THE PRIVATE EQUITY PLAYBOOK FOR HEALTHCARE M&A

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For at least the last decade, health care providers (e.g., physician practices, imaging centers, ambulatory surgical centers, assisted living facilities) have been the targets of robust merger and acquisition (M&A) activity, including by health systems and, in some cases, acquisitions by insurers seeking vertical integration. More recently, a new player has entered the fray – private equity-sponsored firms. This article provides an overview of the goals and objectives of private equity investments in health care providers and some of the key issues involved in a private equity acquisition transaction.

Private Equity – General

For purposes of this article, "private equity" refers to a broad range of pooled investment vehicles (funds) that raise equity capital from multiple investors to finance their investment and trading activity in private companies. A typical private equity fund (a "Fund") will seek to "exit" its portfolio companies (e.g. sell to other private equity buyers, strategic acquirers or take public) in 5-7 years. Depending on its strategy, a Fund may seek a "platform" acquisition (initial acquisition made as the starting point for other acquisitions in the same industry/service line, where the target has strong management expertise and infrastructure that can be leveraged), followed by "tuck in" acquisitions of smaller practices which can then realize operational efficiencies.

PE's Laser Focus: All-Important EBITDA and Quality of Earnings

The primary benchmark for a private equity investor is "EBITDA" (earnings before interest, taxes, depreciation and amortization) since it provides a useful measure of cash flows (historical and anticipated "pro forma" future cash flows). For valuation purposes, EBITDA is multiplied by a negotiated multiple in order to establish an enterprise valuation (which, after deducting liabilities, results in the equity value). Given its critical importance, EBITDA is closely scrutinized and adjusted to eliminate non-recurring items.

"Scrape" and its Impact on Valuation and Taxes

At this point, consider just how many physician practices have no EBITDA – because they "zero out" the corporation (or other entity) by paying out all or substantially all profit as compensation to physicians. However, EBITDA can be created through financial engineering – the target practice will reduce physician compensation by 20-30% of earnings before physician compensation (this reduction is sometimes called "scrape" since the acquirer "scrapes" compensation off the top from physicians in order to provide a return on investment). So, from the physician owner standpoint, there is an important trade-off: (a) cash at closing (taxed at favorable capital gains rates, subject to certain exceptions, plus the 3.8% net investment income tax) vs. (b) compensation paid in the future (taxed at less favorable ordinary income tax rates and subject to FICA, FUTA, etc.).

Certain Regulatory Issues

From a health care fraud and abuse perspective (generally meaning the "wide and deep" regulatory footprint arising from the Ethics In Patient Referrals Act (42 U.S.C. § 1395nn) and related legislation (the "Stark Law"), the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-76(b), CMS conditions of participation and coverage and reimbursement rules, anti-markup rules, etc.), careful structuring is required to assure that the transaction and resulting venture, where its physician owners are sources of referrals, is compliant (e.g., no unexcepted Stark Law financial relationships with a designated health services provider).

Rollover Equity – The Good, the Bad and the Ugly

A Fund will seek to invest in companies with strong management teams and will often require some of the target company's equity owners, particularly those members of the management team who are critical to the future success of the business, to "roll over" a portion of their equity such that they will own a minority equity position in either the target company or a higher-tier holding company (which holds the target company and other similar acquisition targets). Rollover equity raises a number of negotiation issues, such as:

- Whether the rollover equity will be on par (pari passu) with the equity interests held by the Fund or sit lower (subordinate) in the capital structure of the target or holding company?
- Whether, given the continued service requirement, the rollover equity will be taxable as compensation (ordinary income under IRC §83), the timing of recognition of that income, or whether the rollover equity can be structured on a tax-deferred basis as a contribution to a partnership?
- The events triggering forfeiture (what if a physician is forced out?) and the purchase or redemption price upon those events.

Generally speaking, careful structuring can result in tax-deferral on the rollover equity component of the transaction.

Corporate Practice of Medicine – Profits vs. Patients

Utah's corporate practice of medicine prohibition is not particularly strong, but does prevent a corporation (including evil MBAs acting as holding company management) from interfering in a physician's clinical judgment (doing so would constitute the unlawful practice of medicine). While this provides a legal barrier against interference in clinical matters, from a practical perspective it often falls short and is an unsatisfactory barrier when physicians are forced to object to "financial" decisions. Well-advised physicians will negotiate for sole control or veto power (supermajority voting) over clinical decision making (e.g., hiring and firing nurses, medical directors, etc., clinical protocols and quality improvement initiatives). This effort seeks to strike a balance between (a) profit motives of the Fund (or the subsequent owner once the Fund exits its investment) and (b) physician control over quality of care and the best interests of patients.

Conclusion

We can be certain that the trend of private equity investments in health care providers will continue, whether as "platform" or "tuck in" acquisitions, and that the resulting networks of affiliated providers (owned and managed by the same Fund or its portfolio holding company) will gain market strength through collaboration, back office efficiencies with respect to human resources, coding and billing, etc. Those physicians in a later career stage will generally have far more interest in pursuing a private equity "exit" transaction, whereas the trade-off for earlier career physicians is not as simple and often causes consternation. In any event, the good news is that, at least in the current market environment, deal competition between hospitals and health systems (as strategic acquirers) and private equity funds (as financial acquirers) should benefit physicians through higher multiples and resulting valuations.

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