Post-Pandemic Crisis Affiliation: Which Way is Up?
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The COVID-19 pandemic has, in essence, turned the world upside-down. Healthcare in the United States and around the world will never be the same. At its core, this transformation applies to all aspects of clinical care, especially with the rapid adoption of telehealth as a viable alternative to a significant portion of in-office patient-physician visits and a greater focus on remote monitoring as an alternative to in-hospital observation. Likewise, we believe that the economic and transactional sides of the U.S. healthcare system will change as well, both in temporary and permanent ways.
As much is unknown about the direction patients will choose, there is uncertainty in healthcare providers’ appetite for further affiliation or consolidation, post-pandemic. Prior to COVID-19, the volume of affiliation transactions was robust, as were the varied structures used to memorialize the agreements. There was also a strengthening and expanding element among physician practices toward privatization or keeping a private structure. Private equity investments were also becoming more popular, especially for larger groups and certain specialties. Hospitals, physician groups, related consortiums (such as clinically integrated networks), and competitive service offerings (like ambulatory surgery centers), continued to collaborate. Numerous transactions were occurring in these areas.

First, hospital and physician clinic budgets and financial plans based on patient volumes for 2020 and 2021 are now outdated. Predictions for what will happen after the COVID-19 pandemic subsides is anyone’s guess. Will American consumers rush to have elective surgeries that were deferred during the pandemic crisis? Will they become more deliberate afterward, focusing on only the essential areas of care, for some time? Are the widespread lockdown and shelter-in-place requirements something that many consumers have accepted and will now be reticent to leave their homes unnecessarily? Or, more likely, will they leave only for more pleasurable experiences than going to the doctor, dentist, or hospital? All these dynamics are unfolding in different ways each day, and only time will tell the outcome.
So, it is safe to say that everyone, providers, investors, and, especially, the American consumer, have suffered significantly throughout the COVID-19 pandemic. As we begin to plow our way out of this crisis, we ask the question, “Which way is up?” By this, we consider what the strategies for affiliation among the players will be as we emerge from the pandemic and reestablish life under our “new normal.” This paper will carefully consider affiliation strategies and strategic planning.

The onset of the COVID-19 pandemic brought nearly all discussions and potential transactions to an immediate halt or delay. Venture capital firms, for example, were reticent to move ahead, not knowing how their historical investments would react to the pandemic crisis, especially considering the significant reduction in workforce and lost productivity, or what benefits new investments would yield. Many temporarily halted almost all new deals and have yet to return to deal-making.

Hospitals and physician groups will undoubtedly continue to consider transactional opportunities. However, with many employed or contracted physicians placed on furlough or asked to take a salary reduction, some are reticent to continue affiliating with hospitals. Those hospitals that ceased elective surgeries and other elective procedures to focus strictly on COVID-19 patients have experienced enormous financial drains on their cash reserves. Post pandemic, the immediate economic improvement in their bottom-lines is uncertain.
Overview of a pandemic crisis and the characteristics of U.S. healthcare
Without question, the COVID-19 pandemic crisis has changed the healthcare landscape and how we react to and respect healthcare providers. Physicians and hospitals have extended far beyond their typical borders of care for their patients and overall services, even to the point of risking their own physical and fiscal welfare. In many respects, this has changed the clinical delivery paradigm, and it has massively favored one form of delivery: telehealth (or telemedicine). Before the onset of COVID-19, telehealth was growing in the U.S., although in some circumstances limited to rural areas due to reimbursement constraints and where providers chose to locate. However, even before the pandemic, the technology had demonstrated the ability to deliver high-quality care, and the future was indeed bright. Then, practically overnight, the COVID-19 pandemic further solidified telehealth not just as a viable alternative, but as a preferred form of clinical care in response. Now, most providers of healthcare have or are looking to implement telehealth services.

Certain experts believe within the next three years, telehealth could comprise one-fourth to one-third of our entire U.S. healthcare delivery system.

Whether telehealth is a positive or a negative result of the COVID-19 pandemic, it appears to be a reality and will continue to grow and expand. The federal government played a major role in promoting telehealth by relaxing certain telehealth requirements and improving reimbursement allowances. Whether the government retains all of the more relaxed requirements or reinstates the former more stringent requirements that were in effect before the COVID-19 pandemic is debatable. We anticipate that the likelihood of retraction of all the restrictions is slim. However, the relaxed provisions in several circumstances will probably continue.
Physicians’ attitudes toward rendering care have also been affected—not just by telehealth, but the overall premise of how best to deliver care to patients. For example, surgeons and other proceduralists who had their elective work curtailed have gone through an unprecedented period of lost income. They are understandably concerned about the next pandemic or other crisis that could cause another significant reduction in their earnings. In comparison to other industries, physicians can be viewed as having a shorter career span. If earning capacity is constrained for a period of time during that career span, concern about future earning capacity may be heightened. Therefore, physicians’ attitudes toward affiliation and consolidation will acquire an even greater emphasis post-pandemic. We will consider their options in detail, below.
Hospitals have also experienced significant financial drains because of the COVID-19 pandemic. Many rural hospitals are “hanging by a thread.” **Will these facilities survive, and if they do, what will be their attitudes toward provider employment?**

With limited resources and more challenges ahead post-COVID-19 pandemic, we must navigate carefully through these options for hospitals while being fiscally prudent.
Independent or clustered investors, such as private equity and venture capital, must likewise revisit their strategies for investing in healthcare. In comparison to other industries, healthcare is still a solid prospect. And while the COVID-19 pandemic will change the paradigm of care, care providers will be essential. Given the fiscal limitations of both hospitals and physicians, independent investor groups, e.g., private equity, could comprise a much higher percentage of the total affiliation model participant.

Finally, patients and the general population in the U.S. must adjust to these changes. They must realize that healthcare providers, while human, have a career to consider. Providers must build their own business and professional structures to respond to the country’s overall healthcare delivery system and the related fiscal requirements. Consumers, therefore, will have to become accustomed to increased consolidation in one form or another. In the remaining sections, we delve deeper into alignment and related affiliation perspectives based on the COVID-19 pandemic and its effects. While no one has all the answers, we are all engaged in this transition together.
Physician-hospital alignment
Will there be a post-pandemic rush of physicians affiliating and aligning with hospitals? While the answer is uncertain, physicians across various specialties will undoubtedly have an interest in alignment. The impetus exists for working together and creating greater affiliation structures. Whether employment, professional services agreements (PSAs), clinically integrated network (CIN) affiliation, or other less integrated forms of “full” alignment, the post-pandemic interest in such models will occur.
Will hospitals be equipped to complete such deals? While most transactions may entail relatively little up-front money and capital, the attention of hospital leadership teams may be diverted post-COVID-19 pandemic as they focus on servicing patients on a “normal” basis. Meaning, structuring elective surgeries and other typical areas of care will be a priority and will require capital that might have otherwise been dedicated to alignment transactions.

Physicians will be seeking further assistance. Many physicians will decide that they cannot remain independent and must have a partner. That partner will more than likely be hospitals and health systems as they seek protection, not only for COVID-19 recovery but from future crises.
Hospital-based specialties, e.g., hospitalists and inpatient physicians, radiologists, anesthesiologists, pathologists, and emergency medicine physicians, will still be in demand post-crisis. Before the crisis, many of their arrangements were PSAs and subject to extra support payments. These arrangements, or the level of financial support within them, may become more limited due to the financial stress on hospitals, post-COVID-19 pandemic. In the alternative, these arrangements may be converted to employment structures that have more fixed compensation (and thus, less variability in their payments and are easier to budget).

Assuming a groundswell of interest among physicians for hospital affiliation, how will these transactions be formulated? As stated, these transactions may now involve relatively little upfront money. One notable exception is a “private equity-like” structure where earnings are created through a physician compensation reduction and then value placed up front. These deals will continue to involve relatively little, if any, dollars associated with the purchase. Compensation, which has sometimes been a source of improvement when physicians become employed or contracted by hospitals, may not be as robust under the post-COVID-19 pandemic transaction structures. As hospitals can afford less as a result of the 2020 COVID-19 pandemic, compensation may be lower, or greater portions of compensation will be held at risk based on performance. Finally, future benchmark metrics may reflect lower compensation; specifically, surveys published in 2020 (based on 2019 data), may reflect lower than usual production and compensation standards. Compensation models tied to these benchmarks would be impacted. These dynamics could contribute to fewer alignment transactions.
Hospitals will continue to have demand for physicians, and perhaps in some ways, more than ever. But the transactions may look different due to the economic issues, in addition to the ever-growing presence of telemedicine. Telehealth services will be a major part of alignment and affiliation transactions, clinical delivery structures and overall economic outcomes. While telehealth services are being recognized with improved reimbursement by both commercial payers and the federal government, there are still unanswered questions about how this productivity will be converted to physician compensation.

Thus, the following key characteristics will emerge post-pandemic:

**Physicians will have an enhanced level of interest in affiliation and alignment.**

The interest from hospitals will be more selective, and potentially the compensation they offer to physicians may be less lucrative (in economic terms). In the alternative, contract structures may change putting a greater portion of compensation to the provider at risk such as being based on production and clinical outcomes.

Hospitals will be able to select from those physician groups they believe are most strategically, tactically, and clinically proficient. This factor will depend on the overall supply within their service area.

While the interest in alignment transactions will increase, transactions may not happen quickly, given the priorities of hospitals and health systems, as well as private practicing physicians to return to their normal progression and volume of services.

Telehealth will be an increasing factor of transactions going forward. This will include its ability to impact quality of care and value-based reimbursement.
Physician-to-physician affiliation
Another important question is, “Will there be more group mergers after the pandemic wanes?” The answer is likely “yes,” especially if hospitals are slow to respond to physician groups that still need a level of affiliation and collaboration with other providers. Group mergers of single specialties are usually easier to form. Multispecialty group mergers are more challenging and cumbersome, involving issues such as an appropriate income distribution plan (IDP). They often require an extended period to complete. Therefore, the first wave of mergers will most likely be tied to single-specialty group mergers. These affiliations could be under the banner of a clinically integrated organization (CIO) or some other loosely formed alliance, even if it is a single provider number merged entity.

All the challenges that exist for merging groups will continue when the pandemic crisis subsides. Further, the problems may be more significant, given the economic hurdles. Increased capital is typically not a derivative of a group merger other than some cost economies of scale. Usually, increased cash flow is realized down the road as opposed to nearer-term, soon after the merger. The other reasons why groups merge, such as the ability to project “strength in numbers” in payer contracting, vendor contracting, information technology (IT) contracting, hospital relations, etc., all will be in play. However, whether these factors will be sufficiently compelling for physicians to pursue merging, is unknown.
As a result, physician-to-physician affiliation post-pandemic may assume the following characteristics:

| **Multispecialty group mergers, while always a difficult challenge, will not predominate in the marketplace in the immediate term.** |
| **Single-specialty mergers may create interest as an alternative, especially if hospital integration is not probable.** |
| **The reasons for merging will continue to exist post-pandemic, but because of financial and other more pressing needs, mergers among groups—single-specialty or otherwise—will be limited.** |
| **Mergers, though the interest may be limited, may be “legal only” structures with limited and-or deferred operational combinations.** |
| **Many physician groups will seek a private equity investor instead of or in addition to group mergers.** |
Physician-investor affiliation
Primarily, this option pertains to private equity (PE) firms investing in physician practices. Post-COVID-19 pandemic, the initial emphasis among the private equity firms will be to address the economic challenges (reductions in profits) that resulted from the 2020 pandemic volume reductions. Most PE firms will be addressing what they already own and may not be quick to consider new deals. However, the turnaround time and movement of PE firms to consider new transactions will not be extensive. Two major reasons support this premise. First, the PE firms that invest in other companies in other industries may prefer gravitating to healthcare. The volumes and growth in healthcare services will be better than most other industries. Second, most PE firms still have significant capital to invest and may have even more when the pandemic subsides. PE investors will be looking for safe places for investing.

Once again, medical practices and other healthcare consortiums would appear to be a strong alternative.

Assuming PE firms will have a heightened interest, albeit a slight delay of as much as six months, post-pandemic, to adjust to the effects of the pandemic crisis on their existing investments, how will these deals be structured? Typically, a PE firm will focus on earnings before income taxes, depreciation, and amortization (EBITDA) and, ultimately, negotiate a multiple tied to market dynamics and other variables, including aggregation of practices within a geographical area, to derive the up-front value. This multiple of EBITDA may be adjusted dramatically because of the COVID-19 pandemic (i.e., lower profits on existing investments) and a new metric referred to as EBITDAC. The “C” in this metric is, in fact, “COVID-19.” For instance, many PE firms will look for ways to reduce the earnings upon which they base the up-front value due to the COVID-19 pandemic and its effect on the bottom-line.
Whether this matter is a legitimate consideration will be debatable and seriously negotiable. However, with less interest and/or financial ability for hospitals and physician alignment, as well as fewer group mergers, the PE firms may have negotiating prowess to lower multiples and earnings upon which those multiples are based. Hence, lower valuations may result. The stronger groups and healthcare provider consortiums will demand higher multiples, but there may be a period, post-COVID-19 pandemic where values will be lower. This may cause a reduced number of transactions. But as physicians are looking for partners to mitigate risks of future uncertainty, they may accept lower valuations and, therefore, lower sales prices. Additionally, private equity may require groups to retain a higher ownership percentage, although still a minority interest, looking for a better valuation for all investors, including the physicians, within the “second bite of the apple” (i.e., the subsequent sale).
Private equity will be a narrower option for groups. Only those that can internally sell the private equity concepts to their partners will pursue private equity deals.

Thus, from a physician-to-PE-investor standpoint, the following key areas appear in our post-COVID-19 forecast:

- Private equity deals may be deferred for a short period as PE firms address the issues of existing investments.
- Private equity firms will be in the healthcare market in a substantial way—perhaps more than any other industry.
- Because they will have abundant options from which to choose, PE firms will be more selective and only align with top performing groups and consortiums.
- Physician groups and related healthcare entity sellers to private equity may have to retain greater equity (albeit a larger minority interest) and be willing to accept lower multiples on EBITDAC.
- In general, private equity organizations will be aggressive, selective, and still subscribe to significant ROI, placing more stress on the physicians to perform.
- Physician groups will be challenged to convince their partners to pursue a PE transaction. Compensation reductions that result from PE deals will not be well-received, given the significant loss of income in 2020.
Valuation and compensation ramifications
Valuation and compensation ramifications are woven into the fabric of this paper, though not in detail. Briefly, the key areas of consideration will be historical and future projected profits (i.e., EBITDAC) upon which valuations will be based, and the post-transaction compensation parameters. These include the pay reduction to create up-front earnings to mitigate COVID-19 pandemic losses. The up-front earnings opportunities work both ways as physicians are looking for opportunities to improve or restore their compensation, post-pandemic. At the same time, PE firms, hospitals, and other buyers of practices want to minimize their losses from employing physicians, given the economic stresses created by the pandemic.
Valuation approaches for going concerns will continue to focus on the market and income methodologies. However, the basis will reflect lower historical earnings, and potentially more conservative future projections. Valuation firms must be savvy, on top of the latest trends in assigning multiples, and adept at assessing financial as well as operational risk. On matters involving physician compensation, valuation firms may not factor, as least not to the same degree as they have historically, industry benchmark survey data that has not had time to reflect COVID-19 pandemic effects on compensation and productivity. The past trends and precedents may (at least initially) require adjustment until the COVID-19 results are sufficiently documented.
Independent appraisal firms will still be at the focal point of the transactions and, as noted, should be up to date on the latest trends and the resulting assumptions that form the foundation of valuations going forward. **Not only will this approach apply to the economic terms but also their regulatory and legal ramifications.**

Post-pandemic physician compensation will likely be lower, at least on a guaranteed basis, with physicians potentially bearing more risk for the relative same total compensation level. The ability to realize a legitimate increase in compensation post-transaction (which has historically been the case in some affiliation models discussed herein) will be less achievable. For the first time in many years, we may very well experience benchmark-sourced compensation rates that are lower than in previous years across many specialties.
Post-pandemic conclusions
With these key areas in mind, we continue to ask, “Which way is up?” This question relates to physicians, hospitals, investors, and others’ interests in affiliation transactions. Will there be a “mad scramble” to align with hospitals and other such entities? Will hospitals and private equity firms be a source of safety and security for physicians for the future? Will security be of greater importance than economic improvement? Will physicians be willing to accept less from these purchasers in exchange for more protection from the next crisis? (One can argue that hospitals and PE firms will not provide a safe-haven, especially considering that during the COVID-19 pandemic, many hospital-employed physicians had to take a pay cut.)

Another factor will be the generational dynamics of the physicians. The NextGen and Millennial generations are apt to continue to gravitate to aggregation and consolidation. This group is inclined toward employment and are less drawn to independence and privatization. The Baby Boomers will continue to retire at a rapid pace, which may speed up due to the COVID-19 pandemic.

The answers to “which way is up?” relative to post-pandemic crisis affiliation will be varied, complex, and not “one-size-fits-all.” We believe there will be a groundswell of interest toward alliances especially with hospitals and health systems. Nevertheless, there will be greater scrutiny based on economics, and valuations will be lower, at least initially. The activity in healthcare will be tremendous, post-pandemic. All the players involved should remain flexible and nimble. No transaction should be forced, especially those that are not meant to be.
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