III. OPERATIONS AND ORGANIZATION

A "Friendly" Guide to Private Equity Acquisitions of Physician Practices

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I. Introduction

In recent years, private equity ("PE") firms and similar financial sponsors have demonstrated a flurry of interest in the economic model offered by physician practices. What was once an industry dominated by smaller, privately owned family practices that occasionally were acquired by local hospitals and strategic providers has quickly turned into a competitive landscape in which these PE firms take their business acumen to the management of physician practices. In particular, the competitive advantage held by PE firms in their ability to execute these practice acquisitions swiftly and efficiently has shaped the entire industry. While some aspects of the acquisition of a privately held physician practice mirror any other merger and acquisition ("M&A") transaction, there are also key differences and peculiarities that are important for all parties involved to keep in mind. This article is intended to provide some helpful context to the "ins and outs" of the purchases of private physician practices by PE firms and to serve as a detailed roadmap for both healthcare professionals and first-time Buyers and Sellers in this market. Notably, this article describes the key considerations of the Buyer and the Seller when entering into a sale transaction, in each case with a view from every

stage of the process. This will include a discussion of the various stages of the transaction, the various types of transactional structures, the key documents and negotiated items contained therein, critical risk management and insurance considerations, regulatory approvals and other diligence considerations, navigation of the communications with payors and other third parties, and other key considerations to track following the closing of the transaction.

II. Key Considerations in Structuring Physician Practice Transactions

A. Corporate Practice of Medicine

One of the biggest differentiators between physician practice acquisitions and non-healthcare transactions involve the "Corporate Practice of Medicine" ("CPOM") doctrine. California, Texas, New York, and many other states have enacted a CPOM doctrine, which in short provides that "lay" or non-professional entities (i.e., entities not owned by practicing physicians) cannot engage in the practice of medicine. In practice, CPOM prohibits lay entities from both (i) owning physician practices and (ii) directly employing physicians for the practice of medicine. The purpose of the CPOM doctrine is to ensure that physicians can exercise their professional judgment in the best interests of patients without being influenced by financial drivers or business concerns. The goal is to foster the physicians' independent practice of medicine and protect the public from unprofessional, improper, and incompetent actions that may arise between a physician's duty to patients (e.g., to provide necessary medical care), on the one hand, and the physician's duty as an employee to their corporate employer (e.g., to generate profits/other financial considerations), on the other hand.

Many states have codified a CPOM doctrine in statute. For example, California codified its CPOM in the California Business Professions Code.[2] Section 2052 states that "any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing,

[2]Med. Board of Cal., *Information Pertaining to the Practice of Medicine*, MBC.CA.Gov (last accessed Oct. 6, 2022).

[medicine] without being authorized to perform the act pursuant to a certificate . . . is guilty of a public offense." Cal. Bus. & Prof. Code § 2052. This provision bars lay entities from practicing medicine, as such lay entities are not eligible to be licensed as physicians. Further, Section 2400 states that "[c]orporations and other artificial legal entities shall have no professional rights, privileges, or powers." This provision is intended to prevent unlicensed persons from interfering with, or influencing, the physician's professional judgment.[3] In Texas, on the other hand, a CPOM doctrine is found in (i) broad Texas Medical Board rules that limit the practice of medicine to a licensed natural person, as well as in (ii) attorney general opinions and (iii) court cases. Many states (including Texas and California) provide an exception to CPOM to allow for the employment of physicians by certain entities (such as professional entities[4] or hospitals).

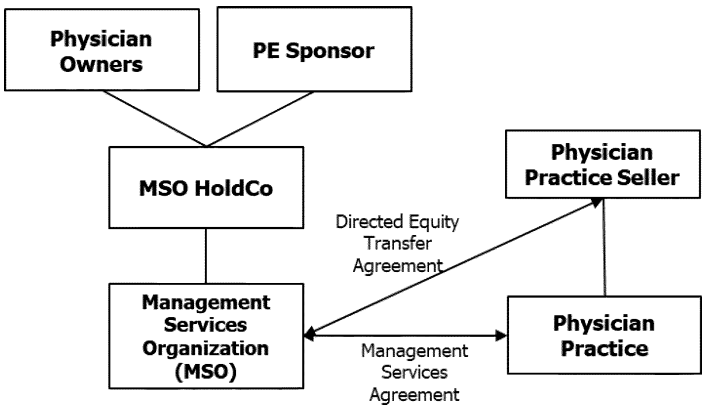
So, then, how can a PE sponsor, which would surely qualify as a lay entity, "acquire" a physician practice in a CPOM state? Technically, it cannot. Instead, many lay entities structure their investments and corresponding contractual and business arrangements in the physician practice space to align with what has been called the "Friendly PC Model" or the "Friendly Physician Model." Rather than the PE sponsor acquiring the entire practice or the equity of the practice, it instead acquires only certain non-clinical assets. The physician practice (which is often a professional corporation) employs the physicians, while a lay management company or management services organization ("MSO") employs the non-clinical employees and owns the non-clinical assets that were acquired under the transaction. The MSO then enters into an agreement, a management services agreement ("MSA") with the physician practice to manage the non-clinical business operations of the practice. One or more physicians continue to own and practice through the physician practice entity. Revenue for professional services continues to be paid to the practice, as it continues to hold payor agreements and professional services agreements

[3] *Id.* § 2400.

[4] Professional entities are entities that are formed under state law. These entities are generally directly owned by one or more licensed professionals (such as physicians) and can include professional corporations, professional associations, and professional limited liability companies.

(which are clinical assets that remain with the practice). The management fee paid by the practice to the MSO under the MSA is structured to be compliant with law, and it ideally represents the revenue of the practice after certain clinical expenses are paid through the practice. The practice often pays the MSO either a flat, fixed fee; the MSO's expenses plus a markup of those expenses; or a percentage of the practice's gross or net revenues.[5] Additionally, under the MSA, the MSO typically furnishes space, equipment, supplies, certain non-physician clinical staff, administrative staff, billing services, and other administrative and management services to the practice. Depending on state law, the practice management documents may also include a "directed equity transfer agreement." This agreement can be the most controversial part of the Friendly PC Model. It is among the practice, MSO, and the owner of the practice physician, and it restricts the physician owner's ability to transfer the equity of the practice. If not prohibited by state law, it permits the MSO to replace the owner without cause upon notice by requiring the owner to transfer the equity of the practice to a person designated by the MSO.

Sample MSO Structure



[5]Certain states have so-called "fee-splitting" laws that prohibit a certain percentage of revenue fee arrangements between physicians and MSOs, or specifically require that the compensation paid reflects fair market value for the MSO's services.

The practice management documents (including, importantly, the MSA) must be structured to be compliant with applicable law. Because CPOM doctrine originates in state law, unfortunately a one-size-fits-all approach will not work. However, as a general and practical matter, there are certain threads of consistency to keep in mind when structuring these arrangements. First, the MSO should not be involved in the clinical decision-making of the physicians. For example, in no circumstance should the MSO direct the practicing physicians to order certain diagnostic tests or to refer patients to certain specialists. Further, the MSA cannot permit the MSO to exert excessive control over the business aspects of the physician practice, causing the MSO to be essentially practicing medicine. Areas of focus by which to avoid CPOM issues in most states include (i) engagement and termination of physicians, (ii) physician scheduling, (iii) physician compensation, and (iv) procurement of medical equipment and supplies. Ideally, the practice management documents should strike a balance of permitting the MSO to lead the non-clinical aspects of the practice while simultaneously allowing the clinical aspects of the practice to be managed by the physicians.

CPOM considerations vary for the Buyer and Seller in a sale transaction. From a Buyer's perspective, it is important to understand that, in a CPOM state, the financial sponsor Buyer will not own the practice post-close, as the practice will continue to be owned by a physician or multiple physicians. The Buyer should carefully consider who this physician should be, whether it is a selling physician or another physician affiliated with the Buyer. Further, as discussed earlier in this article, the Buyer should be aware that it cannot exert control over the clinical aspects of the practice. In some states, this could mean that the Buyer cannot control the engagement or termination of physicians or physician compensation. Depending on the Buyer's relationship with the physician owner of the practice, the Buyer may consider utilization of a directed equity transfer agreement (as discussed elsewhere in this article) as a way to protect its investment. Further, in most PE investments, the issuance of rollover equity (discussed elsewhere in this article) as a portion of the purchase price consideration could potentially help maintain alignment with the physician practice owner. All in all, because the financial sponsor

Buyer, such as a PE company, has made a bona fide investment in the physician practice, it is essential that the practice physician owner be "friendly" to the Buyer and cooperate with the Buyer's budgets and business plans. For example, the financial sponsor would not want to be in a position in which the practice hires new physicians, increases practice expenses, and reduces the management fee without first confirming that the engagement of additional physicians is covered by the practice's budget as developed by the MSO. Accordingly, the financial sponsor Buyer should select a physician who will be "friendly" to the Buyer and the Buyer's business interest.

From the Seller's perspective, the Seller must come to grips with the fact that the Seller will not have control with respect to most management decisions related to the business post-closing, and that it has been compensated thusly. To the extent that the Seller continues to own the physician practice post-close, the Seller may seek indemnification from the MSO for any losses incurred in connection with such ownership.

Finally, it is important to note that not all states have a CPOM doctrine. For example, Florida does not have a CPOM doctrine, but, under certain circumstances, a non-physician–owned clinic requires licensure. If the physician practice transaction is occurring in a non-CPOM state, a Buyer may still consider the Friendly PC Model for several reasons: (i) consistency across its company if the Buyer is conducting transactions in CPOM states; (ii) disclosure requirements associated with Medicare and Medicaid enrollment (discussed more in the Change of Ownership section); and (iii) utilization of a business structure that does not require state licensure. In the event that a financial sponsor Buyer does not plan to enter into states that have a CPOM doctrine, they will likely opt to avoid a Friendly PC Model to maintain simplicity in structure and practice.

B. Change of Ownership

Healthcare businesses, including physician practices, are heavily regulated. As a result, these businesses often are required to hold numerous licenses, permits, certificates of need, accreditations, and enrollments. In the context of a sale transaction, it is important to ensure a smooth transi-

tion of these issued items so that there is not any lapse or breach of law post-closing. Sometimes government bodies will require notice, have approval rights or require the application of a new license or permit when a new Buyer acquires a physician practice. These notices and consents should be identified early in the transaction process to ensure that they do not become gating items to reaching a timely closing.

In a physician practice acquisition, the first step with respect to this analysis is simply to identify all of the applicable licenses and permits. Typical items include Clinical Laboratory Improvement Amendments, permits or waivers, registrations and accreditations for imaging equipment, permits related to biomedical waste disposal, and licenses for controlled drugs. Most physician practices hold Medicare and Medicaid enrollments. Further, depending on state law, a physician practice may hold a certificate of need in connection with the acquisition and operation of certain medical equipment, such as magnetic resonance imaging equipment.

Once the licenses, permits, and accreditations are identified, research should be conducted to confirm whether the issuing agency requires notice or consent in connection with the proposed transaction. As a practical matter, equity transactions are more likely to trigger post-close notification to the issuing agency (as opposed to pre-close consent or a new application). However, to the extent that a physician practice does hold a certificate of need, this agency may require pre-closing consent even with an equity transaction. On the other hand, most asset transactions will require that the Buyer obtain new licenses and permits, as these items are not assignable like other assets that move freely in an asset acquisition. Further, state Medicaid programs can be unpredictable with how they interpret the applicable change-of-ownership regulations. Accordingly, it is a best practice to reach out to these agencies (and, to the extent necessary, others) to confirm the change-of-ownership analysis. Once the change-of-ownership analysis is confirmed, then the transaction timing can be planned. To the extent that the transaction involves the Friendly PC Model, notices and consents may be limited, as the equity composition of the practice may remain the same and the practice would only sell its non-clinical assets to a MSO (leaving the permits, licenses, accreditation, and certificates with the practice).

Further, to the extent that any burdensome consent process is identified, depending on other transaction dynamics (most frequently, tax considerations), the Buyer and Seller may strategically revisit the transaction structure to evaluate whether updates to the structure could avoid the requirement to obtain consent. Both Buyers and Sellers want the transaction to close as quickly as possible. Therefore, the change-of-ownership process, including agency communication, should ideally be a collaborative process involving both Buyer and Seller.

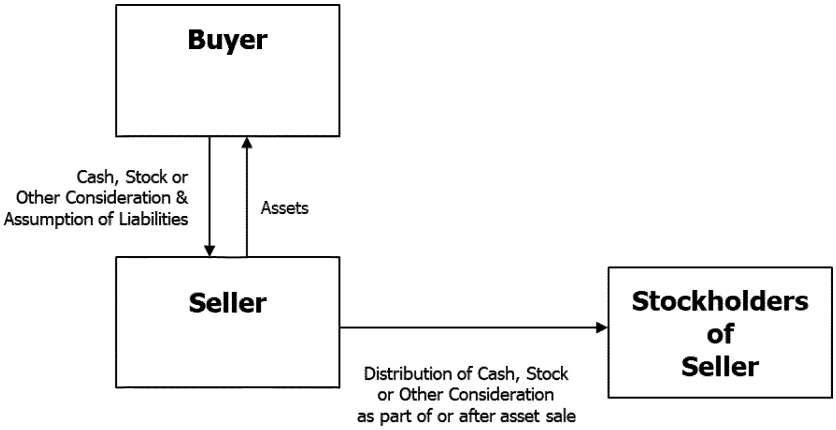
C. Corporate and Tax Considerations

While healthcare regulatory considerations are critical when determining the most appropriate structure for a physician practice transaction, there are often, if not always, corporate and tax considerations that will also impact structuring decisions. Therefore, it is important for the corporate, regulatory, and tax teams (both legal and business/accounting) to work closely together at the beginning of any physician practice transaction to determine the appropriate structure and any pre- or post-closing restructuring needs. There are three basic corporate transaction structures that can be used for any M&A transaction: (i) an asset acquisition, (ii) a stock acquisition, and (iii) a merger transaction.

The first of these, an asset acquisition, occurs when a Buyer purchases a particular set of assets, often "all or substantially all" of the assets, of the Seller in exchange for cash, equity rollover in the Buyer entity, or other consideration, including the assumption of some, none, or all of the related liabilities of the Seller. In this structure, the Seller entity will survive the acquisition as a stand-alone entity separate from the Buyer and will continue to own the assets and liabilities that were "excluded" from the transaction, and, unless it is otherwise distributed to its equityholders or creditors, will continue to hold the consideration paid by the Buyer during the transaction. This structure is used in M&A transactions for a variety of reasons, including principally when the Buyer wants to acquire only a specific set of assets, equipment, or other property, and there are specific liabilities that the Buyer is concerned about and does not want to assume. In physician practice acquisitions in particular, the asset structure is often employed when the Friendly

PC Model described earlier in this article is utilized and the Buyer, or its MSO entity, chooses to acquire certain non-clinical assets of the Seller directly.

Asset Acquisition Model



Buyers should always consider whether an asset acquisition structure would work well for them, as there are significant benefits to utilizing this structure from a Buyer's perspective. In an asset acquisition, the Buyer can essentially cherry-pick the assets and liabilities that the Buyer would like to acquire and assume. This also means, however, that the Buyer must take its time and carefully perform due diligence regarding the Seller's business, structuring the representations and warranties in the asset purchase agreement appropriately to ensure that no important assets are inadvertently left behind. Additionally, with an asset acquisition, there is a lower risk for the Buyer of assuming unknown or undisclosed liabilities. This does not eliminate all risk of assuming unknown liabilities, however, since there are some successor liability issues and potential fraudulent conveyance risks that could be the Buyer's responsibility post-closing regardless of whether or not the Buyer tries to leave certain liabilities as "excluded." Sellers, on the other hand, often prefer stock acquisitions because, in asset acquisitions, the Seller can be left with assets or liabilities that the Buyer did not want to acquire and assume, and therefore does not get to "walk away" from the deal free and clear. For instance, if a particular physician Seller wants to utilize a sale transaction as a mechanism to obtain liquidity in retirement and walk away from the business, that physician Seller likely will not want assets and liabilities that remain their responsibility following the closing. Additionally, Sellers tend to shy away from asset sales when possible, as asset sales typically cause less favorable tax treatment for Sellers because (i) depending on the entity classification of the target company, it may cause two layers of tax (one with respect to gain on the assets sold at the target level and another upon the distribution of the purchase price to the ultimate stockholders), and (ii) some portion of the gain may be characterized as ordinary income instead of capital gain (and thus be taxed at a higher rate). There may also be state tax considerations that are implicated by an asset sale, such as transfer taxes for the direct sale of real estate.[6] From a Buyer's perspective, structuring the transaction as an as-

[6]Note that tax consequences and treatment will vary depending on, among other reasons, the tax classification of the target entity or the company that owns the assets being sold. This article generally discusses

set acquisition for tax purposes can be beneficial, as it allows for a "step-up" in the basis of the acquired assets. This step-up in basis allows the Buyer to amortize or depreciate the purchase price through tax deductions to offset future Buyer (or target company) income. This is often a more critical point for strategic buyers who expect to hold the assets for a long period, as the amortization or depreciation frequently occurs over a period of 15 years or less (depending on the type of asset). On the other hand, PE Buyers, who expect to hold the assets for a shorter period, may not be as focused on this particular tax strategy.

While there are a number of benefits from a Buyer's perspective of utilizing an asset structure, asset acquisitions can often be more complex and time-intensive than the other corporate structures. This complexity is due to several factors, including the time needed to identify the particular assets of the Seller that will be transferred and the work necessary to actually transfer and assign each of the assets and the employees to the Buyer entity. In an asset acquisition, each of the assets, including both tangible (e.g., furniture and equipment) and intangible (e.g., contracts, licenses, and intellectual property) assets, will need to be transferred to the Buyer. As a part of this transfer process, the parties will need to carefully perform due diligence of the assets to determine what, if any, consents or other processes are needed to facilitate the transfers. For example, contracts (including leases and payor agreements) often include anti-assignment provisions, which prohibit assignment of the contract without a third party's consent, and, as such, in an asset acquisition, the parties will need to consider whether to seek the third party's consent before completing the assignment and transfer of each such contract. As noted earlier in this article, certain healthcare licenses and permits are not easily transferrable in an asset acquisition, and they can require the Buyer to obtain new licenses. Both parties will also need to be attuned to the fact that employees of the Seller will not automatically transfer with the business or

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tax implications related to target entities that are classified as C corporations or S corporations for tax purposes, but, even in those instances, the tax treatment may be different than as described herein due to other circumstances. It is important to seek advice from tax advisors for any specific transaction.

assets being sold in an asset acquisition, but instead each employee will need to be individually hired and onboarded by the Buyer (and terminated by the Seller). There are several implications of this that can complicate asset acquisitions further, including, among others, which employees will be retained, what documentation is needed for the onboarding process, the need to set up benefit plans and payroll at the Buyer entity, and whether any employees will receive new employment agreements.

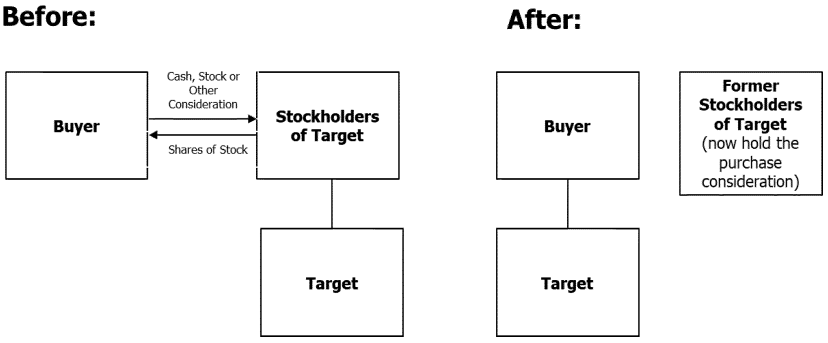
The second corporate structure type, a stock[7] acquisition, occurs when a Buyer acquires the stock of a target entity from its stockholders in exchange for cash, equity, or other consideration. Following the closing, the target entity remains intact but with new ownership as a direct subsidiary of the Buyer. This means that, here, unlike in the asset acquisition in which Buyers could cherry-pick which assets and liabilities to acquire, the Buyer will necessarily acquire all of the assets and liabilities of the target entity, whether occurring during the pre- or post-closing period. Because of this, it is critical for a Buyer to identify any pre-closing liabilities in due diligence that may have a significant economic impact on the business and determine the best way to address that risk allocation. Stock acquisitions can be used if the Buyer is acquiring all, or less than all, of the outstanding shares. In contrast to an asset acquisition, Sellers typically prefer the stock acquisition structure, as all of the assets and liabilities go with the physician practice entity being sold. Additionally, Sellers typically receive better tax treatment with this structure, as each Seller generally recognizes a taxable gain or loss on the sale equal to the difference between the purchase price received by such Seller and the Seller's existing basis in its stock, rather than the harsher tax treatment discussed earlier in this article applicable to asset sales. These tax consequences will vary depending on,

[7]This structure can be used for all different types of target entities (e.g., corporations, limited liability companies, partnerships, limited partnerships). Depending on the type of the target entity, this may not be referred to as a "stock" acquisition, but instead would be referred to as an "equity" acquisition, or by the particular type of equity that is being acquired (e.g., a "membership interest" acquisition or a "unit" acquisition). For simplicity, this article will assume that the target entity is a corporation, and all references to this structure type will be a "stock" acquisition.

among other reasons, the tax classification of the target entity or the company that owns the assets being sold.

Stock acquisitions can also frequently be streamlined, as compared to asset acquisitions, given that many of the factors that slow down the pace of asset acquisitions are not applicable in a stock acquisition context. For example, the parties do not need to be concerned with "anti-assignment" provisions in contracts in a stock acquisition, and instead only need to seek third-party consent for contracts in the event that a contract has a provision requiring a third party's consent upon a change of control of the target entity. These "change-of-control" provisions are much less common than "anti-assignment" provisions, so there are often fewer third-party consents needed in a stock acquisition. Additionally, the employment relationship between the target entity and its employees is not impacted by a stock acquisition, and, as such, the employees do not need to be individually hired and onboarded as with an asset acquisition. The employees, their agreements, and their benefit plans will all automatically transfer in a stock acquisition.

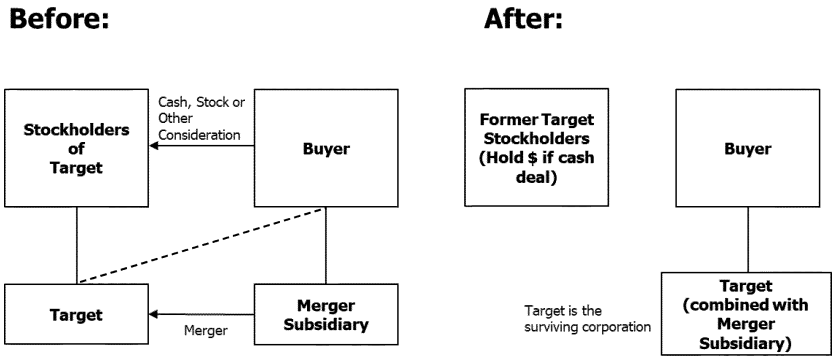
Stock Acquisition Model



Whenever considering a stock acquisition, both parties should at the outset understand the capitalization table and ownership structure of the target entity. This is critical because a stock purchase agreement requires that all shareholders sign on to the agreement. Therefore, structuring the transaction as a stock acquisition may not be possible or practicable with a large stockholder base if there are selling shareholders who might try to block the deal by not signing. This is not a common concern for physician practice acquisitions, as the stockholder base of physician practices is typically small, and the selling physicians often come to a sale process by unanimous agreement. If the target physician practice has a larger stockholder base, or if there are any stockholders that could be potential holdouts to approving the sale, this may be a reason to consider a merger transaction structure instead.

A merger transaction structure is not frequently utilized in physician practice acquisitions as compared to other M&A opportunities, but it is still important to understand and consider. There are three basic types of merger transactions—a straight merger, a reverse triangular merger, and a forward triangular merger. A reverse triangular merger tends to be the most common structure, as it allows the target entity to be purchased and survive post-closing as a subsidiary of the Buyer (similar to a stock acquisition), so we will focus this section only on the reverse triangular merger. In a reverse triangular merger structure, a subsidiary of the Buyer (typically a newly formed shell entity) merges with and into the target entity, with the target entity surviving the merger. This occurs by converting the stock held in the target entity into the right to receive cash, equity, or other consideration. The target entity, as the surviving entity, retains all of its assets and liabilities, assumes any assets and liabilities of the merger subsidiary by operation of law (which is typically nothing, given that the merger subsidiary is a newly formed shell), and the merger subsidiary no longer exists following the closing. Merger transactions are creatures of statute and occur by operation of state law for the jurisdiction or jurisdictions where the merging entities are organized, or incorporated. As such, if considering a merger transaction, it is critical to understand the underlying merger statutes in the applicable jurisdictions in which the target and Buyer are organized or incorporated at the outset.

Reverse Triangular Merger Model



Merger transactions typically share many similarities with stock acquisitions. In a merger transaction, the Buyer cannot pick and choose specific assets and liabilities of the target entity that it would like to acquire, but instead the target entity would retain all of its assets and liabilities post-closing. As noted in the preceding paragraph, mergers can be attractive if the target entity has a large stockholder base or if there is a high risk that any stockholder could be a potential holdout, as typically a merger transaction only requires the approval of a majority (rather than all) of the target entity's stockholders.

Depending on the regulatory and tax factors for a particular transaction, multiple of these corporate transaction structures may be utilized for a single transaction. In particular, physician practice transactions can often involve complex pre- or post-closing reorganization transactions that can involve a variety of these transaction structures. These pre- and post-closing reorganization transactions are almost always necessitated by tax considerations, as tax considerations are a key driver of determining the most advantageous and appropriate structure for a particular acquisition. The opportunity for such structures relates to the manner in which physician practices are historically structured.

Physician practices are often organized as professional corporations, rather than partnerships or limited liability companies, as a number of states do not recognize (or have just recently started recognizing) professional limited liability companies or professional partnership entities. Because of this, and to avoid the double-taxation issues related to being taxed as a C-corporation, many physician practices elect to be classified as an S-corporation for tax purposes. The classification of a target entity as an S-corporation presents a valuable opportunity to Buyers—converting a stock sale to an asset sale for U.S. federal income tax purposes.

The tax benefits of an asset sale to Buyers—achieving a "step-up" in asset basis—have been discussed earlier in this article. As noted, however, asset sales generally present an additional tax cost to Sellers. In the context of the acquisition of an S-corporation, however, the tax benefit to Buyers often greatly outweighs the additional tax cost to Sellers (as the shareholders of an S-corporation do not have a "second

layer of tax" and so have to only bear the additional cost of the character change).

In the acquisition of an S-corporation, there are two ways that are commonly used to convert a stock sale to an asset sale—a "Section 338(h)(10) election" and a "pre-closing F reorganization." A Section 338(h)(10) election is simply a tax filing made jointly by Sellers and Buyers that generally has the effect of converting a stock sale to a "deemed asset sale" for U.S. federal income tax purposes. However, the requirements of such elections are complex and are often the subject of a large amount of tax diligence. Importantly, the successful execution of the election requires that the target be a so-called "good S-corporation," which in turn depends on a target company's historic compliance with the highly detailed legislative and regulatory legal framework for S-corporations. The tax benefits of an F reorganization structure, on the other hand, are not dependent on whether the target is a good S-corporation. Accordingly, to insulate the "step-up" in tax basis from historic S-corporation compliance issues, Buyers will frequently require or request the use of a F-reorganization structure when acquiring an S-corporation.[8]

The F-reorganization structure gets its name from Section 368(a)(1)(F) of the Internal Revenue Code. In an F-reorganization structure, typically what occurs is that the stockholders owning the target company will (i) form a new holding company ("Holdco"), (ii) contribute all of their stock of the target company into Holdco in exchange for stock of Holdco, and (iii) cause Holdco to make an election to have the target company treated as a "qualified subchapter S-subsidiary." Following the "F-reorganization," Sellers will also most often convert the target company (now a subsidiary of Holdco) into a limited liability company pursuant to applicable state law.[9] The reason this is done is because a "qualified subchapter S-subsidiary" will revert to a

[8]Additionally, certain fact patterns may cause a Section 338(h)(10) election to be unavailable entirely, such as acquisitions that include "rollover" equity beyond a certain threshold. An F-reorganization structure may also allow more flexibility to achieve a tax-deferred rollover, which can be a crucial tax consideration for the Seller.

[9]The conversion to a limited liability company can be accomplished through a simple filing for states with a "conversion statute," but may require a state-law merger if simple conversion is not available.

C-corporation upon its acquisition by an entity other than an S-corporation, and this added layer of tax is generally not desired. Following this conversion, Holdco will then sell the equity securities of the target company to the Buyer.

D. Seller Rollover

Physician practice transactions frequently involve some form of Seller "rollover"—i.e., a structure that allows (or often requires) the physician Seller or Sellers to roll over a portion of their cash purchase price proceeds back into the Buyer's business and remain partial equity owners of the business following the closing. Seller rollover is extremely common in PE physician practice roll-ups. Here, more so than in many other industries, the PE Buyers rely heavily on the Seller physicians to continue running the business post-closing (they are the doctors, after all). So, in requiring the Seller physicians to roll equity, it keeps them interested with skin in the game and mitigates the risk of them retiring earlier or jumping ship to another practice. The actual structure of the rollover can vary and depend on various considerations including, most importantly, the corporate structure of the transaction and tax considerations; however, a common structure utilized in stock acquisitions will have the Seller selling most of its stock in the target company for cash purchase price and exchanging its remaining stock in the target company for equity in the Buyer entity.

Seller rollovers can be attractive to both Buyers and Sellers in a physician practice acquisition. From the Buyer's perspective, as mentioned in the preceding paragraph, the equity rollover serves both to align incentives of the Buyer and the Sellers post-closing and as a retention tool for Sellers that have continuing employment or consulting arrangements with the target company. Since a portion of the Sellers' purchase price for the transaction is tied to the ongoing post-closing business, both the Buyer and the Sellers will be incentivized post-closing to ensure that the value of the equity is maximized. From a Seller's perspective, the equity rollover can serve as a potential avenue for more long-term economic upside than simply receiving all purchase price consideration in cash up front, and, if structured properly, equity rollovers can often be completed on a tax-deferred basis so that the Sellers do not pay taxes on their gains from the sale transaction until a later sale or exit transaction.

The size and terms of the equity rollover can vary, and they will be determined as a part of the overall purchase price discussions and transaction negotiation, but it is fairly typical to see a rollover in the 20% to 40% range. In addition to size and percentage, however, there are certain key issues that both parties should consider when structuring a transaction that includes a Seller rollover. In many instances, the rollover equity issued to the Sellers will be *pari passu* to the equity held by the PE sponsor or Buyer post-closing, meaning that the rollover equity held by the Sellers would have the same economic rights and be entitled to receive the same distributions and proceeds from a later sale or exit transaction as the PE sponsor's equity (on a per unit or share basis). While having the same economic rights, the PE Buyer will typically want to control the governance and management of the target company post-closing. This often results in rollover equity having limited, or no, voting rights post-closing. Depending on the size of the rollover, the Sellers may be granted a board seat or board observer rights post-closing, although they will have to come to grips generally with the idea that they are no longer in control of their company.

There is often tension between the Buyer and the Sellers in negotiating whether the rollover equity will be subject to repurchase rights post-closing. Since a primary objective of rollover equity is to align the parties post-closing on maximizing the value of the business, Buyers will frequently want to include certain repurchase rights for the rollover equity that are triggered in the event that the Seller's employment or consulting relationship with the target company is terminated post-closing for any reason. Sellers will regularly push back on this, given that Sellers view the rollover equity as purchased by them or given to them as purchase price rather than as an employment incentive or benefit.

Sellers receiving rollover equity should also seek protection against future dilution of their rollover equity. Given that their rollover equity is a part of their purchase price for the sale transaction, it is critical from a Seller's perspective that the ownership amount is not diluted and made essentially worthless. To this end, the Buyer will typically grant the Sellers preemptive rights, which give the Sellers the right to acquire their proportionate share of any future equity issuances. When the Buyer or the PE sponsor invests

new money in the post-closing business, so too can the Sellers on a proportional basis.

Finally, Sellers receiving rollover equity will want to ensure that they understand and carefully consider their exit strategies for the investment. Transfers or sales of rollover equity are often prohibited, outside of certain permitted estate planning–related transfers. As such, the Sellers cannot easily liquidate their rollover equity, but instead are typically expected to hold such equity until a later exit event. Sellers can request "put" rights where, upon the occurrence of certain events, the Seller would have the option of requiring the target entity or the Buyer to buy back its equity; however, PE Buyers are hesitant to grant put rights, given, among other things, typical financing requirements and covenants. Buyers will frequently grant "tag-along" rights to Sellers, which allow the Sellers to sell their rollover equity, on a pro rata basis, if the PE Buyer moves to sell all or a portion of its equity; however, Buyers will likely expect the Sellers' rollover equity to be subject to "drag-along" provisions, which require the Sellers to cooperate, and go along with, a potential equity sales process. All of these provisions can be negotiated in various directions depending on the leverage of Sellers and, most importantly, what percentage of the post-closing business they will own.

III. Transaction Stages

A. Letter of Intent

Once the parties to a potential physician practice transaction are ready to move into the documentation preparation and negotiation stage, the first document that is executed is usually a letter of intent ("LOI"), term sheet, memorandum of understanding, or similar document. The LOI typically serves to outline the key terms of the proposed transaction. While an LOI is generally non-binding in relation to most of those key terms (including purchase price, closing timeline, and other items that get addressed in the definitive purchase agreement), a handful of binding provisions are agreed upon by the parties, most notably an exclusivity clause. From the Buyer's perspective, obtaining binding exclusivity from the Seller is the most important aspect of the LOI, as it provides the Buyer with comfort that it can engage fully in the time,

effort, and expense needed to consummate the transaction without fear (or at least with a lot less fear) that the Seller will abandon the deal in favor of another buyer. This is because the exclusivity clause serves to explicitly prohibit the Seller from talking to other Buyers and even entertaining such offers for defined period (typically in the 30- to 60-day range, but it can be shorter or longer). Obviously, the longer the better for a Buyer. From a Seller's perspective, the focus should be on how detailed the non-binding terms can get. Since the Seller has a lot more leverage before it agrees to exclusivity, the LOI negotiations serve as the time for the Seller to negotiate a higher purchase price, favorable indemnification provisions, a meaningful equity package, and other provisions. Including more detail can be helpful, as this may expedite some of the negotiation of the definitive purchase agreement and other transaction documents; however, as these terms are usually subject to due diligence and other considerations, they may still evolve over the course of the transaction. However, sometimes Buyers will be perfectly happy giving as little as they need to in order to lock in exclusivity.

B. Due Diligence

i. Primary Business and Legal Diligence

Distinct from the healthcare diligence mentioned later in this article, Buyers in acquisition transactions will also typically conduct significant due diligence on financial, tax, and other legal matters. And while this process is often time-consuming and, at times, frustrating for any typical Seller, it is exacerbated in the physician practice sale context because many physician Sellers are seeing patients during much of their working day and are not able to assist in diligence while sitting in front of a computer looking at documents. This section describes the typical diligence process in a physician practice acquisition, although it should be viewed as an overview generalization. As is always the case, no two transactions are the same, and so no two diligence processes are the same, either.

Typically, the Buyer will begin with financial due diligence. In fact, this is often the only part of due diligence that begins before an LOI is signed. Why? Because Buyers need at least

a basic understanding of a practice's financials in order to inform their decision on purchase price. Once the LOI is signed, Buyers will then do a deeper dive into the financials, including reviewing the practice's financial statements, accounts receivable, accounts payable, working capital, tax returns, and other filings, and often engage with a third-party firm to perform a "quality of earnings" analysis to validate the financials.

In parallel with the deeper dive into financial due diligence, post-LOI Buyers will typically conduct internal work and engage with third-party advisors to conduct significant due diligence in areas of employment, insurance, IT, tax, and legal. And within legal, there often is time spent in the areas of corporate governance (and more recently environmental, social, and governance concerns), entity structure and capitalization table diligence, commercial contract review, real estate, employment and employee benefit plans, intellectual property, and other topics. Frequently, the Buyer will produce a large list (or often multiple lists) of questions and document requests for the physician Sellers or their operations team to answer. There are follow-up lists, diligence calls, and then even more lists.

Internal Buyer teams and the external advisors hired to conduct due diligence will typically each prepare a formal written report of their findings. These reports are not often shared with the Seller until after closing, if at all. These reports are incredibly useful to the Buyer for a number of reasons: (i) they can help inform certain corrective actions and changes to be made post-closing; (ii) if there are certain material issues identified, they could impact purchase price or create the need for special indemnities or escrows under the transaction documents; (iii) in the event that the Buyer is obtaining third-party debt financing to fund the acquisition, its lender will want to review the reports; and (iv) as discussed elsewhere in this article, any insurer underwriting a representation and warranty insurance ("R&W Insurance") policy will require review of all diligence reports to complete its underwriting and bind the policy.

ii. Healthcare Diligence

In physician practice acquisitions, healthcare regulatory diligence is understandably a focal point of the transaction

process. The processes for completing healthcare diligence are similar to non-healthcare diligence and generally involve written requests for documentation and an interview with the management of the Seller. Additionally, the Buyer may engage various third-party consultants, such as a billing and coding specialist or a fair market value–assessment evaluator, to provide input with respect to certain aspects of diligence. Most law firms are not equipped to perform medical record documentation reviews. The Buyer's counsel can cover this important aspect of diligence through engagement of a billing and coding specialist. Similarly, most attorneys are not in a position to opine on whether a compensation arrangement is consistent with fair market value (a requirement that is implicated from a fraud and abuse perspective). A fair market value–assessment evaluator can be engaged to confirm compliance. These experts do not replace legal diligence, but they are complementary to the legal diligence performed by Buyer's counsel.

Thorough healthcare regulatory diligence requires review of a variety of topics, including the Seller's compliance program, exclusion screening procedures, licenses and permits, and compliance with laws governing fraud and abuse, billing and coding, and privacy. Notably, the topics of healthcare regulatory diligence remain relatively similar, notwithstanding the size of the transaction. Accordingly, the healthcare regulatory areas of diligence are generally the same for acquisitions involving a small practice and acquisitions involving large, multi-state physician practices. Healthcare regulatory diligence should, however, be customized based on the specialty of the physician group. For example, the issues applicable to hospital-based groups, such as emergency medicine or anesthesia groups, are different from the issues applicable to clinic-based groups, such as cardiology or orthopedics.

The scope and depth of healthcare diligence will vary based on the Buyer's diligence budget and whether the parties will attempt to obtain representation and warranty insurance coverage (as further discussed later on in this article). Although the Buyer may request a more limited review of healthcare diligence items based on the Buyer's budget, there are areas of diligence that would present significant regulatory risk and should be appropriately reviewed. For example, the Physician Self-Referral Law ("Stark Law") is a strict li-

ability statute; therefore, related diligence should be adequate. On the other hand, diligence related to a Seller's compliance program could be more limited, as most physician practices do not have robust compliance programs and will join the Buyer's compliance program post-close. Finally, if the parties desire to obtain representation and warranty insurance coverage for the transaction, the insurer will not provide coverage for healthcare liabilities without thorough diligence. While different transactions necessitate different areas of focus for healthcare diligence, set forth in this section are some of the most common areas that Buyers will want to address, such as compliance programs, exclusion screening, licenses and permits fraud and abuse, billing and coding compliance, and HIPAA compliance (discussed later in this article). As a result, any physician group considering a sale might want to proactively be thinking about these items even before a sale to make its practice more desirable to Buyers.

1. Compliance Program

Buyers should consider whether the Seller has created and operationalized a compliance program. In practical terms, if a Seller has an effective compliance program, the Buyer can have more confidence that any past or pending healthcare regulatory issues were timely identified and appropriately addressed. During the diligence process, the Buyer should benchmark the Seller's diligence program against the elements of the U.S. Health and Human Services' Office of Inspector General ("OIG"),[10] noting that many physician practices will not have sophisticated compliance programs.

2. Exclusion Screening

Similarly, Buyers should evaluate whether the Seller has

[10]The OIG's core elements of an effective compliance program include the following: (i) implementing written policies, procedures, and standards of conduct; (ii) designating a compliance officer and compliance committee; (iii) conducting effective training and education; (iv) developing effective lines of communication; (v) enforcing standards through well-publicized disciplinary guidelines; (vi) conducting internal monitoring and auditing; and (vii) responding promptly to detected offenses and developing corrective action.

established policies and procedures requiring employees, independent contractors, and vendors to be screened against state and federal exclusion screening lists because failure to do so may result in the submission of a claim for services furnished by an excluded individual, resulting in civil and administrative penalties such as recoupment of paid funds. As part of the diligence process, Buyers should evaluate a Seller's exclusion screening practices and review logs of screening results. Further, it is common for a Buyer to perform a one-time screening of Seller employees to confirm that there are no excluded employees at the time of the transaction.[11]

3. Licenses and Permits

As noted elsewhere in this article, physician practices are typically required to maintain a number of licenses and permits allowing them to operate. Buyer will want to ensure these licenses and permits exist and have not lapsed. Buyer will also want to ensure that Seller has established procedures for the maintenance of and adherence to these required licenses and permits. As discussed earlier, Buyer should identify entity-level licenses during the structuring phase to address any change-of-ownership considerations.

4. Fraud and Abuse

Other critical consideration for Buyers conducting healthcare diligence are the two important federal fraud and abuse laws, the Anti-Kickback Statute ("AKS") and the Stark Law. Unless an exception applies, the Stark Law prohibits a physician from making a referral of "designated health services" payable by Medicare to an entity if the physician (or an immediate family member) has a financial relationship (including both ownership and compensation arrangements) with the entity. Designated health services include, among other things, radiology, and other imaging services; outpatient prescription drugs; durable medical equipment and supplies; and clinical laboratory services. The Stark Law is a strict li-

[11]Exclusion screening should include screening employees, contractors, and vendors through the List of Excluded Individuals and Entities, the U.S. General Services Administration's System for Award Management, and state exclusion databases.

ability statute, meaning that any non-compliance or breach applies regardless of the intent of the parties and whether they knew they were out of compliance. On the other hand, the federal AKS prohibits the knowing and willful solicitation, receipt, offer, or payment of any remuneration (i.e., anything of value) in return for referring an individual or recommending or arranging for the purchase, lease, or ordering of any item or service that may be wholly or partially paid for by a federal healthcare program. Violations of the AKS may be punishable as a felony with imprisonment, fines, penalties, and/or federal healthcare program exclusion.

As part of the diligence process, it is essential that a Buyer confirm whether the Stark Law is implicated for the Seller. To the extent that it is implicated, based on the strict liability nature of the Stark Law, the Buyer must confirm that the Seller's business is compliant. Importantly, it is crucial that compliance be confirmed with respect to compensation and ownership relationships. Notably, most physician practices rely on the "in-office ancillary services" exception to the Stark Law. If the conditions of this exception are satisfied, it protects both ownership and compensation relationships. Smaller physician practices may not be aware of the Stark Law. Further, because the Stark Law is complicated, while physician practices may attempt to be Stark Law—compliant, often the attempt is insufficient. The discovery of a Stark Law issue is not per se a red flag for healthcare diligence purposes. In such event, the parties can avail themselves of the CMS Self-Referral Disclosure Protocol to address historical non-compliance and make an operational adjustment as necessary post-close.

The Buyer's diligence should include evaluation of arrangements with referral sources from an AKS perspective. This diligence may include review of written agreements and questions related to the facts and circumstances surrounding the arrangements. AKS diligence should also include review of marketing activities, co-insurance waivers, and the provision of free items or services to patients.

5. Billing and Coding Compliance

The Buyer should evaluate the Seller's billing and coding practices and related policies and procedures to determine whether there is a risk of recoupment or civil and adminis-

trative penalties that may be imposed as a result of inappropriate billing and coding. As noted earlier, it is recommended that the Buyer engage a third-party consultant to conduct a medical record and coding review as part of diligence. This review is often conducted by a clinician (but it can be conducted by other qualified professionals), and it evaluates coding and medical documentation accuracy.

6. HIPAA Compliance

The Buyer's diligence should include an evaluation of the Seller's compliance with the Health Insurance Portability and Accountability Act of 1996, and Subtitle D of the Health Information Technology for Economic and Clinical Health Act, as implemented through regulations promulgated thereunder by the Office for Civil Rights, including the Omnibus Final Rule, the Privacy Rule, and the Security Rule (collectively, "HIPAA"); HIPAA compliance program, including its use of its notice of privacy practices and policies and procedures; and its provision of HIPAA compliance training. Diligence may include a review of written agreements, such as business associate agreements and, to the extent available, employee confidentiality agreements. Privacy diligence should also include review of potential and reported breaches and security incidents.

Unlike some other areas of diligence that may not be implicated for a physician practice, HIPAA is typically implicated for physician practices. Small physician practices often have under-developed HIPAA compliance programs. Typically, small physician practices provide HIPAA training, maintain a HIPAA notice of privacy practices, and execute business associate agreements with the appropriate vendors. However, such practices may only partially comply or fail to comply with other HIPAA requirements. For example, small physician groups may maintain few or no policies on HIPAA privacy and security. Further, small physician groups may not have identified a HIPAA privacy or security officer, or, if they have identified such an officer, may not have formally made the designation in writing. Small physician practice groups may not track potential HIPAA violations or data breaches, or, if they experience such an incident, they may not have detailed documentation regarding the incident, the response, or any required notifications. Small physician

groups may also confuse unsuccessful hacking attempts with bona fide data breaches and security incidents.

C. Transaction Documents

i. Purchase Agreement

Once the transaction structure has been determined, including whether any rollover equity will be involved, and the due diligence process is thoroughly underway, the parties will then move into preparing the definitive transaction documentation. The most critical of these documents is the purchase and sale agreement, which can take the form of an asset purchase agreement, stock purchase agreement, or merger agreement, depending on the agreed-upon transaction structure. For purposes of this section, all such agreements will be referred to as the "Purchase Agreement." There are several critical provisions in the Purchase Agreement that the parties will negotiate, including the form and timing of consideration paid, purchase price adjustments, representations and warranties, covenants, closing conditions, and indemnification provisions.

1. Purchase Consideration

Above all else, a Seller's primary objective in a sale transaction is to achieve a realization or monetization event, where they are justly paid for the sale of their practice. As a result, all Purchase Agreements detail the form, timing, and breakdown of how the ultimate consideration is calculated. While the most important figure is the overall "enterprise value" being paid for the business, it is critical for Sellers to understand all of the details surrounding the amounts to be paid. Typically, the enterprise will have various adjustments (discussed in the section that follows). It may likely be subject to holdbacks or escrow related to indemnification or the post-closing adjustment. And in addition to the split of cash versus equity rollover consideration that Buyers and Sellers will focus on, so too must they focus on whether the purchase price is being paid entirely at closing, or if any will be deferred for some period. And if deferred, will there be any milestones or contingencies upon which that piece of the consideration may or may not be paid? These milestones are often referred to as "earnouts." They could, for example,

state that Sellers will be entitled to an additional 10% of the purchase price in the event that EBITDA for the business exceeds some floor amount in the year following closing. These earnout structures are extremely common in PE-backed acquisitions; however, in the physician practice arena they are a lot less common. This is because fraud and abuse laws, such as the AKS discussed earlier in this article, may be implicated. Notably, there may be fraud and abuse risk (including AKS risk) when a selling physician is in the position to increase revenue through referrals to the physician practice and an earnout is based on achievement of revenue milestones.

2. Purchase Price Adjustments

In most private M&A transactions, the acquisition will be made on a "cash-free/debt-free" basis and the purchase price will be based, in part, on the assumption that the target company has maintained a normal amount of working capital consistent with its past practices. Given this, the Purchase Agreement will often include provisions that provide for the adjustment of the purchase price based on (i) the working capital of the target company as of the closing date as compared to some target working capital amount to be agreed upon by the parties, (ii) the amount of debt held by the target company on the closing date, and (iii) the amount of cash held by the target company as of the closing date. These adjustments will be made based on estimates on the closing date, and then they will typically be "trued up" 90 or so days following closing once the books and records of the Seller are able to be more accurately digested by the Buyer.

3. Representations and Warranties

The Purchase Agreement will often include detailed representations and warranties regarding the target company, among others. These serve as definitive statements made by the Seller or the target company as to the ins and outs of the company. These representations and warranties are often heavily negotiated, because the scope of the representations and warranties determines the allocation of risk among the parties and is often the basis for post-closing indemnification rights and obligations. The representations

and warranties regarding the target company will cover a broad array of topics, including general corporate matters (such as organization, authority, capitalization, third-party approvals, etc.), business matters (such as financial statements, litigation, real estate, title to assets, employment matters, tax matters, etc.), and industry-specific matters. In healthcare M&A transactions, there will be a number of industry-specific representations that the Buyer will expect to be included in the Purchase Agreement, including representations relating to (i) healthcare regulatory compliance, including fraud and abuse laws and HIPAA compliance; (ii) Medicare, Medicaid, and other governmental reimbursement programs; (iii) healthcare compliance programs; (iv) payors and suppliers; (v) referrals and referral policies; and (vi) licensed personnel and medical staff–related matters.

In crafting and negotiating the representations and warranties, the Buyer will be focused on ensuring that the representations are broad and very detailed, covering a wide range of matters and with a significant lookback period of the business. This helps the Buyer understand the business being acquired, but it also forces the Seller to assume risk for any inaccuracies in the representations being made. Because of this, Sellers will be focused on narrowly tailoring the representations and warranties, and limiting their scope by including knowledge and materiality qualifiers and limited lookback periods. The Sellers will also be focused on reviewing the representations and warranties for any disclosure burdens, as the Seller will need to prepare disclosure schedules that include the various disclosures required by the representations (e.g., attaching financial statements or lists of material contracts) and any exceptions or qualifications to the representations (e.g., if there is a representation that states that the target entity is not subject to any ongoing litigation, but the target entity is a party to an employment-discrimination matter, then the Seller would disclose that matter on the disclosure schedules).

The negotiation of these provisions can often be extremely detailed and time-consuming; however, in transactions where the parties avail themselves of R&W Insurance, which is discussed in more detail elsewhere in this article, this negotiation can sometimes be mitigated. If the Sellers will have little or no exposure to indemnification liabilities post-

closing (other than for fraud) because the Buyer has taken out an R&W Insurance policy that will cover breaches of representations and warranties, the Sellers will often be much more willing to give detailed representations.

4. Covenants

The Purchase Agreement will also include a number of covenants of the parties. If the transaction has a bifurcated sign and close (meaning the agreement is signed as binding on a certain date, but the sale is not completed nor the money transferred until a later date), then the covenant provisions will include both pre-closing and post-closing covenants. The pre-closing covenants serve to govern how the parties can operate in the period between signing and closing. Some will require certain action or inaction of the target company to ensure that the business is operated in the ordinary course. Others relate to cooperation of the parties in the event that the Buyer is obtaining third-party debt to finance the deal, and the Buyer needs the Seller's help locking in the financing. There will also often be a "No Shop" covenant in transactions with a bifurcated sign and close. This covenant broadly prohibits the Seller and the target company from soliciting, negotiating, or consummating any alternative divestiture or business combination transaction with any other potential Buyers.

In terms of post-closing covenants, the most consequential ones are post-closing restrictive covenants. In these, Buyers will require that Sellers receiving adequate consideration agree to a non-competition and non-solicitation provisions, for up to five years or longer, to ensure that Sellers do not go and create a rival business of the one they just sold. In the physician practice context, states often have strict rules about how broad these covenants can be, as they typically require that they be reasonable in scope and duration. Preventing a physician Seller from opening up a competing practice down the street from the acquired business is fairly reasonable, but requiring the physician Seller to only practice medicine for the Buyer, and nowhere else in the country, is not reasonable. Buyers will view the restrictive covenants as a critical aspect of the transaction and necessary to ensure the value of the business they are acquiring for some period post-closing. The Seller should ensure that

the restrictive covenants are structured to be reasonable, such that the restricted geography and scope of the covenants does not cause an undue burden upon their livelihood, and that they include any specific exclusions that are necessary for any ongoing business operations they conduct that are not being acquired in the transaction.

5. Indemnification and Escrows

The indemnification provisions are a critical component of most Purchase Agreements in private M&A transactions. These provisions are often highly negotiated and can be the primary focus of negotiation during preparation of the Purchase Agreement. In the last few years, with a very competitive market that is "Seller friendly," Sellers have had increased leverage to demand "no survival" transactions. In a "no survival" structure, the Seller's representations and warranties, including the representations and warranties regarding the target company, do not survive the closing. As such, the Seller has no post-closing indemnification obligations related to breaches of representations and warranties. The sale can be viewed as buying something "as is." To help the Buyer bridge the gap with some protection, in "no survival" transactions the Buyer will typically obtain R&W Insurance to protect them against any such breaches. This structure allows the parties to accelerate the transaction negotiation, as none of the typically heavily negotiated indemnification provisions need to be included in the Purchase Agreement. The Sellers get to simply walk away with their proceeds.

On the other hand, in transactions with a more typical indemnification structure, the survival period for the indemnification obligations, the scope of the indemnification, any limitations on indemnification obligations, and related escrow or holdback provisions are critical deal terms. In these transactions, indemnification provisions typically cover breaches of representations and warranties, breaches of covenants, pre-closing tax matters, and any special indemnifications arising from diligence. For the survival periods, the Buyer will typically push for the longest survival period that is reasonable to ensure extended coverage for any potential issues or claims that could arise post-closing, while the Seller will look to limit the survival period to the shortest possible

time to limit its potential exposure for indemnification obligations. Often, the survival of the representations and warranties (other than certain fundamental and healthcare representations) will range from 12 to 24 months post-closing, with most transactions falling within the 12- to 18-month range. Fundamental representations (such as organization, authority, capitalization, and title to assets) will frequently survive for an extended period, such as five to 10 years post-closing or for the applicable statute of limitations period plus 60 or 90 days.

In M&A transactions with a typical indemnification structure, the Seller will be particularly concerned with the contractual limitations on liability, including ensuring that there are appropriate caps and deductibles. For the cap, the Seller will often push for both a cap, or top limit, on breaches of representations and warranties, as well as an overall cap on all indemnification obligations. The amount of the cap on liability for breaches of representations and warranties will vary depending on the transaction size, whether R&W Insurance is involved, and any red flags identified in diligence. Without R&W Insurance, a cap around 10% of purchase price (ranging from 5% to 20%) is the market standard for breaches of general representations and warranties, whereas a greater cap exists for special (including healthcare) and fundamental representations (up to the full amount of the purchase price at times). In addition to negotiating the amount of the applicable cap(s), the Buyer will also often be concerned with ensuring that there are certain standard exclusions from the cap(s), including for breaches of fundamental representations and for any fraud claims. The Seller may wish to clearly define fraud and to negotiate for a limited definition of "fundamental representations," but otherwise the Seller generally agrees to those exclusions from the cap. For the deductible, the Seller will frequently ask for a true deductible, meaning that the Seller will not be liable for any indemnification claims until the losses exceed the deductible amount and then only for those amounts that exceed such deductible amount. This provision is intended to reduce the Seller's exposure for immaterial claims.

As discussed in more detail elsewhere in this article, the Purchase Agreement will also often include provisions for an escrow or adjustment holdback to provide the Buyer with some readily accessible cash in the event that there are post-

closing indemnification claims. The structure (i.e., escrow vs. holdback), amount, and term of these provisions are all highly negotiated, and, as with the entire indemnification scheme, will ultimately depend on the specifics of a particular transaction and the negotiating leverage of the parties involved.

ii. Healthcare Documents

Physician practice acquisitions in CPOM states will also require the negotiations of a MSA and related documents, also known as the practice management documents. As discussed earlier in this article, the MSA allows the non-physician investor to receive compensation for the administrative services provided to the physician practice, while the physician practice itself remains owned by one or more physicians to comply with state law. The MSA is between the physician practice and an MSO owned by the financial sponsor. Under this agreement, the MSO provides management and administrative services (billing and collections, non-provider personnel, office space, equipment, supplies, IT, accounting, etc.) to the physician practice. One of the key regulatory considerations of the MSA is the amount of the fee. This fee should be carefully structured so that it does not create an issue under CPOM or fee splitting or from a fraud and abuse perspective. State fee-splitting laws may prohibit fees that are a percentage of revenue. Further, to the extent that the MSO provides marketing services, then the parties may consider a flat fee in light of fraud and abuse concerns.

To the extent not prohibited by state law, the owner of the physician practice will enter into a directed equity transfer agreement, along with the MSO and the physician practice. This agreement prohibits the physician owner of the practice from transferring the equity of the practice without the prior written consent of the MSO. The agreement also specifies a number of events that would require the physician owner to transfer the equity of the practice to another physician that is designated by the MSO. These share transfer events include death, disability, revocation/suspension/lapse of a physician's license to practice medicine, breach or termination of the MSO, breach or termination of the physician's employment agreement, among other transfer events. Fur-

ther, this agreement permits the MSO to replace the "friendly" physician without cause at the election of the MSO.

Several agreements accompany the MSA, including an employee lease, lockbox agreement, power of attorney, and security agreement. The employee lease agreement defines how the MSO will recruit and employ certain personnel (including administrative staff and certain clinical staff, such as nurses and medical assistants) to support the physician practice as leased employees. The lockbox agreement establishes how the physician practice will set up a lockbox account for receipt of payment from public payors and how the funds will be distributed to an account managed by the MSO. The power of attorney agreement sets forth that the MSO may act to effectuate the MSA, including taking legal action on behalf of the physician practice and payor agreements, business agreements, and leases. The security agreement requires the physician practice to grant a security interest to the MSO in the physician practice's personal and real property to secure the performance of the physician practice under the MSA.

iii. Ancillary Agreements

In addition to the Purchase Agreement, employment agreement, and rollover documents, Buyer and Seller will typically enter into several additional agreements in connection with the transaction. In the legal world, we often refer to these documents as "Ancillaries" because these agreements provide the documentational support and framework to consummate the entirety of the transaction as supporting instruments to the primary transaction documents such as those mentioned earlier in this article. While these documents are typically not the focal point of the transaction, each and every Ancillary serves an important purpose and is typically required to complete the transaction.

1. Lease Agreement

In many typical M&A transactions outside of the physician practice space, lease agreements are not particularly concerning—the target company is party to a third-party lease, and that lease continues (sometimes with the required consent of the third-party landlord) following closing. What

makes leases often more significant in the physician practice space is that it is common for the physician Sellers (or their family members) to also own the real estate where the practice operates. And though not true all of the time, most often a PE Buyer will not want to acquire the real estate along with the practice. The result of this process is that, as part of the closing of the transaction, the Buyer (on behalf of the practice, as the new lessee) will have to negotiate an arm's-length third-party lease with the Sellers or their affiliates and the lessor, or landlord.

Why is this sometimes so important, and something that can become a gating factor to getting to closing? Because not only do the legal terms of the lease need to be negotiated (term, termination, responsibility of maintenance, repairs and upgrades, payment of taxes, alterations/improvements to the space, signage, payment of utilities, insurance requirements, and termination/default rights), but also even more critically the monthly rent amount, which could be meaningful in size, has to be agreed upon. This gets to real dollars and cents beyond the purchase price that was in all likelihood agreed upon at the LOI stage.

2. Escrow Agreement

Another important, but slightly less negotiated Ancillary, is an Escrow Agreement. In many M&A transactions, the Buyer will request that a portion of the purchase price be held back by the Buyer at the closing or placed into a third-party escrow account at closing to satisfy any indemnification obligations of the Sellers, post-closing purchase price adjustments, or other post-losing payments by the Sellers. While Buyers would prefer to simply hold back a portion of the funds themselves in what is called a "holdback," Sellers will often insist (and Buyers will often agree) that the funds instead be placed in a third-party escrow account to ensure that the money is secure and does not provide the Buyer with an advantage in the event of a dispute. Establishing an escrow is often particularly important from a Buyer's perspective in physician practice acquisitions as the physician Sellers often, if not always, remain on as practicing physicians with the business post-closing. Since the Buyer will have a critical employment relationship with the Sellers post-closing, the Buyer will want an avenue to get paid for

any post-closing Seller obligations without having a dispute process with the Sellers. Whenever an M&A transaction involves a third-party escrow, the parties will need to execute an Escrow Agreement at the closing of the transaction, which will evidence the relationship between the Buyer, the Seller, and the escrow agent, including how long the escrow will last, how funds can be released from the escrow, whether any interest will accrue, the escrow agent's fiduciary obligations, and other provisions. Escrow agents typically have their own form of Escrow Agreement that the parties will modify for the specific needs of the particular transaction.

3. Funds Flow

While not a legal document per se, both parties should be particularly focused on ensuring that there is a detailed and clear funds flow file ready for the closing of any transaction. The funds flow will detail the calculation of the final closing payment to be made to the Sellers, as well as all other payments (e.g., debt payoffs, transaction expense payments) being made on the closing date. It is the document that ensures all of the money spent and paid through the transaction gets to the correct recipients.

D. R&W Insurance Coverage

While the use of R&W Insurance in M&A transactions has been fairly widespread for some time, there has been significant growth in the use of R&W Insurance in healthcare M&A transactions (including physician practice acquisitions) in particular in recent years. R&W Insurance, typically paid for and obtained by the Buyer, is an insurance policy that provides coverage for losses resulting from breaches of representations and warranties in a Purchase Agreement (and at times also covers losses related to pre-closing taxes).

R&W Insurance can be attractive to both Buyers and Sellers in M&A transactions for many reasons. First, obtaining R&W Insurance can help reduce or eliminate post-closing indemnification obligations for Sellers—specifically, post-closing liability with respect to breaches of representations and warranties and certain pre-closing taxes. Having coverage under the R&W Insurance policy may also mean that the Buyer is willing to lower the amount of escrows or eliminate them altogether, resulting in an acceleration of Sellers'

receipt of their entire purchase price proceeds. While these are particular benefits to the Sellers, lowering these risks for the Sellers often means that the overall negotiation of the Purchase Agreement can be expedited, increasing the likelihood of getting to closing.

Another important benefit of R&W Insurance coverage for Buyers is that this coverage can protect against recoverability or collectability concerns. This is especially important in physician practice acquisitions, which often involve a number of individual physician Sellers. This is important from a general recoverability perspective (as there is always some collection concerns when individual Sellers are involved), but even more importantly from a post-closing relationship perspective. As noted earlier in this article, physician practice acquisitions often involve physician Sellers who remain key employees of the practice group following the transaction. In these instances, if the Buyer is able to seek recovery for breaches of representations and warranties under an R&W Insurance policy, then the Buyer's need to go back to the physician Sellers who are now employees can be eliminated or significantly limited. This is critical as post-closing indemnification disputes between the Buyer and the physician Sellers, who are now key employees of the practice group, can sour the ongoing business and working relationship.

If contemplating utilizing R&W Insurance for a particular transaction, there are several key considerations that the parties should ensure that they keep in mind. First, the parties should consider transaction size and whether the use of R&W Insurance will make sense or be an option for that size transaction. As the use of R&W Insurance has increased in M&A transactions generally, including in the healthcare industry, underwriters have expanded coverage to include mid-market and large transactions. However, the cost of underwriting and obtaining R&W Insurance coverage may not be an option or be the right path from a cost/benefit analysis perspective for smaller transactions. Second, the parties need to be aware of the additional timing considerations associated with obtaining R&W Insurance. Most underwriters provide that policies can be bound within 10 to 15 days. This timeframe can certainly be accelerated if needed, but building this timeframe into the overall transaction timeline is critical. Third, both Buyers and Sellers should be

prepared for the diligence process associated with obtaining R&W Insurance. Diligence must be thorough to ensure that the Buyer will receive full coverage and to avoid exclusions. In healthcare M&A transactions, underwriters will expect full healthcare regulatory diligence, including a billing and code audit, full documentation review and a management interview. Finally, the parties should understand that in addition to the diligence efforts, Buyer will have to negotiate a form of policy with the insurer as well.

E. Post-Closing Obligations

As discussed earlier in this article, healthcare transactions, with their significant set of licenses and permits, can often require a lot of work post-closing to ensure a smooth transition for the acquired business. This includes notice to the Medicare and Medicaid programs, payor notifications, consents and notices regarding ongoing licenses and permits, and more. There are also non-healthcare concerns, such as employee onboarding, employee benefit transition and management, corporate governance changes (boards of directors, officers, etc.), and other topics. Since the Buyer owns the business at this point, these post-closing considerations are largely the responsibility of the Buyer. However, since the Seller knows the business better than the Buyer, it is typically a collaborative process. It is also a lot easier for the parties to work well together once they are all on the same metaphorical team.

IV. Conclusion

Private equity interest in private physician practices is unlikely to wane in the near term, and, instead, it is anticipated that PE and similar financial sponsor investment in physician practices will continue to be a dominant trend in the market, only growing more extensive in the years to come. Healthcare professionals and physician Sellers, as well as first-time Buyers, should be prepared for the complex issues that arise in these transactions. Attorneys representing these parties need to help them navigate the challenges of physician practice acquisitions and understand the various considerations involved, including structuring, CPOM matters, Purchase Agreement issues, and other complexities such as R&W Insurance and post-closing obligations.