QUARTER 2 2019

FMVantage Point™

HealthCare Appraisers' Industry Insight

QUARTERLY INDUSTRY INSIGHTS

AT A GLANCE

PERSONAL EHR AND CARE MANAGEMENT

GROWTH IN VALUE-BASED CONTRACTS

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Monitoring Industry Activity from Quarter 2 of 2019

As part of our ongoing research into the healthcare industry, HealthCare Appraisers follows commentary of 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.

PERSONAL EHR AND CARE MANAGEMENT

Some of the largest payors are introducing personal electronic health records for their beneficiaries. Personal electronic health records give patients quick and easy access to their claims history and other health data, including within a mobile application. It is anticipated that these records will enhance patient engagement opportunities for providers and payors. In addition, payors are investing more in care management strategies, including the employment of providers and health coaches with an emphasis on behavioral health. HAI regularly works with clients focused on care management, including both technology/data analytics platforms as well as providers, and we have observed an uptick in transaction and investment interest within this space. Giving patients easy and quick access to their health data, along with several other patient engagement and care management strategies being implemented by payors and providers, should help facilitate the continued transition from a volume-based to a value-based healthcare system.

GAIL BOUDREAUX – CEO OF ANTHEM, INC.

"One of the areas where we see an opportunity to directly improve the health of the people we serve is with the launch of Anthem's electronic personal health record. Our electronic personal health record gives consumers access to their own electronic health record containing claims history, lab data and CMS's Blue Button data to a secure and easy-to-use mobile application. We believe easier access to this information for consumers and their families will empower them to be more engaged in healthcare decisions and support greater alignment and communication with care providers. The electronic personal health record will be available to our Commercial and Medicare members in the fourth quarter and will roll out to all members by early 2020."

DAVID WICHMANN – CEO OF UNITEDHEALTH GROUP

"The first 20 million real-time, interoperable individual health records are being scheduled for market deployment. We remain optimistic about the potential of

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

these deeply personalized health records and associated Next Best Action recommendations to improve the health of people we serve and the overall system performance."

DAVID CORDANI – CEO OF CIGNA CORPORATION

"We have more than 1,000 coaches and specialists helping individuals set goals and improve their behavioral and mental health conditions. We have 600 nurses who visit our customers' homes every day. And we have more than 650 aligned Collaborative Accountable Care relationships who are now rapidly expanding services to include behavioral health programs. And we have game-changing connective data, thanks to the combination of Cigna and Express Scripts."

GROWTH IN VALUE-BASED CONTRACTS

Although a complete transition from fee-for-service reimbursement to value-based payment arrangements has not yet occurred, some of the largest payors are reporting strong growth in the value-based components of their books of business. In particular, UnitedHealth Group indicated that value-based payments are growing at more than 15 percent thus far in 2019 and are expected to accelerate in the coming years, while Anthem indicated that 85 percent of its membership growth was from risk-based membership. More broadly, the shift to value appears to be accelerating in certain states including North Carolina[2] and Oregon[3]. It is important to note that the at-risk amount observed by HAI varies significantly, from single digit percentages up to 100 percent fully capitated. In addition, we have frequently observed that value-based arrangements are not always renewed following the initial contract term due to one or more parties not meeting their objectives. While the momentum is certainly in the direction of value, there is a "two steps forward, one step back" element to the growth that is occurring.

DAVID WICHMANN – CEO OF UNITEDHEALTH GROUP

"Consumer engagement aligned to this actionable health information plays a critical role in developing the next generation health system. By the end of this year, Rally's[4] digital engagement capacities will be available to nearly 20% of the U.S. population, solidifying its opportunity to advance individual health at scale. Physician data sharing and value-based incentives round out a true end-to-end alignment of a progressive health system. Value-based payments to care providers are growing at more than 15% in 2019, aligning incentives to practice high-quality care while improving the effective use of health system resources. We expect these value-based payments to ramp at an even more accelerated pace in the coming years."

ANDREW WITTY – CEO OF OPTUM

"Managing these chronic patients requires a multidisciplinary, hands-on approach that Optum is building in its next-generation condition management programs. These include the management of emerging high-cost specialty drugs, which are expected to continue to be a leading driver of medical cost inflation. We address these trends through a broad range of approaches, including direct delivery of home and office infusion services and direct delivery of specialty pharmacy prescriptions for the home with digital care services provided by Optum pharmacists to educate patients on how to properly take their medication."

GAIL BOUDREAUX – CEO OF ANTHEM, INC.

"Overall, risk-based membership represents more than 85% of our total growth…Through the second quarter, approximately 59% of medical spend is tied to value-based care, ahead of our full year target of 58%. In addition, 36% of value-based care is now tied to shared savings programs, which is also tracking ahead of our full year target."

[2] *https://www.nytimes.com/2019/08/26/business/north-carolina-health-care-outcomes.html?action=click&module=News&pgtype=Homepage.*

[3] *https://www.opb.org/news/article/oregon-medicaid-reform-contracts/*

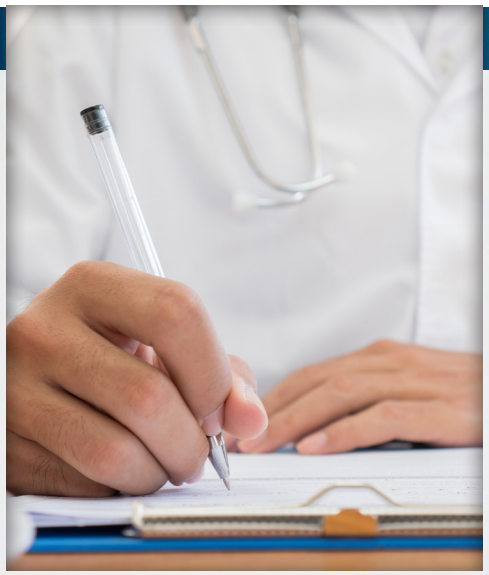
[4] *Rally is one of Optum's patient engagement platforms; https://www.rallyhealth.com/*

CMS PROPOSED RULE

There were a number of favorable developments for ASCs announced in the recent CMS proposed fee schedule for 2020. In particular, high volume specialties, including ophthalmology and gastroenterology, will receive rate increases in the coming year if the proposal is finalized. CMS also continues to evaluate moving higher acuity procedures, including total knee replacements and total hip replacements, to the outpatient setting. While physicians have already been performing total knee replacements and other complex orthopedic procedures at outpatient surgery centers, CMS does not currently reimburse for these procedures at ASCs. Enabling Medicare beneficiaries to get these types of procedures done at an ASC represents a significant growth opportunity in the coming years. In addition, CMS approved three new cardiac procedures for ASCs, and industry participants believe this represents another long-term growth opportunity for high acuity cases to shift to the outpatient setting. While ASCs are expected to receive rate increases, the largest operator of outpatient imaging centers indicated its overall government rate will be slightly negative in 2020 if the CMS proposal is finalized. Although it appears reimbursement will decline if the proposed rates are finalized, the decline will not be as steep as some past years have been when CMS cut radiology fees significantly. Providers also have the ability to offset some of the rate cuts with quality incentives earned under the MIPS program.

WAYNE SCOTT DEVEYDT – CEO OF SURGERY PARTNERS, INC.

"CMS introduced proposed calendar 2020 fee schedule updates for Medicare's hospital outpatient prospective payment system and ambulatory surgery centers. The proposed rates appear attractive with increases for musculoskeletal procedures at approximately 2%, ophthalmology at approximately 3% and gastrointestinal codes at approximately 1%. Based on our case mix, we estimate that we will benefit from at least a 2% increase if finalized, a solid increase we believe recognizes the quality and value that we provide in the marketplace. Importantly, CMS also proposed adding multiple high acuity procedures including total knee replacement procedures to the ASC covered procedure list. We remain confident that we can provide a high-quality result on these procedures in our facilities as we do them routinely for our commercial and other patients. As an example, in the second quarter of 2019, we conducted nearly 300 total joint procedures in our ASCs alone, which was more than double the amount we did in the second quarter of 2018. CMS also proposed moving total hip replacements from the inpatient-only list in our recent proposal, which is the same step they took for total knees for the 2018 payment year. Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries with more than 400,000 procedures in 2014, costing more than $7 billion for the hospitalizations alone. We look forward to seeing the development of the final fee schedule for 2020 and remain optimistic that our ability to access exciting new market [opportunities] remain just around the corner."



MARK STOLPER – CFO OF RADNET, INC.

"While there is a small negative impact from [CMS] pricing, our performance bonus under MIPS, which is a merit-based incentive payment system in 2020 based upon our measurement year of 2018, fully mitigates this impact. For those of you who are less familiar with MIPS, CMS is required by law to implement a quality payment incentive program, which rewards value and outcomes. Performance is measured in four areas, quality, improvement activities, promoting interoperability and cost. RadNet's performance under MIPS was excellent in 2018 and provides us a bonus for 2020 reimbursement, whereas a poor performance could have resulted in a negative reimbursement impact. We are obviously very pleased with the reimbursement outcome as reimbursement has at times been challenged in the past. Of course, the proposed rates for the physician fee schedule are subject to comment from lobbying and industry groups and there is no assurance the final rule to be released in the November 2019 timeframe will reflect these same proposed rates."

RADIOLOGY VALUATION MULTIPLES

Radiology continues to be a very popular specialty for private equity investors, and the influx of capital has driven valuation multiples higher. Specifically, one of the largest physician groups in the country indicated that it has observed valuation multiples for radiology practices in the double digit range, and has stopped making investments in these practices as a result. This trend is also consistent with the overall healthcare space, as recent data presented by BVResources indicates that the median EBITDA multiple of 6.4x in the healthcare and social assistance sector is more than double the 3.0x median EBITDA multiple across all sectors.[5]

ROGER MEDEL – CEO OF MEDNAX, INC.

"We also have taken a step back on radiology acquisitions, and that is related to valuation. We have seen that there are a number of private equity firms that have jumped into the radiology field and those [valuation] multiples are higher than double-digit [valuation] multiples. And so that's not a field that we're going to be joining in -- for the foreseeable future at those kinds of [valuation] multiples."

SHIFTS WITHIN THE DIALYSIS MARKET

One of the largest dialysis providers in the United States indicated it has significantly curtailed investment in California based on recent ballot initiatives to cap reimbursement from private insurance companies, and general uncertainty surrounding future disruption to dialysis reimbursement rates. Reimbursement rates in 2020 and beyond will also be impacted by the Trump Administration's executive order on kidney health.[6] While many of the implementation details are still to be determined, the administration will pilot five new kidney programs, one of which is mandatory for providers to participate in. The mandatory model includes a rate increase for home dialysis in year one, as well as an increase in the amount of reimbursement tied to performance. The large operators estimate that the overall impact of the mandatory model will have a negative impact on Medicare reimbursement rates in 2020, if finalized. These operators were also non-committal regarding participation in the voluntary models given the lack of details and negative past experiences with participation in government programs.

JAVIER RODRIGUEZ – CEO OF DAVITA, INC.

"We have only signed 2 new leases in California this year, which compares to a typical full year of closer to 25 to 30. This will have a negative growth consequence in the future, but will reduce capital deployment in the market where we feel it is not prudent to invest at this time, given the threats of disruption from unions."

ROBERT POWELL – CEO OF FRESENIUS MEDICAL CARE MANAGEMENT AG

"The question one might ask is whether we as FMC will participate in these voluntary demonstrations in light of our recent experience with the ESCO program. Health and Human Services has taken steps in developing these models to address some of our concerns from the ESCOs. For instance, voluntary models will have upfront alignment and more transparency when it comes to benchmark setting. We remain cautious given the lack of claims transparency and the moving benchmark targets that have made it difficult for us to be as successful as planned in the ESCO program that is an overhang for us as we contemplate how we go forward in these future programs."

JAVIER RODRIGUEZ – CEO OF DAVITA, INC.

"First, [there] is a rate increase of 3% in year 1 for home dialysis. We expect this to result in approximately $5 million to $10 million revenue pickup for us in 2020, which will decline in subsequent years, as the rate increase goes away. The second component, which is probably the most important, is a potential for higher or lower revenues based on [a chain of clinics performance with respect to home and transplant metrics.] CMS expects this to have a negative impact on Medicare reimbursement to the dialysis industry. Given that the dialysis industry already loses money on Medicare reimbursement, we will have to work with CMMI to ensure sustainable long-term economics. However, if it remains as announced and if 50% of our clinics nationwide are part of the demonstration, we should expect to also have some negative impact on our Medicare reimbursement."

[5] *https://sub.bvresources.com/pdfs/DVIBrief.pdf*
[6] *https://www.whitehouse.gov/presidential-actions/executive-order-advancing-american-kidney-health/*

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