kickbacks with respect to healthcare items, services or providers and suppliers, self-referral by healthcare providers and suppliers, corporate practice of medicine or a profession, and licensure and registration of healthcare providers; (xi) all federal and state laws regulating disposal of Medical Waste and radioactive waste; (xii) all federal and state laws regulating the provision of radioactive or radiologic services to human subjects, including the licensure, registration or certification thereof; (xiii) all statutes and regulations of the federal Drug Enforcement Administration and the federal Food and Drug Administration; and (xiv) any and all other applicable health care laws regulations, manual provisions, policies and administrative guidance, each of (i) through (ivx) as may be amended from time to time.
CHANGES IN OWNERSHIP: MEDICARE RULES AND OTHER ISSUES

Ari J. Markenson, Esq.
Winston & Strawn LLP
New York, NY

Tammy Ward Woffenden, Esq.
Locke Lord LLP
Austin, TX

Introduction

When a healthcare provider or supplier is enrolled in Medicare, certain transactions, including an asset transfer to a new owner, are typically classified by the Centers for Medicare & Medicaid Services ("CMS") as a change of ownership, or CHOW, which requires notification from both seller and buyer, and CMS Regional Office ("RO") approval. Such a transaction often results in formal assignment of the Medicare number and, if applicable, Medicare provider agreement, to the new owner. In comparison, transactions involving stock or membership transfers or other reorganizations that do not change the tax identification number ("TIN") on file with CMS typically require the filing of an update of ownership information with CMS. However, CMS will ultimately make the final determination—based on the structure of the transaction—as to whether a CHOW has occurred. Therefore, notification of any changes in ownership information affecting a Medicare provider number is important to ensure that all CMS requirements and approvals are obtained. Failure to timely and properly notify CMS of a CHOW or update of ownership information can lead to deactivation or revocation of a Medicare identification number (also known as a Provider Transaction Number ("PTAN") for Part B and CMS Certification Number ("CCN") for Part A) or Medicare billing privileges.

When initially structuring and negotiating a transaction involving a Medicare provider or supplier, parties to the transaction should review applicable Medicare regulations and CMS guidance to determine whether the proposed transaction is a CHOW or requires only an update of ownership information; understand applicable pre- and post-closing filing and notification requirements; determine whether regulations affect the proposed structure of the transaction; and identify other legal and business issues that may affect the transaction, such as successor liability and arranging for post-closing payment for Medicare services during the CHOW process.

providers and suppliers

When reviewing Medicare requirements relating to CHOWs and ownership updates, it is important to understand that Medicare classifies "providers" and "suppliers" as follows:

- Providers are defined generally to mean: (1) a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility ("CORF"), home health agency, or hospice that has in effect an agreement to participate in Medicare; (2) a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or (3) a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. Providers typically use Form CMS-855A to notify CMS of a CHOW or update of ownership information.

- Suppliers are defined to mean a physician or other practitioner, or an entity other than a provider, that furnishes healthcare services under Medicare. Suppliers include ambulance service providers, ambulatory surgery centers, clinics and group practices, independent clinical laboratories, independent diagnostic testing facilities, and other healthcare services that bill under Medicare Part B. Suppliers typically use Form CMS-855B to notify CMS of a CHOW or update of ownership information. Suppliers of durable medical equipment, prosthetics, orthotics, and supplies ("DMEPOS") use Form CMS-855S.3

Medicare CHOWs

What Are Medicare CHOWs?

A Medicare change of ownership generally means:

- In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law.4

- In the case of a sole proprietorship, transfer of title and property to another party.5

- In the case of a corporation, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation.6 An asset transfer of a corporation would be considered a CHOW, whereas the transfer of corporate stock or the merger of another corporation into the provider corporation typically would not.7

- Medicare regulations and guidelines do not specifically address limited liability corporations ("LLCs"). CMS recognizes that LLCs have characteristics of both a partnership and corporation and that the members in an LLC are very similar to those of stockholders in corporations.8 It is common for CMS to view an asset transfer involving an LLC as a CHOW but, similar to
is based on the net revenue or profit limitations and even if the management fee have wide latitude in making decisions, is considered an agent of owners' general approval of operating decisions (or management agency agreement). This is the case even if the management company do not typically result in a change that constitutes a CHOW occurs. 22 In anticipation of a CHOW, the new owner of an approved supplier must submit a complete Form 855B and submit a copy of the sales agreement to the MAC. The CHOW must be reported to the MAC within 30 days of the change. 23 However, a CMS-855B CHOW application may be accepted by the MAC up to 90 calendar days prior to the anticipated date of the proposed ownership change. 24 The MAC will review the sales agreement submitted with a CMS-855B application indicating a CHOW to determine whether: (1) the ownership change qualifies as a CHOW under the principles of 42 C.F.R. § 489.18; (2) its terms indicate that the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner; and (3) the information contained in the agreement is consistent with that reported on the new owner's Form CMS-855B (e.g., same names provided). 25 However, the RO—not the MAC—makes the final determination regarding whether a CHOW has occurred. 26

Assignment of the Provider Agreement

CMS will automatically assign the existing provider agreement to the new owner unless the new owner rejects assignment in its Form 855 filings. 27 With automatic assignment, the new owner becomes subject to all of the terms and conditions under which the existing agreement was issued, including, but not limited to:

1. Any existing plan of correction. 28 The new owner must meet the time frames for correcting deficiencies cited in the existing plan of correction. A CHOW is not a basis for extending the time given for correction. 29

2. Compliance with applicable health and safety standards. 30 Assignment of an existing provider agreement assumes that a CHOW will have no adverse effect on patient health and safety. If there is any indication that patient care has deteriorated following a CHOW, the SA must conduct a survey. 31

continued on page 32
3. Compliance with the ownership and financial interest disclosure requirements applicable to the provider.  

4. Compliance with civil rights nondiscrimination requirements.

With automatic reassignment, the new owner assumes all penalties and sanctions under the Medicare program, including the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayment was discovered unless, under certain circumstances, fraud was involved. In addition, the new owner receives any benefits of assuming the Medicare provider agreement, such as receiving underpayments discovered after the CHOW. A sales agreement stipulating that the new owner is not liable for overpayments made to the previous owner is not evidence enough for recovery from the new owner to be avoided; however, the parties may privately negotiate indemnification for such losses. Medicare will attempt to recover from the new/current owner regardless of the sales agreement, and it would be up to the new owner to enforce the sales agreement. If CMS is unable to recover an overpayment from the current/new owner, CMS may decide to collect the overpayment from the previous owner.

If the new owner rejects automatic assignment of the seller's existing provider agreement or, if applicable, supplier approval, the existing Medicare provider agreement—including the associated Medicare numbers—is considered voluntarily terminated. The voluntary termination is effective as of the date the acquisition is completed, and, with few exceptions relating to certain providers like skilled nursing facilities, no Medicare payments are made for services to beneficiaries under the rejected (and thus terminated) provider agreement furnished on or after that acquisition date.

The refusal to accept assignment must be put in writing by the prospective new owner and forwarded to the appropriate CMS RO 45 calendar days prior to the CHOW date to allow for the orderly transfer of any beneficiaries that are current patients. If the new owner refuses to accept assignment but also wishes to participate in the Medicare program, the RO will first process the refusal and then treat the new owner as it would any new applicant to the program. The earliest possible effective date of Medicare enrollment for the new owner that refuses automatic assignment is the date the RO determines that all federal requirements have been met. The federal requirements include, in addition to the Conditions of Participation, enrollment and any other special requirements applicable to specific providers. A new Medicare number will be issued at some time after closing, depending on how long it takes to meet all federal requirements. Consequently, if the new owner refuses assignment and applies for a new Medicare number, there will be a gap between the date of the CHOW and the effective date of the new Medicare number.

**New Certification Surveys**

A certification survey of the provider is generally not required as a result of a CHOW with automatic assignment; however, a CMS RO may exercise its discretion to direct the state survey agency to conduct a survey in individual cases when it has cause for concern about quality of care. Furthermore, if new locations are added or different types of services will be provided, a new survey may be required. In the case of deemed status providers or suppliers, automatic assignment also means that the new owner must notify the applicable accrediting organization (“AO”) of the acquisition and agree that accreditation continues until the AO decides whether a resurvey is necessary.

If the new owner rejects automatic assignment, but wishes to participate in the Medicare program, the facility under the new ownership is considered an initial applicant to the Medicare program. For providers subject to certification, this means that, in addition to completing the Form 855 enrollment process, they must also satisfy any other applicable federal Medicare participation requirements, including undergoing an announced full survey of the compliance with applicable Medicare requirements. If the seller was deemed to meet the applicable conditions based on its accreditation under a CMS-approved Medicare accreditation program, the AO may not extend its prior accreditation of the new owner, but must conduct a full initial accreditation survey after the acquisition date. The effective date of the new owner’s Medicare provider agreement or supplier approval is calculated based on the time of the accreditation survey and decision.

Initial certification surveys are subject to a number of requirements, which result in gaps between the date of an acquisition and the effective date of a Medicare enrollment for a provider or certain types of suppliers that reject automatic assignment. Specifically:

- State survey agencies or AOs must not conduct a survey for initial certification purposes until after the date the acquisition is complete; the survey must be a full, standard survey and must take place when the facility is under its new ownership in order to assess compliance of the new owner.
- The survey cannot be conducted until the applicable MAC has issued a recommendation for approval of the new owner’s enrollment application.
- The new owner must be fully operational and providing services before it may be surveyed.
• CMS workload instructions, issued on November 5, 2007, require initial surveys conducted by SAs generally to be the lowest workload priority, particularly in the case of provider or supplier types for which there is an accreditation option. Due to these workload priorities, it may take several years for an SA to conduct an initial accreditation survey.

A buyer that rejects automatic assignment of the seller’s Medicare number but wishes to participate in the Medicare program must be aware of the potential gaps in certification and enrollment and the impact on cash flow. The provider or supplier undergoing the CHOW will not be able to bill Medicare or receive payment for services provided during this gap period.

**Cost Reports**

When providers that are required to file Medicare cost reports undergo a CHOW, Medicare regulations require the seller to file a final cost report, which should cover the period from the end of the provider’s prior cost reporting period to the effective date of the CHOW. The final cost report is due no later than five months following the effective date of the CHOW. Items to be considered in the seller’s cost report include: (1) gains and losses on disposal of depreciable assets; (2) accelerated depreciation; (3) involuntary conversion losses; (4) demolition and abandonment losses; (5) lease-purchase agreements/rental charges; (6) startup and organization costs; (7) self-insurance; (8) insurance purchased from a limited-purpose insurance company; (9) administrative costs incurred after change of ownership; (10) tentative retroactive adjustment; (11) carryover of reasonable cost not reimbursed due to the “lower of reasonable cost or customary charges” provision; and (12) cost to related organizations.

The new owner can designate its cost reporting year. In a CHOW, the new owner is considered to be a new provider in the program and may file its initial cost report covering a period of at least one month of provider operations, but the cost report cannot exceed 13 months of operations under the program. A change in provider ownership may have an immediate effect on the manner in which the new or incoming provider is reimbursed for Medicare services. Some of the reimbursement areas requiring special treatment on the new provider’s cost report include: (1) basis of depreciable assets; (2) donated assets; (3) involuntary conversion losses; (4) demolition and abandonment losses; (5) recovery of accelerated depreciation; (6) startup costs; and (7) organizational costs.

**Payment Issues Associated with a CHOW**

When a CHOW involving automatic reassignment is pending, Medicare will continue to pay the previous owner (seller) until the CHOW is approved by the CMS RO and a final tie-in notice is issued. When a CHOW is pending, any application from the old or new owner to change the electronic funds transfer (“EFT”) account or special payment address to that of the new owner will be rejected by the MAC.

CMS advises that it is ultimately the responsibility of the old and new owners to work out any payment arrangements between themselves while the MAC and CMS RO are processing the CHOW. Therefore, if the buyer wishes to continue billing Medicare under the existing Medicare number while a CHOW is pending approval, the parties to the transaction should negotiate terms for handling the funds received by the seller during this transition period. Parties to a transaction involving a provider that bills under the Prospective Payment System (“PPS”) should also be aware of billing requirements relating to patients whose episode of care straddles between buyer and seller. Payment is determined by date of discharge, and CMS does not prorate payment between buyer and seller. Other payments for cost-reimbursed capital payments, direct medical education, certain anesthesia services, organ acquisition, and bad debt are made to the buyer and seller in accordance with the principles of reasonable cost reimbursement. Parties to a CHOW should be aware of these payment implications when negotiating the terms of the purchase agreement or other agreements ancillary to the transaction.

**Medicare Updates of Information**

Not all transactions involving a Medicare provider or supplier result in a CHOW. For example, stock transfers in a corporation, even if such transfer involves 100 percent of the stock ownership, typically do not result in a CHOW. Instead, such transactions require an update of the ownership information on file with CMS for the current Medicare number. This update is accomplished by filing a Form CMS-855A, CMS-855B, or CMS-855S with the applicable MAC. Updates of ownership information may be filed by some suppliers, such as a group practice, that are not permitted to undergo a CHOW.

Most changes to a provider’s or supplier’s enrollment information must be filed with the MAC within 90 days of the change. Medicare regulations specify that providers and suppliers (other than physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dieticians or nutritional professionals, and organizations [e.g., group practices] consisting of any of the categories of the preceding individuals) must report a “change of ownership or control, including changes in authorized official(s) or delegated official(s)” within 30 days. CMS’s reference to a

*continued on page 34*
Changes in Ownership: Medicare Rules and Other Issues

continued from page 33

change of “control” leaves some uncertainty as to whether providers and suppliers must report a stock transfer, or similar change of information relating to control, within 30 or 90 days. Historically, a transaction that does not qualify as a CHOW has been treated as an update of information, for which updates must be filed within 90 days. However, DMEPOS suppliers must report any changes in information supplied on the enrollment application, including a change of ownership information that does not change the current TIN, within 30 days of the change to the National Supplier Clearinghouse (“NSC”).

Once an “855” update of ownership or control information is filed with the MAC, the MAC will send the update to the RO for approval. However, if the transaction is a stock transfer, the MAC may not send the transaction to the SA/RO if the following three conditions are met: (1) the contractor is confident that the transaction is merely a transfer of stock and not a CHOW; (2) the RO in question (based on the contractor’s past experience with this RO) does not treat stock transfers as potential CHOWs; and (3) the contractor knows that the particular SA/RO in question does not review, approve, or deny this type of transaction.

Failure to Report a CHOW or Update of Ownership Information

Failure to file a CHOW or change of information within the applicable 90-day or 30-day reporting period may result in deactivated billing privileges or revocation of the provider’s or supplier’s Medicare number. If an incomplete enrollment application is submitted, CMS may also deactivate the Medicare billing number based upon material omissions in the submitted enrollment application, or based on preliminary information received or determined by CMS that makes CMS question whether the new owner will ultimately be granted a final transfer of the provider agreement.

Additional Considerations for Certain Providers/Suppliers

Home Health Agencies

Under the home health “36-month rule,” which applies to home health agency transactions effective on or after January 1, 2011, if a majority ownership of a home health agency changes by sale (including stock transfers, mergers, consolidations and transfers) within 36 months of the home health agency’s Medicare enrollment or prior change of majority ownership, the provider agreement and Medicare billing privileges will not be conveyed to the new owner.

The prospective provider/owner of the home health agency must instead enroll in the Medicare program as a new (initial) home health agency and obtain a state survey or accreditation from an approved AO.

There are four primary steps to follow to determine whether the 36-month rule applies to a home health transaction:

1. Determine whether a change in direct ownership has occurred. The 36-month rule does not apply to “indirect” ownership changes.

2. Determine whether the change involves a party assuming a greater than 50 percent ownership interest in the home health agency. For purposes of the 36-month rule, a “change in majority ownership” occurs when an individual or organization acquires more than a 50 percent direct ownership interest in a home health agency during the 36 months following the home health agency’s initial enrollment in the Medicare program or the 36 months following the home health agency’s most recent change in majority ownership (including asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the home health agency’s most recent change in majority ownership).

3. Determine whether the effective date of the transfer is within 36 months after the effective date of the home health agency’s initial enrollment in Medicare or most recent change in majority ownership. If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the 36-month rule does not apply.

4. Determine whether any of the following exceptions apply: (1) if the home health agency submitted two consecutive years of full cost reports (low utilization or no utilization cost reports do not qualify as full cost reports); (2) a home health agency’s parent company is undergoing an internal corporate restructuring, such as a merger or consolidation; (3) the owners of an existing home health agency are changing the home health agency’s existing business structure (for example, from a corporation to a partnership [general or limited]; from an LLC to a corporation; from a partnership [general or limited] to an LLC) and the owners remain the same); or (4) the individual owner of a home health agency dies, regardless of the percentage of ownership the person had in the home health agency.

If a change in majority ownership has occurred within the previous 36 months and none of the exceptions apply, the home health agency must enroll as a new entity in Medicare if the parties move forward with the transaction. As previously discussed, new enrollment for the home health
agency would require filing a CMS 855-A for initial enrollment and a new certification survey and deemed accreditation, which cannot occur prior to the transaction or before the MAC processes the initial enrollment application.

**Subunits**

Providers that have subunits and undergo a CHOW may need to file multiple CMS-855 forms to transfer the subunits to the new owner. Any subunit that has a separate provider agreement (e.g., home health agency subunits) must report its CHOW on a separate Form CMS-855A rather than using the main provider's CMS-855A. However, if the subunit has a separate Medicare provider number but not a separate provider agreement (e.g., hospital psychiatric unit, home health agency branch), the CHOW can be disclosed on the main provider's Form CMS-855A because the subunit is treated as a practice location of the main provider and not a separately enrolled entity.

**Subtypes**

On occasion, a CHOW may occur in conjunction with a change in the facility's provider subtype. This can happen when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information, all information (including the change in hospital type) should be reported on the CHOW application, and the entire application will then be processed as a CHOW. However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.

**DMEPOS Suppliers**

Updates of ownership information or CHOWs must be reported to the NSC within 30 days. Failure to timely report such changes to the NSC within the required 30-day period will lead to a revocation action.

If a DMEPOS supplier undergoes a CHOW, the buyer must obtain accreditation that covers all of the supplier's locations. If the seller has such an accreditation, the buyer can be enrolled as of the date of sale if the accreditor determines that the accreditation should remain in effect as of the date of sale. If the buyer submits an application without evidence that the accreditation is still in effect for the buyer, CMS has instructed the NSC to reject the application.

Effective May 4, 2009, DMEPOS suppliers submitting an enrollment application to change the ownership of an existing supplier are also required to obtain and submit a copy of that supplier's required surety bond to the NSC with the CMS-855S enrollment application. The surety bond must be in an amount of not less than $50,000 and is predicated on the National Provider Identifier ("NPI"), not the TIN. Thus, if a supplier has two separately enrolled DMEPOS locations, each with its own NPI, a $50,000 bond must be obtained for each site. Ownership changes that do not involve a change in the status of the legal entity (as evidenced by no change in the TIN), or changes that result in the same ownership at the level of individuals (corporate reorganizations and individuals incorporating) are not considered to be "changes of ownership" for purposes of the May 4, 2009 effective date.

**DMEPOS Suppliers Participating in Competitive Bidding**

DMEPOS suppliers participating in the Competitive Bidding Program have additional CHOW filing requirements relating to their contracts. A DMEPOS supplier that is negotiating a CHOW must notify CMS at least 60 days before the anticipated date of the change. Contract suppliers that do not notify CMS of a CHOW are in breach of their contract.

A CHOW does not automatically grant contract supplier status of the new owner; however, CMS may permit the transfer of a competitive bidding contract to an entity that merges with or acquires a competitive bidding contract supplier if the new owner assumes all rights, obligations, and liabilities of the competitive bidding contract. CMS divides filing requirements relating to a CHOW into two groups: one for "successor" entities and the other for "new" entities. A successor entity is an existing entity that merges with or acquires a contract supplier and continues to exist after the CHOW as it existed before the transaction. A new entity is an entity that is formed as a result of merger or acquisition and did not exist prior to the transaction.

CMS may award a contract to the new or successor entity if: (1) the entity meets all requirements applicable to contract suppliers for competitive bidding program(s) to which the contract supplier's contract applies; and (2) the entity submits to CMS documentation needed to substantiate compliance with basic eligibility requirements, quality standards, accreditation requirements, and financial standards.

The parties must also prepare a novation agreement that is signed by all parties involved in the contract transfer, including CMS. CMS will review all novation agreements and will only accept those that assign all applicable contract supplier obligations to the purchaser. An acceptable novation agreement should include a number of provisions specified by CMS through guidance. A sample novation agreement can be found at 42 C.F.R. § 42.1204. If the transaction involves a successor entity, an executed novation agreement must be submitted to CMS at least 30 calendar days before the anticipated effective date of the change of ownership. If a continued on page 36
CHOW involves a new entity, the existing contract supplier must submit its final draft of a novation agreement to CMS at least 30 days before the anticipated effective date of the CHOW. The new entity must submit an executed novation agreement to CMS within 30 days after the effective date of the CHOW. The new entity must submit a change of ownership notification to CMS at least 30 days before the anticipated effective date of the novation agreement. The new entity must also submit a change of ownership notification to the Public Health Service Administration (PHSA). The new entity must also submit a change of ownership notification to the State Health Department (STD). The new entity must also submit a change of ownership notification to the State Insurance Department (SID). The new entity must also submit a change of ownership notification to the State Social Services Agency (SSA).

In the event of a CHOW or even a change of ownership interest of at least five percent (including a stock transfer), DMEPOS suppliers participating in the Competitive Bidding Program will have reporting obligations to the Competitive Bidding Implementation Contract (“CBIC”) as well as the NSC. For example, for stock purchases that result in five percent or more ownership transfers, the seller must notify the CBIC by mailing or faxing all pertinent information and include all information sent to the NSC.

Conclusion

When engaging in an acquisition involving a Medicare provider or supplier that results in a CHOW, buyer and seller parties should address various Medicare requirements to ensure that appropriate and timely filings are made to assign or obtain a Medicare number, and should also plan for how the transaction may affect post-closing Medicare payments. Buyers must consider whether to accept assignment of the seller’s Medicare number and, if not, the business impact involved with enrolling as a new provider or, if applicable, supplier. For transactions that qualify as updates of information, rather than CHOWs, it is also important for the parties to ensure that ownership updates are appropriately and timely filed. Failure to properly handle CHOWs or updates of information could result in deactivated billing privileges or revocation of the provider or supplier Medicare number.

This article is adapted from the ABA Health Law Section’s new book, What is . . . ? The book provides readers with a general understanding of the regulatory and other processes involved when a healthcare provider or supplier undergoes a change in ownership. For more information, go to www.shopABA.org.

Art J. Markenson is a healthcare partner in the New York Office of Winston & Strawn, LLP. He has more than 20 years of experience at the intersection of healthcare, law, and business. He advises healthcare industry clients on a broad range of matters, with significant experience in the representation of healthcare providers and suppliers. He represents private equity firms on healthcare transactions, including regulatory, merger and acquisition, and portfolio company work, and working in an outside general counsel role. He advises clients on mergers, acquisitions, and divestitures; due diligence; corporate matters; legal and regulatory compliance matters, including requirements and conditions for participation; fraud and abuse; state licensure; certificate of need approvals; and survey, certification, and enforcement issues. He is an active participant in many professional organizations related to healthcare, law and business. He is a Past Chair of the New York State Bar Association, Health Law Section and still serves on its Executive Committee. He is currently an Adjunct Associate Professor at Columbia University Mailman School of Public Health and at the School of Health Sciences and Practice at New York Medical College, where he teaches courses in healthcare policy, management and law. He has been acknowledged as a Best Lawyer in America 2012 to 2018 and a NY-Metro Superlawyer in 2011 and 2013 to 2018. He is also AV Preeminent Peer Review Rated by Martindale-Hubbell. He may be reached at amarkenson@winston.com.

Tammy Ward Woffenden is a partner in the Austin, Texas office of Locke Lord, LLP. Her principal area of practice focuses on transactional, corporate, regulatory, and administrative health law issues for healthcare industry clients, including providers and suppliers, payors, vendors, and investors. She regularly advises clients on changes and updates of ownership (CHOWs / CHOIs), transaction structures, regulatory due diligence, and other regulatory and corporate matters that arise in transactions involving healthcare providers, including hospitals and large healthcare systems, pharmacies, home health agencies, hospices, assisted living facilities, intermediate care facilities, durable medical equipment suppliers, therapy clinics and rehabilitation agencies, medical and dental practices, laboratories, management services organizations, and many other providers and businesses that cross into the healthcare industry. She has extensive experience in counseling clients on various healthcare laws, which include HIPAA and state privacy and data security laws, Medicare / Medicaid reimbursement and compliance, fraud and abuse such as the Anti-Kickback Statute and Stark Law, corporate practice of medicine and fee-splitting, practice management and management services agreements, telemedicine initiatives, and healthcare licensure, surveys and certification. She also assists clients on regulatory enforcement matters such as Medicare / Medicaid billing and overpayment audits and HIPAA compliance and breach audits and investigations. She may be reached at twoffenden@lockelord.com.
Current Trends in Private Equity Investment in Ancillary Healthcare Providers

Patrick Souter, Gray Reed & McGraw LLP, Dallas, TX

The U.S. healthcare system has recently experienced events that would ordinarily cause those considering private equity investments in the industry to be hesitant to do so. A new Administration, uncertainty regarding the status of the Patient Protection and Affordable Care Act (PPACA), consolidation in the provider and payor world and changes in reimbursement would seem to all be material in making investments in the healthcare sector. However, these considerations, which may be red flags to some, appear to be opportunities to others. While there has been a slight drop-off in healthcare merger and acquisition activity, private equity investment in the healthcare sector continues to be significant across areas of the spectrum. This activity is not limited to hospitals and physician practices. Significant investment continues to flow into ancillary providers. These ancillary providers supplement the care provided by hospitals and physician practices or provide products or services utilized by those providing direct patient care. For purposes of this review, all such ancillary providers are considered ancillary healthcare providers.

Why Does Private Equity View Healthcare Investment Favorably?
Despite the uncertainties tied to the healthcare industry, the total value of private equity investment in 2016 reached its highest level since 2007. Investors continue to view the healthcare industry as a safe haven from economic volatility. The value of disclosed transactions involving private equity was $36.4 billion on a global basis. This investment activity was across all major sectors of the healthcare industry, with significant activity involving those referred to as “healthcare-light companies”. This classification encompasses those in the healthcare industry that are usually not directly impacted by changes in reimbursement. This industry positioning allows for those entities to benefit from market forces, causing growth in healthcare without being detrimentally impacted by some of the regulatory risk. Many types of ancillary providers fit within that category.

North America healthcare investment experienced a tumultuous 2016 in light of the competition for choice asset targets, political uncertainty and aggressive valuations but still witnessed a total deal value of $28.4 billion. The focus away from those companies overly affected by regulatory and reimbursement concerns fueled much of this activity. Interestingly, nine of the top ten healthcare deals globally involved U.S. assets with 40 percent of those transactions involving European buyers.

**Niche Ancillary Provider Investment Areas**

The healthcare industry has certain niche ancillary providers that are of particular interest to the private investment community. These ancillary providers include healthcare IT and electronic health record (EHR) vendors, laboratories, behavioral health, urgent care, revenue cycle management, and management companies offering business services to dental and anesthesia providers. The reason these areas are of heightened interest is three-fold. First, some ancillary provider segments of the marketplace are experiencing high profits which are not expected to last for a significant period due to pending regulatory or payor action or market saturation. Second, the products and services of these ancillary providers may be in high demand in patient care so profits are reasonable and explainable. Third, these providers often offer profitable ancillary products or services to a primary business line such as laboratory services in a physician office.

Those ancillary providers who have seen significant investor interest but which have recently experienced less activity include medical devices, ambulatory surgery centers and specialty pharmacies. While these three areas still maintain solid returns, each has issues that may make them less attractive than the other highlighted ancillary providers. These concerns do not necessarily mean that any of the three would not be an attractive industry for investment
purposes. Rather, market attention has simply shifted to new areas that appear to have greater potential from a financial aspect or in light of market conditions dictated by the government or payors.

Digital Health

The healthcare IT and EHR space, or what is recently been referred to as the “Digital Health” space, has seen the market mature where the number of market participants has narrowed significantly. This reduction in providers fosters incentivizing those remaining to outpace competition by creating and offering advances in technology. The result of such activity makes for an attractive market. Also, the various governmental and payor efforts to create and utilize common information platforms in the delivery of care will continue to create a market for these products and the underlying support services they have to offer. Significant private equity transactions in the second quarter of 2017 include Modernizing Medicine, which provides EHRs for specialists; it raised $231 million, increasing its total funding to $318 million.

Laboratories

Laboratories continue to be appealing to investors, since their services are necessary in the delivery of care by hospitals and medical practices and are a basic component in the national effort to provide preventive care and coordinate care among providers. There have been several recent highly publicized private equity transactions in the laboratory area. However, there has been significant enforcement activity involving fraudulent billing, unneeded services performed and kickback schemes between laboratories and other providers.

In addition, laboratories that utilize management and distribution companies to create a financial arrangement with a referral source rather than the provider having an investment in the laboratory may be subject to additional regulatory scrutiny. The laboratory will establish a management or distribution company and will offer providers, commonly those who refer business to the laboratory, the opportunity to invest in the company. The general concept of a management or distribution company may fit within certain safeguards and be lawful, but the use of this business model has pushed the boundaries. For instance, a laboratory may pay the management or distribution company for questionably needed services or amounts that may exceed fair market value for services performed. There are also instances where the laboratory has established multiple management or distribution companies and offered investment opportunities to small groups of physicians. The company will then provide management and
distribution services related to the laboratory’s business associated with the investors. However, this type of arrangement usually reveals no business purpose for a laboratory to have multiple management companies performing the same service and the investor physicians commonly receive distributions that may be similar to their referral patterns. The Department of Health and Human Services’ Office of Inspector General (OIG) remains sensitive to management arrangements that involve companies with physician investors that are providing products and services to ancillary providers that the physician investor may refer to and in turn benefit from the management fees derived from such referrals.\(^{18}\)

**Behavioral Health**

Behavioral health and substance abuse treatment operations have seen a significant increase in investor attention. The attractiveness of this ancillary area is due to the increased demand for their services in conjunction with limitations on the ability of payors to utilize more onerous standards when determining reimbursement for such services than those used for pure medical services.\(^{19}\) Additionally, governmental regulation requiring behavioral health payor coverage and significant revenue and profit margins are other driving forces that have caused this area to be appealing for the past five years.\(^{20}\) Indications are that such drivers will continue to create a positive effect on this segment’s outlook.

**Urgent Care**

The urgent care market encompasses more than just a neighborhood urgent care centers. Investments in this area include CVS’ Minute Clinic, free-standing emergency departments and specialty urgent care, such as orthopedic-specific urgent care facilities.\(^{21}\) Since 2008, approximately $3 billion has been invested in this industry with speculation of continued activity in this area occurring through 2019 and beyond.\(^{22}\) A recent transaction involving the majority acquisition by a private equity firm of a majority stake in the 68-unit CityMD urgent care chain is example of such activity.\(^{23}\)

**Revenue Cycle Management**

One may not believe that revenue cycle management (RCM) providers are ancillary providers in the healthcare world. However, the core business of these providers pertains to the fundamental issue encountered by all healthcare providers: efficient tracking, billing and collecting of revenue. RCM is more than just billing and collecting services. It may be as complex as the administrative
department of an enterprise that handles all financial aspects of operations, performs analytics and offers revenue solutions, or as simple as providing software that may be used to perform such functions. With the variety of RCM services, its market is expected to grow at a 26.5 percent compounded growth rate through 2018. Private equity has been instrumental in expanding RCM operations through internal growth as well as acquisitions of smaller targets to shore up end-to-end RCM service offerings.

Practice Management

Practice management companies, such as in dentistry and anesthesia, have been attractive to private equity groups. Similar to RCM providers, these companies provide a valuable tool in navigating the business aspects of healthcare. From the mid-2000s to 2015, more than 25 private equity firms committed significant investment in dental practice management companies, with some of the larger companies in this space achieving annual revenues in excess of $100 million. Similar projected growth continues to make this an appealing ancillary provider even in spite of a 2013 Senate committee investigation that concluded some dental practices should be excluded from Medicaid due to questionable practices. Recently a private equity group committed $25 million to fund the organization of a dental practice management start-up.

Anesthesia practice management companies have exploded onto the market in the past few years, and private equity has taken notice. Anesthesia practice management services allow for platforms that are scalable without the need to incur high cost since anesthesia services are primarily located at facilities such as hospitals and surgery centers. It is not a capital-intensive venture to expand anesthesia operations because they generally do not require significant space, equipment or staffing. This allows for a much more profitable type of medical practice that will in turn generate revenue for the management company.

Why Has Private Equity Increased Its Focus on Ancillary Providers?

There are several reasons why ancillary providers have experienced increased investment activity by private equity compared to physician practices. First, hospital acquisition of physician practices has increased, so physician practices do not seek private equity to fund aspects of the practice. Rather, the health systems may acquire a physician practice and provide the funding necessary to expand it and its capabilities, a function ordinarily served by private equity. Second, the prohibition against the corporate practice of medicine doctrine restricts private equity from investing in physician practices. In those states that follow this doctrine, it limits the ability of a
private equity firm to invest in physician practices since a non-licensed person would be an owner in or control a medical practice. Finally, ancillary providers have experienced substantial revenue growth due to PPACA's expansion of the need for such services through incentivizing preventive medicine and quality of care measures that rely upon ancillary providers and their services.

The availability of capital from private equity has been of significant value in the various ancillary markets. The opportunity for increased access to funding allows local or regional providers to expand the markets where they offer services. It may also provide funding for new equipment or personnel or the ability to move into other complementary ancillary services. By providing avenues for funding, private equity enables the ancillary providers to be more independent and not reliant on health systems as a funding source by being acquired or entering joint venture arrangements. Ultimately, new sources of capital that ancillary providers may access has been a “win-win-win” for all involved. It allows the ancillary provider a different source of capital from that it has traditionally utilized through health systems and physicians. The private equity firms are able to invest in healthcare and obtain significant positive return on investment through a focused healthcare vehicle. Non-ancillary providers and their patients have additional, and more advanced, opportunities from those ancillary providers that have expanded their operations, either through geographic footprint or services offered, which may lead to better care.

Conclusion

Private equity investment in ancillary healthcare entities will continue to thrive even with the uncertainty in the U.S. healthcare system. Ancillary providers that have made a niche in the industry addressing product and service lines necessary to comply with governmental and payor requirements are popular investment vehicles since they are needed by those who provide medical services. Those that provide value-added services, especially without incurring significant cost in doing so, have been particularly attractive to private equity. Many of these ancillary providers were spawned out of the need to bring additional expertise to the healthcare provider in the delivery of care. Continued evolution of further ancillary providers that identify additional niches will be those whom private equity will continue to seek out for investment purposes.


Id. at 1.

Id. at 6.

Id.

Id. at 12.

Id.


Id. at Introduction.


The impact on private equity interest in each of these ancillary services are the result of varying market-driven forces that may make each less attractive to those in search of a private equity opportunity. The medical device industry, while highly concentrated with a limited number of major participants on a national level, has a high degree of market fragmentation on the local level. Ambulatory surgery centers still produce profitable financial results but the industry itself has not recently witnessed significant overall growth. Special pharmacies have more risk due to the possibility of significant swings in revenue.

Id. at Section 2. Healthcare IT and EHR.


*Id.*


Id.


Id.


Id.


Generally, the prohibition against the corporate practice of medicine doctrine prohibits a layperson from controlling a physician in the delivery of medical services, owning or controlling an entity that provides medical services or participating in revenue derived from such services. The rationale is that the physician should be free to provide care to the patient as needed and such not be impacted by commercial or business purposes.

Authors

Patrick Souter
Gray Reed & McGraw LLP

Patrick D. Souter is Of Counsel with the law firm of Gray Reed & McGraw, LLP in Dallas, Texas where he is a member of the Healthcare, Corporate and Securities Practice Groups. Mr. Souter’s practice focuses on transactional, administrative, regulatory and antitrust matters for healthcare providers and suppliers. His representation includes organizational and operational issues with specific emphasis on the areas of fraud and abuse, licensure, reimbursement and compliance. He is an Adjunct Professor at Baylor University School of Law in Waco, Texas where he teaches Healthcare Law, Healthcare Fraud and Abuse and Regulation of Healthcare Professionals. He is also an Adjunct Professor in the MBA Program at the Baylor University Hankamer School of Business Robbins Institute for Health Policy and Leadership where
New Vistas for Physician Organizations: Transactions with Private Equity Firms

Andrew Demetriou, Lamb & Kawakami LLP, Berkeley Research Group LLC, Los Angeles, CA

Background: The Changing Market

In the past few years, the market for the delivery of physician services has seen a class of new investor entrants — private equity firms have become active acquirers of physician groups and practice assets, providing an alternative to hospital-physician organizations and the traditional growth of physician groups through small acquisitions. For those of us with longer memories, this trend has some parallels to the physician practice management company (PPM) saga of the 1990s, but given the profound changes in reimbursement ushered in by the Patient Protection and Affordable Care Act, the development of enhanced technology (such as electronic medical records) to support physician practices and the availability of advanced data analytic techniques to model and modify physician practice behavior, the transactions which are occurring in the current environment are markedly different from those of a generation ago.

In addition, the profile of physician practices has changed significantly. A large percentage of physicians are now employed by hospital-based systems or large groups affiliated with such systems (such as medical foundations), eliminating the needs for capital and infrastructure support that drove physicians to seek refuge with PPMs in the 1990s. In addition, after a period in which some physician organizations, principally large independent practice associations (IPAs), collapsed due to their inability to deliver value to their physician members, large multi-specialty groups are reasserting themselves in the marketplace, and this is creating pressure on solo and small practices which are unable to adapt to required technological innovations, the shift to value based purchasing for physician services and the re-emergence of risk-based compensation systems in markets which abandoned such systems in the past.
Many of the current models for large physician organizations are showing signs of instability.\(^1\) Physician-hospital affiliation models created years ago and modeled on the then current, primarily fee-for-service reimbursement models have not shown the ability to adapt to changing circumstances and shifts in the means by which medical services are being delivered, including the emphasis on population health management. While large physician organizations have more capital resources than their smaller peers, their ability to continue to grow and remain relevant players in the marketplace is fundamentally constrained by laws which restrict ownership and limit physician organizations from assuming risk for the services of other providers.\(^2\) As a consequence they are seeking new sources of capital (other than hospital systems) and partners that can provide the means to expand service offerings and support practice improvement initiatives.

This article will provide an introduction to private equity (PE) firms which are entering the market to acquire physician and ancillary services provider organizations, explore the nature of the deals being proposed to physician organizations and identify a number of important considerations and common deal terms which characterize PE transactions with physician organizations, reflecting the expectations and investment perspective of these firms. While much of the discussion will focus on acquisitions of physician organizations or practice assets, it is equally applicable to joint venture transactions to create new organizations to be engaged in risk contracting or population health management.

Enter the PE Firms

PE firms\(^3\) have appeared in the fractured marketplace described above, presenting an alternative for physicians and groups.\(^4\) These organizations have raised large pools of capital for investment in physician services and allied businesses, lured by the $600 billion marketplace,\(^5\) and their investments in provider services in recent years are substantial.\(^6\)

Many of the PE firms are market sector agnostic, e.g. physician services as opposed to diagnostic services, as they are focused on deals promising absolute financial return to their investors and healthcare investments in general have provided better returns over the past few years than comparable investments in other industry sectors.\(^7\) In addition, they may lack a meaningful pedigree in the delivery of healthcare services, which on the one hand means they may be naïve as to the environment in which physician organizations operate, but also that they are not limited in their imagination by traditional tropes and are not burdened by regulatory constraints which affect hospitals. Since they are not providers of care they are willing to be more concrete in their support
for clinical independence of their physician partners, within the confines of financial performance parameters established in their models.

As noted, private equity investors are primarily motivated by absolute return on invested capital. The managers of these funds rely on outside investors for capital and are aggressive users of debt to magnify their returns. Since they typically are compensated based on a formula that includes a two percent annual return, based on invested funds and 20 percent of gains on the disposition of investments, they must achieve significant returns to satisfy the expectations of their investors and this fuels an appetite for debt, particularly in the current low interest rate environment. In addition, the managers enhance returns by rotation of their investments, typically within time horizons of five to seven years. This is a stark contrast to hospital-physician deals which, in the author’s experience, are typically premised on extremely long partnership periods (20 years or more) and means that physicians involved in PE deals need to be prepared for prospective change in their PE partners relatively frequently. A benefit for physicians in these deals is that they are offered an equity upside from future transactions (which is generally not available in hospital deals), and if the PE firm offers a significant increase in scale by rolling up a number of specialty practices, prospective gains which are substantially higher than the physicians would realize from the sale of just their practices.

The need for returns influences the types of deals that are attractive to PE investors. They tend to be interested in practices which are readily scalable due to similar services offerings, those which make use of relatively capital intensive technology (e.g., ophthalmology practices which use lasers and dermatology practices offering Mohs surgery), and those for which they forecast stable to increasing levels of reimbursement in the investment horizon. They are also interested in reimbursement schemes (such as managed Medicaid) in which there is opportunity in managing risk through improved practice performance, even if the reimbursement rates are below those offered for private pay or Medicare services. As a consequence the targets for their acquisitions may vary from year to year.

**Preliminary Considerations: Meeting the PE Firm**

PE firms may approach what they believe to be an attractive group without regard to existing relationships or commitments the group may have. If the physician group is already party to a management or services arrangement with a hospital or system, its leadership must consider the degree to which it has freedom to discuss a potential transaction with a third party. It may be that the physician group is only bound to joint contracting in a limited sphere of payment
arrangements, leaving it with the right to pursue other opportunities on its own initiative. The group may have certain exit rights from its current arrangement, or believe that its hospital partner has not fulfilled its obligations with respect to investment in practice assets, management infrastructure or negotiation of managed care arrangements. Before initiating discussions with a PE firm, the group must carefully explore the extent of its commitments and devise a strategy, including communication and transition plans that will permit it to seek a new partner. In addition, knowledge of its obligations may inform the negotiation of terms with a PE firm that will include funds to exercise buyout or other rights necessary to terminate its contracts and move on to a new relationship.

Unlike negotiations with hospitals over joint ventures or affiliations, in which physicians and groups often enter based on significant historic relationships, preliminary meetings with a PE firm must be approached with regard to the firm's expectations and experience. The PE firm may bring some expertise from other transactions into the discussions, but it will not have the same orientation toward delivery of care as would a hospital or another provider group. Rather, the PE firm will be much more focused on financial aspects of a transaction, since it does not directly benefit from clinical integration — unless it is acquiring multiple practices in a specialty area and is looking to gain market share for competitive and contracting purposes. Hence the ability of the group to demonstrate predictable future earnings will be an important consideration, both in determining price and in evaluating the feasibility of financing the transaction. Since most physician groups distribute substantially all of their earnings to their owners and do not have audited financials, physicians who negotiate with a PE firm must be prepared to see their financials “reconstructed” (with caps on physician income) to reflect profitability at the entity level — either the group itself, in states where that is permitted, or through a management enterprise jointly owned by the physicians and the PE firm. In addition, the PE firm will expect to have an outside accounting firm perform what is called a “quality of earnings” or QoE, analysis to test the historical accounting practices of the group and develop a forecast of likely future earnings. It may also retain a consulting firm that can provide an assessment of prospective changes in federal or state law and policy that will affect reimbursement for the group's services in the future. Finally, the PE firm may have certain baseline expectations concerning physician work commitments and revenue generation to support its financial models and the capital structure of the deal.

The PE firm will want to enter into a non-disclosure agreement very promptly and get authority to do preliminary financial testing to determine whether a deal makes sense without being committed to complete the transaction. To get there it may issue a preliminary “expression of interest” with a proposed purchase price and other key terms. It is important for the group to
understand that such a document is not binding, and will be highly qualified, leaving the PE firm with substantial opportunity to renegotiate terms or walk away from the deal.\textsuperscript{12}

The Letter of Intent

After the PE firm has conducted its preliminary investigation, it will make a decision on whether to present a letter of intent (LOI) for the acquisition. While the LOI will be characterized as “non-binding,” unlike the expression of interest the LOI will include relatively definitive terms, including price and structure of a proposed transaction as well as a requirement that the group negotiate exclusively with the PE firm. In addition, the LOI will set out more detailed requirements for due diligence, conditions precedent to the obligations to complete the transaction and termination rights. It is important that the group be well advised on what are typical (or in the jargon of dealmakers, “market”) terms in the LOI, to avoid a situation in which the group is tied up negotiating an inferior transaction and unable to seek better terms. In one case with which the author is familiar, the PE firm’s LOI was exclusive for a set period of time, but did not include a right of the group to terminate, creating an ambiguous situation where, several months after the LOI was signed, it was not at all clear whether the PE firm was intent on proceeding, but the group was at potential risk for entertaining other offers.

In some instances, the group may wish to propose a “fiduciary out” term, which allows the group to terminate negotiations during an exclusivity period if it receives an unsolicited offer that it deems superior to the pending offer from the PE firm. The rationale is that the board of the group cannot truly exercise its fiduciary duty to the owners of the group if it cannot seek the best price and terms for a deal. If the PE firm is amenable to such a provision, it will typically require either the ability to match the other offer or to receive a “break up” fee (which may be two to five percent of the value of the transaction), to compensate for the time and expense associated with its investigation of the deal. These types of protections for the PE bidder will tend to discourage competing offers from being made at all, and the group should not seek a fiduciary out unless it is reasonably sure that competitors are likely to approach it without being invited to submit a bid.

As noted, the LOI is still non-binding, except for provisions related to confidentiality of information exchanged, the obligation to negotiate in good faith toward definitive agreements, termination rights, and in some cases remedies for a breach of the LOI. As a result, it is important that the group have a sense of whether the PE firm is truly serious about the deal or is just kicking the tires. In many instances it is useful to perform “reverse due diligence” on the PE firm to learn about its track record in closing deals and possibly to interview physicians with whom the PE firm has worked in
the past. As important as the terms of the deal are going in, it may be far more important for the group to have an understanding of how it may be treated by the PE firm after the closing — for example, will the PE firm be faithful to key understandings or does it say whatever is necessary to get the deal signed and then become a bad partner? Will it respect bargains about governance and truly involve the group in key decisions or just pursue its own agenda? Will it be committed to making the partnership successful, or will its attention be focused on the next deal? The answers to these types of questions should play an important role in proceeding with a PE firm.

Deal Artifacts

Traditional hospital-physician affiliation models involve the acquisition of practice assets coupled with a long term provider agreement, the purpose for which is to bond the physician group to the hospital or health system. Physicians will realize some gain on the initial sale and benefit (hopefully) from a compensation package which will afford some protection from market pressures and alliance with provider system that remains relevant to payors in the future. In the case of non-profit hospitals and health systems there are regulatory limits (such as the Anti-Kickback and Stark laws) on the amounts that can be paid to acquire assets and in compensation going forward, in addition to charitable trust concerns and the inability to afford physicians a continuing equity role in the enterprise. For-profit hospitals do not face the latter constraints and can create true joint ventures with physician equity participation, but must still contend with patient referral concerns and fair market value considerations in structuring the financial relationship with physicians.

In contrast, PE firms do not typically face these types of hurdles. Since they are not providers, and generally are focusing on a relatively narrow silo of services, they are usually not concerned with anti-kickback issues with respect to the acquisition of assets or compensation to physicians, although they are disciplined by (some would say) the harsher mistress of financial performance. Rather than being unable or unwilling to offer an equity upside to physicians, PE firms typically require that sellers retain 20 percent of the equity in the acquisition vehicle, so that the physicians have “skin in the game” and to reduce capital investment in the acquisition phase. Physicians need to be concerned about two issues in this regard — the first being what rights they may have to sell the 20 percent “strip” in the future, and second, ensuring that it represents a meaningful stake in the future if the PE-backed enterprise grows. Typically, the physicians will be required to sell their interest into a transaction the PE firm negotiates, a so-called “drag along” obligation, and may be able to participate electively in a potential sale, a “tag along” right, but they typically do not have the right to require the PE firm to buy them out in the future or to sell their equity to a third party.
In addition, an important point of negotiation is the equity rights the physicians will have, if any, in a parent entity which owns the practice acquisition vehicle. Having a right to convert subsidiary equity into parent equity more closely aligns the physicians with the ultimate financial interests of the PE firm, rather than potentially being limited to owning a piece of an entity that serves their practice alone, or a small universe of local practices, and consequently may reduce the risk of holding the equity investment over the longer term. Conversion rights, if offered at all, will be heavily negotiated by the PE firm, since granting them to physicians prospectively dilutes returns for the PE sponsor and its investors.

Depending on the relative sophistication of the physician group and its financial history, there may be significant negotiation about how the purchase price is to be paid. PE firms may try to set a high price to attract interest from the physicians, but minimize front-end capital outlays by making certain elements of the purchase price contingent, whether on post-closing adjustments based on audits of profits or working capital, or through “earnout” arrangements where additional payments are tied to attainment of financial performance targets by the management vehicle after closing. These bits of financial engineering can have significant implications for the actual proceeds physicians can expect to receive in a transaction, as well as the value of the equity interest they retain. In a more perverse situation, the physicians may discover that they are ultimately paying themselves by providing all of the financial returns that generate future contingent payments. It is important that the group have counsel and other advisors who are familiar with these types of arrangements and can analyze the risk and reward associated with different payment models.

Physicians also need to be aware that PE firms will be more aggressive than hospitals in implementing IT systems and financial reporting infrastructure, and are more likely to require changes from the platforms the physicians may be using with hospitals. Often the PE firm will see such systems as drivers of profitability through decreasing operational costs. On a related note, the PE firm will be focused intently on revenue enhancement through careful attention to coding for services, prompt billing and aggressive collection practices, and this can be disruptive to physicians, as it represents changes in the way they have typically conducted their business. There will likely be a loss of collegiality and understanding of certain practices which are viewed by the PE firm as inefficient.

In addition, in situations where the basic agreement anticipates management of the physician group or a complex contracting strategy, the PE firm will insist on a fairly iron-clad long term provider agreement. Unlike the rationale for such arrangements with hospitals — insuring long term loyalty — the PE firm is seeking to lock in a revenue stream that will facilitate the sale of the
enterprise in a relatively short time frame. Consequently, financial terms in the provider agreement need to be reasonably acceptable into the future and include downside protection against changing reimbursement patterns, since physicians will not have a right to terminate, say in the event of a sale of the management enterprise or a financial restructuring by the PE firm.

Not surprisingly, termination rights are also heavily negotiated. The PE firm will want exits in situations where its financial projections are upset by material changes in regulations or reimbursement rules or where the physicians fail to meet basic productivity targets. They will resist termination rights in favor of physicians and groups in situations where the PE firm has failed to achieve market share or growth targets. Rights to terminate for breach will be very limited. Neither side should be looking for, or expect, a near term exit. In addition, the deal terms need to address the disposition of assets in the management enterprise on termination. Unlike the typical hospital-physician relationship, in which physician practice assets have little value to the hospital, the PE firm may have a strong interest in certain assets that support its management of other groups, and the physicians need to contemplate how they might replace the systems for maintaining medical records and which support billing and financial reporting in the event that the PE firm is unwilling to sell them to the physician group on termination.

Another important consideration is governance rights. While the PE firm may offer the physicians parity in board representation, it may insist on tie-break rights on key issues that affect financial performance and provide only limited “reserved powers” to the physician representatives on the board. In addition, managers appointed by the PE firm will typically have fairly broad discretion in business operations. The physicians should expect control over clinical matters, but even in this area, the PE firm may want a voice in clinical decisions that affect revenues and profitability, to the extent this is not limited by laws governing the professional practice of medicine. In addition, as is the case with equity interests, the physicians need to appreciate whether their governance rights are limited to the subsidiary which acquired their practice or includes representation in a parent entity, which may be charged with making decisions that affect the subsidiary based on regional, or even national, considerations.

Finally, the parties need to consider the issues of capital investment. Physician groups are chronically short of capital and one factor that PE firms emphasize in pitching for deals is their ability to provide resources for better practice support. The key question is whether the PE firm will deliver on its promises and meet the expectations of the physician group, which may also turn on a meeting of the parties’ minds about common expectations. Physicians should expect that future capital decisions by the PE firm will be based on fairly hard-edged financial metrics and need to
become familiar with terms like “hurdle rates” for investments. This is in stark contrast to historical relationships they might have with a hospital, where the hospital may be motivated to make capital investments for political or other non-financial reasons.

The Transaction Process

Traditional hospital-physician transactions are often idiosyncratic, with terms negotiated to suit the particular local situation and influenced by personal relationships between the principals. In many cases the parties may even choose common legal counsel in an effort to save expense and limit contentious negotiation. In contrast, physicians should expect the PE acquirer to come to the table armed with very specific transactional norms in mind and detailed reasoning behind its negotiation strategies. It may demand use of its form deal documents and entertain only limited changes. Physicians are well advised to retain knowledgeable transaction advisors, both to assess the reasonableness of proposed terms and provide a context for the group to appreciate the consequences of the transaction as well as to negotiate favorable terms based on prior experience. Counsel can play a valuable role in shaping physician expectations concerning the outcome of negotiations as well as helping the group deal with transactional customs such as disclosures and due diligence investigation, which form the basis for representations the group will need to make in definitive agreements.

The decision to enter into a purchase contract dramatically increases the liability of the parties; they are no longer in a situation in which they can easily walk away from the deal without consequence. The purchase agreement is a binding contract and must be treated with seriousness, as it contains all of the specific terms of the transaction. A discussion of the key elements common to these documents follows.

Representations and warranties will comprise a substantial share of the base acquisition or joint venture documentation, and physicians must appreciate subtleties in what they are promising about the business being sold. Breach of representations and warranties implicates contractual remedies, so it is very customary to negotiate limitations on the extent of representations, for example the extent of the representation is based on the actual knowledge of key physicians in the group (rather than being absolute) or limited to matters that are “material” (those for which a misrepresentation would have a substantial impact on the acquired practice). In addition, there are customarily time limits on the duration of the representations, after which the acquiring entity has assumed the risks of a state of affairs inconsistent with the representation. In this area it is also
important to have advisors with experience in negotiating representations and prepared to propose customary limitations to protect the physicians’ interests.

The representations generally tie into provisions which require the physicians to indemnify the acquiring firm if certain events occur after the closing. The indemnity language may require that the physicians actually assume the defense of the acquisition entity or, alternatively, pay for any expenses or damages incurred. The obligations may also be affected by the availability of insurance to cover losses, obviating the need for indemnification by the selling physician organization. As with the representations, it is important for the physicians to understand customary terms for indemnification, for example capping exposure to a percentage of the purchase price, or requiring that the damages exceed a negotiated threshold before the obligation is triggered. It is also important that there be time limits on the assertion of any claim for indemnity to provide certainty as to the extent to which the physicians may be exposed.

The purchase agreement may also contain specific promises concerning matters to be addressed by one or both parties as conditions precedent to closing, in situations where there is a gap period between signing the purchase agreement and the closing date. These “covenants” can include securing governmental or third-party consents where required to complete the deal; addressing employment matters, such as assisting the purchaser in hiring key personnel or transitioning employee benefit plans; restrictions on the pre-closing conduct of the business; protection of the confidentiality of deal terms; and limits on the ability of the selling physicians to compete with the acquiring entity in certain lines of business in the future.

Finally, the purchase agreement will contain certain terms that are described as “boiler plate” and which seldom attract attention from businesspeople negotiating a deal, as they address somewhat mundane issues such as governing law and whether singular terms refer to the plural as well. Nonetheless, some of these often-neglected provisions can become significant to the parties in the future — for example, the right of the PE firm to assign its interests to another entity or the manner in which disputes between the parties are to be resolved. Competent advisors will recognize the importance of such terms and at the least focus the attention of the physicians on the potential consequences of certain choices.

The Aftermath

Once the transaction is closed, the parties must now accommodate themselves to coexistence based on the terms of the agreements they have negotiated. Early decisions on the conduct of the business will test whether the governance arrangements mirror the expectations of both sides and
provide for a solid working relationship. As the management of the new enterprise begins to dig into operational details it may discover problems which implicate the accuracy of representations, such as the existence of an undisclosed claim or non-compliance with a key license, and the parties must determine how to address the situation — either by working cooperatively to solve the problem or seeking recourse to the contractual terms they have negotiated. It is perhaps only at this time that the physicians may appreciate the importance of the representations and covenants they agreed to. Operational decisions that may be left to management under the key agreements can be escalated to the governing board if, for example, physicians become dissatisfied with policies concerning support personnel, creating tension concerning the appropriate roles of management and the board.

Over the longer term, compensation arrangements will be subject to contractual adjustments, and this will be tested against the parties’ expectations. Physicians may become dissatisfied and seek to leave the group, creating potential issues with exit strategies and possibly with maintaining sufficient practice revenues to support the management structure. At some point the PE firm will reach the point at which it seeks to roll over its investment to raise cash for distribution to its investors, or to find new acquisition targets with better returns, but keep the physician group bound to provider or other agreements to assure that it has a salable asset. This will prompt discussions with the physician owners concerning the future course of the business, including the willingness of the physicians to work with a potential new partner or alternatively to exercise rights to reacquire the business. While these issues should properly be addressed in the negotiation of the purchase agreements, even the best advisors have limited foresight as to issues that may emerge, particularly if the PE firm is inexperienced in operating the business or the physicians were not well advised on their undertakings.

The transactional documents may also contemplate a potential breakup of the deal in certain events — for example, if the entity is unable to meet agreed upon targets for revenues or profitability, or changes in law or regulation jeopardize the viability of the organization. Some recent transactions involve the creation of joint venture entities that will be risk bearing organizations, contracting with health plans to provide a wide range of services for a global capitation payment. This is an area in which state laws in many instances are undeveloped or developing, and the transaction structure chosen by the parties may not be in compliance with changing requirements. Changes in law may require additional capital commitments or expenses associated with licensure, which were not contemplated by the parties and may be beyond their capabilities. Negotiation of exit provisions (as noted above) is often difficult and distasteful to the parties; who wants to contemplate divorce on the precipice of marriage? Nonetheless, having
certain plans against future events built into the relationship at the outset may create a basis for resolution and the avoidance of disputes. The working relationship developed between the parties may be critical in how they address potentially unforeseen circumstances that force reconsideration of the basic deal.

Conclusion

The recent interest of PE firms in acquiring provider organizations has created new opportunities for physicians and introduced an element of disruption into the traditional relationships between physicians and hospitals. The access to capital and ability to innovate afforded by PE firms may create new models for service delivery that better address the reimbursement profiles of the future, with increasing bundles, value based payments and true risk arrangements. While deals with PE firms may be superficially attractive to certain physicians, completion of deals can be quite challenging given the ways in which the expectations of PE firms differ from well-trod ground that underlies the provider deals negotiated in the past. As a consequence, it is important that physician organizations take the time to understand the new players in the market and seek out counsel and other advisors who can be effective in evaluating and documenting potential deals.


2 Examples of these laws are so-called “corporate practice of medicine laws” which prohibit laypersons from owning interests in, or exerting management influence over, professional medical practices, and laws concerning the business of insurance which impose financial and legal barriers for physicians who try to assume financial risk for the delivery of healthcare services.

3 The term “private equity firm” is used as a generic reference, for simplicity, to investment entities which pool capital from private sources for the purpose of making acquisitions. There are many variations in the organization and operation of private equity firms, which are the subject of treatises such as Breslow and Schwartz, Private Equity Firms: Formation and Operation (2d Ed.), Practicing Law Institute (2017) and Schell, Koren & Endreny, Private Equity Funds: Business Structure and Operations, Law Journal Press (2017). This article will address
features of private equity firms which are fairly common and useful for explanation of the
types of transactions discussed.

4 A catalog of leading PE firms that are making investments in healthcare enterprises can be
found in a series of articles by Walsh & Cockrell in *The Healthcare Investor* (McGuire Woods)

5 Centers for Medicare & Medicaid Services, National Health Expenditures, 2015 Highlights,
Reports/NationalHealthExpendData/downloads/highlights.pdf.

6 A good analysis of PE investment by sectors, with examples of recent deals, can be found in
Becker, Murphy, Cockrell, Walker & Walsh, *Private Equity in Healthcare – A Review of 15 Niche
Investment Areas*, Becker’s Hospital Review (April 11, 2016).

7 Abraham, Cha & Nyaruwata, *Capturing Returns in healthcare*, McKinsey & Company (July
2015), https://mckinsey.com/industries/healthcare-systems-and-services/our-
insights/capturing-returns-in-healthcare.

8 This is probably the most common formula employed by PE firms and their sister investment
organizations, known as hedge funds. A light hearted but helpful discussion for the uninitiated
can be found in *So, Why Do You Make Millions of Dollars in Private Equity – And Will It Last?*
Mergers and Inquisitions, https://www.mergersandinquisitions.com/private-equity-
compensation/.


10 *See*, Becker et al., *supra* n.7 and Krause, *Why PE firms are buying orthopedic and
ophthalmology practices*, The PE Hub Network (August 3, 2017), www.pehub.com/2017/08/why-
pe-firms-are-buying-orthopedic-and-ophthalmology-practices/.

11 A physician group seeking an acquisition by a PE firm will generally have retained an
investment banker, with access to contacts in the PE community, in order to solicit interest.
This is less common than PE firms identifying groups on their own or through their contacts.

12 Gomez & Jackson, *Dealmaker’s Corner: Physician Practice Acquisitions*, BNAs Health Law
The hurdle rate is the promised rate of return on investment to the partners in a PE firm which must be achieved before the managers are entitled to participate in profit distributions. Consequently the managers are highly focused on showing profitability levels which exceed the hurdle rate.

The PE firm may insist that the group impose non-compete covenants or other restrictions on its members to discourage departures.

Authors

Andrew Demetriou
Lamb & Kawakami LLP Berkeley Research Group LLC

Andrew J. Demetriou is a Partner in Lamb & Kawakami LLP, a law firm based in Los Angeles and a Managing Director in the Health Analytics Practice of Berkeley Research Group, LLC. He provides legal advice to healthcare industry participants on strategic transactions and affiliations, governance matters and compliance issues. He also consults on provider strategy and governance and serves as an expert witness in litigation matters involving corporate governance, fiduciary duty and healthcare transactions. He is a former Chair of the American Bar Association Health Law Section (2007-08) and has served as a leader of a number of committees and working groups of both the Health Law Section and the American Health Lawyers Association. He has been recognized for professional accomplishments by Martindale Hubbell (AV Preeminent), Best Lawyers in America, Chambers Guide to Leading Lawyers and California Super Lawyers.

Mr. Demetriou obtained his law degree from the Boalt Hall School of Law at the University of California Berkeley in 1979, where he was elected to Order of the Coif and served as the Research and Books Editor for the Ecology Law Quarterly. He graduated from the University of California Los Angeles with a degree in Economics, summa cum laude in 1976. He may be reached at ademetriou@lkfirm.com.
The Anatomy of Private Equity Investment in Health Care Services

AMERICAN BAR ASSOCIATION
BUSINESS LAW SECTION ANNUAL MEETING
HEALTH CARE AND LIFE SCIENCES COMMITTEE PANEL
SEPTEMBER 13, 2019

General Deal Dynamics

- Why is health care so interesting to PE funds?
- What types of health care companies are PE funds investing in?
Pre-Deal Development

- How are PE funds sourcing health care transactions? - Auctions vs. Proprietary
- How are transactions being initiated, what types of exclusivity are buyers getting/sellers giving?
- What is happening at the LOI/IOI stage?

Due Diligence

- What are buyers undertaking in their due diligence process?
- What are some of the snags that have occurred in the process?
Transaction Documents

- What deal terms are the most negotiated?
- Differences in Health care PE deals vs. non-health care deals?

Financing

- How are deals being financed?
- What are debt providers paying the most attention to?
Closing

- What affects deal timing and certainty of closing?
- Differences in health care PE deals vs. non-healthcare deals?

Post-Closing

- What types of challenges/opportunities are PE funds seeing post-close?