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Financings of Medical Practices: Considerations for Lenders


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Introduction

Over the past decade, healthcare spending in the United States has increased significantly, reaching $4.5 trillion in 2022 or more than 17% of U.S. gross domestic product.[1] Due to the non-discretionary and non-cyclical nature of healthcare spending as well as the offsetting of consumer healthcare costs by public and private insurance programs, healthcare is viewed by private equity sponsors as an attractive investment, especially during periods of macroeconomic uncertainty. As a result, private equity investment in the healthcare industry has similarly grown: investment in healthcare services increased from 238 deals with a total value of $24.8 billion in 2011 to 733 deals with a total value of $77.5 billion in 2021.[2] Private equity acquisitions of physician practices, in particular, increased from 75 deals in 2012 to 484 deals in 2021.[3] Private equity ownership has also become more attractive to some medical practitioners operating in an increasingly complicated and, for smaller medical practices, potentially less financially sustainable, regulatory environment.[4,5]

The ownership and operation of medical practices is subject to a complex and often changing web of federal and state regulations. Private equity sponsors considering – and lenders providing the financing for – leveraged buyouts of medical practices accordingly face industry-specific challenges in structuring these transactions, especially with respect to restrictions on the corporate practice of medicine ("CPOM"). CPOM limitations, which arise from the intersection of laws, regulations and caselaw, vary in scope and detail from state to state, but fundamentally require medical, dental, optometry, veterinary and similar medical practices to be owned and controlled exclusively by practitioners licensed in the applicable jurisdiction.

In states subject to material CPOM restrictions, private equity sponsors and other corporations do not invest in medical practices directly, but instead invest indirectly through one or more special purpose management services organizations ("MSOs"), which, in turn, enter into management services agreements ("MSAs") with the medical practices. Through the MSO and MSA arrangement – sometimes referred to as the "friendly physician model" – the sponsor is able to receive the ongoing economic benefits of a medical practice without owning or controlling it directly. Lenders financing such CPOM acquisition structures must understand and analyze how they differ from a traditional buyout of the equity interests in an operating group of companies, and how these differences affect their rights and remedies as creditors. This chapter describes the structuring, diligence and loan documentation considerations for lenders providing financing for medical practice acquisitions subject to CPOM restrictions.

Key Structuring Considerations

In contrast to most other leveraged buyouts and secured financings, lenders to an MSO will generally have no direct recourse to or credit support from the underlying group of operating companies – here, medical practices – acquired with the financing. Rather, lenders are, during the term of the loan and during any enforcement, subject to the same restrictions on ownership and control of the underlying medical practices and practitioners as the private equity sponsor. The terms and conditions of the contractual relationships among the MSO, the sponsor, the medical practices and the licensed medical practitioners that own the medical practices are, thus, of critical importance to properly structuring any CPOM financing. This contractual arrangement is established in two main parts: (i) the MSA between the MSO and each medical practice; and (ii) a stock transfer restriction agreement ("RSA") between the MSO and the licensed medical practitioners.

Management Services Agreement

Each MSA is deal-specific and its scope depends on the permissibility of certain contractual rights and obligations under applicable state law. At a high level, an MSA should not permit the MSO to exercise undue control over the medical practice, including the clinical decision-making of the medical practitioners. While there is no bright line rule, factors which states consider in making this determination include: restrictions on the ability of medical practices to hire and fire practitioners; private equity sponsor oversight over or limitations on clinical decision-making; and imposition of quotas on either patients or types of clinical services. The consequences of non-compliance with the CPOM limitations are significant, including loss of practitioner licenses and unwinding of the MSO structure.

At the broadest end, an MSA may provide for the MSO to employ all non-medical personnel, provide all non-clinical administrative services (e.g., human resources, marketing, payroll and information technology), collect and hold all revenues

generated by the practice and own all non-clinical assets of the medical practice. Lenders may prefer a more robust MSA, as the greater the rights of the MSO under the MSA, the greater the control lenders may obtain over the medical practice upon an exercise of creditor remedies. In this regard, the interests of lenders and private equity sponsors are aligned in implementing as strong an MSA as legally permissible.

In exchange for providing these non-clinical services, the MSA will require the medical practices to pay the MSO a management fee. The management fee may be set at a fixed annual amount or, in states where permitted, may be based on a split of the revenue generated by the medical practices. In all cases, this fee should be at fair market value and commercially reasonable in relation to the services provided, and not be based on the amount or value of patient referrals or services. Lenders should confirm that the MSA includes robust cash management practices between the MSO and medical practices. The MSA should require regular – ideally daily – sweeps of cash generated by the medical practices into an account in the name of the MSO. Such cash management arrangements are intended to result in as much of the revenue generated by the medical practices flowing to the sponsor-controlled MSO, which may then serve as collateral for the financing obligations.

Stock Transfer Restriction Agreements

Upon the acquisition of a medical practice, the private equity sponsor will typically install, or retain from the existing pool of sellers, one or more "friendly" practitioners who own the equity interests in the medical practice (a single such practitioner with the necessary medical licenses may own multiple medical practices in multiple jurisdictions). The friendly practitioners enter into RSAs with the MSO that limit the transferability of their ownership interests in the medical practices and afford the private equity sponsor remedies if a practitioner sells such interests in violation of the agreed limitations. In addition, practitioners providing clinical services in a sponsor-controlled MSO structure may enter into employment and non-compete agreements (to the extent enforceable in the applicable state) with the medical practice to prevent them from establishing a competing practice. The collective goal of the RSA and employee agreements is to incentivize the owner and employee practitioners to continue to generate revenue for the sponsor-owned MSO. In reviewing RSAs, lenders should confirm, among other things, that the agreements require MSO consent for transfers of the ownership interests in the medical practice and afford the MSO an option to purchase (or to require a practitioner to transfer) such interests at its discretion or upon certain triggers, which may include death of or malpractice by a practitioner, actual or proposed transfer by a practitioner of its ownership interests in the medical practice, termination of the practitioner by the medical practice or any other action or inaction by the practitioner that would jeopardize the ability of the medical practice to provide medical services.

Guarantees and Collateral

CPOM limitations restrict the medical practices and practitioners from guaranteeing or otherwise providing direct credit support with respect to any acquisition financing by the private equity sponsor or its MSO. Rather, the MSOs themselves act as the borrowers and guarantors of the financing and pledge all of their assets and equity interests as collateral to the lenders. The assets pledged by the MSOs in favor of lenders may include cash swept from the medical practices, medical equipment, real property or leases where the medical practices are located, receivables owing from the medical practices (including the management fee pursuant to the MSA) and all rights and remedies of the MSOs under the MSA and RSA.

In particular, it is critical that the MSA and RSA themselves are collaterally assigned by the MSO to the lenders, and that such agreements permit the granting of such liens to the lenders, are freely assignable to (and by) the lenders upon enforcement and are not terminable by the practitioners upon a change of control in an exercise of remedies. Absent these protections, lenders – and the entities to whom they sell the agreements upon enforcement – will not have the ability to manage, and ensure friendly physician ownership of, the medical practices, in accordance with each MSA and RSA. Similarly, the MSAs should require the medical practices to grant liens to the MSO on their assets (not already owned by the MSO), which security should also be collaterally assigned to the lenders. Finally, lenders should require control agreements to be entered into in respect of the MSO collection accounts in order to provide lenders with a perfected security interest in the medical practice revenues collected by the MSO.

Loan Documentation Considerations

In a CPOM credit agreement, lenders may impose restrictions on the medical practices only indirectly (the medical practices are not – and cannot under the CPOM doctrine be – subsidiaries of the private equity sponsor or its MSOs, and therefore, are not directly subject to the covenants and other limitations therein). In particular, lenders may include representations and warranties, covenants and events of default in the definitive documentation to ensure they receive adequate information regarding the medical practices, the medical practices continue to operate in the ordinary course, leakage in revenues is minimized and key "trigger" events at the medical practices result in enforcement rights under the financing.

Lenders may also include in the financing documents mitigants against credit risks created by the MSO structure and any related weaknesses identified during diligence. For instance, specific and detailed cash management requirements with respect to the MSO and medical practice may be included as a covenant in the credit agreement, even where such arrangement is not included in the MSA. Further, where the employee agreements contain weak practitioner transfer restrictions or where non-competes are unenforceable under state law, lenders may also require that the compensation for the initial buyout or subsequent acquisitions be structured as an earnout or other contingent consideration to ensure practitioner incentives remain aligned with those of the private equity sponsor.

Two primary categories of financing covenants need to be considered in MSO financings. The first are provisions that seek to ensure that the MSO structure remains robust throughout the term of the financing, including in advance of any exercise of remedies by lenders. These covenants include ensuring that all existing and future acquired medical practices are party to a lender-approved form of MSA, with limitations on adverse amendments, requiring the MSO to own all non-clinical assets and facilities of the medical practices and mandating that the MSO cure any breaches or defaults under the MSAs and RSAs.

The second category arises from the fact that, as previously noted, the medical practices are not subsidiaries of the MSOs and, as a result, the customary credit agreement representations, covenants and financial definitions and tests – which apply to the borrower and its restricted subsidiaries – do not apply to the medical practices. It is necessary to determine the extent to which revenues, which are generated by the medical practices and not the MSO, should be taken into account for purposes of negative covenant basket sizes, financial covenant calculations,

financial reporting and related provisions. Medical practice financials may be consolidated with those of the borrower and its restricted subsidiaries, but lenders should also consider requiring, as a condition to such consolidation, that the medical practices be subject to a lender-approved MSA, such that practice revenue may be collected and held by the MSO and, therefore, subject to a lien in favor of the lenders. Relatedly, lenders should consider whether the credit agreement should restrict the making of investments in or distributions to the medical practices. CPOM financing documents vary widely on this topic, as each MSA reflects a negotiated balance between the MSO's desired control over the medical practice, on the one hand, and the operating flexibility of licensed practitioners and requirements of state law and regulation, on the other.

Conclusion

The wide variety of CPOM restrictions across jurisdictions impose unique challenges for private equity sponsors investing in, and lenders financing, medical practices. A comprehensive MSO structure together with carefully negotiated financing covenants and conditions may largely mitigate many of the structural gaps and risks associated with the inability of the sponsor to own or pledge, or provide direct credit support from, such medical practices.

Endnotes

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