FMVantage Point™

HealthCare Appraisers' Industry Insight

QUARTERLY INDUSTRY INSIGHTS

AT A GLANCE

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Monitoring Industry Activity from Quarter 4 of 2019

As part of our ongoing monitoring of developments in the healthcare industry, HealthCare Appraisers follows reports from publicly-traded health systems, physician services providers, ambulatory surgical center management companies, and other healthcare service providers. The following paragraphs are important valuation-related takeaways from recent earnings calls and conference presentations, as well as supporting quotes[1] from publicly-traded operators. Most of this information was provided during the months of January and February, with minimal discussion of COVID-19 or its anticipated impact on the healthcare system. Most providers and payors were optimistic about the near-term outlook for their businesses, and provided insights into their plans for the coming months and years. In recent weeks, the spread of COVID-19 has dramatically reshaped the healthcare landscape. Hospitals and outpatient facilities have cancelled or postponed non-essential visits and procedures to keep capacity available for a surge of COVID-19 related cases. Hospitals in many areas have reported shortages of staff, supplies and hospital beds, and Congress recently passed the CARES Act which allocated more than $100 billion of stimulus to hospitals and healthcare providers, based on certain requirements. While it is unclear what the ultimate impact of COVID-19 will be on the healthcare system, it is apparent that many early plans for 2020 will be sidetracked or put on hold. Despite this, we believe that there were important discussions on the fourth quarter earnings calls that may influence the healthcare landscape following a return to normalcy.

HUMANA'S PROVIDER STRATEGY DEVELOPS FURTHER

Humana announced that it is expanding its Partners in Primary Care platform through a joint venture with private equity firm Welsh, Carson, Anderson & Stow (WCAS). Partners in Primary Care is Humana's senior-focused primary care center platform that provides value-based care to seniors, and the new joint-venture with WCAS is expected to enable Humana to open at least 50 new centers over the next three years. WCAS owns a controlling interest in the joint venture and has committed $600 million in funding, while Humana has an option to acquire full ownership in the centers in five to ten years. While the centers initially lose money as providers grow their patient panels, Humana's insurance business benefits as its members receive better care and ultimately incur fewer medical expenses (the centers are payor agnostic and accept patients with coverage from all payors, not just Humana patients). UnitedHealth Group has had similar experiences with its new Harmony product,

[1] *All quotes have been adapted from transcripts provided by S&P Capital IQ.*

HUMANA'S PROVIDER STRATEGY DEVELOPS FURTHER *(CONTINUED)*

through which UnitedHealthcare provides coverage and Optum provides care, with savings up to 20 percent compared to traditional UnitedHealthcare insurance products. Humana's approach to partnering with providers has been different than some of its competitors, including UnitedHealth Group and Anthem. Humana has been starting small and growing senior-based practices (with the exception of Kindred at Home which was also a structured transaction involving WCAS) while UnitedHealth Group has been focused on acquiring existing groups and Anthem has largely stayed out of the provider space all together. Aetna, through its combination with CVS, has incorporated a retail strategy whereby the clinics and pharmacies function as a type of "gatekeeper" to the healthcare system. Humana's focus on seniors and home healthcare also ties in with its insurance business which is concentrated in Medicare Advantage products.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *HUMANA'S PROVIDER STRATEGY*

BRUCE BROUSSARD – CEO OF HUMANA, INC.

"In 2019, we opened 29 senior-focused primary care centers under our wholly-owned alliance and JV model, bringing our center total to 262; and we continue to see the maturity of our value-based care platform resulting in more providers in surplus and improving the operating performance of our legacy Conviva operations. We are now evolving from proof-of-concept to scaling these senior-focused, value-based primary care assets. And just this week, we announced an exciting strategic partnership with Welsh, Carson, Anderson & Stowe that will accelerate our payor-agnostic center expansion giving more seniors access to quality primary care built around their unique health needs, especially in geographies that lack the access today. WCAS, together with Humana, has committed approximately $600 million to create a joint venture that is expected to open a minimum of 50 payer-agnostic, senior-focused primary care centers over three years beginning in 2020. WCAS, together with Humana, has committed approximately $600 million to create a joint venture that is expected to open a minimum of 50 payer-agnostic, senior-focused primary care centers over three years beginning in 2020. WCAS will maintain majority ownership, and Partners in Primary Care[2] will manage the centers for a management fee. Similar to our innovative deal to acquire Kindred at Home, put and call options provide Partners in Primary Care with a path to full ownership of the centers in 5 to 10 years."

DIRK MCMAHON – CEO OF UNITEDHEALTHCARE

"Harmony, a new collaboration with OptumCare providers, unites high-quality care and coverage, creating a more integrated and effective consumer experience with as much as 20 percent savings for our fully-insured customers."

[2] *Partners in Primary Care is a wholly-owned subsidiary of Humana, Inc.*

UNITEDHEALTHCARE PLANS TO TERMINATE CERTAIN MEDNAX CONTRACTS

UnitedHealthcare plans to terminate contracts with Mednax physician groups in Arkansas, Georgia, North Carolina and South Carolina. The terminations impact contracts for groups involved in the provision of anesthesia, neonatology, and maternal fetal care. In addition to the Mednax contract terminations, UnitedHealthcare has terminated contracts with several other large anesthesia and physician services groups. UnitedHealthcare indicated that these terminations are due to Mednax charging rates that are 60 percent higher, on average, than what UnitedHealthcare pays other groups for similar services. These terminations, which started in March, could expose UnitedHealthcare members to more surprise bills and higher out-of-pocket costs for services provided by Mednax physicians in these states. Mednax indicated that the terminations, which impact $70-$80 million in net revenue, will have an impact on its financial results, but was unable to quantify the impact given the many implications of shifting from in-network to out-of-network. In particular, physician groups and other healthcare entities that operate outside of payor networks typically charge higher amounts for services provided, but can have higher adjustments and write-offs, incur more costs associated with their revenue cycle, and assume greater legal and regulatory risks. From a valuation perspective, the greater uncertainty associated with out-of-network revenue streams typically results in lower valuation multiples, all else being equal.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *UNITEDHEALTHCARE PLANS TO TERMINATE CERTAIN MEDNAX CONTRACTS*

ROGER MEDEL – CEO OF MEDNAX, INC.

"We have been told that the only avenue for negotiation will be to accept a 50 percent reduction in the rates our practices are paid for their services. This is neither an approach nor an outcome that we will accept. And I sincerely doubt that our patients or their parents think that the work that we do is worth 50 cents on the dollar. We have also heard that we are not alone in receiving these notices and that several large anesthesia groups and other physician organizations have also recently received terminations with demands for 50 percent rate reductions. In fact, the American Society of Anesthesiologists recently conducted a survey of its members and found that more than 60 percent of respondents have had their contracts terminated over the last 6 months. Of those, 4 out of 5 were terminated by UnitedHealthcare."

EARLY SIGNS OF DISRUPTION FROM PDGM

Large operators in the home health space are seeing early signs of disruption from the new patient-driven groupings model ("PDGM") payment system that went into effect in 2020. Consistent with the outlooks provided on prior calls, companies like Amedisys and LHC Group reported an uptick in inbound calls from small operators regarding potential business combinations as the smaller organizations struggle with the lower reimbursement rates, increased coding requirements and reduced cash flow associated with the new payment model. Of particular interest to buyers are small operators in Certificate of Need ("CON") states where acquiring an agency may be easier than obtaining a new CON. Larger operators are in a better position to enter into value-based care arrangements, which could make them more attractive partners for smaller operators. Value-based arrangements are growing rapidly throughout home health, with Amedisys citing a large increase in arrangements involving gain-sharing. Home health operators are also ramping up their use of telemedicine as a way of providing better care at lower cost to patients. We note that telemedicine and home health have been emphasized as part of the COVID-19 response effort as a means of keeping people with non-emergency clinical issues out of hospitals. These efforts could help accelerate the adoption of these modalities of care provision once the healthcare system returns to normalcy. For a deeper dive on how the COVID-19 pandemic is influencing telemedicine adoption, read HAI's FMVantage Point: Telemedicine Adoption to Combat Novel Coronavirus and Fair Market Value.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *EARLY SIGNS OF DISRUPTION FROM PDGM*

PAUL KUSSEROW – CEO OF AMEDISYS, INC.

"In home health, we have already seen early signs of the disruption caused by PDGM, having already absorbed one asset in Missouri, while more and more have been calling. We will continue to grow share via absorption, but are also interested in strategic inorganic opportunities as they present themselves, particularly in CON states. There's three M&A buckets, if you will. There's one, which is where some of these folks overlap with our licenses. And so that's about 16 percent of the United States at this point and we can just bring in the business, bring in some select employees, and we don't have the liability that a provider number would bring with it. In home health, there is a unique thing that's called a six-year look back. And so when we go outside our license area and acquire a provider number, we have to be very careful because then we're liable for some of the things that occur in that six-year look back. The third bucket is a CON bucket, and we're pretty interested in seeing anything in a CON state, because these are more difficult markets to get into and obviously, operators tend to do better in CON states. There's a higher value associated with them. So those are the three buckets we're looking at."

KEITH MYERS – CEO OF LHC GROUP, INC.

"As a result of the PDGM transition, in Q4 and the first 2 months of 2020, we have seen an increase in the number of inbound calls from smaller agencies looking to add to the business. Some of these opportunities could be good acquisition candidates and others we can naturally roll into our organic growth through market share gains as we earn more of the business in our existing locations instead of acquiring that volume. It's still too early to say whether the projected 30 percent closures among smaller home health agencies is the right number, but it is our and the industry's expectation that consolidation will accelerate in 2020 and continue over the next several years."

CHRISTOPHER GERARD – COO OF AMEDISYS, INC.

"...almost every negotiation that we're having around either new contracts or renewing contracts has some component of gain share that's being contemplated...gain share last year was 5 percent of our Medicare Advantage or non-Medicare book. It will be quadrupled this year to 20 percent."

JOSHUA PROFFITT – CFO OF LHC GROUP, INC.

"Keith mentioned over 2,000 additional patients receiving telephonic visits over the run rate of Q4. That was telephonic visits that have been incorporated as part of the care delivery model in the field."

SURGERY PARTNERS EXPECTS THE PACE OF TRANSACTIONS TO ACCELERATE IN 2020

One of the main drivers of its growth, Surgery Partners anticipates its three-party joint ventures with hospitals and surgeons to increase in 2020. Hospitals are increasingly looking to ASC management companies to help manage their ASC strategies, according to Surgery Partners. This is consistent with HAI's 2020 ASC Valuation Survey (to be published this spring), in which the majority of respondents observed an increase in three-party joint ventures in the marketplace. Under the optimal scenario, all parties to the joint venture benefit, as the hospital helps bring better rates and potentially additional volume, and the management company efficiently operates the center, assists in development and syndication, and provides benefits of scale in the case of national management companies like Surgery Partners, while surgeons bring more cases as a result of the efficient operations and enhanced capabilities enabling them to perform more complex procedures (e.g., total joints, cardiac procedures).

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *ASC TRANSACTIONS*

THOMAS COWHEY – CFO OF SURGERY PARTNERS, INC.

"During 2019, we deployed over $37 million of capital, enhancing our portfolio at a highly attractive multiple of 5.4x trailing adjusted EBITDA."

WAYNE DEVEYDT – EXECUTIVE CHAIRMAN OF SURGERY PARTNERS, INC.

"My optimism on partnering with hospitals that need a partner to run their ASC strategy is high. We are having regular dialogue with local, regional and national systems."

MEDICARE ADVANTAGE CONTINUES ROBUST GROWTH, PAYORS FOCUSING ON ESRD COVERAGE

Enrollment in Medicare Advantage offerings has been an area of rapid growth for some payors as CMS continues to emphasize these plans and approve new benefits for coverage. Recent changes include the hospice carve-in and allowing individuals with end-stage renal disease ("ESRD") to enroll in Medicare Advantage plans. While payors have expressed broad support for Medicare Advantage covering ESRD, some are advocating for better rates from CMS. There are several important differences between fee-for-service Medicare and Medicare Advantage when it comes to ESRD coverage, including the fact that fee-for-service Medicare has no maximum out-of-pocket cost while Medicare Advantage does.[3] In addition, payors note that Medicare fee-for-service is essentially subsidized by private payors and frequently does not cover dialysis provider costs per treatment, so using the Medicare fee-for-service rates as a reference for payments to Medicare Advantage plans may underestimate the appropriate benchmark. DaVita indicated that its Medicare Advantage rates will be above Medicare fee-for-service rates but significantly below commercial reimbursement rates. Outside of advocacy, Medicare Advantage, and managed care more broadly, could help accelerate some of the goals emphasized in the Advancing American Kidney Health initiative, including the push for more dialysis to be provided in the home setting.

WHAT INDUSTRY LEADERS ARE SAYING ABOUT *MEDICARE ADVANTAGE GROWTH*

BRUCE BROUSSARD – CEO OF HUMANA, INC.

"...seniors continue to increasingly choose Medicare Advantage ("MA") over original Medicare with compelling individual MA industry growth of 8.7 percent in 2019, excluding the impact of cost plans, compared to 7.2 percent in 2018 and 6.1 percent in 2017. MA penetration continues to increase, reaching 34 percent in 2019[4], and 2020 industry growth is expected to keep pace with 2019..."

BRIAN KANE – CFO OF HUMANA, INC.

"[With respect to Medicare Advantage ESRD advocacy], rates are one factor, and we'll see where CMS comes out. I think it's just important for people to understand why the benchmark may be understated. And that's a function of the fact that there is not a maximum out of pocket in fee-for-service while there is for MA. Also, typically, HMOs pay higher rates than original Medicare to the large dialysis providers...We're working with CMS on what sort of innovative capabilities can we bring to bear in the ESRD space, whether it's around home, whether it's around micro clinics, various alternative sites of care to provide dialysis."

JAVIER RODRIGUEZ – CEO OF DAVITA, INC.

"...our [Medicare Advantage] rate is above Medicare but substantially below commercial."

[3] *No maximum out-of-pocket cost with fee-for-service Medicare due to the 20% co-pay for members.*

[4] *Humana's commentary that 34% of the Medicare-eligible population is enrolled in Medicare Advantage is consistent with data from Kaiser Family Foundation.*

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