

HCPEA 101

September 9, 2025

Agenda

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11:30 – 12:30 Keynote Lunch with Andrew Cavanna
12:30 – 1:15 Healthcare Industry Overview
1:15 – 2:30 US Healthcare Reimbursement & Regulatory Diligence
2:30 – 3:15 Emerging Leaders Panel
3:15 – 3:30 Break
3:30 – 4:30 Legal Considerations
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- 4:30 5:30 Foundational Deal Considerations
- 5:30 6:00 Roundtable Mentor Discussions
- 6:00 7:00 Reception



Keynote Lunch

11:30 - 12:30



Keynote Lunch w/ Andrew Cavanna

Andrew Cavanna is the Managing Partner of Overstory Partners. Previously, Andrew was an Equity Partner at Apax Partners where he served as Co-Head of the Healthcare Group from 2017-2024. Prior to joining Apax, Andrew spent eleven years at Vestar Capital Partners where he was a Managing Director and Co-Head of the Healthcare Sector. Andrew came to Vestar in 2006 from The Blackstone Group. Prior to Blackstone, Andrew was a Senior Associate at JPMorgan Partners. Andrew started his career as an Analyst in Leveraged Finance at Merrill Lynch. Andrew holds an MBA from Columbia Business School and a BA, cum laude, in Economics and Government from Cornell University. Andrew serves on the Cornell College of Arts and Sciences Advisory Council and is a board member of School in the Square. Andrew is also an Instructor at the Harvard School of Public Health.



Healthcare Industry Overview

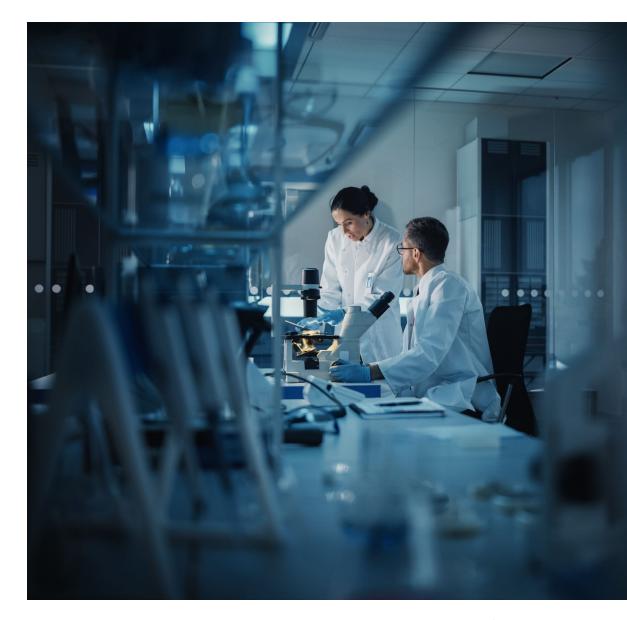
12:30 - 1:15





Disclaimer

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Today's Presenters



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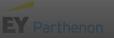


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Healthcare Overview and Commercial Considerations



EY-Parthenon combines sector-specific strategy, transactions, and corporate finance capabilities to enable our clients' transformation agenda

EY-Parthenon overview

What we do

From strategic realignment to gamechanging M&A, capital allocation to growth and new market access, EY-Parthenon combines sector-specific transformative strategy, transactions and corporate finance capabilities to enable our clients' transformation agenda.

Specialists across six core industry groups

- ▶ Consumer and Health
- ▶ Private Equity
- ▶ Financial Services
- ▶ Government and Infrastructure
- Industrials and Energy
- ▶ Technology, Media & Entertainment, Telecommunications

25,000+

EY-Parthenon professionals globally



EY works with 100% of the Private Equity International's Global Top 100 buyout firms and over 300 PE funds worldwide

EY has delivered transaction advisory services to 100% of Private Equity International's top 25 global private equity firms and has completed 500+ buy-side and 200+ value creation projects over the last 24 months

EY-Parthenon — in tandem with broader EY capabilities — can optimize opportunities at C-suite inflection points throughout the non-linear transformation journey with comprehensive, multi-dimensional, joined-up solutions to enable our clients to create new types of value.

EY offers a holistic, sector-focused approach to Private Equity consulting services from pre-acquisition to exit

EY diligence offering

Commercial diligence

- Market size, growth, and cyclicality
- Customer usage and purchasing behaviours
- Competitive landscape structure / ecosystem
- Company market positioning / performance
- Growth potential (organic and inorganic)

Operational diligence

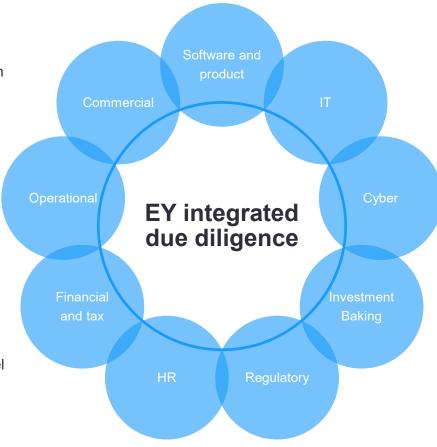
- Synergy opportunities
- Competitor benchmarking
- Pricing and cross-sell opportunities
- Value creation opportunity assessment

Financial and tax diligence

- Quality of earnings
- Net working capital
- Tax profile and tax exposures

HR diligence

- Compensation, benefits, and other personnel programs
- Organization structure review



Software/product diligence

- Product and tech capability
- R&D and go-forward roadmap
- Architecture, tech debt and tech stack assessment

Information technology diligence

- IT strategy assessment
- Evaluation of performance, reliability, and security of key IT systems

Cyber diligence

- Information security capabilities and risks for key networks and systems
- Key mitigation steps

Investment Banking

- Array of M&A, and debt & equity advisory
- Extensive industry relationships with global presence
- ▶ Full-suite of middle-market focused deal services

Regulatory and reimbursement

- ▶ Bipartisan professionals delivering real-time, politically savvy, and business-specific insights
- Monitor and help navigate all legislative and regulatory processes



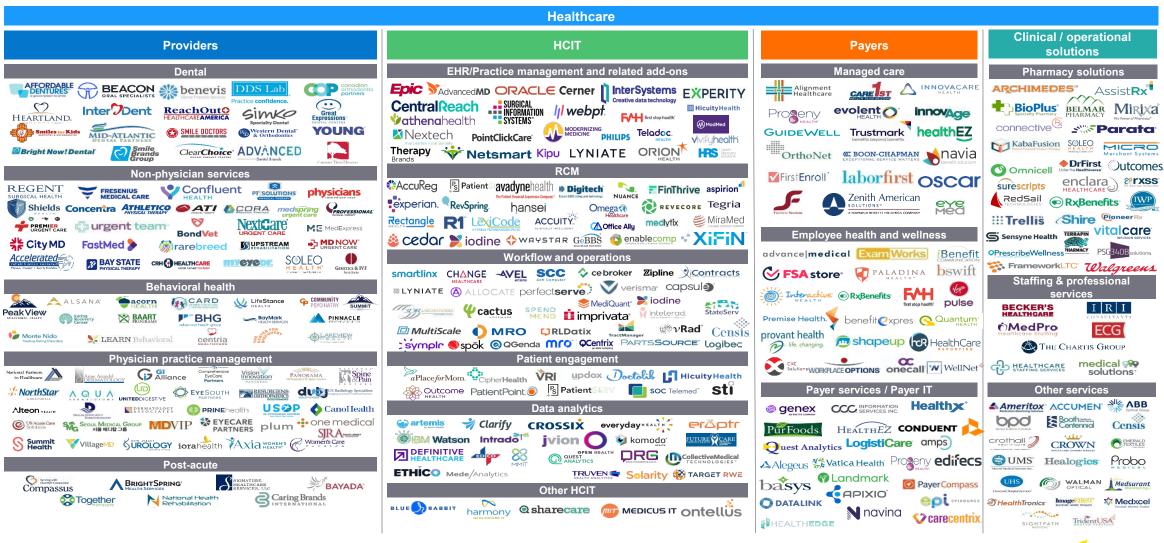
EY-Parthenon's healthcare and life sciences experience: ~1,800 commercial diligence engagements over life of the practice (1 of 3)

Private equity clients and partners



EY-Parthenon's healthcare and life sciences experience: ~1,800 commercial diligence engagements over life of the practice (2 of 3)

Private equity targets and portfolio companies



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Source: Company websites

EY-Parthenon's healthcare and life sciences experience: ~1,800 commercial diligence engagements over life of the practice (3 of 3)

Private equity targets and portfolio companies



EY Parthenon

Agenda

► Health market overview

- Healthcare overview
- Provider services
- Healthcare IT
- Payer services
- Macroeconomic outlook and investment theses
- ► Commercial diligence considerations for healthcare transactions

The US health sector is large



~\$4.9t

 US GDP for healthcare marketplace (2023); projected \$8.6t by 2033

~17.6%

▶ Health share of GDP in 2023; health care spending grew by 7.5%, increasing from the 4.6% growth in 2022

~18 million

 People work in the healthcare, accounting for 11% of all jobs in the US economy

Providers

- ▶ Hospitals/IDN
- Physician groups
- ▶ Home health/hospice
- Academic medical centers
- Outpatient clinics/retail health
- ▶ Post-acute continuum

Services, investors

- Private equity
- Health and wellness
- Healthcare staffing
- Outsourced HC services
- DME
- Healthcare technology
- Pharmacy
- Infusion services
- Outsourced vendors

Payers

- Commercial
- Provider sponsored plans
- Long-term services and supports
- Government
- Self-funded employers/TPAs
- Tricare

Adjacent

- Retail
- Medical devices
- Distributors
- Diagnostics and lab services

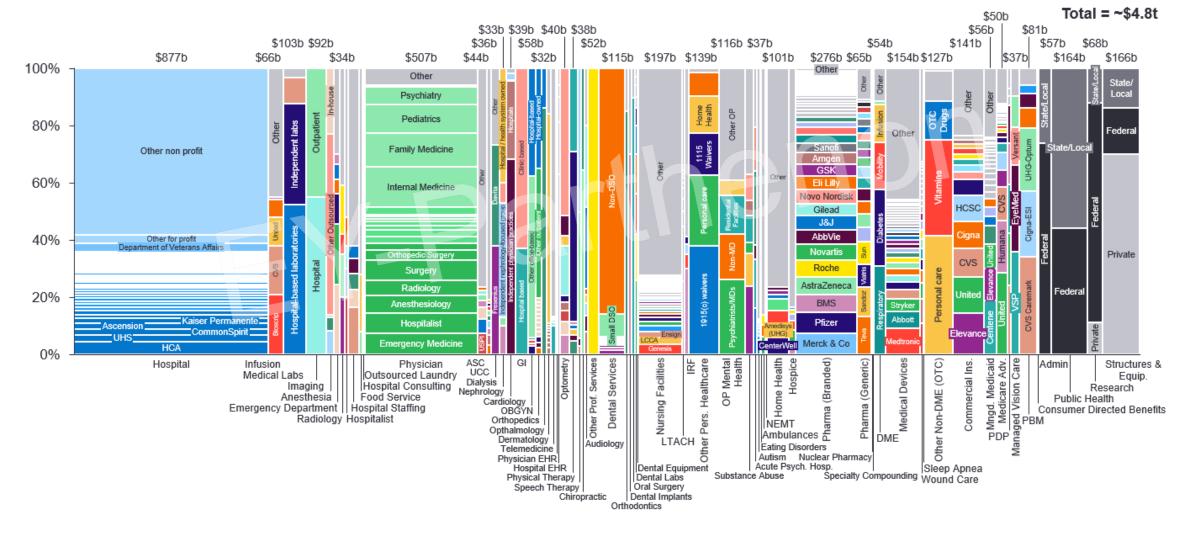
Life Sciences

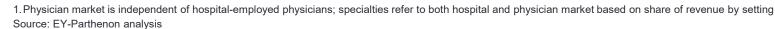
- Biopharma
- Medical technology



Characteristics of the market – vast, localized, generally unconsolidated – remain the same

US national health expenditures (2023)







The healthcare ecosystem comprises of multiple complex stakeholder relationships that increasingly center around the consumer

Employers

Description



Sponsors of health insurance for employees and their dependents. Can purchase fully insured or self-insured services

Types

Small, mid-size and large employer groups

Regulators

Description



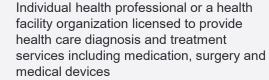
Protect healthcare consumers from health risks, provide a safe working environment for healthcare professionals, and ensure that public health and welfare are served by health programs

Types

State and federal regulatory bodies including departments of insurance (DOI), health and human services (HHS), labor (ERISA)

Providers

Description



Types

Hospitals, Specialty, Primary Care, Federally Qualified Health Centers (FQHCs), ACOs, Urgent Care, Physician Groups, Ancillary Medical Services, Rehabilitation, Home Care, etc.

Payers

Description



Any employer, health plan, insurance company, managed care organization, or any other entity that finances payment of health care services to a group of beneficiaries

Types

Commercial Insurers (employer-sponsored & individual marketplace) and Government Sponsored (Medicare, Medicaid, CHIP, Tricare)

Source: EY-Parthenon analysis Page 18



Broadly speaking, the US healthcare ecosystem is large and includes provider services, HCIT, payer services, and life sciences verticals

ILLUSTRATIVE | FOR DISCUSSION

| Healthcare Control of the Control of | | | | | | | |
|--|----------------------|--|---------------------------|-------------------------------|--|-------------------------------------|----------------------------------|
| Provider Services | | Healthcare (HC | | Payer Services | Other Services & Pharmacy solutions | Life Sc | iences |
| Physician Practice Management (PPM) | Dental (DSOs) | EHR, Practice Management & Related Tools | Workflow & Operations | Managed Care | Pharmacy Solutions | Biopharma CDMO | Biopharma R&D Services and |
| Hospitals | Post-Acute | Revenue Cycle Management | Patient I Engagement I | Employer Health & Wellness | Non-Clinical Services | | Tools |
| Non-Physician / Outsourced Provider Services | Behavioral Health | Data Analytics | Other HCIT | Payer Services / Payer IT | Staffing & Professional Services | Biopharma Commercial- ization | MedTech |

EY Parthenon

Source: EY-Parthenon analysis

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Healthcare is delivered across a variety of care settings based on acuity of the injury and patient considerations

Healthcare care setting overview







Post-acute



Home health



Ambulatory and outpatient



Virtual and Digital Care

Description

- Organizations that focus on short-term treatment of severe injuries or episodes of illness
- Locations that support recovery after acute illness hospitalization
- Care delivered within a patient's home
- Providers that offer acute care without overnight stay
- Technology driven care delivery

Example organization types

- ► Academic Medical Centers
- System / IDN Affiliated (Primarily Urban)
- ▶ Large Independent
- Rural / Critical Access Hospital
- Specialty

- ► Long-Term Acute Care Hospitals
- Inpatient Rehabilitation Facilities
- Skilled Nursing Facilities
- ► Hospice and Palliative Care Providers
- ▶ Home Health Agencies
- Personal Care Services
- ▶ Hospital-at-Home Programs

- ▶ Primary Care Clinics
- ► Specialty Clinics (i.e., cardiology, orthopedics)
- Ambulatory Surgery Centers
- Urgent Care Centers
- ▶ Retail Health

- ▶ Telehealth Platforms
- ▶ Remote Patient Monitoring
- ▶ Digital Therapeutics
- Virtual-First Primary Care

Highest acuity

Lowest acuity



Acute care settings vary based on ownership model, services and community needs

Landscape of select acute care settings

| Provider type | Number of locations | Description | Ownership model | Exemplary services | Representative organizations |
|--|--|--|---|---|---|
| Academic Medical Center | ~150 Systems ~2000 locations | Large teaching hospitals affiliated with universities, providing advanced care and conducting research | Non-ProfitGovernment | Specialized surgeries Research trials Tertiary care Teaching | Mass General Brigham MedStar Health MAYO CLINIC Singi Cleveland Clinic |
| System / IDN Affiliated | ~250 systems¹ ~2100 locations | Hospitals that are part of integrated delivery networks with multiple locations, mostly located in urban areas | Non-ProfitFor-ProfitGovernment | Broad inpatient and outpatient services Emergency care Specialty clinics | HCA Hospital Corporation of America Lifepoint Health SCENSION CommonSpirit |
| Large Independent (incl. Children's hospitals) | ~400 | Large standalone hospitals with significant capacity and service breadth | ➤ Non-Profit ➤ For-Profit | General medicineSurgeryMaternityDiagnostics | Boston Children's Hospital Until every child is well' Parkland Children's Hospital of Philadelphia Parkland Jefferson Regional |
| Rural / Critical Access Hospital | Rural / Critical areas providing essential Government Primal | | Emergency carePrimary careStabilization | FREDONIA Regional Hospital SASPEN VALLEY HOSPITAL FREDONIA YORK GENERAL CEMME CENTRAL MONTANA MEDICAL CENTER | |
| Specialty Hospital | ~1100¹ | Hospitals focused on specific areas such as cardiac, orthopedic, or cancer care | ➤ Non-Profit ➤ For-Profit | Elective surgeriesChronic disease managementRehabilitation | Memorial Sloan Kettering Cancer Center HSS HOSPITAL FOR SPECIAL SURGERY |



Patient care extends beyond the hospital into a variety of post-acute care settings

Landscape of select post-acute healthcare settings

| | | | Р | ost-acute care setting | gs | | |
|-------------------|--|---|---|---|--|--|--|
| | Long term acute | | Nursing facilities | | | | |
| | care hospital (LTAC) | Inpatient rehab facility (IRF) | | Senior housing (ALF, ILF) | Hospice | Palliative care ¹ | |
| No. of facilities | 0.4k | 1.2k | 15 | 5.6k | 28.9k | 6.5k | 2.5k-4k |
| Patient type | For individuals with complex conditions requiring hospital-level care Treatment typically in excess of 6 months | For individuals requiring intense rehabilitation treatment | For individuals requiring nursing services for short- term rehabilitation following hospital discharge Typically, elderly patients | ➤ For individuals requiring a greater intensity of care than provided in other senior housing options (e.g., ALFs / ILFs) | ► For individuals requiring help to mange conditions and assistance with activities of daily life (ADLs) | ➤ For individuals receiving end of life care (<6 months life expectancy) | ➤ For individuals looking seeking comfort focused care for terminal illness with no timeline for death ➤ Often serves as precursor to Hospice |
| Location | ► Acute care hospital | ► Free-standing rehab hospital/rehab unit in acute- care hospital | ➤ ~95% of SNFs and are co-located within | | Assisted living facility (ALF) Independent living facility (ILF) | Hospice agencyAt homeSNFALF | Acute care hospital Nursing home At home |

Highest acuity Lowest acuity



^{1.} The palliative care definition often includes hospice so for purposes of comparison, we are considering non-hospice palliative care Source: CMS; MedPAC; EY-Parthenon analysis

Provider-focused investors are evolving to pursue alternative investment opportunities beyond traditional multi-site provider/physician practice management platforms

| Provide | er servi | ces investment considerations | 4 | | |
|-----------------|----------|---|--|---|--|
| | | | Most similar to PPM | | Least similar to PPM |
| | | Physician practice management / multi- site provider management | Managed service organization (MSO) | Ambulatory surgery center (ASC) management company | IT managed service provider (MSP) |
| Descr | iption | More traditional investment type, focusing on acquisition of physician practices to build a platform and develop scale efficiencies | Organizations providing non-clinical, admin and management support to medical practices and outpatient facilities | Companies similar to MSOs with a specific focus on ASCs as an expanded care setting | Organizations delivering IT-specific services e.g., cyber security, cloud and infrastructure development, and data management |
| Invest strat | | Traditional strategies | Care delivery enablement | Infrastructure development | Technology enablement |
| Potentia | l upside | ✓ Offers pathway to growth and scale through additional practice add-ons ✓ Supports providers in navigating growing financial pressures with operational expertise ✓ Fundamental tailwinds remain (aging population, opportunity to scale, labor turnover, need for improved access and care quality) | ✓ Prioritizes clinician enablement in line with broader market trends ✓ Enables clinicians / offices to practice top of license ✓ Offers flexible partnership / investment models vs. traditional PPM format | ✓ Benefits from growing trend to shift care from expensive inpatient to outpatient settings while offering additional patient access ✓ Relatively nascent area offering whitespace for interested investors in provider categories that are in early stages of outpatient migration (e.g., cardiovascular, infusion, etc.) | ✓ Generates notable cost and time savings ✓ Enables end customer's focus on core clinical operations ✓ Provides access to higher technical skill and levels of IT security |
| Ris conside | | FTC oversight against existing platforms driving anti-competitive regulatory uncertainty Rising costs and challenging labor dynamics, while reimbursement has remained steady Lower valuations have led to fewer high-quality assets in market as firms extend hold periods | May encounter similar scrutiny given management involvement Partnership models may experience some similar exposure to reimbursement as primary revenue driver | Pependent on annual updates to the inclusion and reimbursement trends of the CMS-approved ASC covered procedures list Need for dedicated focus on developing favorable provider and network partnerships that enable positive unit economics | Requires recruiting appropriate talent by sub-service and industry credibility for certain areas Requires understanding of and developing profitable contracting models, based on service type, to remain competitive |

Source: EY-Parthenon analysis Page 24

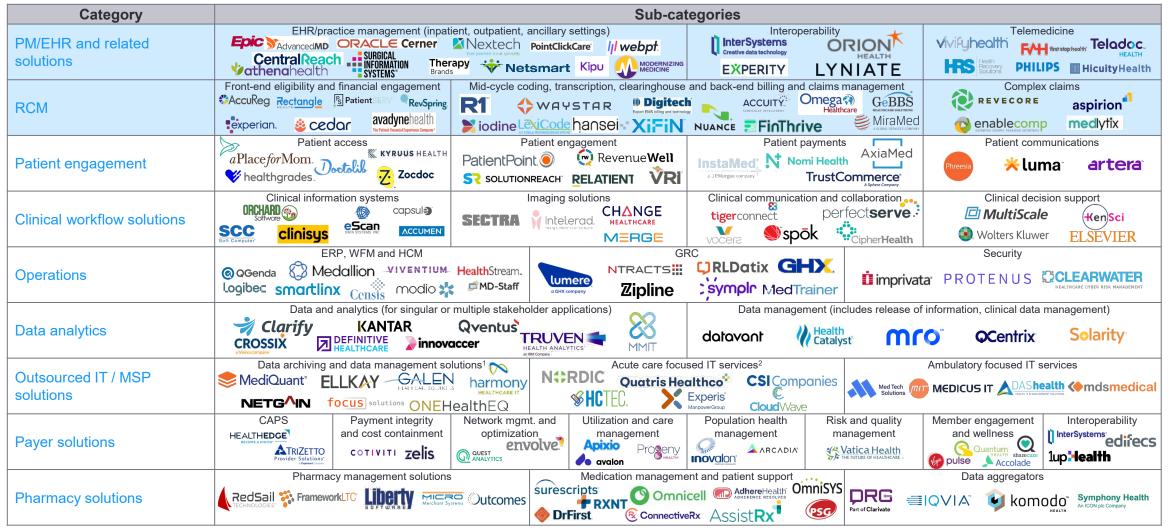
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The HCIT ecosystem consists of a wide range of players

Landscape overview



^{1.} Galen Healthcare Solutions is owned by RLDatix

^{2.} Quatris Healthco is owned by AthenaHealth Source: EY-Parthenon analysis

PM/EHR solutions are widely used across inpatient, outpatient, and post-acute care settings, accounting for a ~\$20b market in total

PM/EHR: Overview by care setting

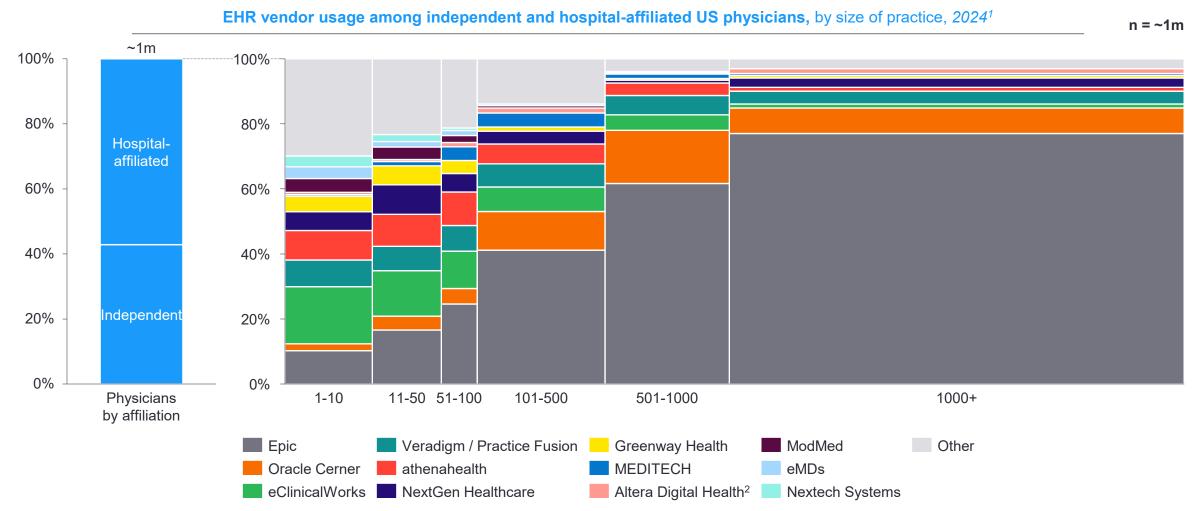
| | Description and settings included | Relative penetration |
|----------------------|--|----------------------|
| Inpatient | Care settings which require patient admission for a period of time Includes hospitals (both health system affiliated and independent) | ~95%+ |
| Outpatient clinical | Care settings where treatment is provided without requirement that a patient stays overnight Includes physician practices (both health system affiliated and independent), urgent care centers | ~95% |
| Ancillary outpatient | Other outpatient care settings, typically with a specific focus area and unique treatment needs Physical therapy, chiropractor, behavioral health, and dental | ~80% |
| Post-acute | Care settings that provide services after hospitalization, including longer term residential treatment settings Skilled nursing facilities, assisted living facilities, home health and hospice | ~80-85% |

While most outpatient / post-acute practices have a PM / EHR, they may not have robust solutions in place and may only be using scheduling / billing functionality



~30% of physicians in 1-10 physician groups use specialized EHRs; this share drops to <5% of physicians in >1,000 physician groups

PM / EHR: EHR vendor usage across physician groups by size



^{1.} Includes physician groups with available EHR usage data; these groups have ~80% of physicians

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^{2.} Formerly part of Allscripts

RCM covers the patient journey from pre-encounter services, such as scheduling, through post-encounter billing, and bad debt collection

RCM: Process flow

| Pre- | | Revenue Cycle Management (RCM) workflow | | | | | | |
|----------------|-------------------------------|---|---|-------------------------------------|---|--|---|---|
| encoui | nter | Patient journey | Workflow components | | | | | |
| | 31 | Pre-encounter patient access/engagement | Patient scheduling, referral management, and pre-visit engagement | | | | | |
| | | Patient registration & eligibility | Patient registration/ pre-registration | | Health and liability eligibility verification | | Prior authorization/ certification | |
| lourney | % | Patient financial engagement | Patient out-of-pocket estimation | Propensity-to- pay assessment | Charity care | Point-of-service payment / papture | Payment reminders | |
| nt Jour | 1010110 1001001 1101010 | Coding | Dictation and transcription | HIM and coding | | Charge captur reconciliation | re/ Clinical doc. management | |
| Patient J | | Claims processing/clearing | Claims scrubbing, denial prevention, and analysis | Claim status and | submission | Clearinghouse EDI | Workers' comp and other cover discovery | |
| | | Claims follow-up/collection | Claims and payment processing | Appeals & resolution | | Charge integrity | | |
| | | Billing & collection | Billing statement | Early-out collections | | Receivables and external collections within payment period | | s |
| Bad debt | | Bad debt | Bad debt collection outside payment period | | | | | |
| Posi encoui | | Front-end (pre-encounter) | Middle (d | during encounter) | Ва | ck-end (post-encount | ter) | |

Note: Some market participants consider patient access and engagement to be the first step of revenue cycle management, while others consider it to be distinct with RCM beginning with patient registration & eligibility

Source: EY-Parthenon analysis

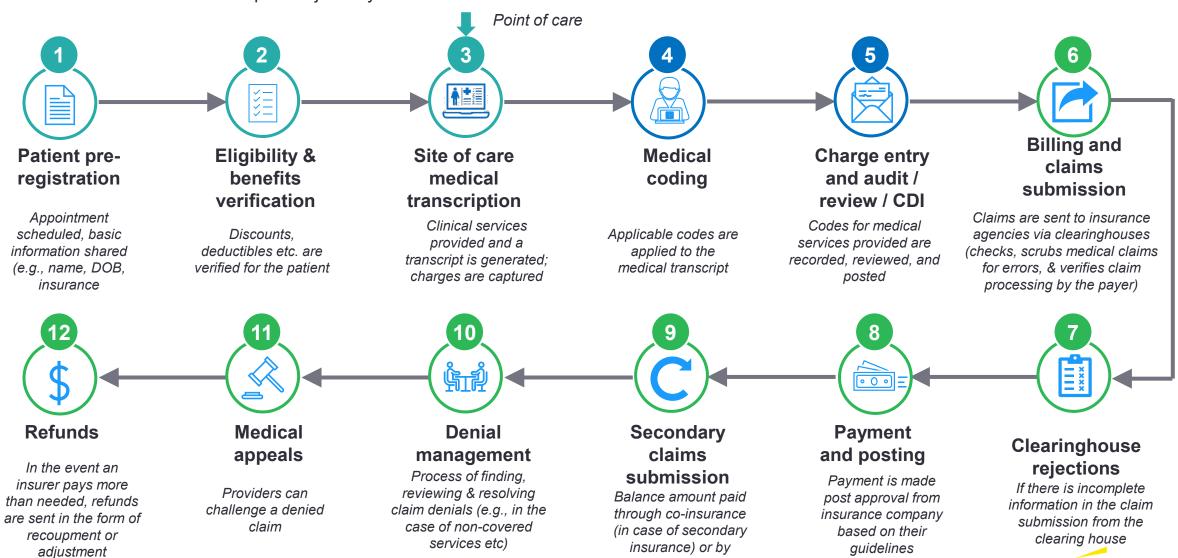


Source: EY-Parthenon analysis

Front-end

RCM workflow is initiated once a patient pre-registers for an appointment and runs through multiple steps to reach its conclusion

RCM: workflows across the patient journey



Back-end

Mid-cycle

patient

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RCM vendors position themselves across several different archetypes ranging from broad suite providers to specialized point solutions

RCM: Vendor archetypes

| | Broad suite RCM vendors (onshore leaning) | Multi-shore RCM suite vendors (offshore leaning) | Point solutions vendors in a specific RCM process | Specialty-focused RCM vendors | Diversified BPOs |
|-------------------------------------|--|--|---|--|---|
| Service offerings description | ➤ Offer a broad range of tech / onshore / offshore capabilities with ability to either entirely carve out the RCM process or provide modular RCM workflows | Broad set of services that can serve end to end workflow across the revenue cycle; historically offshored but converging to onshore Can serve as subcontractors for broad suite RCM vendors, but moving more to direct agreements | ➤ Deep expertise in 1-2 competencies within the RCM lifecycle | ➤ Focused on providing capabilities and domain expertise required for specific specialties (e.g., emergency medicine, radiology, anesthesiology, etc.) | Broad set of services that can serve end to end workflow across the revenue cycle Scaled tech implementation expertise |
| Tech offerings | ➤ Software developed or white- labeled and sold to providers (e.g., claims submission) | ▶ Internally leveraging tech / automation, but not sold to clients | ► Range from service-oriented to software solutions, and | ➤ Range from service- oriented to software solutions, and can serve | ► Limited solutions (e.g. Prior Auth solution by Cognizant) |
| Service offerings | ▶ Broad suite of onshore and offshore services (direct and indirect) | Broad suite of onshore and offshore services (direct and indirect) | can serve as subcontractors for broad-suite RCM vendors | as subcontractors for broad-suite RCM vendors | ➤ Broad suite of outsourcing services as well as Tech implementation |
| Value proposition | ➤ Considered to be a broadly comprehensive / modularized offering to support needs flexibly | ➤ Resolve specific pain points in RCM lifecycle especially around large work volume requirements or high costing manual tasks | ➤ Deployed in conjunction with RCM suite vendors, or broader healthcare service providers to resolve specific pain points | ➤ Able to cover end-to-end RCM capabilities with deep expertise in a specific specialty | Ability to scale Existing relationships and experience with tech solution providers |

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There are two major payer groups - government sponsored and commercial insurance

US Healthcare coverage

Government-Sponsored Programs

Medicare

- ▶ Government sponsored programs for those over the age of 65 or aged, blind, disabled
- ▶ Rules and regulations are set at the federal level
- ▶ Varying levels of coverage exist (hospital, physician, drug, managed care)
- ▶ Up to 20 % cost sharing, leading beneficiaries to buy supplemental insurance or move into managed care

Medicaid and CHIP

- ▶ Eligibility is based on household income
- ▶ Each state can devise specific programs if minimum federally defined benefits are met
- ▶ Cost sharing is generally limited due to income levels

TRiCARE and Veteran Affairs

▶ Department of Defense health care programs for active and retired military personnel and their dependents

Commercial Insurance

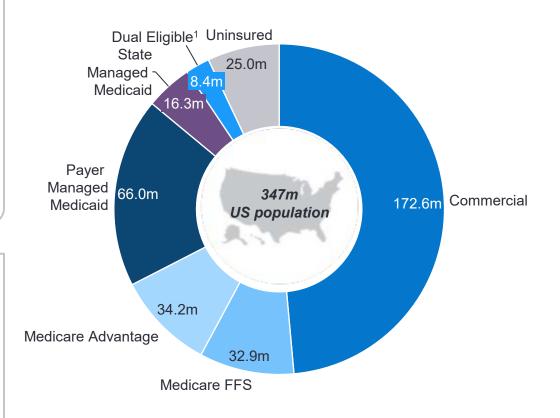
Employer-sponsored Insurance

- ▶ Employer may provide 1-3 options, offered to eligible employees and their dependents
- ▶ Employer typically shares some of the cost of premiums and co-pays with the employee

Individual Marketplace

- ▶ Created for those not covered by employer plans, but not eligible for Medicaid
- ▶ Purchased by individuals directly from health plans on government run exchanges
- Community-rated underwriting

Health Insurance Coverage of the United States (2025)¹





^{1.} Dual eligible insurance refers to individuals who qualify and receive benefits from both Medicare and Medicaid Source: DRG

Medicare offers health insurance for people 65 or older as well as for under-65 population with specific disabilities

Medicare overview

Overview

- ▶ Medicare is a federally sponsored health insurance program covering the population:
 - 65 years or older
 - Disabled entitled to Social Security benefits
 - End-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease)
- ▶ Medicare has 4 parts:
 - Part A and B are collectively known as traditional Medicare or Medicare Fee for Service (FFS)
 - Medicare Part C is known as Medicare Advantage
 - Medicare Part D is known as Medicare Prescription Drug Benefit
- ▶ Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care to special needs individuals:
 - An institutionalized individual
- A dual eligible
- An individual with a severe or disabling chronic condition, as specified by CMS

| Medicare Parts | Coverage details |
|-----------------|---|
| Medicare Part A | Inpatient hospital care Skilled nursing facility care Hospice care Home health care |
| Medicare Part B | Services from doctors and other health care providers Outpatient care Durable medical equipment Some preventive services, including certain vaccines and cancer screenings |
| Medicare Part C | Includes all benefits and services covered under Part A and Part B provided by CMS-approved private insurance companies May include extra benefits and services Usually includes Medicare prescription drug coverage (Part D) as part of the plan |
| Medicare Part D | Prescription drugs Provided by CMS-approved private insurance companies |

Source: CMS Page 34



Medicaid is a public health insurance program that provides health care coverage to low-income families and individuals

Medicaid overview

Overview

▶ Medicaid is jointly funded by federal and state governments

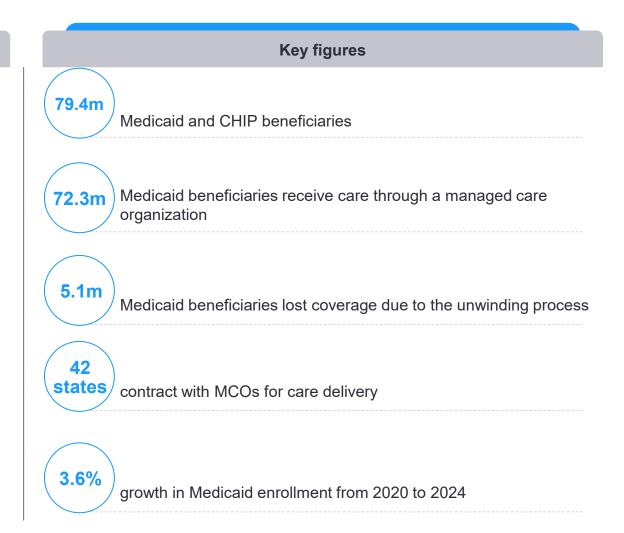
 While the federal government establishes standards, often states will partner with health insurance companies (payers) to manage their Medicaid population

▶ Populations covered under Medicaid:

- Temporary assistance for needy families (TANF) recipients
- Social security insurance (SSI) recipients
- Children and pregnant women, if income is at or below 133% of federal poverty level (FPL)
- "Medically needy" population as designated by a state

▶ Types of Medicaid

- State Medicaid
- Children's Health Insurance Program (CHIP)
- Managed Medicaid



Source: KFF, EY-Parthenon analysis.

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Commercial health insurance is provided and administered by non-government entities and is usually obtained through an employer

Commercial insurance overview

Overview

- ▶ Commercial health insurance is often provided and administered by non-government entities
- ► Most commercial health insurance plans are structured as either a preferred provider organization (PPO) or health maintenance organization (HMO)
- ▶ Health insurance in the commercial market is commonly obtained through an **employer that covers a portion of premiums**, making this a cost-effective way for employees to obtain health coverage
 - Employers are often able to get attractive rates and terms because they negotiate contracts at scale
- ▶ The specific coverage details of a commercial insurance plan can vary widely and are determined by the company that offers the plan
- ▶ State regulatory and legislative bodies dictate certain requirements around what plans should offer and how they must operate

Methods of administering

- ► Common types of commercial health insurance include HMOs, PPOs, POS (point-of-service), HRAs (health reimbursement accounts), and LTC (long-term care) plans
- ► Although not administered by the government, plan offerings, to a large degree, are regulated and overseen by each state

Key Commercial Payers











Source: CMS, Company websites Page 36

National payers are investing to improve capabilities across the value chain, with varying go-to-market strategies

Competitive landscape

LOB focused play

Humana.

Leading Medicare payer owning the end-to-end member journey



- Focus on becoming vertically integrated payvider to enable bestin-class cost management for managed senior population
- Investments in complex Medicare capabilities:
 - Kindred at Home
 - One Homecare Solutions
 - Elite Health
 - Independent Care Health Plan
- Expanded presence in Medicaid with acquisition of Inclusa, Inc.
- Recently announced exit from commercial LoB



Comprehensive employer benefit partner



- ► Focus on differentiating through member engagement and experience
- Expanded into ancillary benefits and funding types (i.e., level funded plans, medical stop loss, dental and vision)
- Investment in PBM, convenient care, disease management, technology:
 - ESI
 - MDLive
 - VillageMD
 - Omada Health
 - Cricket Health
 - Verify Solutions
- Wants to offer scaled "services" through Evernorth



Managed care organization



- ➤ Focus on caring for critically ill population (Medicaid, Duals, high risk Medicare patients)
- ► Involved in significant M&A activity to refine portfolio:
 - Acquisitions
 - WellCare to enter MA
 - Magellan to acquire BH assets
 - Collaborative Health Systems (provider enablement services)
 - AT Medics to enter UK
 - Divestitures
 - USMM (home health asset)
 - MagellanRx

Elevance. Health

Regional excellence including provider relationships/ experience



- Leverages a combination of M&A and partnerships to grow and deliver services
- M&A focused on earlystage companies with diverse capabilities that can be "tucked-in"; recent examples:
- Health services (Carelon)
- Care providers (Aspire palliative care, Beacon for BH, MyNexus homebased nursing)
- Pharmacy (IngenioRx, BioPlus)
- Plan expansion (MMM in Puerto Rico, BCBSLA)
- Also leverages several "local partnerships" with provider entities



National, consumer focused integrated health platform



- Focused on building "one-stop shop" for all patient needs nationwide strategy and physical presence
- ► Growth via "mega deals"
 - Health plans: CVS acquired Aetna for \$69b
- PBM: Acquired Caremark for \$21b
- Provider assets:
 Acquired Oak Street
 Health (integrated
 primary and behavioral
 health) for \$10.6b,
 Signify Health (home
 care provider) for \$8b
- ▶ Other acquisitions
- Joyable (virtual health)
- Aetna HK, IlliniCare (plan expansion)

Diversification play



Health ecosystem oligopoly leader



- ▶ Focused on owning the full value chain in every market across all LoBs
- Offers scaled services through Optum
- Significant investments made into:
 - Health plans (e.g., Bindpersonalized health)
 - Provider assets across care continuum (e.g., Landmark Health – house calls)
 - Provider enablement (e.g., LHC Group)
- PBM / Pharmacy (e.g., Optum, Diplomat)
- Technology (e.g., Change Healthcare)



There are different types of provider risk-sharing models today, with increasing levels of provider accountability

Payment models



Risk spectrum



Traditional fee-for-service

- Payments made for care that is delivered
- No adjustments made for quality or value of care provided



Fee-for-service: pay for performance

- Traditional FFS with added bonuses (and in some cases subject to penalties)
- Bonuses and/or penalties are determined by quality data reported by providers and performance on cost and quality measures



Shared savings/risk models

- ▶ In a shared savings model, the provider may retain a portion of generated savings (up to 100%) if incurred medical costs are kept below expectations
- ▶ In a shared risk model, the provider is liable for a portion (up to 100%) of cost overruns if incurred medical costs exceed expectations



Capitation-based payment

- Payments are a fixed, per patient per unit of time sum paid in advance to a provider (e.g. PMPM)
- Provider assumes full risk for any costs above the capitation amount
- Provider retains all savings if costs fall below capitation amount
- Provider may also be subject to bonus payments and/or penalties depending on the quality of care



Several macroeconomic factors are impacting the payer landscape

Payer trends and macroeconomic factors

| Macroe | economic factors | Description |
|--------|---|---|
| KE2 | Rising healthcare costs | ▶ Several factors have contributed to growth in healthcare costs, including rising input and labor costs, a sickening population and increasing drug prices leading to unsustainable growth in U.S. healthcare spend |
| | Shift towards government- sponsored plans | ▶ Employer sponsored plans are losing share while government sponsored programs are growing, this is driven partially by shifting demographics and rising costs |
| | Transfer of healthcare costs onto the patient | ▶ As costs rise, an increasing share of the burden is being borne by members, in-turn driving a market shift towards healthcare consumerism; additionally, the increasing prevalence of high deductible plans is increasing patient out-of-pocket costs |
| Ç | Transition to value-based care (VBC) | There is an ongoing market shift away from fee-for-service (FFS) payment models towards VBC, given VBC models have been proven to reduce costs and improve outcomes Greater adoption of VBC payment models is challenging among smaller providers and payers |
| | Shift towards digital healthcare delivery | Health systems are expected to adopt Health IT tools and systems to meet HEDIS score requirements and quality metrics; payers are expected to invest in integrated health IT systems |
| | Increasing role of regulations in healthcare delivery | As government sponsored programs continue to represent a growing share of the market, government regulations and legislation will play an increasingly important role for payers |

Source: EY-Parthenon analysis Page 39

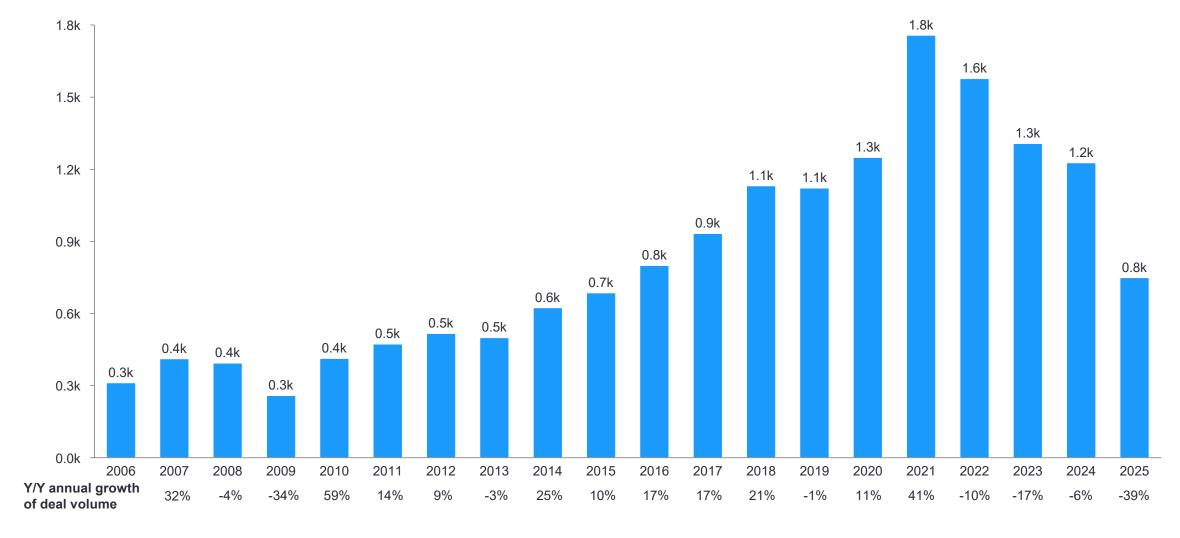
Agenda

► Health market overview

- Healthcare overview
- Provider services
- Healthcare IT
- Payer services
- Macroeconomic outlook and investment theses
- ► Commercial diligence considerations for healthcare transactions

Private equity deal volume outlook: health care PE deal volume has declined since the pandemic but is expected to rebound from 2025 forward

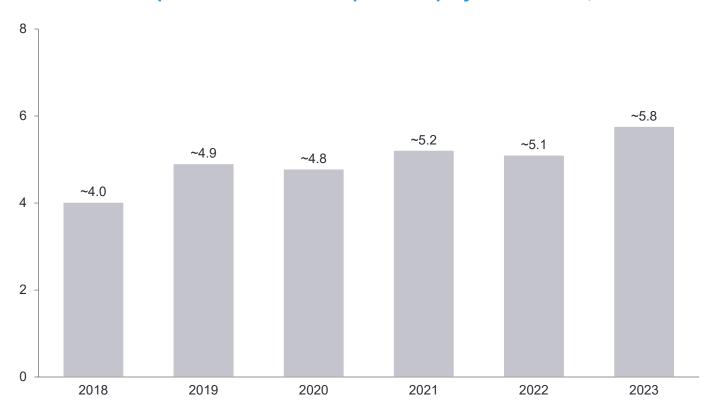
US health care PE deal count (calendar year), 2006-20251



Median hold periods for health care investments have increased since 2018

Private equity hold periods

Median hold period for health care private equity investments, 2018-20231



Commentary

- ► Longer median hold periods are a function of higher interest rates and inflationary pressures
 - PE assets became more expensive to invest in post-COVID as the Fed raised interest rates to fight inflation
 - PE assets were also harder to sell given more costly financing
 - The relative illiquidity created a more challenging environment for private capital fundraising
- ▶ PE firms responded to the macro challenges by:
 - Focusing more on portfolio value creation opportunities
 - Using continuation vehicles to roll over assets from existing investment pools
- ► As interest rates decrease, PE deal activity is showing signs it is poised for a turnaround
 - Market participants note slowly filling acquisition pipelines and decreasing seller price expectations signaling that a gradual increase in dealmaking could be coming



^{1.} Median hold period calculated based on exits that occurred in each respective year from private equity buyout deals for which health care is reported as the primary industry sector

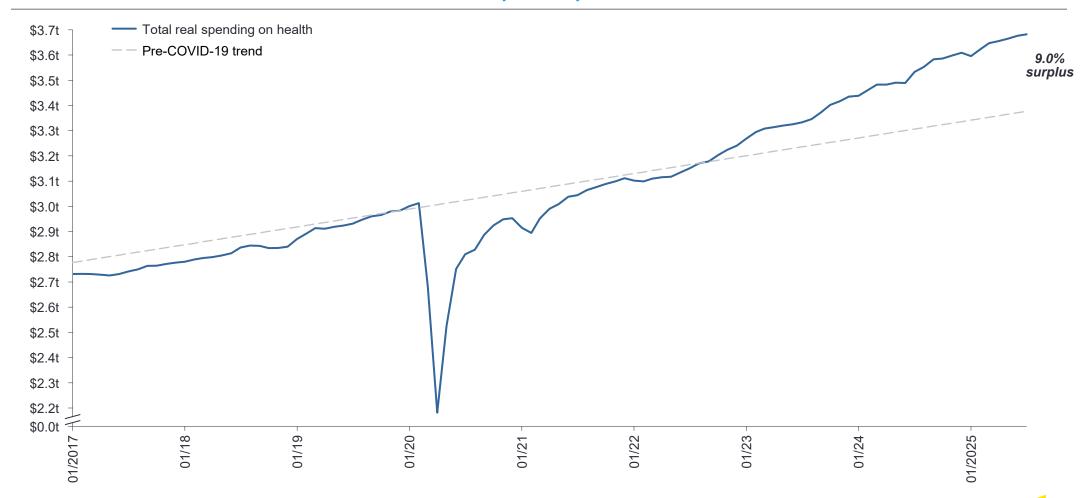
^{2.} Data shown as of 9/13/2023

Real consumer spending on health has continued to exceed the pre-pandemic trend

US health spending trends

Total real spending on health (services + goods) vs. pre-COVID-19 trend,

January 2017-July 2025

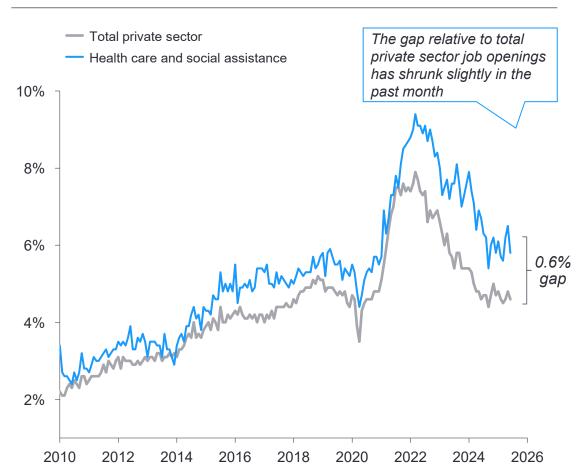


EY Parthenon

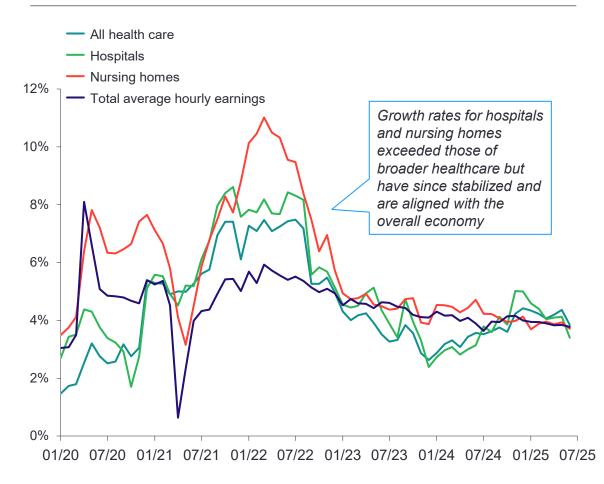
Demand for healthcare and social assistance workers and associated labor costs rose rapidly; trends are now are stabilizing and normalizing to the overall economy

Trends in health care job openings and average hourly earnings

Job openings rate, January 2010-June 2025 (seasonally adjusted)



YoY % change in average hourly earnings, *January 2020-June 2025 (seasonally adjusted)*



Source: BLS; EY-Parthenon analysis

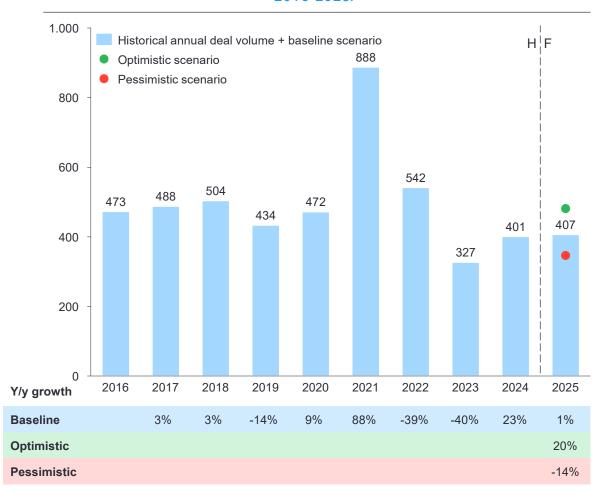
Page 44

EY Parthenon

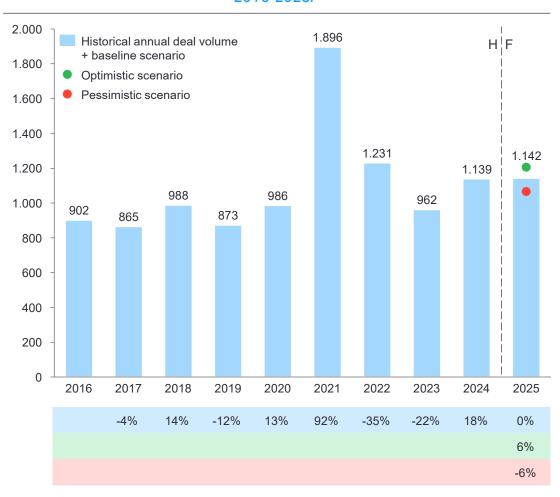
Our baseline outlook for US deals suggests annual deal volume recovery of ~23% and ~18% in 2024 for private equity and corporate M&A, respectively

US deal volume

Annual US PE deal volume (deals 100m+)^{1,2} 2016-2025F



Annual US corporate M&A deal volume (deals \$100m+)^{1,2} 2016-2025F



^{1.} Based on Dealogic data with historicals shown through 2025 Q1. Note historicals subject to revision across report editions, especially for most recent history.

EY Parthenon

^{2.} Scenarios based on EYP Macroeconomics team's outlook scenarios for the US economy.

The US health sector is facing pressure from macroeconomic and market forces, creating opportunity for transformative transactions

Macroeconomic forces and emerging investment trends

Macroeconomic and market forces



Underlying health conditions

- ▶ The global population is getting older, fatter, and sicker, which will exponentially increase problems facing healthcare providers

Untenable cost structure

- As costs balloon, all parties are affected, impacting every person in the US, their employers, and the states in which they live

Labor shortages and workforce expectations

- ▶ Continuing labor shortages will keep pressure on provider organizations while wage growth and increasing expenses are resulting in ailing operating margins

Health disparities

- ▶ Health disparities are ingrained within the healthcare system, at significant cost to individuals and the overall system

Consumerism and "care everywhere"

▶ Patient-consumer expectations have moved faster than systems that provide care; they are demanding more, sooner, and closer

Emerging investment trends



Search for value

Value based payment models are increasing in penetration and sophistication



Technology and digital transformation

Healthcare CFOs are prioritizing digitization as part of organizational capital strategy





Transactions everywhere

Across the sector, transformative transactions continue to be an option to diversity capabilities



New entrants and disruptors

Big tech, retail and other Fortune 100 players are forcing health systems to plan beyond core business

Source: EY-Parthenon analysis



Several themes exist that might serve as catalysts for opportunistic investments in the healthcare sector

Key investment themes in healthcare and life sciences

NON-EXHAUSTIVE | FOR DISCUSSION



Revenue cycle management: Focus on outsourced capabilities from tech-enabled vendors for both inpatient and outpatient settings, with increasing interest in offshore and AI investment

Specialty pharmacies: *Infusion (site of care; home vs. clinic); channel* (digital, physical, mail order, therapeutic areas); pharma services, population-specific (e.g., long-term care), and health-system specialized pharmacies benefit from population shifts and services demand



Data management and organization: Disparate systems across tech ecosystems create interoperability and integration considerations



Technology: Investment opportunities in tech supporting the ecosystem – including prescription workflows, pharmacy management systems, inventory management, data aggregation and others



Novel cost containment: Employers continue to seek innovative funding mechanisms to reduce healthcare costs, including defined contribution models (ICHRA / MERP) and risk mitigation strategies (e.g., out-ofnetwork services)



Clinical trial site enablement: clinical research is becoming more patient and site-centric, fueling demand site enablement solutions that improve recruitment and retention and technologies that streamline workflows, strengthen patient engagement, and enhance data analysis



VBC enablement / population health: Growth in value-based arrangements and cost pressure on payers and providers drive need for services and tech platforms



sciences

Cold chain logistics for advanced therapeutics: High interest in vendors with capabilities to offer both end-to-end traceability of temperature-controls in response to regulatory pressures, as well as JIT distribution capabilities; 4PL model is succeeding



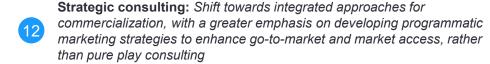
Post-acute care: Home health and hospice continue to experience tailwinds from aging population and payer preference for lower-cost care settings



Biopharma programmatic advertising: Pharma budget shifts towards non-personal promotion, away from sales reps by pursuing programmatic solutions with very high ROI, especially as pharma pursues more niche patient populations requiring hypertargeting for promotional solutions



Applied Behavioral Analysis (ABA) therapy: Active sector for investment given attractive macro tailwinds and favorable supply/demand dynamics driving consolidation





Agenda

- ► Health market overview
- **▶** Commercial diligence considerations for healthcare transactions

Commercial diligence assesses the attractiveness of a target by providing insights into critical factors such as current and forecasted market attractiveness, trends and risks

Understanding the market landscape

Understanding power dynamics within the industry

Identify industry trends

Assess customer expectations

Identify risks and opportunities

Common goals of a commercial diligence

- What is the industry and sub-sector that we play in?
- What is the value chain of service offerings?
- Who are the different stakeholders in our industry (e.g., clients, patients, suppliers, regulators, etc.)
- What are the relative power dynamics between these stakeholders?
- ► How has the industry changed over time? How is it poised to change in the future?
- What are the underlying drivers of change? -
- What are the incumbent expectations of doing business with us (e.g., pricing models, capabilities, service, etc.)
- ▶ How are these projected to change with new disruptions?
- What are the risks / headwinds facing us?
- What are opportunities can we leverage?

Commercial diligence provides significant value to an entity across a range of growth scenarios: buying or selling assets, or refining the organic growth strategy



Commercial diligences are critical to understand "where to play" and "how to play"

Market study focus areas



What are the best ways to **grow** our business?

Main objectives



How should we properly respond to **regulatory trends**?



How can we strategically bring products to market?



Enabling components



Market dynamics

- ▶ Is the total addressable market serviceable, sizeable, and growing?
- ➤ What are the macro-factors that may impact the industry?
- What are the implications of tailwinds and headwinds?



Competitive landscape

- ▶ Is the competitive landscape fragmented or consolidated?
- Who are the main players and disruptors stealing share?
- How are competitors differentiated and how can they be segmented?



Customer dynamics

- ► How can customers be segmented (e.g., industry, geographies)
- ➤ What are the purchasing behaviours and value propositions?
- ▶ What are the factors that may drive switching or impact "stickiness"



Growth opportunities

- ▶ What are the inorganic / organic growth opportunities?
- ➤ How can we increase share of wallet amongst existing customers?
- Which growth levers should be prioritized based on "right to win"?



GTM strategy and roadmap

- ► How should we design our GTM strategy to enter a new market?
- ▶ What are the immediate "quick wins" and moves of no regret?
- ▶ What are the tactical next steps in realize our strategic ambitions?

Market assessments help determine strategic options and inform investment viability questions



On the buy-side, market studies help to provide a better understanding underlying market trends and the target's competitive positioning

Buy-side market study focus areas

Is this a good market to invest in?

Quantitative market fundamentals:

- Total addressable market size
- Realized market/penetration
- Customer segmentation
- Market growth
- Number of annual opportunities

▶ Qualitative market fundamentals:

- Market structure/function
- Customer buying behavior
- Key decision-making criteria
- Upstream/downstream ecosystem participants

- Industry trends
- Exogenous factors (e.g., regulation, population)
- Alternatives to the target and its peers

Is this a good company within the market to invest in?

▶ Relevant competitive landscape:

- Range of competitors & segmentation
- Competitive positioning
- Strategic approach

▶ Target growth prospects:

- Core opportunities
- Adjacent opportunities
- M&A potential

► Target relative performance:

- Differentiation
- Perceptions
- Customer base satisfaction / stability
- Win rates

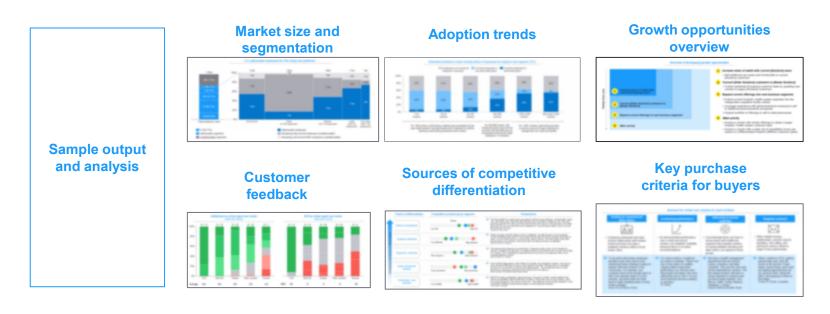


In sell-side engagements, market studies help potential buyers better understand key market dynamics and company positioning

Sell-side market study focus areas

Sell-side market overview

- ▶ In today's competitive deal process environment, sell-side diligence helps potential buyers quickly "climb the learning curve" and appreciate the merits of an investment opportunity
- Fact-based, target-centric approach helps buyers conduct diligence efficiently and often reduces timeline to closing
- Pre-emptive diligence helps inform go-forward strategy and prepares management team for critical investor questions
- All projects focus on exploring an asset's "full potential"



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US Healthcare Reimbursement & Regulatory Diligence 101

1:15 - 2:30



BRG Healthcare

Always HEALTHCARE

US Healthcare Reimbursement & Regulatory Diligence 101





US Healthcare Reimbursement & Regulatory Diligence 101

| Agenda | |
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Introduction



BRG Overview

BRG is a global consulting firm that helps leading organizations advance in three key areas: disputes and investigations, corporate finance, and performance improvement and advisory.

2010

ESTABLISHED BY EXPERTS

1,400+

PROFESSIONALS

1,500

HEALTHCARE CLIENTS SERVED

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OFFICES AROUND THE WORLD



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Relevant and timely information required to make fully informed business and legal decisions.



PERFORMANCE IMPROVEMENT & ADVISORY

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Healthcare Transactions & Strategy

With decades of experience in both the public and private sectors, our professionals offer unmatched expertise for investors, companies and advocacy groups when navigating today's evolving regulatory and reimbursement environment. Our team includes former policy makers and regulatory professionals from the Executive branch, including CMS/HHS and the White House, as well as from Capitol Hill, trade associations and state governments. This wealth of experience enables us to provide valuable insight throughout the transaction process or to inform strategic initiatives.

Integrated Services and Solutions

Healthcare Transactions

- Regulatory and Reimbursement
 - Federal
 - State
 - Health plan
 - Other payers
- Data Analytics
- Market Survey and Sizing
- Revenue Cycle Management Assessments
- Billing/Coding Audits and Compliance Program Reviews
- Financial and Tax Diligence (Quality of Earnings)
- Merger Integration

Healthcare Strategy

- Corporate Strategy
- New Market Growth/Business Intelligence (BI) Tools
- Focused Commercial Diligence

Healthcare Operations

- Performance Improvement
 - Cost reduction
 - Revenue cycle improvement
 - Physician alignment solutions
 - · Value-based transformation
 - Clinical variation
 - Integration solutions
 - Staffing optimization
- Finance
 - CFO Solutions
 - · Turnaround and restructuring
 - · Transition and interim management
- Compliance
 - · Investigations and disputes
 - Mock audits
 - Program and process improvement



John Kelliher

Managing Director

jkelliher@thinkbrg.com



John Kelliher has over 25 years of healthcare policy experience, including four years as chief counsel of the Committee on Ways and Means of the US House of Representatives.

During his tenure at the committee, he participated in the drafting and enactment of the Medicare prescription drug benefit. He was also involved with the passage of major tax legislation in 2001 and 2003. He served as a congressional staff member for nine years and has worked for over twenty years as a healthcare policy consultant. He has deep transactional diligence expertise, advising institutional investors on more than 1,500 acquisitions in the healthcare sector.

Mr. Kelliher also served as an active-duty Army officer for four years.

James Teisl

Managing Director

jteisl@thinkbrg.com



Jim Teisl, MPH, is a healthcare policy professional with 20+ years of Medicaid payment and financing experience. At BRG, Mr. Teisl has advised institutional investors on the buy-side of approximately 400 healthcare transactions. He joined BRG from the Medicaid and CHIP Payment and Access Commission (MACPAC), at which he authored and presented work related to Medicaid payment policies for institutional and non-institutional providers, primary care payment incentives, supplemental payments to hospitals and other providers, state approaches to Medicaid financing, state policies for dual eligibles, and Medicaid value-based purchasing initiatives (e.g., accountable care organizations, episodes).

He has a Master of Public Health and Certificate in Health Finance and Management from The Johns Hopkins Bloomberg School of Public Health, and a BA from The Johns Hopkins University.



Macro Context

Health Policy Is Primarily Guided By Congress, Carried Out By Federal Executive Branch (Mainly HHS) And States



State and local gov't

responsibilities

share public health

The 3 federal branches of government and states influence health policy. Defined roles and responsibilities aim to create "balance" of power.

| | 3 Branche | es Of Government Influence On Health Po | licy | |
|--|--|---|--|--|
| Executive Branch | • Carries out laws enacted by Congress • Operates federal health programs, often fills in details Congress has left out through rules and regulation | | | |
| Legislative Branch | Creates new programs or modifies existing Conducts "oversight" of how Executive Brace Sets budget for "mandatory" and "discretion" | anch implements laws passed by Congress | | |
| Judiciary Branch | Passes judgment on how or whether certaSettles disputes between federal government | | nies | |
| | Executive | Legis | lative | States |
| | | | | |
| | HHS | House | Senate | Licensing of |
| Implements policies thr13 divisions within HHS, | ough annual rulemaking | Of House's 21 committees, 13 have health jurisdiction: • Agriculture | Of Senate's 20 committees, 12 have health jurisdiction: • Appropriations | Licensing of healthcare professionals Distribution of |
| 13 divisions within HHS,Coordinates annual fund | ough annual rulemaking including CMS OMB ding requests ations, Congressional testimony, and policy | Of House's 21 committees, 13 have health jurisdiction: | Of Senate's 20 committees, 12 have health jurisdiction: | healthcare professionals |

Oversight & Accountability

Small Business

Veterans Affairs

Ways and Means

Judiciary

Small Business

Veterans Affairs

Select Committee on Aging

National Economic Council

Council of Economic Advisors

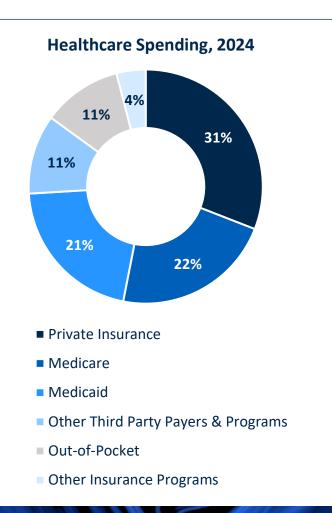
Domestic Policy Council

55% US Population Insured Through Private Plans, 37% Gov't Programs, 8% Uninsured



Most healthcare services in the US health system are paid for via health insurance – either commercial or government sponsored.

| Priva | te Plans | More than half of Americans have commercial coverage Most have large group or self-funded (ERISA) plans, others have individual market or small group (for employers with 2-50 employees) |
|-----------|--|--|
| ~55% | 178M Lives | Individual Market/Exchanges |
| | | Small Group |
| | | Large Group/ERISA |
| | | Expansion of Medicaid and growth in Medicare population |
| Governme | ent Programs | Growing number of these plans are privately managed |
| | , and the second | Medicaid/CHIP |
| ~37% | 120M Lives | Medicare |
| | | Duals (Medicaid/CHIP) |
| | | • Tri-Care, VA, IHS |
| Uninsured | | ~8% do not have health coverage as of 2023, all time low Reduced from 15% prior to ACA |
| ~8% | 26M Lives | Declines in uninsured since 2019 correspond with increases in individual |
| | | market and Medicaid/CHIP coverage |



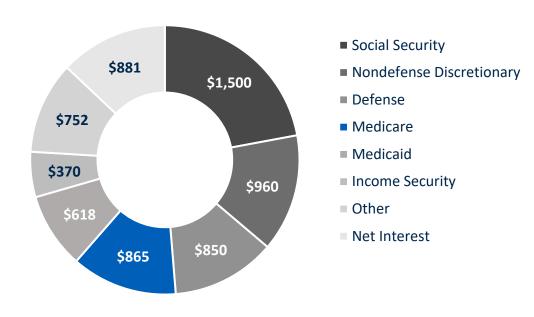
Medicare – Insurance For Older Americans, Those With Disabilities, And Those With ESRD



Medicare is administered by CMS and covers ~18% of the US population, accounting for ~13% of the federal budget.

| Medicare | | |
|----------------|--|--|
| Eligibility | People 65 years of age and older People under age 65 with certain disabilities People with End-Stage Renal Disease (ESRD) | |
| Lives Covered | • 67M lives, 18% of US Population | |
| Dual Eligibles | Eligible for Medicare due to age or disability and are also eligible for Medicaid Primary healthcare services covered by Medicare, with beneficiary cost sharing and other medical benefits (e.g., long-term nursing) covered by Medicaid | |

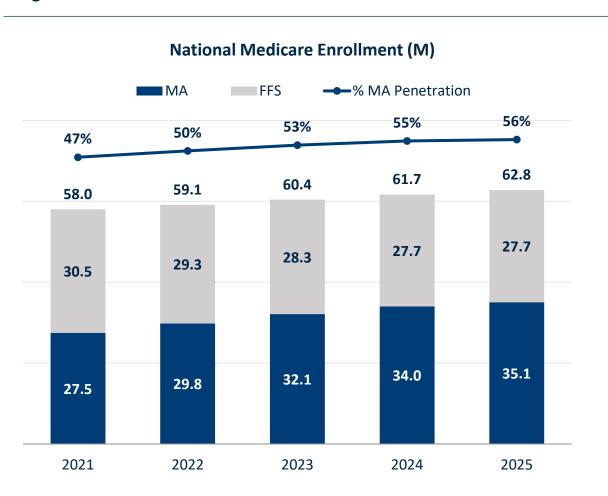
Medicare As Share Of Federal Budget, 2024 (\$B) \$6.8 Trillion Total

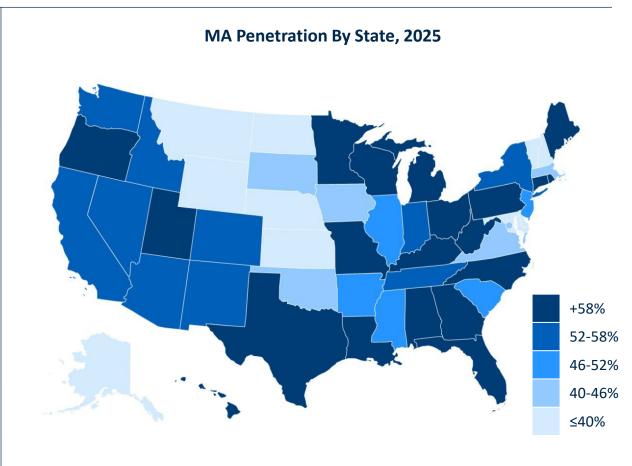


National MA Penetration Currently At 56% And Growing



Majority of Medicare Part A and B beneficiaries were enrolled in FFS in 2021 but shifted to MA in 2022. In 2025, national MA penetration rate is ~56% of eligible beneficiaries but varies across states.





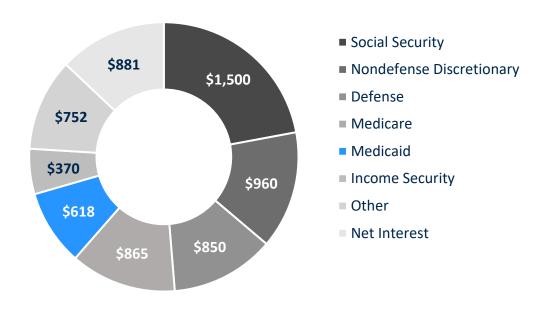
Medicaid – Joint Federal-State Program, Insurance For Diverse Low-Income Population



Medicaid covers ~21% of the US population, accounting for ~11% of the federal budget.

| Medicaid/CHIP | | |
|----------------------------------|--|--|
| Program | Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports | |
| Lives Covered | Medicaid is for low-income populations, including children, pregnant women, adults, individuals with disabilities, and people aged 65+ | |
| Funding | Eligibility levels, the use of managed care, and payment methods and rates all vary Federal government provides each state with funding called federal medical assistance percentage (FMAP) Federal funding ranges from floor of 50% to nearly 83% | |
| What it means for diligence work | State-specific coverage and rates vary widely Many services mandatory for kids Medicaid MCOs often negotiate rates State budgets and politics play roles | |

Medicaid As Share Of Federal Budget, 2024 (\$B) \$6.8 Trillion Total







OBBB Contains Multiple Measures That Alter Medicaid Administration And Financing As Well As Provisions That Would Reduce Access to Marketplace Coverage



These provisions aim to reduce spending and limit Medicaid enrollment for expansion population adults and aim to limit tax credit eligibility and increase administrative hurdles for enrollment and retention among low-income and immigrant populations in the marketplace.

| Category | | Policy |
|-------------|--------------------------------|---|
| Medicaid | Eligibility | Introduces work requirements for expansion population |
| | | Increases frequency of eligibility evaluations for non-elderly "able-bodied" adults |
| | | • Exempts adults 65+, Medicare/Medicaid dual eligibles, and medically fragile individuals from eligibility changes |
| | Rule Moratoria | Delays implementation of states' rules related to eligibility and enrollment |
| | Provider Taxes | Prohibits new taxes on providers and MCOs that are used to fund Medicaid programs |
| | | Freezes existing provider and MCO taxes while lowering allowable tax rate to 3.5% |
| | | Requires tax rate uniformity across entity types |
| | State-Directed Payments | Limits amount of reimbursement to certain providers like hospitals via SDPs |
| | Cost Sharing | Requires cost sharing for expansion population adults with income over 100% FPL |
| | | Limited to \$35 per instance |
| | Eligibility | • Limits tax credit eligibility to U.S. citizens and specific lawfully present immigrants, excluding many categories of |
| | | lawfully present non-citizens from Marketplace subsidies |
| | PTC | • Denies premium tax credits to immigrants with incomes below 100% of the FPL, even if they are lawfully present |
| | FIC | and ineligible for Medicaid |
| Marketplace | Verification | Requires annual re-verification of eligibility for both enrollment and tax credit receipt |
| Marketplace | | Tightens verification requirements for changes in income or household size |
| | SEP | Eliminates COVID-era SEP that allowed broader and more flexible enrollment opportunities |
| | Tax Credits | Removes current cap on repayment of excess tax credits, requiring enrollees to repay the full amount of any |
| | | overpaid subsidy, regardless of income level |
| | Re-Enrollment | Prohibits automatic re-enrollment in Marketplace plans |

Source: BRG analysis of H.R.1 - One Big Beautiful Bill Act.

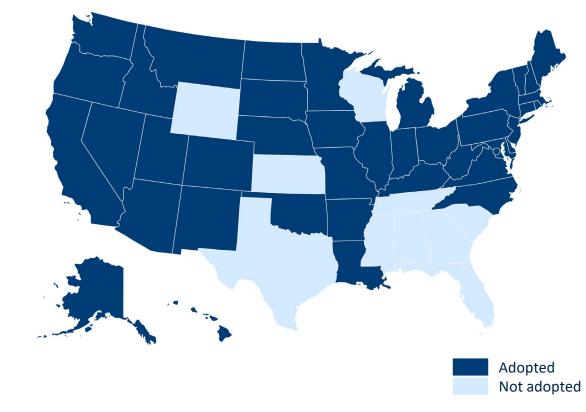
40 States And DC Have Expanded Medicaid Coverage; South Dakota And North Carolina Most Recent To Expand



ACA's Medicaid expansion expanded Medicaid coverage to nearly all adults with incomes up to 138% of the FPL, \$21.6k for an individual in 2025, and provided states with an enhanced FMAP for their expansion populations.

- Coverage under Medicaid expansion became effective January 1, 2014, in all states that adopted Medicaid expansion under original expansion
- 40 states + DC have implemented full expansion
 - Supreme Court made expansion optional
 - Federal gov't contributes 90% of funds for expansion population
 - NC most recent to expand, effective December 1, 2023
- 2 states implemented policies to partially expand
 - WI covers adults up to 100% FPL but has not fully expanded
 - GA covers adults to 100% FPL if they meet work requirements
- Some non-expansion states discussing possibility of expansion
 - Recent efforts to expand in FL, KS, and MS have been unsuccessful

Medicaid Expansion States, August 2025

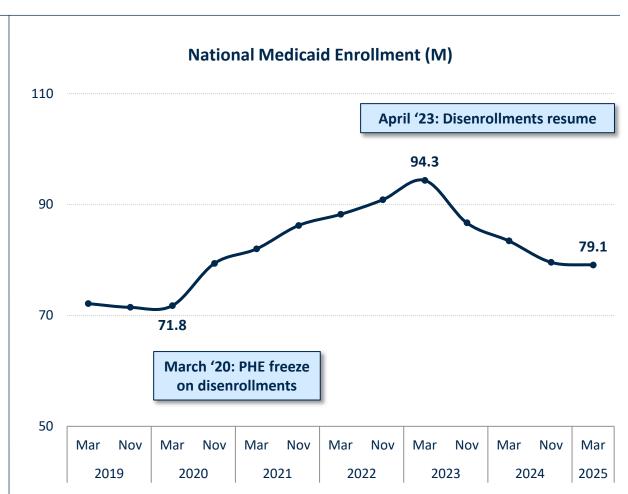


US Medicaid Enrollment Increased By 32% From March 2020 To April 2023; Stabilized Above Pre-Pandemic Levels Following Resumption Of Disenrollment Process



March 2020 to April 2023, Federal COVID-relief legislation prevented states from disenrolling Medicaid enrollees who lost eligibility; eligibility redeterminations and disenrollments resumed in April 2023 and led to -20% decline in enrollment.

- Dec. 2022, Congress passed legislation requiring Medicaid eligibility redeterminations to resume starting April 2023
 - -20% net decline in enrollment during eligibility redeterminations process (April 2023 through May 2024)
 - Many who lose Medicaid coverage are eligible for other sources (e.g., ESI, Marketplace); not all may enroll
- States finalized eligibility redeterminations process for almost all Medicaid enrollees by May 2024
 - Enrollment stabilized ~10M above pre-pandemic levels following eligibility redeterminations
 - States disenrolled > 25M beneficiaries and renewed coverage for >56M individuals
- March 2020, FFCRA increased each state's federal share of Medicaid spending (FMAP) by 6.2 percentage points
 - Tied to continuous coverage requirement that prohibited disenrollment, driving enrollment to historic peaks



Federal Rule Requiring ≥80% Of Certain Medicaid Payments To Direct Care Compensation By 2030 Unlikely To Be Implemented



80/20 requirement applies to compensation for direct care workers providing homemaker, home health aide, and personal care under certain programs. Advocates believe election, implementation challenges, and a new 2029 administration effectively eliminate likelihood of implementation as required.

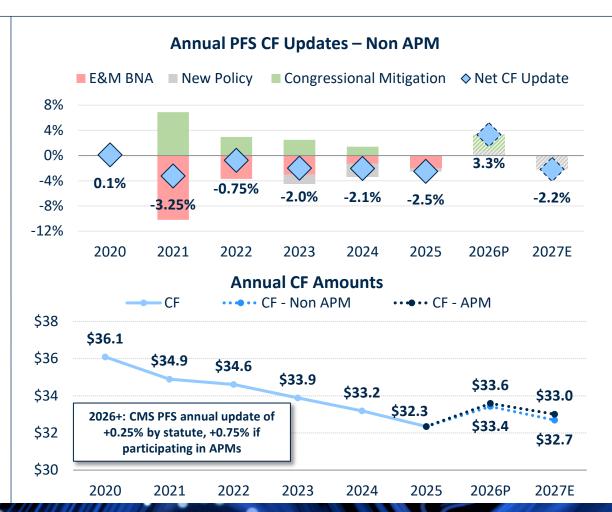
- Provider advocates do not believe final Medicaid Access Rule will be implemented in 2030 as currently required
 - Rule met with strong provider pushback and faces implementation challenges, including likely litigation, prior to its 2030 effective date
 - Homecare advocates believe Trump election effectively ended prospects for implementation through regulatory repeal or legislation blocking rule
- Payment Adequacy Provision (80/20) would require ≥80% of Medicaid payments for homemaker, home health aide, and personal care under certain authorities be spent on compensation for direct care workers
 - Services chosen because most payment comprised of compensation for direct care, with low facility or other indirect costs
 - Payments include wages, benefits, education, workers compensation, taxes, non-admin costs related to clinical supervisory positions
 - Applies to FFS and managed care
 - Habilitation not included in 80/20 requirement
- Numerous other provisions of Access Rule are generally good for Medicaid providers—states must:
 - Publish fee schedules
 - Regularly compare their rates to Medicare
 - Demonstrate that proposed cuts will not diminish access

Physicians: Budget Neutrality Achieved Through CF Changes, Congressional Relief Across Entire PFS Helped Mitigate Impact Through Phase-In



OBBB increased physician rates by +2.5% for 2026, which will be applied in addition to existing MIPS/APM payment updates of 0.25% or 0.75%, respectively. Congress did not provide PFS relief in 2025.

- OBBB provides one-time rate increase of +2.5% for 2026, while maintaining existing policies
 - Without further intervention, the +2.5% increase will expire, resulting in a cut in '27
- Prior year mitigation has delayed reductions that were scheduled in 2021 to offset E&M increases
 - Congress has not changed existing policy, just mitigated impact in a specific year
- -2.5% in 2025 from:
 - Leftover -1.25% BNA from 2023 mitigation
 - 2022 end of year budget mitigated a -4.5% PFS reduction, resulting in YoY impact of -2% in '23, -1.25% in '24, and -1.25% in '25
 - PFS 2024 final rule included additional -2.1% BNA for new policies
- March 2024 healthcare package partially mitigated −3.4% reduction that went into effect January 1
 - Annualized impact for '24 was -2.1% reduction
 - Rate increased +1.68% effective Mar 9, 2024
 - No mitigation from Jan 1, 2024 to Mar 8, 2024



Biden Administration Inflation Reduction Act Allows Medicare To Negotiate Drug Prices



CBO projects impact of changes within Medicare program to reduce total US drug spend by <5% over decade, estimated savings of \$99B over 10 years.

- Drug provisions in Inflation Reduction Act include:
 - Medicare to negotiate price of certain prescription Part D drugs starting in 2026, Part B 2028
 - Effective 2023, manufacturers of single-source drugs and authorized generics pay rebate equivalent to difference between CPI & AMP (Part D drugs), or ASP (Part B drugs) multiplied by units sold to Medicare
 - Increases add-on payment for biosimilars from 6% of reference product ASP to 8% from 2022-2027
 - Return of sequestration in 2022 reduced add-on payment to +6.272%
- Studies indicate in typical year ~50% of prescription drugs have price increases above inflation
 - According to BLS, since 2000, overall prescription drug inflation has been 0.3ppt above CPI-U
 - Prescription drugs average inflation of 2.9% above CPI-U average rate of increase of 2.6%

| Category | Analysis | | | | |
|------------------|--|--|--|--|--|
| New Authority | • Drug pricing legislation requires the HHS Secretary to negotiate prices for certain single-source Part B & Part D drugs among the top 50 in Medicare spend | | | | |
| Drugs Excluded | nd, orphan, and plasma-derived drugs are exempt | | | | |
| Drugs Included | Small-molecule drugs on market for 9 years and biologics on market for 13 years Minimum price reduction of 25% rising to 60% by time drug has been on market for 16 years | | | | |
| Timing Of Impact | Part D drugs selected in 2023, updated pricing effective in 2026 Part B drugs eligible for negotiations in 2026, updated pricing effective 2028 | | | | |

Source: BRG analysis of Inflation Reduction Act, 2022.

Trump Administration Proposed Drug Pricing Reform Is An Attractive Political Issue But Enacting Meaningful Change Very Difficult Politically



Vast majority of voters across political spectrum support greater regulation of drug prices. Second Trump Administration pursuing aggressive agenda, reflected in EOs on April 15 and May 12.

- First Trump Administration's drug pricing reforms blocked by operational, legal challenges
 - MFN model, list price in advertising thrown out by Courts
 - Rebate prohibition in Part D delayed by Congress

April 15 EO

- Contains 11 policy sections
- Includes IRA reforms, support delaying when a small molecule drug may be selected for negotiation
- Calls on Medicare to move forward with a CMMI demonstration that aims to "obtain better value for high-cost prescription drugs and biologics

May 12 EO

- Calls on manufacturers to equalize drug prices between the US and certain foreign countries
- If unsuccessful, requires rulemaking to enforce MFN pricing, consider importation, facilitate direct-to-consumer drug sales, initiate FTC investigation, etc.

 Trump Administration has signaled it plans to return to a model it tried in 2020 that would require Medicare to pay MFN prices for Part B Drugs

| Category | Analysis |
|----------|--|
| Proposal | Model would be designed to test whether aligning payment for Medicare Part B drugs with international prices and removing incentives to use higher-cost drugs can control growth in Medicare Part B spending without adversely affecting quality of care |
| Impact | 2020 model would have lowered price by 65% for top 50 Part B Drugs Oncologists, Hospital would face significant cuts, create political hurdle for |
| Timing | Would likely go into effect second half of 2026 or first half of 2027 |

2026 Home Health Rule Proposes 6.4% Decrease; Final Rule Likely Softens BNA



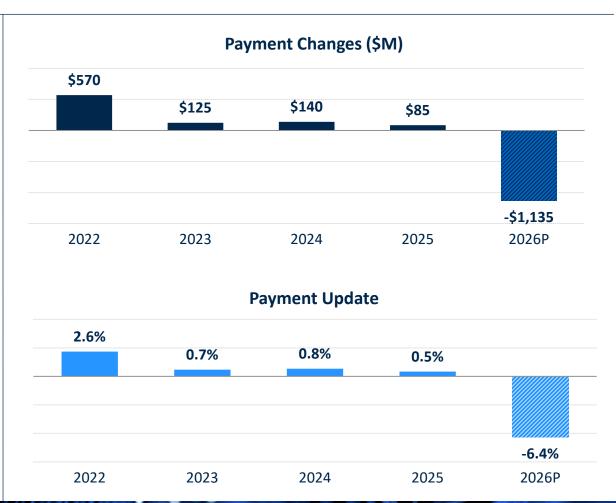
The 2026 proposed home health rule estimates that Medicare payments to home health providers in CY 2026 would decrease in aggregate by 6.4% or \$1.135B compared to CY 2025; final rule likely phases-in budget neutrality policies to avoid an abrupt rate decrease.

Proposed -6.4% is net of:

- +2.4% in payments based on proposed annual market basket increase
- -3.7% reflects proposed permanent behavior adjustment
- -4.6% reflects proposed temporary behavior adjustment
- -0.5% reflects proposed update to FDL ratio

CMS likely to spread -6.4% over 2026-27, possibly longer

- As in past years, CMS may only implement half of the proposed permanent adjustment for 2026
- This is the first year that CMS is proposing to make the temporary adjustment required by law to reconcile actual versus assumed behavior in 2020-2026
- -4.6% proposed temporary adjustment is only 15% of full adjustment CMS has calculated would be necessary for 2020-2024
- CMS may delay the temporary adjustment beyond 2026





IV

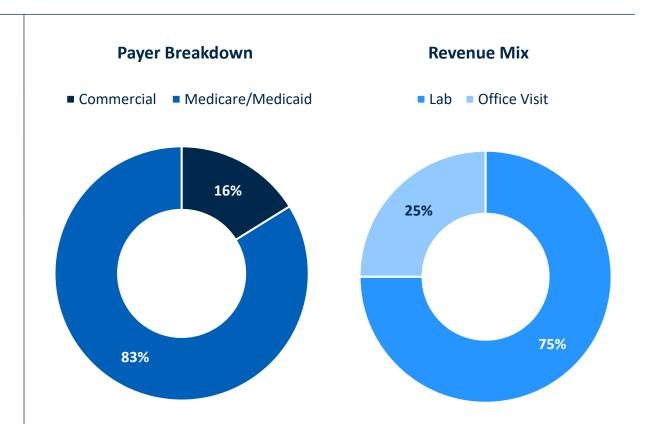
Diligence Focus Case Studies

Case Study 1: Office-Based Substance Use Disorder Treatment



What potential diligence issues does the Company revenue profile present?

- Multi-state office-based substance use disorder treatment provider
- Patients generally prescribed buprenorphine to control opioid addiction
- Prominent use of telehealth for patient visits
- Attributes?
- Things to "dig into"?



Case Study 2: Autism Therapy (Applied Behavior Analysis)



What potential diligence issues does the Company rate profile present?

- Multi-state autism service provider—rates in table are from the Company's single largest state
- Services are provided by both Masters-level Behavioral Analysts (BCBA) and paraprofessional technicians (RBTs)
- Autism service provider revenue is typically ~90% RBT
- Attributes?
- Things to "dig into"?

| Payor Name | Payor Type | Clients | RBT | ВСВА |
|--------------------------|--------------------|---------|-------|-------|
| Payor 1 | Payor 1 Commercial | | \$49 | \$72 |
| Payor 2 | Payor 2 Medicaid | | \$100 | \$110 |
| Payor 3 Managed Medicaid | | 54 | \$100 | \$110 |
| Payor 4 | Commercial | 27 | \$60 | \$92 |
| Payor 5 | Commercial | 4 | \$76 | \$92 |
| Payor 6 | Commercial | 6 | \$200 | \$240 |
| Payor 7 | Commercial | 15 | \$68 | \$68 |
| Payor 8 | Managed Medicaid | 18 | \$50 | \$42 |

Case Study 3: Outsourced Benefit Manager



What potential diligence issues does the Company client profile present?

- Company contracts with states and MCOs to manage specific benefits
- Much of Company revenue is "at risk"
 - Company paid a contracted amount per member per month and pays providers for any services used
- 82% of members are Medicaid enrollees
- Attributes?
- Things to "dig into"?

| Operational Scale | 2018 | 2021 | 2018-2021 |
|---------------------------|------|------|-----------|
| Total Members (M) | 25 | 33 | +36% |
| Medicaid Risk Members (M) | 6 | 12 | +94% |
| MA/Commercial Members (M) | 4 | 6 | +54% |

| Financial Performance | 2018 | 2021 | 2018-2021 |
|-----------------------|---------|---------|-----------|
| Revenue (M) | \$1,791 | \$2,635 | +47% |
| Adjusted EBITDA (M) | \$97 | \$197 | +102% |
| Margin | 5.4% | 7.5% | 204bps |

Case Study 4: Interoperative Neuromonitoring



How can pending but not yet enacted legislation affect a transaction? How should investors think about forward looking scenarios for the legislative process?

- IONM has received media scrutiny for out OON billing practices
 - Neuromonitoring provider association have issued position statement on ethical business practices
- Several recent media articles have drawn attention to surprise billing for IONM services
 - In 2019, Texas patient received \$94,031 balance bill for IONM 1 year after undergoing a spinal procedure, patient's insurance only covered \$816 of IONM services
 - Multiple Colorado patients were charged up to \$169,000 for IONM after undergoing spine surgery from single provider in 2015
- American Society of Neurophysiological Monitoring (ASNM) issued position statement on business practices in neuromonitoring July 2019
 - ASNM raised concern about certain financial arrangements, including kick-backs and self-referrals
 - Acknowledged that some groups have charged excessive fees for IONM in order to gain business by paying the money back to surgeons
 - While technically legal in a few states, the ASNM is clear in their view that the practice is unethical

- ASNM has also raised concerns about timing for when patients sign the consent for neuromonitoring
 - Because the majority of IONM is considered elective, surgeons and hospitals may fear that if they tell the patient IONM is OON, the patient will choose not to have their surgery at that location
 - Patients are often informed IONM is OON in the minutes just before surgery when they sign the consent for neuromonitoring

| | Compromise Proposal |
|-----------------------|---|
| Scope Of Bill | Regulates surprise OON billing for both emergency and non-emergency services Applies to all commercial plans, including self-insured Superseded by state legislation Treat OON services as if in-network for purposes of cost-sharing, deductibles, and OOP limits |
| Payment Standard | Requires health plans to pay OON emergency and facility- based providers the median contracted rate for the relevant service in geographic area |
| Dispute Resolution | For services over \$750 doctors will be allowed to appeal to an outside arbitrator for reconsideration |

Case Study 4: PT Assistant Rate Reductions



Can an investor become comfortable with target company plans to mitigate the impact of a known regulatory or legislative that has a negative impact on the target company business model?

- PTAs will be reimbursed at 85% of full PFS rate beginning in 2022
 - Reduction from full PFS rate in past years
 - Independent PTA care specified by time threshold for services
- 2018 law repealed Medicare physical therapy caps, but implemented this reduced rate for PTAs
 - Therapy cap had limited total payments for PT services per year
- Process for E&M restructuring began in 2019 rulemaking and culminated in a substantial (-10.2%) budget neutrality adjustment
 - Congress mitigated by spreading impact from 2021 to 2024

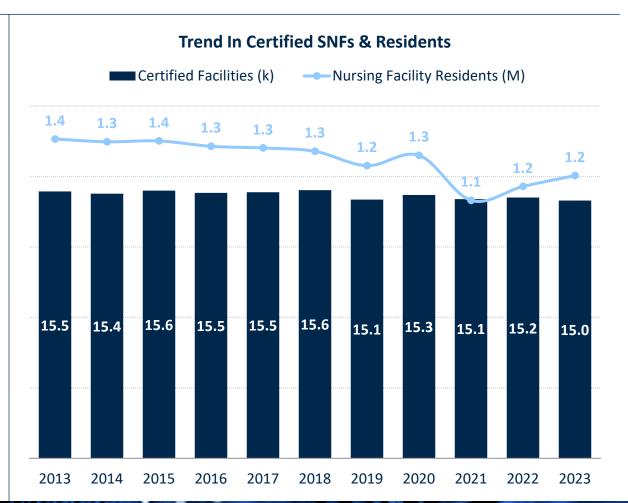
| Codes | 2020 | 2021 | 20-21 | 2022 | 21-22 | Total | | |
|-------------|---|------------|----------|------|-------|-------|--|--|
| Physical Th | Physical Therapist Reimbursement, 2020-2022 | | | | | | | |
| 97110 | \$31 | \$30 | -3% | \$29 | -4% | -7% | | |
| 97140 | \$29 | \$28 | -3% | \$27 | -4% | -7% | | |
| 97530 | \$40 | \$39 | -2% | \$38 | -4% | -6% | | |
| 97112 | \$36 | \$35 | -2% | \$34 | -4% | -6% | | |
| 97161 | \$88 | \$102 | 16% | \$98 | -4% | 12% | | |
| 97535 | \$35 | \$34 | -3% | \$33 | -4% | -7% | | |
| 97162 | \$88 | \$102 | 16% | \$98 | -4% | 12% | | |
| PTA Reimb | ursement | (85% of PT | in 2022) | | | | | |
| 97110 | \$31 | \$30 | -3% | \$25 | -18% | -21% | | |
| 97140 | \$29 | \$28 | -3% | \$23 | -18% | -21% | | |
| 97530 | \$40 | \$39 | -2% | \$32 | -18% | -20% | | |
| 97112 | \$36 | \$35 | -2% | \$29 | -18% | -20% | | |
| 97161 | \$88 | \$102 | 16% | \$83 | -18% | -5% | | |
| 97535 | \$35 | \$34 | -3% | \$28 | -18% | -21% | | |
| 97162 | \$88 | \$102 | 16% | \$83 | -18% | -5% | | |

Case Study 6: SNF End-Market



What can be a consideration for an investor other than the direct reimbursement or regulation of the target company model? How can investors become comfortable that the market into which a vendor or provider is selling is healthy?

- Facilities closures in recent years due to low Medicaid rates, lower rates and ALOS by MA enrollees, and oversaturation of SNF market
- Closures particularly in rural areas drive press coverage and may be only local SNF
- Newly-opened SNFs receive less press but siphon off more profitable Medicare patients from existing SNFs
- SNFs, even with poor financial outlooks, will often change management or restructure through bankruptcy
- Operator may have long-term lease that cannot be broken through closure – SNFs can borrow money based on property value
- 2020 reflects partial COVID impact due to report timing





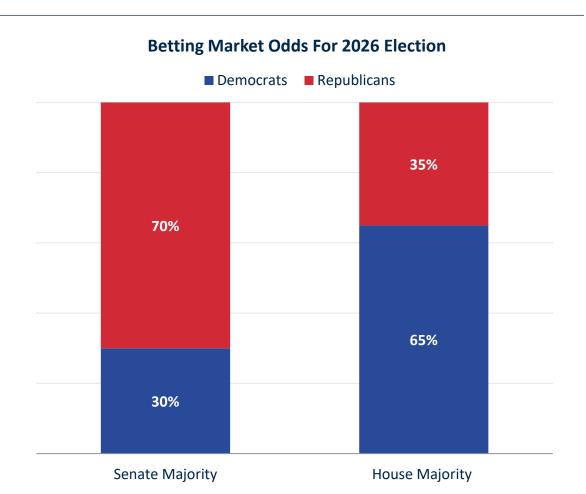
Election Politics

Historically, Party In White House Loses Control Of House Or Senate During Midterms - Limits Chance Of Major Legislation



Return to divided Congress – Republican Senate and Democratic House would freeze legislative activity for next Congress (2027-2028). Risk to Medicare providers would be a surprise Republican win in the House.

- 2026 midterm election likely to result in divided government, limiting any major healthcare legislation
- 2026 risk would be continued Republican control of Senate and House creating political window for deficit reduction efforts that could include Medicare
- 2024 election resulted in an all-Republican government with slim majorities in the House and Senate
- 2028 election could be gateway to deficit reduction regardless of political outcomes as external economic pressure forces Congress to address federal fiscal posture



Federal Focus On PE In Healthcare Includes Anti-Trust Scrutiny & Ownership Transparency Proposal; Trump Administration Likely Reduces Scrutiny On Transactions



Scrutiny of PE in healthcare was recent focus of Democratic Chairwoman Lina Khan; Trump administration likely to be less focused on anti-trust and friendlier to corporations.

Trump Administration Outlook

- Populist sentiments from Trump administration may continue consumer welfare protections, but reduce scrutiny on consolidation within that lens
- Recent FTC action likely to be dropped or scaled back considerably as Republican chairman takes over

| Recent Activity | Description | Outlook |
|---|--|---|
| FTC, DOJ, HHS RFI on PE ownership in Healthcare Industry | RFI on deals conducted by health systems, private payers, PE funds, and other alternative asset managers that involve healthcare providers, facilities, or ancillary products/services Understand how transactions may increase consolidation and generate profits for firms while threatening patients' health, workers' safety, quality of care, and affordability | Investigation will likely go on for years, unlikely to produce more than a report |
| FTC US Anesthesiology Partners Anti- Trust Lawsuit | September 2023, FTC sued US Anesthesia Partners Inc., and its PE investor for series of acquisitions that allegedly enabled firm to gain market power FTC alleged that in 2012, PE firm and USAP began scheme to consolidate anesthesia practices in Texas through series of roll-up acquisitions | May 2024, Federal judge dismissed the case |
| H.R.1754 - Healthcare Ownership Transparency Act | Bill would require healthcare corporations participating in Medicare to disclose PE interests and related financial info Bill mandates transparency about debts, assets, and financial transactions Providers controlled by PE funds must disclose info relating to PE fund, such as % equity contributed by partners Sponsor: Rep. Jayapal (D-WA) very progressive | Legislation unlikely to be enacted |



Q&A



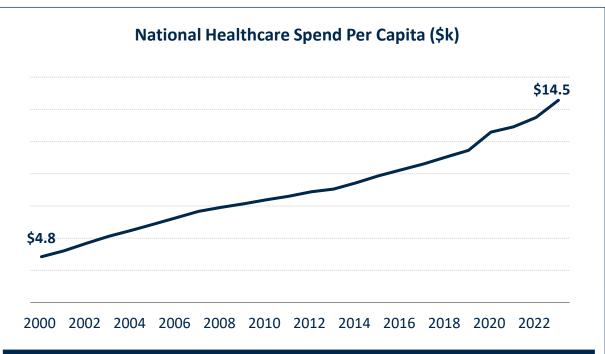


Appendix

US Per Capita Healthcare Spending Increasing, Particularly For Aged Population

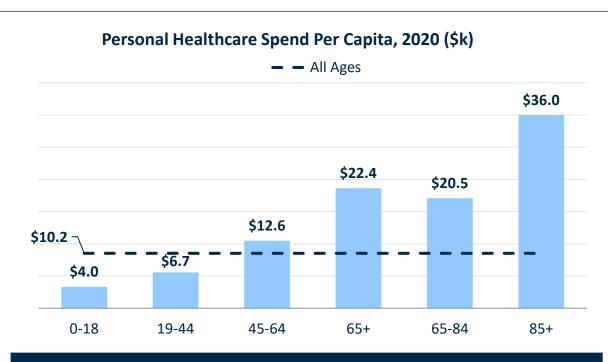


Aging U.S. population and rising prices drive increasing healthcare spending; Spending on U.S. health care has grown steadily, rising from \$4.8k per person in 2000 to \$14.5k per person in 2023, ~200% increase.





- Phenomenon is known as Baumol's cost disease
 - Baumol, an economist, observed that labor intensive sectors with little technology driven productivity growth, like health care, must have constantly rising prices in order to preserve the purchasing power of individuals employed in the industry



Aging Of The U.S. Population Drives Increasing Spend

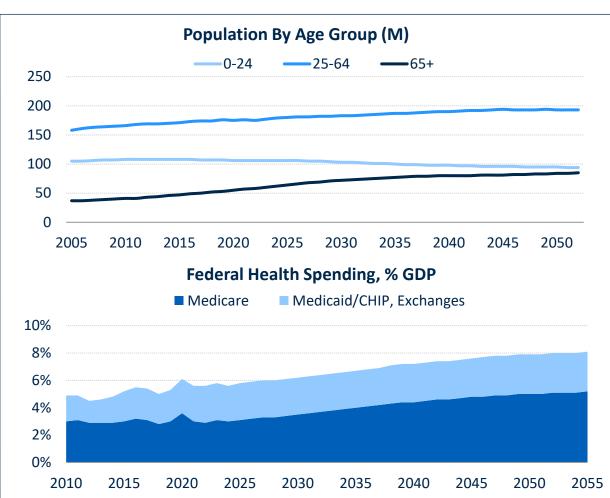
- \$22,350 for an average person 65 to 84 years old
- \$36,000 on an average person 85 or older
- \$4,000 on an average person 18 or younger

Aging Demographics Increase Demand For Healthcare



The percentage of the population age 65+ is projected to rise in the coming decades, with the aging population likely to increase demand for healthcare services—80+ cohort also growing.

- In 2024, the ratio of people ages 25 to 64 to people age 65 or older was 2.9 to 1. By 2055, it will be 2.2 to 1
- Aging population is likely to increase demand for healthcare services as higher percentage of the US population will be 65+
- Government and private payor policy changes only slow the growth of spending, not actually reduce it
- Major Federal healthcare programs are projected to double their share of GDP
- Medicaid and related programs are larger in total spending and serve more beneficiaries than Medicare



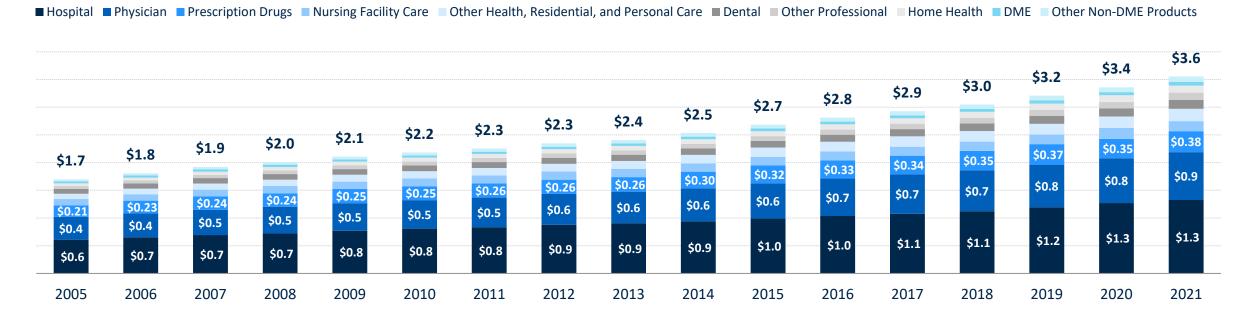
Hospital Spending Is The Biggest Component Of Healthcare Spend And Among Top 3 Fastest Growing



Hospital spending is the biggest component of healthcare spend and has risen from \$609B (36% of PHC) in 2005 to \$1.3T (37%) in 2021. Physician spending has remained around 24% of spend over this period but has grown 111% since 2005.

- Home health and residential care, historically smaller categories, have grown 6% annually since 2005 to combined \$348B in 2021
 - Nursing home growth (3% CAGR) most impacted by home health growth and in recent years COVID, has still grown over that time period
- Fastest growing category is "Other Non-DME Products"
 - Grown 174% since 2005 \$97B in 2021 largely OOP spending on products such as OTC drugs

NHE Healthcare Spending (\$T)



Source: BRG analysis of NHE 2023 data.



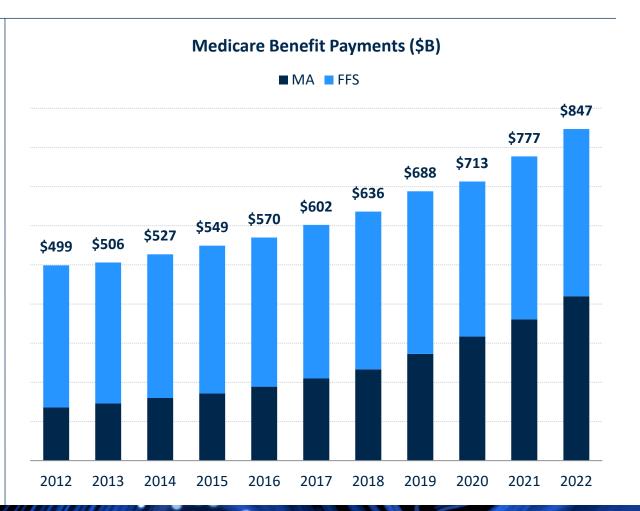
Medicare

Medicare Program Has Four Components, With MA An Increasingly Large Share Of Spend



Medicare Part A and Part B are traditional FFS Medicare, Part C combines A, B and D in a single private plan, and Part D is retail prescription drug benefit.

| | Medicare Program Components |
|-----------------------------------|--|
| Part A | Patients in facility settings: Hospital, skilled nursing home stays, home health services, and hospice care |
| Part B | Physician payment: Physician office and outpatient services such as PT |
| Medicare Advantage (Part C) | Covers beneficiaries via enrollment in private Medicare Advantage insurance plans which negotiate rates with providers and set their own cost sharing criteria Medicare Advantage plans cover all the services covered by Parts A and B; and some also cover Part D • May cover added benefits such as optometry not covered under Medicare FFS |
| Part D | Covers prescription drug costs through enrollment in private Part D or MA health plans |



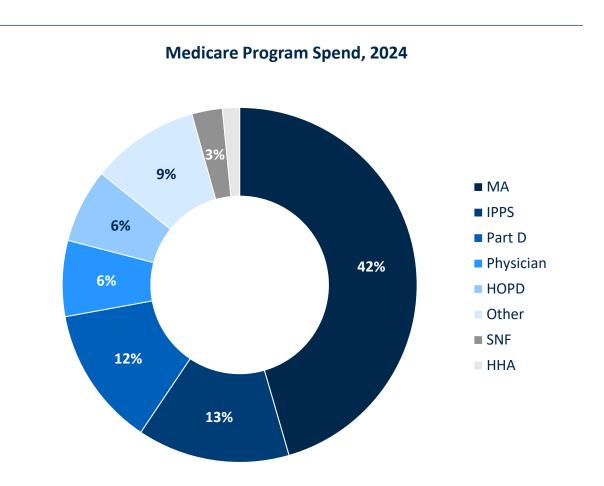
Source: BRG analysis of KFF 2023 data.

Medicare Advantage Spend Growing As More Beneficiaries Trend Towards MA Over FFS



MA spend has grown rapidly in recent years to 42% of program spend, FFS programs make up 46% and Medicare Part D 12%.

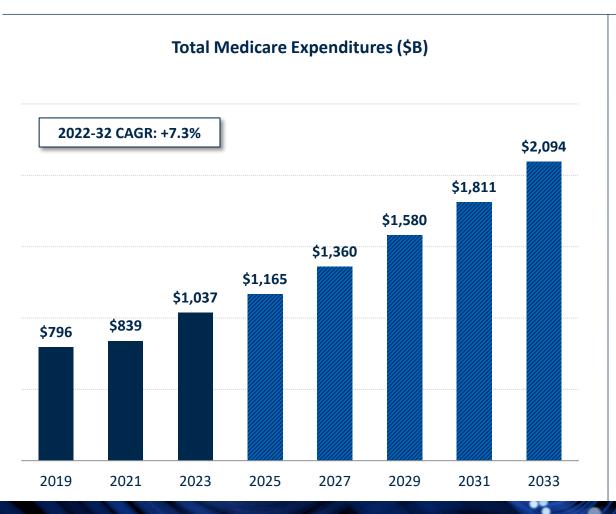
- Hospitals including IP and OP account for ~21% of FFS spend
- PAC spending in aggregate is less than 10% but is a focus of policymakers seeking more efficient care
- MA is almost half of total spending and increasing as more beneficiaries opt to enroll in MA
- Part D drugs are 12%
- Part B drugs grouped within "Other" category

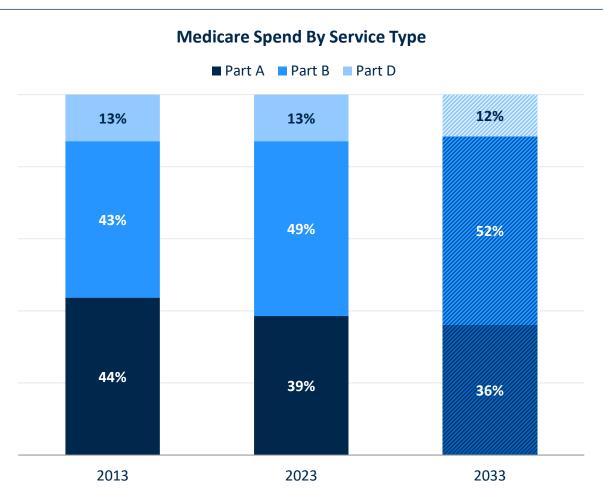


Medicare Spend Projected To Double From \$1T In 2023 To \$2.1T In 2033



Medicare spend projected to double from 2023 to 2033 due to growth in aging population and increased costs. Spending on physician services and other Medicare Part B services accounts for largest share of total Medicare benefits spending – trend likely to continue.





Fee Schedules, Prospective Payment Systems & Managed Care



Medicare has 20 different payment systems – each applying to a different program or type of service.

- Prospective Payment System (PPS) is method of reimbursement in which Medicare payment is made based on predetermined, fixed amount
 - Payment amount for a particular service is derived based on the classification system of that service or per day for that service
- Capitation payments are agreed upon in a capitated contract by a health insurance company and a medical provider
 - Fixed, pre-arranged monthly per patient enrolled in a health plan, or per capita
- Fee schedule is complete listing of fees used by Medicare to pay doctors or other providers/suppliers
 - List of fee maximums used to reimburse physician and/or other providers on FFS basis
- Cost-plus reimbursement pays the provider their reported costs plus a fixed percentage

| | Medicare Payment Systems | | | | | | |
|-----|--------------------------|--------------------|-------------|-------------|-----------|----------------|--|
| | С | apitated | MA | Part D | ACOs | | |
| | PPS | Episode of Care | Hospital IP | LTCH | IRF | Home Health | |
| | a | Per Diem | Hospice | IPF | SNF | | |
| FFS | | Hybrid PPS/ FS | ASC | Hospital OP | Dialysis | FQHC | |
| | F | ee Schedule | PFS | CLFS | Ambulance | DME | |
| | Cost-Plus | | САН | Part B | | | |

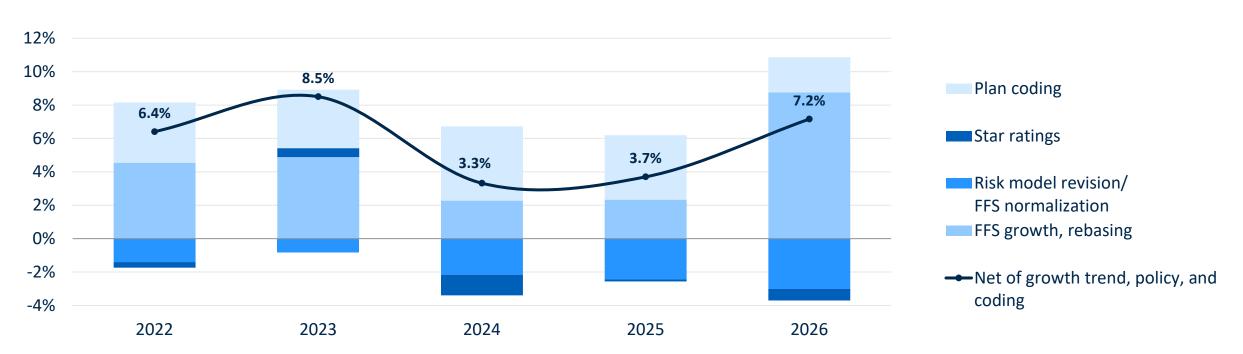
CMS Finalized 2026 MA Payment Update, Estimates Growth From Risk Coding



Annual MA payment updates have been more than 5% in recent years, estimated to be ~7.2% in 2026. The final payment impact is nearly 3 percentage points higher than the proposed rule, driven by a higher estimate of FFS spending using more recent data.

- V28 Risk Model finalizes completion of the three-year phase-in of the updated MA risk adjustment model (v28) in 2026
 - Updates to calculation of growth rates related to medical education costs and other technical changes finalized in CY 2024 Rate Announcement

Annual MA Payment Updates

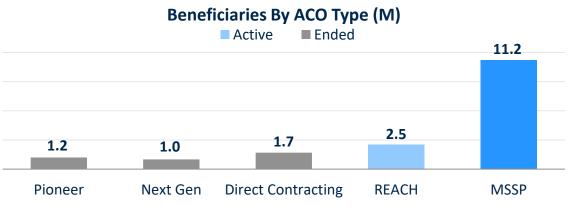


Most Medicare Beneficiaries Are In Value-Based Or Capitated Arrangement, Biden Participation Goal Shifts Under Trump

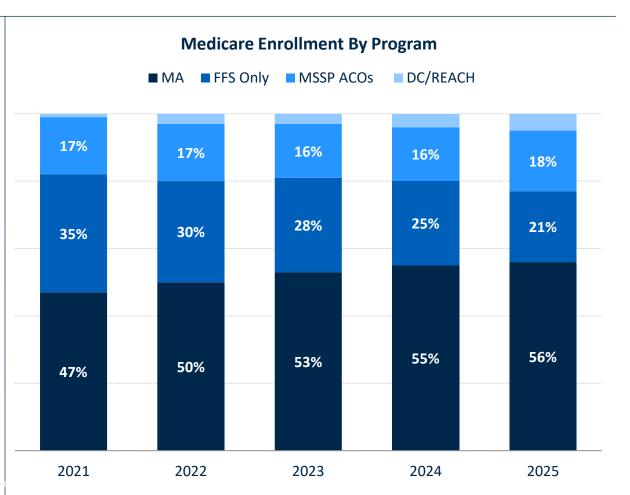


ACOs assigned ~13.7M Medicare FFS beneficiaries in 2025 with 805k providers and organizations participating; Biden Admin focused on reaching 100% FFS beneficiaries in value-based care, Trump focused on two-sided risk.

- CMS Innovation Center likely to continue testing ACO models, elements may be incorporated into MSSP
- Continued adjustments to MSSP with goal to help ACOs be successful, encourage shared risk



| ACO | Status |
|---------------------|----------------------|
| MSSP | Permanent since 2012 |
| ACO REACH | 2023 - 2026 |
| Direct Contracting | 2021 - 2022 |
| Next Generation ACO | 2016 - 2021 |
| Pioneer ACO | 2012 - 2016 |





Medicaid

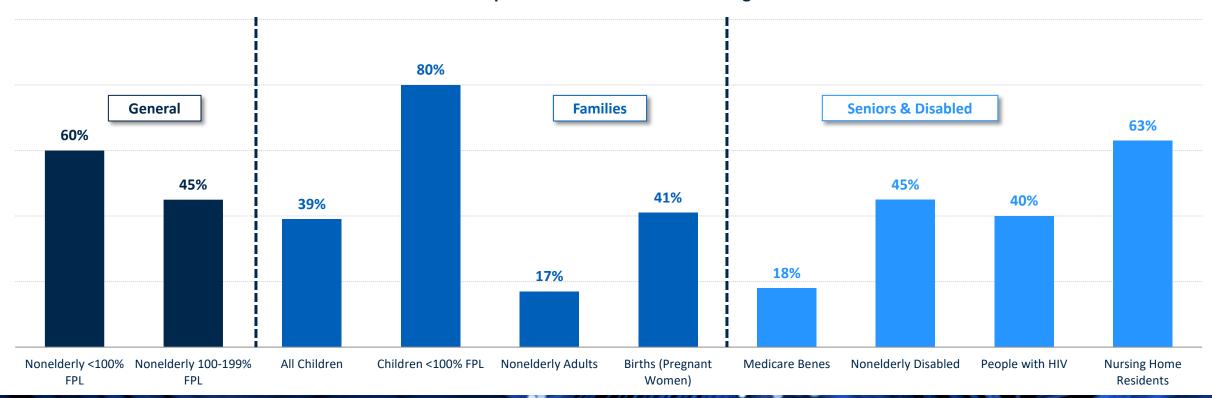
Medicaid Plays A Key Role In Covering Selected Populations



There is substantial variability in Medicaid eligibility across states. Individuals qualify for Medicaid coverage by meeting the requirements of a specific eligibility pathway offered by the state.

- Some eligibility pathways are mandatory, others are optional
- Medicaid provides health coverage for large portions of different populations

% Populations With Medicaid Coverage



Benefits Are Defined By States Within Federal Law Parameters



Medicaid coverage includes primary and acute care services as well as LTSS. States establish and administer their Medicaid programs and determine the type, amount, duration, and scope of services within Federal guidelines.

- Enrollee's eligibility pathway determines the available services in a benefit package
- Federal law provides two primary benefit packages for state Medicaid Programs
 - Traditional benefits
 - Alternative benefit plans (ABPs)
 - ABPs are tailored to meet needs of certain Medicaid population groups, target residents in certain areas of the state, or provide services through specific delivery systems
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit requires Medicaid to cover all medically necessary services for children
- Beneficiary cost sharing is limited under the Medicaid program
 - Medicaid enrollees generally receive benefits through FFS or managed care delivery systems
 - Reconciliation Bill requires monthly premiums or copays limited to 2-5% of household income for some populations

Required Services

- Hospital
- EPSDT
- Nursing facilities
- Home health
- Physicians, CNPs

- Labs, X-Rays
- Pregnancy related
- Transportation
- FQHC/Rural Clinics

Optional Services

- Drugs
- Therapy (PT, OT, SP)
- Respiratory
- Podiatry
- Optometry/Eyeglasses
- Dental/dentures
- Chiropractic
- Prosthetics

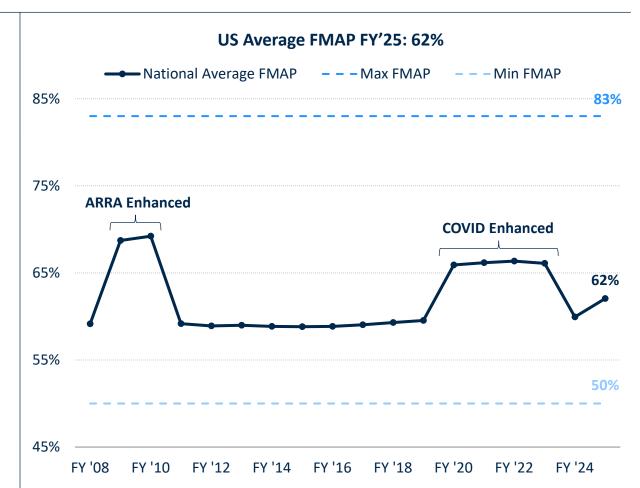
- Personal care/ nurse
- Hospice
- Case Management
- Elderly IMD
- ICF for IDD
- HCBS
- Health homes
- IPFs for youth

Federal Government Reimburses States For ≥ 50% Of Medicaid Spending Based On FMAP



Federal Medical Assistance Percentage (FMAP) is recalculated for each fiscal year and fluctuates by state based on per capita income, with statutory matching limits ranging from 50% to 83%.

- FMAP is inversely proportional to state's per capita income and is recalculated for each federal FY
 - Recalculation is based on state and national income data over the most recent 3-year period
 - Statutory limits are minimum of 50% and maximum of 83%
- For some populations, Federal matching rates are enhanced
 - ACA included enhanced FMAP for newly eligible adults with incomes up to 138% of federal poverty level
 - For this population, Federal government reimburses states for 90% of Medicaid spending
- Congress increased states' FMAP +6.2 percentage-points for duration of COVID-19 PHE
 - Enhancement phased out between April and December 2023
- **FY09** and **FY10**, FMAPs were temporarily increased to provide fiscal relief in response to the Great Recession



States Administer Medicaid Either Through FFS Or Medicaid Managed Care (MCOs); Medicaid Programs Predominantly Rely On Managed Care



States release RFPs and typically allow for a minimal number of awardees. Plans hold multi-year contracts and may negotiate with providers directly.

- Medicaid MCOs are typically limited in each state where they operate
 with states selecting only a handful of contract recipients
- Some MCOs are responsible for select populations (long term care, children, etc.), but structures vary by state

Medicaid MCOs

- Medicaid managed care provides benefits and services through contracts between Medicaid agencies and MCOs that accept a per member per month payment
- MCOs contract with providers at negotiated rates

- Most states use a combination of FFS and managed care, using FFS for select populations, including children and parents
- About half of all benefit spending nationally is FFS majority split between acute care services and LTSS

Medicaid FFS

- Healthcare providers are paid by the state Medicaid agency for each service according to a fee schedule or other state-determined rate
- States describe payment methodologies for mandatory and optional Medicaid services in their State Plan



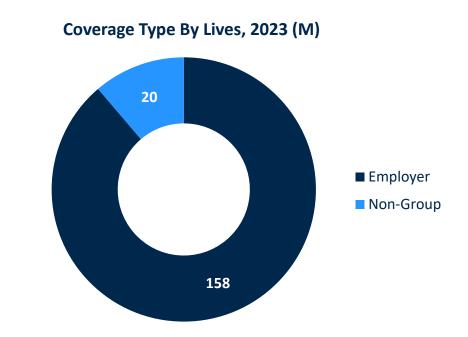
Commercial

Commercial Insurance Covers About 55% Of US Population



Most insurance is provided by employers (large group + small group), some of whom self-insure. Individual insurance (nongroup) market is predominantly individuals who are unlikely to have access to employer coverage.

- **Employers offer insurance coverage to employees,** both as a conventional norm, but also as a tax-incentivized benefit
 - Self-insured employers have more control over premiums and costs, and are regulated at the Federal level by ERISA
- Some people use individual insurance market as a temporary source of coverage
- Individual health insurance is very different than group
 - Individual market carriers are more limited in their ability to spread risk and benefit packages are less extensive
 - Deductibles and cost-sharing are generally higher in order to produce a lower premium
 - Healthcare Reform (ACA) sought to address challenges in the individual insurance market
 - Established guaranteed issue, ratings limits, minimum AVs, essential benefits etc.
 - Established credits to subsidize purchase of plans
- Enhanced subsidies in the American Rescue Plan Act (ARPA), boosted outreach and extended enrollment period – extended under IRA



| | Commercial Insurance Type |
|-----------|----------------------------------|
| Employer | 158M lives, 49% of US Population |
| Non-group | 20M lives, 6% of US Population |

Source: BRG analysis of KFF 2023 data.

ACA Regulated And Subsidized Individual Insurance Market



ACA provides refundable and advanceable premium credits to eligible individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges.

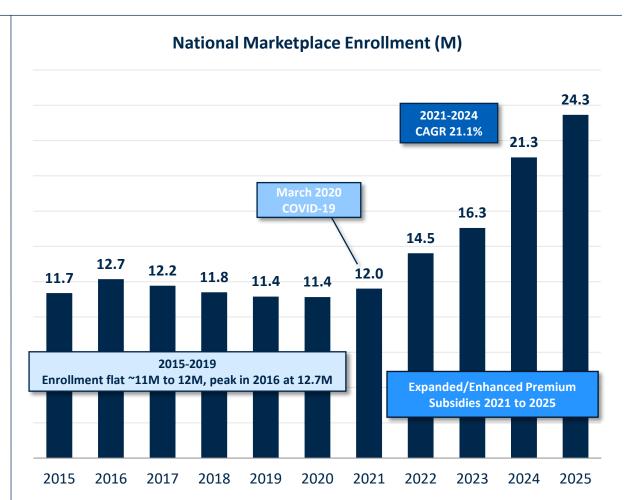
- Premium credits tied to the second lowest cost silver plan in the area
- **Set on a sliding scale** such that the premium contributions by beneficiary are limited to the following percentages of income for specified income levels:

Up to 150% FPL: 0% of income 250% FPL: 4 – 6% of income 300% FPL: 6 – 8.5% of income 400% FPL: 8.5% of income

- Increase premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth
 - Total subsidies capped at 0.5% of GDP

Marketplace Plan Selection By Metal Level, 2025 (M)





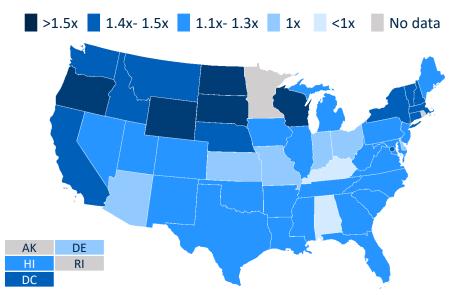
Wide Variation In Commercial Rates As Percent Of Medicare Across States



24 states are 1.1x to 1.3x of National Medicare, 30 states are 1.1x to 1.3x of their own state Medicare geographically adjusted rates.

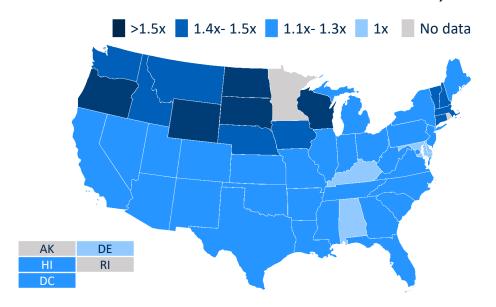
- Average, weighted average, and median rates are ~1.2X Medicare
- 15 states have premium rates >1.4X Medicare, across northern US
- KY and AL are only states below 100% national Medicare average

Commercial Prices Percent Of National Medicare, 2017



- IA, MO, OH, KS, IN, AZ, KY, AL, MD commercial rates are larger percentage relative to state Medicare than national Medicare
 - OH, IN, MO, NE, AZ are 1.1X to 1.3X
- CA, NY, DC commercial rates are smaller percentage relative to Medicare
 - 1.1-1.3X their own state Medicare

Commercial Prices Percent Of State Medicare, 2017

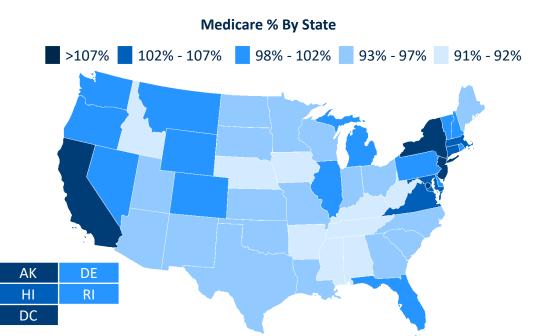


State Medicare Rate And State Concentration Of Payer Market Interact W/ Commercial Rates : BRG

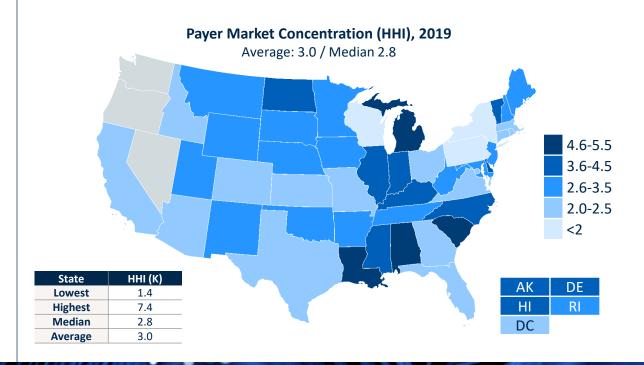


Statewide average Medicare FFS price ranged from 9% lower than national average in MS to 11% higher than the national in DC; Payer concentration and commercial rates somewhat congruent.

- Medicare rates adjusted for local costs
 - Higher Medicare rates generally track with higher commercial
 - 14 states 98%-102%
 - 10 states above 102%
 - 27 states below 102%



- WI has lowest payer concentration, highest commercial rates
- AL has highest payer concentration, lowest commercial rates
 - BCBS of AL has +90% market share





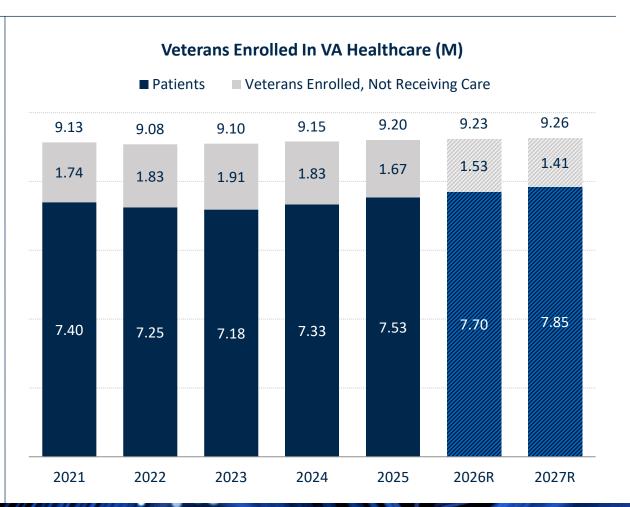
Additional Programs

VA Healthcare System Stable & Serves 7M+ Vets Annually



The VA healthcare system is federally funded through an annual appropriation by Congress and services are provided at VA facilities or contracted providers.

| VA Healthcare Characteristics | | |
|-------------------------------|---|--|
| Funding & Cadence | VA healthcare is discretionary program Annual Congressional appropriations Requested annually | |
| Eligibility | Eligibility based primarily on veteran status, categorized into 8 priority groups | |
| Delivery System | Fee for service reimbursement structure Rate based on fee schedule, Medicare, or percent of billed charges | |
| Facility Type | Provided by VA facilities or contracted providers | |
| Billing | Veterans do not pay premiums for VA care Some veterans required to pay copayments for treatment of nonservice-connected conditions Veterans with significant service-connected disabilities exempt Authority to bill most insurers for non-service-connected care May authorize care in the community | |



340B Is Crucial For Hospitals And Other Providers, Requires Discounted Pharmaceutical Prices For Covered Entities



340B program enables certain healthcare providers and programs (covered entities) to purchase outpatient drugs at discounted prices and resell to Medicare and Commercial plans at full price.

- 340B enables covered entities to purchase outpatient drugs at discounted prices, creating larger profit for the covered entity when the drug is dispensed to a qualified patient
 - Allows CEs "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services" to "at risk" populations
- Manufacturers required to participate and provide 340B pricing on all products if they participate in Medicaid

| Cat | egory | Description | |
|---------|------------|---|--|
| Covere | d Entities | • Eligible providers include certain Hospitals (Children's, Critical Access, Freestanding Cancer, DSH, SCH, RRC), FQHCs, AIDS clinics, Family Planning Providers, a other specialized clinics | |
| Patient | Definition | 340B drugs only provided to individuals who qualify as patients of covered entity, defined as: CE maintains patient records Clinician is employee of CE or is under arrangement with the CE Not considered a patient if only service is dispensing a drug for self-administration | |
| Drugs | Covered | 340B program covers outpatient drugs that are: FDA-approved prescription drugs and biologics OTC or outpatient drugs when prescribed Not inpatient drugs, vaccines, or Orphan Drugs purchased by certain hospital types | |
| | Price | Maximum amount manufacturer can charge CE for 340B covered outpatient drug Statutorily defined as AMP reduced by Unit Rebate Amount HRSA obtains AMP and URA data from CMS as part of Medicaid program reporting Estimated average discount of 59% off list price (WAC) For self-administered drugs (pills, self-injectables), estimated average discount is ~70% | |

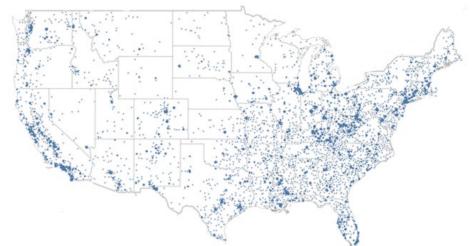
Federally Qualified Health Centers

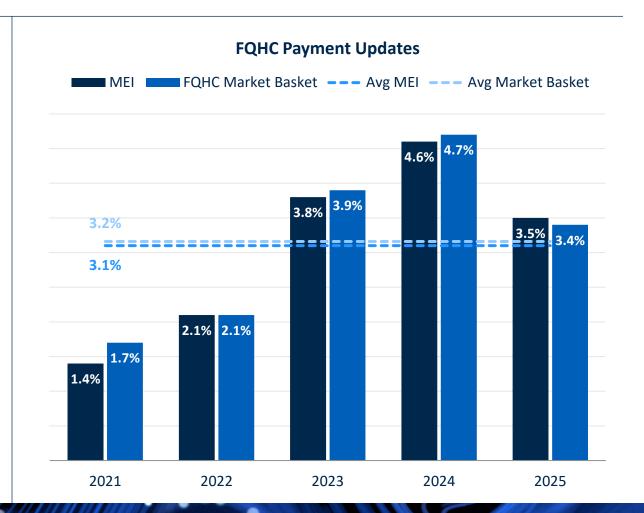


Federally Qualified Health Centers (FQHCs) provide comprehensive primary care services to underserved populations and underserved regions – Medicaid and Medicare both reimburse for FQHC services.

- Medicaid programs reimburse using Federally-mandated methodology based on provider costs
 - MEI used to adjust rates annually
- Medicare pays FQHCs based on fee schedule, adjusted for local differences in practice costs
 - Since 2017, updated annually by FQHC market basket
 - Base payment for 2023 is \$203
 - Previously updated by MEI
 - Paid on lesser of charges or base rate for all services provided on same day







PACE Is A Medicare-Medicaid Program Focused On Community-Based Care For The Elderly



Programs for All-Inclusive Care for the Elderly (PACE) offer comprehensive benefits in the community or in a PACE health center for people who would otherwise qualify for nursing home care.

| Category | Description | |
|---------------|--|--|
| Overview | PACE organizations provide comprehensive medical and social services to individuals living in the community PACE organizations have defined service areas | |
| Enrollment | Enrollment in PACE is voluntary, and individuals may leave a PACE program at any time | |
| Eligibility | Most participants are dually eligible for Medicare & Medicaid To qualify for PACE, an individual must be 55 or older Live in the service area of a PACE organization Need nursing home-level care Be able to live safely in the community with help from PACE | |
| Coverage | PACE provides care in the home, community, and the PACE center (an adult day health center), administered by an interdisciplinary team PACE benefits include, but are not limited to, all Medicare and Medicaid covered benefits | |
| Reimbursement | PACE providers receive monthly Medicare and Medicaid capitated payments for each enrollee Medicare enrollees that are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or any other type of cost sharing | |



Regulatory & Research Agencies

Healthcare System Regulated & Delivered By Agencies & Departments



Beyond the elements of the healthcare system that provider coverage & payment for healthcare consumption are an array of administrative, regulatory and research agencies within HHS.

- HHS agencies administer grants (SAMSHA, HRSA), conduct research (NIH, ARQH, CDC), regulate products (FDA), enforce program integrity (HHS OIG, HHS OCR), and many perform several of these functions
 - Most significant of these functions are the FDA's regulation of drugs and devices, NIH's scientific research and the program integrity functions of the HHS OIG and HHS OCR

| Role | Agency | |
|---------------------------|---|--|
| Administer Grants | SANHSA Substance Abuse and Mental Health Services Administration Health Resources & Services Administration | |
| Conduct Research | National Institutes of Health Agency for Healthcare Research and Quality Agency for Healthcare Research and Quality | |
| Regulate Products | U.S. FOOD & DRUG ADMINISTRATION | |
| Enforce Program Integrity | U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OR OFFICE OR OFFICE OR OFFICE OR OFFICE FOR CIVIL RIghts | |

National Institute Of Health (NIH) & Food & Drug Administration (FDA)



NIH is made up of 27 Institutes and Centers focused on particular diseases or body systems; FDA regulates \$1 trillion worth of products each year.

National Institute Of Health

- NIH funds 50K+ grants to 300K+ individuals at 2.5K+ research institutions
- Largest institutes are:
 - Cancer
 - Infectious Disease
 - Aging
 - Heart & Lung
 - General Medicine

Food & Drug Administration

FDA Regulates:

Food

• Drugs/Biologics

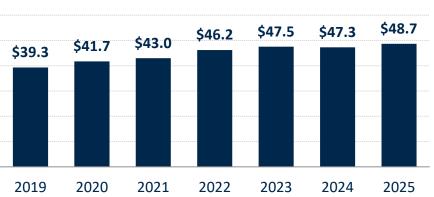
Devices

Animal drugs/Feed

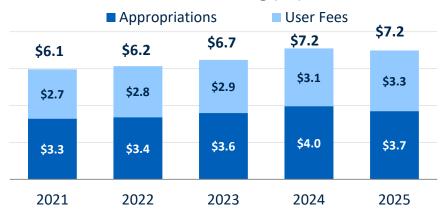
Cosmetics

- Tobacco
- Food and Drugs Act of 1906 was first of 200+ laws that constitute the medical regulatory structure
- Federal Food, Drug, and Cosmetic Act of 1938 regulated the safety of drugs and food
- Kefauver-Harris Amendments of 1962, strengthened drug safety and required effectiveness
- Medical Device Amendments of 1976 applied safety and effectiveness to devices
- FDA is funded with a combination of user fees paid by product applicants and appropriated funds
- FDA has accelerated approval of generic drugs and biosimilars in recent years

NIH Funding (\$B)



FDA Funding (\$B)



HHS Office Of Inspector General (OIG) & Office For Civil Rights (OCR)



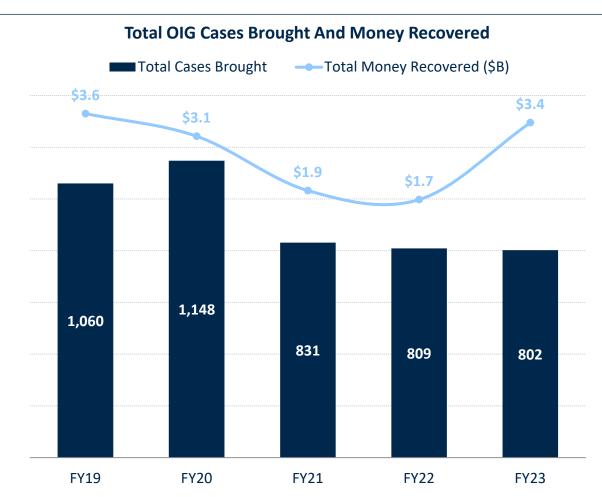
OIG investigates fraud and abuse in Medicare, Medicaid and more than 100 other HHS programs; OCR enforces Federal civil rights laws, conscience and religious freedom laws, HIPAA Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule.

Office Of Inspector General

- · Largest inspector general's office in federal government
- Most of OIG's resources go toward Medicare and Medicaid oversight
- OIG deploys nationwide network of audits, investigations, and evaluations
 - Generates recommendations for policymakers
 - Works with DOJ in development of case
- Each year OIG updates a 5-year strategic plan ("work plan") that delineates areas of program integrity focus
- OIG won or negotiated over \$5B from healthcare fraud cases during FY 2021, with \$1.9B returned to the federal government or private persons

Office For Civil Rights

- Since 2003, OCR has investigated and resolved 30k+ cases by requiring changes in privacy practices and corrective actions by, or providing technical assistance to, HIPAA covered entities and their business associates
- OCR has settled or imposed a civil money penalty in 126 cases resulting in \$134M in fines
- OCR refers to DOJ for criminal investigation cases involving the knowing disclosure or obtaining of PHI
- As of 2022, OCR made 1,580 referrals to DOJ



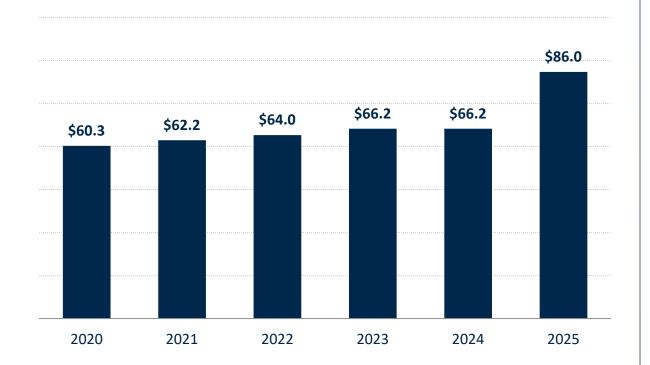
HHS Office of the National Coordinator for Health Information Technology (ONC) & Centers for Disease Control and Prevention (CDC)



ONC supports the adoption of health information technology standards and interoperability; CDC's mission is to protect public health and safety through the control and prevention of disease, injury, and disability in the US and internationally.

 Position of National Coordinator was established by Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009

ONC Budget (\$M)



• CDC focus on infectious diseases, food-borne pathogens, environmental health, occupational safety and health

CDC Budget (\$B)



Agency for Healthcare Research and Quality (AHRQ) & Substance Abuse and Mental Health Services Administration (SAMHSA)

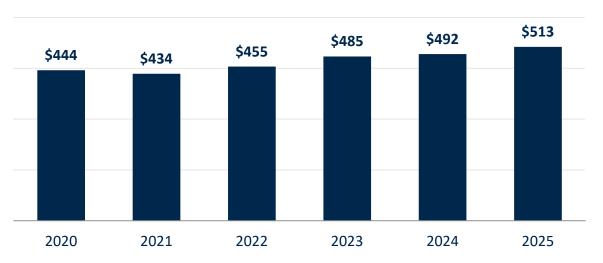


AHRQ funds research and conducts research, primarily focused on quality outcomes. SAMHSA leads public health efforts to advance behavioral health.

AHRQ creates tools/strategies to help providers deliver higher-value care

- AHRQ maintains healthcare databases
 - CAHPS, MEPS, HCUP, SRDR, USHIK

AHRQ Budget (\$M)



SAMHSA's goal is to reduce the impact of substance abuse and mental illness on America's communities

- SAMSHA administers grants to state and local government related to mental health and maintains a searchable online database and directory of mental health providers
- Conduct annual surveys including National Mental Health Services Survey to evaluate available services and utilization

SAMHSA Budget (\$B)



Source: BRG analysis of AHRQ and SAMSHA publications.



. . .

Emerging Leaders Panel

2:30 - 3:15



Emerging Leaders Panel

- Evan Smith, Vice President, WCAS
- Colin Fischer, Senior Associate, WCAS
- Nicole Merken, Senior Associate, Invidia
- Joe Vasile, Senior Associate, Arsenal



Break

3:15 - 3:30



Legal Considerations

3:30 - 4:30





Healthcare private equity association 101: legal considerations

September 9, 2025

Contacts



Nate Wolfe

Partner New York

nwolfe@mwe.com

Nate focuses his practice on complex domestic and cross-border transactional matters. He represents private equity firms, family offices and strategic investors in the structuring and negotiation of a full range of corporate transactions and financings, including leveraged buyouts, mergers, stock and asset acquisitions, joint ventures, growth equity and venture capital investments, minority investments, corporate carve-outs, reorganizations, divestitures and other transactions. Nate also regularly represents private equity clients in all aspects of their investments in portfolio companies, from acquisition through exit, and provides general corporate counseling to portfolio companies and other clients on day-to-day matters such as corporate governance and federal securities laws, employment, commercial contracts, financing and incentive equity.



Smith Alpert

Partner New York salpert@mwe.com Smith focuses his practice on representing private equity sponsors and their portfolio companies as well as other private companies in complex business transactions, including mergers, acquisitions and divestitures, leveraged buyouts, cross-border transactions, corporate carve-outs, joint ventures, minority investments, financings, reorganizations and complex corporate governance matters.

Smith also provides clients with day-to-day general corporate advice and counsel on business operations, including employment matters, equity compensation, commercial contracts and confidentiality agreements.

PE in healthcare: 2025 update – heightened scrutiny & evolving regulatory landscape

- The growing concentration of PE-owned healthcare entities has led to increased scrutiny of PE's role in healthcare and considerable uncertainty around what deals will be subject regulatory review and how strict those processes will be
- In May 2024, the FTC, DOJ and DHHS announced a joint inquiry into PE's increased involvement in healthcare, seeking to identify transactions that may undermine competition
- In January 2025, the FTC secured a settlement with a PE firm requiring prior approval for future stake acquisitions in anesthesia practices, marking a more aggressive stance against PE consolidation (a separate antitrust case against the platform is ongoing)
- Legislatures in several states, including California, Massachusetts and Oregon, have recently passed, or are actively considering, legislation designed to (1) introduce additional reporting requirements and/or (2) strengthen prohibitions on the corporate practice of medicine ("CPOM")
- We are seeing increased audit activity (and more aggressive audit practices) by the federal government relating to billing, coding and documentation

Important compliance considerations

- The Anti-Kickback Statute (AKS):
 - Prohibits the exchange of anything of value to influence referrals for payables under a federal reimbursement program (e.g., Medicare, Medicaid, TRICARE), subject to certain exceptions

The Physician Self-Referral Law (a/k/a the Stark Law):

- Prohibits physicians from referring patients to entities with which the physician (or immediate family) has a financial relationship, subject to certain exceptions
- False Claims Act (FCA):
 - Imposes large civil penalties on any person who conspires to or knowingly submits false claims
 - Permits individuals to file suits on behalf of the government as "whistleblowers" (with financial incentive to do so)

Anatomy of a purchase agreement

- Purpose of the Purchase Agreement
- Purchase Agreement Overview
- Purchase Agreement Structure
 - Stock Purchase v. Asset Purchase v. Merger
 - Bifurcated v. Simultaneous Sign and Close
- Purchase Price
 - Adjustments
 - Earnouts
- Representations and Warranties
- Closing Conditions / Termination
- Covenants
- Indemnification
- R&W Insurance

Purpose of the purchase agreement

· Sellers want:

- Best price
- Quick closing and certainty of closing / consummating the deal
- Minimal continuing obligations and risk (read: buy that yacht and sail off into the sunset)

Buyers want (Inverse!):

- Exclusivity
- Time and process to obtain financing
- Minimal exposure if they fail to close
- Minimal assumption of risk
- Indemnification (flip side of assuming risk)
- Restrictions on sellers' ability to compete post-closing

Purchase agreement overview

- Preamble; Recitals
- Definitions
- Purchase and Sale; Purchase Price
- Reps and Warranties
- Covenants and Additional Agreements
- Closing and Closing Conditions
- Indemnification
- Termination
- Miscellaneous
- Disclosure Schedules and Exhibits

Purchase agreement structure

- Asset v. Stock v. Merger
- Considerations:
 - ∘ Tax
 - Liabilities
 - Number of equityholders
 - Seller type / necessary approvals
 - Timing
 - Costs
- Auction Process
 - Competitive process, so generally more "middle of the road"
 - More standard R&W, knowledge qualifiers, RWI
 - Full mark-up of purchase agreement vs. partial mark-up (i.e., bid memo or mark-up of only corporate reps with footnotes that specialist comments are forthcoming)

Bifurcated vs. simultaneous sign and close

Simultaneous

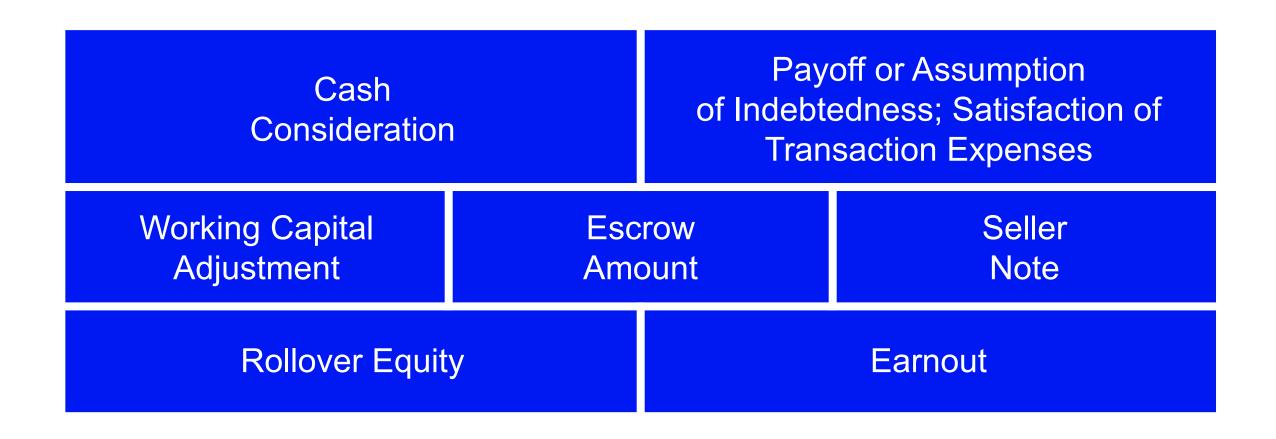
- Simpler process, but no one is bound to terms
- Certain highly negotiated purchase agreement provisions are unnecessary (e.g., pre-closing covenants, closing conditions, termination)

Bifurcated

- May be required for regulatory reasons (government approvals – e.g., antitrust, energy, healthcare, insurance, etc.)
- Buyer may prefer to raise financing after signing the Agreement
- Buyer may want certain consents prior to closing
- Negotiations/documentation more complex & Target must comply with operational and other covenants during interim pre-closing period

Elements of the purchase price

Comprised of a combination of these components...



Purchase price adjustments

- Private company deals are typically done on a <u>cash-free</u> and <u>debt-free</u> basis with normalized levels of working capital
 - Accomplished by adjustments to "headline" purchase price (i.e., enterprise value) which may be done based on pre-closing estimates and post-closing <u>actuals</u>
 - Purchase price is:
 - h by cash of the Target at closing
 - by debt of the Target at closing
 - by Target / seller transaction expenses at closing
 - ∘ ↑ or ▶ by working capital of the Target at closing in relation to agreed upon working capital target

Purchase price adjustments

Working Capital

- Current Assets of the Target less Current Liabilities of the Target (i.e., a balance sheet test)
- Method for calculating working capital is often a key area of negotiation (e.g., consistent with GAAP? Or with the Target's prior practices?)
- Parties agree on a working capital target or band, and the purchase price is adjusted up or down based on the difference between the actual amount at closing and the target

Cash

How to treat restricted cash (e.g., landlord deposits) or trapped cash (i.e., excess cash held offshore)

Debt

 Not just borrowed money – often includes letters of credit, out-of-the-money derivative instruments, deferred revenue and other "debt-like" items

Transaction Expenses

Include any advisor/counsel fees and transaction bonuses being paid out in connection with the transaction

Earnouts – what are they?

- A tool to bridge the valuation gap in the negotiation of the final Purchase Price
- <u>Earnouts</u> provide additional consideration to the Sellers...
 - by tying the payment of the "disputed" portion of the Purchase Price to the actual outcome of certain performance targets or certain events occurring or not occurring post-closing, including non-financial events
 - **Pros:** decreases risk of over-valuation, ensures incentive to stay and grow the company, reduces upfront payment
 - Cons: may restrict Buyer's operation of the business, lack of control for Sellers, difficult to track, motivates Seller to maximize earnout, could affect outside financing
- <u>Potential AKS Risk</u>: Earnouts in healthcare transactions raise potential issues under the Anti-Kickback statute where
 the seller's business derives revenue from federal healthcare programs (FHCPs). If an earnout is triggered by growth
 of FHCP-related business, and the seller remains active in the business post-closing, there is substantial risk that the
 earnout is a violation the AKS

Representations and warranties

Reps & Warranties

A series of factual statements and promises regarding (i) the parties, (ii) the transaction, and (iii) the condition, nature and scope of the business being acquired

Disclosure Schedules

A disclosure schedule is a list attached to an agreement setting forth exceptions to (or affirmative lists of) the factual statements and promises made by a party in the purchase agreement

Together, the Reps and Warranties and the Disclosure Schedules provide the factual statements made by (or on behalf of) Target regarding the business

Incorporating diligence results into certain aspects of the purchase agreement

Reps & Warranties

 Adjust scope of reps and warranties based on nature of the business and diligence findings.

For example:

- More expansive real estate representation in a business where real estate is of particular importance
- More aggressive inventory and accounts receivable reps in a business where inventory and A/R account for a large percentage of the Target's assets
- Specific reps and warranties regarding largest customers for a business that has high customer concentration

Disclosure Schedules

- Reveal additional information that potentially impacts negotiation of reps, warranties and covenants
- Disclose findings that are inconsistent with diligence findings
- Impact indemnification rights
- Avoid "kitchen sink" disclosures

Closing conditions

Closing conditions are commonly negotiated and can include...

Consent under certain contracts or permits

Employment agreements/incentive equity plan

Delivery of other key agreements, like RCAs

Regulatory approvals (e.g., HSR)

Customer calls

No "Material Adverse Effect" has occurred and the reps and warranties made at signing remain accurate (brought down to some materiality standard)

Termination

Bifurcated signing/closing (delayed closing)

Sets forth when the agreement can be terminated (e.g., drop dead dates, breaches of closing conditions, absence
of financing following a marketing period, failure to receive regulatory approvals)

Implications of Termination

- What provisions survive (including indemnification obligations)
- Reverse termination fees/breakup fees

Key covenants – by the seller

| Pre-closing operation of the business / Interim Operating Covenants | Non-solicit (employee and customer) and no-hire |
|---|---|
| General release | Obtain stockholder consent |
| Non-compete | Confidentiality (non-disclosure and non-use) |

Indemnification – what is it?

- Indemnification is the obligation of a party (e.g., Seller) to bear the costs and expenses of specified losses incurred by another party (e.g., Buyer)
- No indemnification is available for public deals
- Who does it apply to?

Buyers. Sellers. And sometimes parent entities...

Typically, each indemnifies the other for damages caused by such party's breach of its representations, warranties or covenants

Who is really at risk? Sellers

It is much more likely that a Buyer will have an indemnification claim against a Seller than vice versa

Joint & Several Liability vs. Several (and not joint) Liability

- Buyer prefers for Seller's stockholders to be jointly and severally liable
- Seller's stockholders prefer for their liability to be several and not joint

What is covered?

Breaches of rep & warranties

Breaches of covenants

Pre-closing taxes

Specific indemnities

Indemnification for... breaches of representations and warranties

Representation and Warranty

 Example: "Except as set forth on Section 3.12 of the Disclosure Schedule, the Company and its Subsidiaries are, and during the last 3 years have been, in compliance in all material respects with all Laws."

Disclosure Schedule

 Example: "On April 11, 2021, the Company received notice that certain of its employees made illegal payments to zoning officials in connection with 6 distribution centers located in Mexico."

What's the deal with Disclosure Schedules?

Since disclosures modify the applicable representations and warranties, if a liability is disclosed then there would be no breach and thus no indemnification.

To be indemnified, Buyer would need to seek a specific indemnity with respect to the disclosed item.

Beware of the overly broad, kitchen sink disclosure.

Limitation on indemnifications

Parties will negotiate various terms to limit or expand indemnification obligations

Definition of "Damages"

Dollar Limitation (deductibles, baskets and caps)

Time Limitations

Substantive Limitations (tax benefits, insurance proceeds)

Line-Item Indemnities

Sand Bagging

Dollar limitations

Deductible

- A party need not indemnify the other for certain liabilities unless the damages exceed a minimum amount
- Party then only responsible for losses exceeding the Deductible

"First dollar" threshold or "tipping basket"

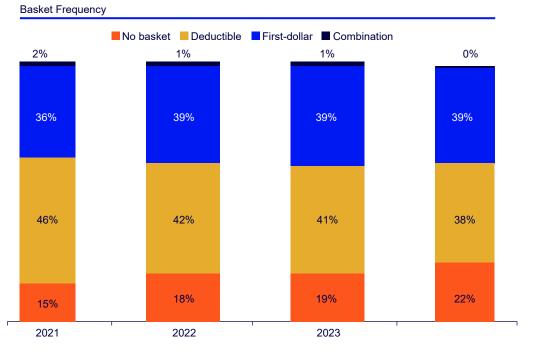
- A party need not indemnify the other unless damages exceed a minimum amount. However...
- Once this minimum amount has been reached, the damaged party may seek indemnity for all of its damages from the first dollar

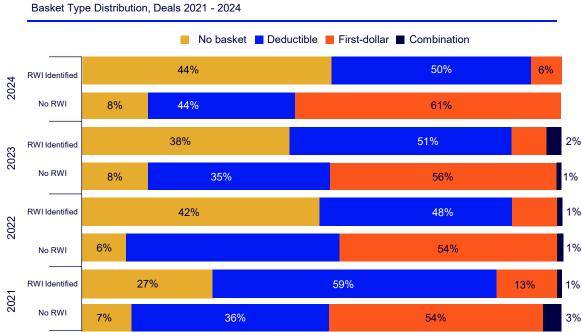
"Mini Basket"

- Individual losses must exceed a de minimis threshold to be subject to indemnification
- Works with Cap and Threshold to provide greater limitations on indemnification obligations
- Mechanism to avoid "death by a thousand cuts"

Baskets – what's market?

SRS Acquiom 2025 M&A deal terms study



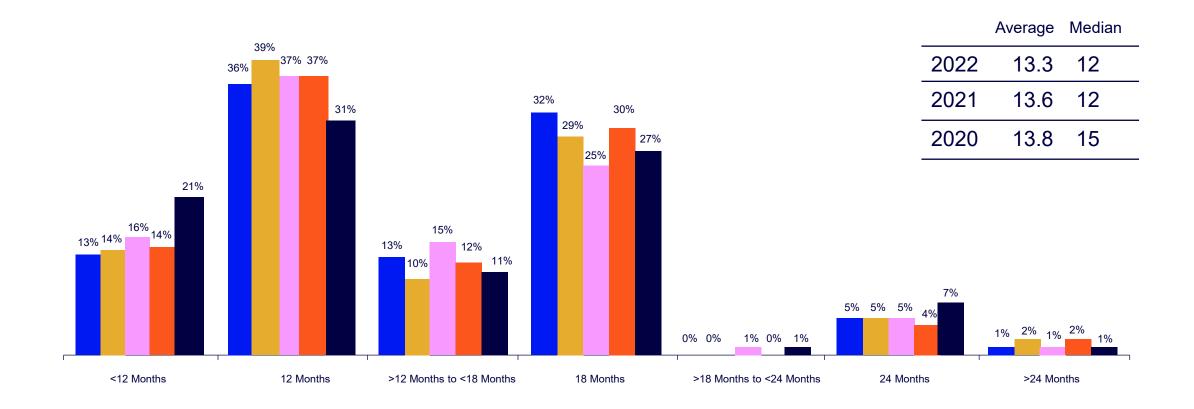


Time limitations

- Representations made by a private company Seller typically survive for an agreed period of time after closing, with certain exceptions:
 - Representations relating to employee benefit matters, tax matters and environmental matters may survive for a longer period of time (or even the applicable statute of limitations)
 - Representations relating to organization, authority, capitalization, stock ownership and brokers' fees (or title to assets in an asset deal) may survive indefinitely (aka the "fundamental" reps and warranties)

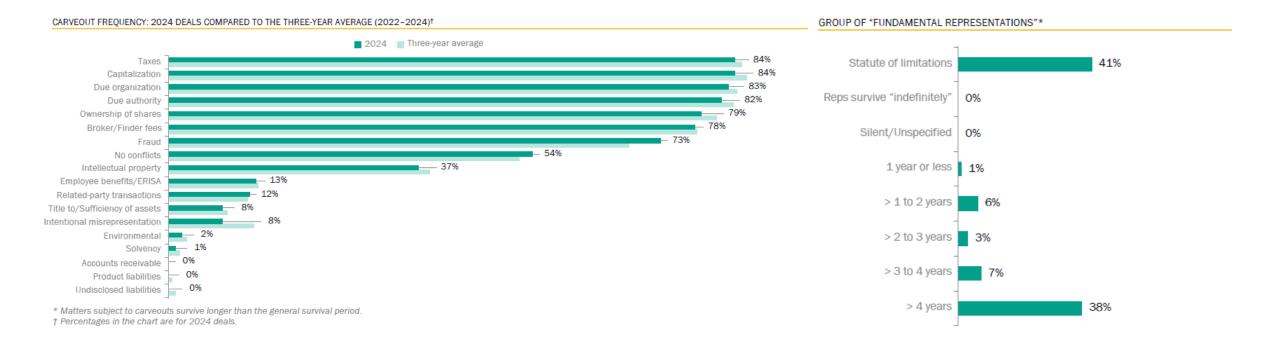
Survival for general reps – what's market?

Basket frequency - SRS Acquiom 2025 M&A deal terms study



Fundamental reps – what's market?

Carveouts to general survival limitation



SRS Acquiom 2025 M&A Deal Terms Study

Satisfying obligations...sources of recovery

- Direct recovery from Seller
- Holdback from the Purchase Price (Buyer or Seller holdback)
- Escrow
 - Deposit cash with a third party for a specified time period, which is later disbursed to the parties upon the occurrence of certain negotiated events
 - Escrow particularly important if Buyer has concerns with the credit-worthiness of the Seller post-closing
 - Strategic buyers prefer having the escrow as a source of remedy
- Rights of Setoff
 - Setoff rights against seller note, earnout or other post-closing payments in favor of the Seller, or against any of Seller's rollover equity
- Representation and Warranty Insurance (54% include indemnification escrow 2025 SRS Acquiom)

Representation and warranty insurance – general

- An insurance policy under which a Buyer can recover for breaches of Seller's representations and warranties
- Key terms and considerations:
 - RetentionPolicy period
 - LimitPremium
 - Exclusions these vary by underwriter and are negotiable, but <u>all known liabilities</u> will be excluded from coverage
 - Sample exclusions include: HIPAA liability, FLSA liability, data privacy liability, environmental liability
 - RWI policy may read out certain materiality qualifiers and "non-standard" provisions
 - Need to discuss allocation of responsibility for losses that are excluded under the RWI policy

RWI high level process overview



 After the underwriting call, broker will assist with working through follow up questions and policy comments.

At signing

Bind

coverage

- Broker receives enhanced policy forms across all RWI carriers.
- Ideally want to bind coverage at deal signing, but can also bind at or prior to closing.

 After signing an NDA, RWI broker will request necessary documents and information required to secure tailored market feedback. Broker will secure indicative feedback from the carriers and present terms (including price, retention and coverage and analysis) in a detailed report.

- Based on the market feedback and broker recommendation, select a carrier and move into underwriting.
- The carrier will require access to the VDR, review of all diligence reports and an underwriting call with the insured and advisors.

Representation and warranty insurance – what's market?

- More commonly used in PE deals, though starting to see strategics use (except in auction contexts)
- Of such deals, Buyer obtains and typically (~95%) pays for the policy
- Parties will negotiate the extent to which the RWI Policy will be the sole source of recovery and who bears the risk / cost associated with specific indemnities / exclusions to the RWI Policy



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Foundational Deal Considerations

4:30 - 5:30





Quality of earnings, net debt and net working capital



Shape the future with confidence

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Agenda

1 Financial due diligence overview

2 Quality of earnings

3 Net debt

4 Net working capital

5 SPA considerations



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Key takeaways

This presentation will give you a high-level overview of the financial due diligence process, focusing on key topics and considerations for the quality of earnings, net debt and net working capital analyses.



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Ernst & Young LLP



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Transactions and Corporate Finance
Director
Ernst & Young LLP



Financial due diligence overview



Health sector landscape

| Care delive | ry providers | Payers/ | insurers | Health services and investors | | |
|-------------------------|----------------------------------|---------------------------------|-------------------------------|-------------------------------|--------------------------------|--------------------|
| Hospitals | Academic medical centers | Healthcare insurance | Commercial | Private equity | Outsourced healthcare services | Pharmacy |
| Physician groups | Outpatient clinics/retail health | Long-term services and support | Managed Medicare/ Medicaid | Health and wellness | Durable medical equipment | Infusion services |
| Home health/ hospice | Post-acute care | Provider-sponsored health plans | Self-funded employers/TPAs | Healthcare staffing | Healthcare technology | Outsourced vendors |





Payment models

- Traditional fee-for-service: This is the oldest payment model in which providers are reimbursed a flat fee for each medical service.
- Capitation: A fixed amount for each patient is paid to providers in advance, for a set time period (typically one month). Specific services are identified.
- Episodic: A fee is provided up front for an entire "episode" of care. An episode is more specifically defined as a specific diagnosis and the services needed to treat that diagnosis over a period of time (such as 30 days). A single payment would cover all the costs of treating the patient.





Healthcare general glossary

- Accounts receivable (AR): The balance of money due to the provider for services delivered.
- Adjudication: The medical claim decision-making process once the claim reaches the insurance payer to determine if they will accept, deny or reject the claim.
- **Allowed amount:** The maximum dollar amount an insurance company will allow a provider to collect for an eligible healthcare service. Depending on the patient's coverage, this amount may be paid by the insurance, the patient or split between them.
- Coinsurance: The amount a patient pays the provider once their insurance has paid its portion (based on their benefit contract).
 Often, the patient must meet their deductible before coinsurance kicks in.
- **Co-payment (co-pay):** A fixed fee that the patient pays the healthcare provider for the services or treatment received.
- Current Procedural Terminology (CPT®) code: CPT codes were developed by the American Medical Association (AMA) to describe a medical, surgical or diagnostic procedure that doctors and healthcare providers perform. CPT codes ensure uniformity and are required for billing medical insurance payers. Every calendar year, the AMA announces changes to the code set.



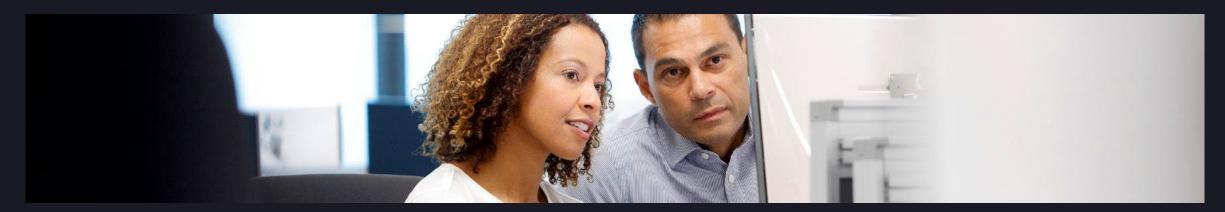
Healthcare general glossary (cont.)

- Date of service (DOS): The treatment date.
- Fee schedule: A fee schedule, which is included in the provider's insurance company contract (except for Medicare and Medicaid), states what the insurance company is willing to pay (allowed amount) for services the provider performs.
- Medicare Advantage Plans: Also known as Medicare Part C, these plans are an alternative to traditional Medicare plans that are
 offered through private insurance companies.
- Provider enrollment: The process of enrolling a provider with commercial or government health insurance plans to which the provider can be reimbursed for services rendered to patients.
- Third-party payer: An entity, such as insurance companies, government agencies, health maintenance organizations (HMOs) and employers, that pays medical claims on behalf of the insured.
- Write-off or adjustment amount: An amount written off or adjusted from a charge. Typically, this is any amount over the insurance's stated allowed amount but may include additional adjustments. Patients cannot be billed for any write-offs or adjustment amounts if a provider is in network with an insurance company.



Typical purchase price calculation

| Component | Due diligence output |
|---|--|
| Enterprise value (adjusted earnings x multiple) | Quality of earnings |
| +/- Difference in working capital as defined and working capital target/peg | Quality of net assets/working capital |
| - Indebtedness and nonoperating liabilities | Debt and debt-like items/commitments and contingencies |
| + Transaction expenses | |
| + Cash (if applicable) | |
| = Purchase price | |





How financial due diligence provides value

Financial due diligence plays an important role in determining the purchase price and presenting a clearer picture of the target's historical operations.

| Currency: \$000 | Reported | Sell-side CIM* | Buy-side |
|---|----------|----------------|----------|
| EBITDA | 20,000 | 25,000 | 18,000 |
| Multiple | 10x | 10x | 10x |
| Enterprise value (adjusted earnings x multiple) | 200,000 | 250,000 | 180,000 |
| +/- Difference in working capital as defined and working capital target/peg | _ | _ | _ |
| - Indebtedness and nonoperating liabilities | (20,000) | (25,000) | (30,000) |
| + Transaction expenses | _ | _ | _ |
| + Cash (if applicable) | 1,000 | 1,000 | 1,000 |
| = Purchase price | 181,000 | 226,000 | 151,000 |



^{*} Confidential information memorandum

Key deal considerations

What is the contemplated deal structure?

- Asset or stock purchase?
- Is the buyer purchasing a whole company or carving out operations?
- Understand the basis of valuation: EBITDA, EBITDAR, revenue multiple
- Will the deal involve investors or lenders?

Other considerations

- Is accounting accrual or cash basis?
- Has the business been audited, and will workpapers be made available for review?
- Does the business have a sell-side diligence report?
- Acquisitions or discontinued operations?
- Are there multiple participating shareholders taking equity draws (especially physician practices)?
- How many provider entities and different lines of business?
- Are there significant capitated or risk-sharing reimbursement arrangements?
- Have there been any significant billing or clinical IT system conversions?
- Will the business be able to produce the data files necessary to perform revenue analysis?
- Is the business subject to self-insurance risk?



Quality of earnings



Overview

- The importance of EBITDA for the buyer and lender:
 - Serves as proxy for free cash flow available to service debt
 - Definitional items (interest, income taxes, depreciation and amortization) addressed separately in model
 - Not "one size fits all"
 - Normalizes results to help better depict underlying trends and drivers
- "Quality" and "normalization" require evaluation and judgment:
 - Is seller's view of normalized earnings oversanitized?
 - Are "anomalies" an indication of reality?
- Typical EBITDA adjustment categories (details on next page):
 - Out of period
 - Noncash transactions
 - Onetime, unusual, nonrecurring
 - Pro forma items



EBITDA adjustment categories

| Onetime, unusual, nonrecurring | Noncash transactions |
|---|---|
| Restructuring charges | Deferred rent |
| Legal settlements | Stock compensation |
| Transaction-related costs | Capitalized internal costs |
| System implementation costs | Impairment charges |
| Loss of a significant customer/payer/service line | Unrealized gains/losses |
| Significant change in contractual terms | Amortization |
| Payroll savings from vacant positions | Minority interest or equity income |
| Noncore sources of revenue | Pension and other post-employment benefit (OPEB) charges |
| COVID-19 relief funds | Premium deficiency reserves |
| Tax holidays | |
| Medical loss ratio rebates | |
| Out of period | Pro forma items |
| Changes in estimate (benefit of hindsight): | Acquisitions or divestitures run rate |
| Bad debt, inventory reserves, allowances | Discontinued operations or product lines |
| Self-insurance, compensation | Stand-alone or transition services agreement (TSA) costs (carve-outs) |
| Timing related: | Cost-saving initiatives |
| Year-end true-up or audit adjustments | Changes in reimbursement (temporary COVID-19 rate lifts or annual fee schedule changes) |
| Revenue recognition | |
| Improper cutoff | |
| Incurred but not reported (IBNR) development | |
| Medicare risk scores | |



Quality of earnings output example

- Typical starting point with reported net income:
 - Ideally, audited figures from audited financial statements (AFS)
 - Beware of accounting basis if not audited under US GAAP (i.e., cash basis vs. modified accrual basis)
- Management-proposed adjustments:
 - Debt EBITDA view
 - Sell-side diligence adjustments
- Pro forma EBITDA:
 - New contracts
 - An acquisition's post-close performance vs.
 pre-acquisition performance

| Currency: \$000 | Ref | FY22 | FY23 | FY24 |
|--|-----|----------|----------|----------|
| Net income | | (10,403) | (17,849) | (12,780) |
| Definitional adjustments | | 9,331 | 17,410 | 21,455 |
| Reported EBITDA | | (1,072) | (439) | 8,675 |
| Management adjustments: | | | | |
| Full year contribution of acquired locations | 4 | 9,847 | 5,425 | 3,153 |
| Sponsor and lender financing fees | 5 | 491 | 830 | 2,925 |
| Acquisition-related costs | 5 | 3,532 | 2,981 | 2,554 |
| Integration-related costs | 5 | 1,379 | 2,132 | 1,487 |
| Other nonrecurring costs | 5 | 327 | 6,697 | 1,493 |
| Lender-approved adjustments | | 15,576 | 18,065 | 11,612 |
| Management-adjusted EBITDA | | 14,504 | 17,626 | 20,287 |
| Diligence adjustments | | 1,348 | 1,539 | 1,228 |
| Diligence-adjusted EBITDA | | 15,852 | 19,165 | 21,515 |
| Pro forma adjustments | | NQ | NQ | 3,925 |
| Pro-forma-adjusted EBITDA | | NQ | NQ | 25,440 |
| Acquisitions under LOI | | NQ | NQ | 5,741 |
| Pro forma EBITDA + Acquisitions under LOI | | NQ | NQ | 31,181 |
| Margins: | | | | |
| Management-reported bank EBITDA | | 12.3 | 14.1 | 15.4 |
| Adjusted EBITDA | | 13.2 | 15.0 | 16.1 |
| Pro forma EBITDA | | n/a | n/a | 18.1 |



Provider diligence considerations

Several financial factors should be considered when evaluating the investment thesis of M&A activity in the healthcare sector:

Business or model risks

Revenue recognition and collectibility of AR

- Does the profit and loss (P&L) statement reflect the net realizable value of revenue?
- Do historical trends indicate current AR may be collectible?
- Does the company have an established compliance function?

Reimbursement environment

- How does the reimbursement strategy (i.e., in network/out of network) impact the deal?
- Are there anticipated legislative changes that may impact future earnings potential of the post-transaction entity?

Acquisitions, de novo and immature providers

What is the mature contribution of recent acquisitions, de novo and/or immature providers?

Provider compensation and other physician costs

What is the impact of the aforementioned matters on providers' compensation?

Key diligence considerations

- Assess whether historical AR and net revenue estimates have been realized through subsequent cash receipts.
- Analyze third-party settlement balances.
- Involve experts to perform a billing and coding analysis to assess the appropriateness of historical claims.
- Analyze historical same store and provider performance (including utilization) to determine whether forecasted growth is (i) consistent with historical experience and (ii) achievable with current capacity and macro trends.
- Analyze provider compensation models to quantify the impact of diligence and pro forma adjustments.
- Analyze labor metrics and costs.
- Analyze malpractice and other self-insurance reserves, considering the need to involve actuaries.



Fee-for-service revenue recognition considerations

- Estimating revenue is a matter of significant judgment:
 - Not all payers reimburse the same amount for the same service:
 - Governmental payers: Medicare, Medicaid and others
 - Managed care payers: distinguished by types of plans and types of contracts
 - Other payers: commercial insurers, private pay and others
 - Many providers don't have contracts loaded into patient accounting systems.
 - Even when contracts are loaded, patient bad debt, denials and out-of-network cases complicate the process.
- Approaches used by providers to record revenue:
 - Percentage of gross charges
 - Unit based: volume x historical rate per unit
 - Cash basis
- Gross-to-net presentation of revenue

| Currency: \$000 | FY22 | FY23 | FY24 |
|------------------------------|---------|---------|---------|
| Gross charges | 6,500 | 7,000 | 8,300 |
| Less: Contractual allowances | (2,000) | (2,100) | (2,500) |
| Less: Bad debt allowances | (500) | (600) | (800) |
| Net collectible revenue | 4,000 | 4,300 | 5,000 |
| Other adjustments | (200) | (250) | (300) |
| Net recorded revenue | 3,800 | 4,050 | 4,700 |



Provider diligence considerations

An inadequate reserve methodology could result in net revenue and associated AR in an excess/deficit position as compared to the net realizable value.

Gross-to-net accounting

Methodology:

- Gross revenue is typically recognized in conjunction with the company's chargemaster, which stipulates per procedure rates.
- Contractual adjustments represent the difference between the chargemaster and the agreed-upon reimbursement rate to be paid by third parties.
- Insurance plans reimburse at different rates based on negotiated contracts.

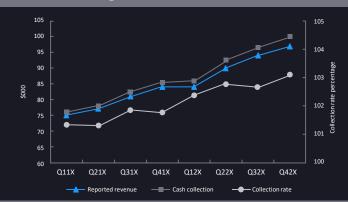
Risk factors:

- Changes in reimbursement and collection rates may not be reflected in contractual adjustments and bad debt percentages applied to gross revenue and AR.
- Historical revenue trends may not be consistent with forecast revenues due to changes in service and payer mix.

Diligence procedures:

 Historical look-back analysis compares actual cash collections to net reported revenue, including an estimate of future collections for immature claims based on historical collection percentages.

Scenario 1: Increasing reimbursement



Scenario 2: Declining reimbursement





Risk-bearing provider diligence considerations

Risk-bearing reimbursement models are becoming more common as the industry moves toward value-based care.

Business or model risks

- Claims expenses and IBNR reserves:
 - Does the plan use fixed capitation payments, fee-for-service models or a blend?
 - Has the plan used consistent reserving practices or experienced large out-of-period reserve adjustments?
 - Does the plan have material risk-sharing arrangements or complex gain share calculations?
- Regulatory/legislative environment:
 - Are there anticipated legislative changes that may impact future earnings potential of the post-transaction entity?
 - What are the potential impacts to the plan's business under different political scenarios?
- Revenue recognition and collectibility of AR:
 - Does the P&L statement reflect the net realizable value of revenue?
 - Does the company have strong controls over the enrollment and member reconciliation process?
- Sustainable operating cost model:
 - Does the company's headcount model balance between efficiency and achieving projected growth?

Key diligence considerations

- Analyze the plan's different provider contract models and understand financial implications of such.
- Coordinate with independent actuaries to review key reserve accounts and stress test methods and assumptions employed by the target.
- Analyze third-party settlement balances.
- Analyze historical product-type performance (e.g., trended medical loss ratio) to determine whether forecasted growth is consistent with historical experience.
- Assess the plan's mix of business (upside only, limited risk, global risk) to understand risk exposures.
- Assess whether historical AR estimates have been realized through subsequent cash receipts.
- Analyze labor metrics and costs.



Net debt



Overview

The importance of net debt for the buyer and lender:

- Identifies on- and off-balance-sheet obligations that need to be either settled upon the transaction close or by the buyer subsequent to close.
- Agreed-upon net debt items are direct reductions to the purchase price (i.e., the seller is responsible to settle the net debt items
 with the proceeds from the sale and the seller's cash on hand upon close).
- Different points of view: The seller wants limited net debt items, resulting in a higher net purchase price. The buyer seeks for more net debt items, so it does not have to cover future cash outflow.

Gross purchase price \$200m paid to seller

Net debt \$25m is paid by seller with proceeds

Net purchase price¹ \$175m



¹ Exclusive of purchase price adjustments for cash, working capital, transaction expenses and other matters

Examples

The identified net debt items are a negotiation between the sellers and buyers. The agreed-upon net debt items are generally included within the purchase agreement within the definition of indebtedness:

- Example 1: Annual bonuses vs. quarterly/monthly bonuses:
 - Estimated closing date: March 1, 2023
 - Due diligence net debt period: January 31, 2023
 - Negotiation:
 - Annual bonuses: If the target paid annual bonuses each March for the services in the prior year, the seller should be responsible for paying the accrued bonuses (e.g., included within the purchase agreement's definition of indebtedness) as it received the benefits of the employees' work during that period. The accrued bonuses for January through March 2023 could also be negotiated.
 - Quarterly/monthly bonuses: This is similar to the January through March 2023 bonus above in that it is an item that could be negotiated, so the period in which the seller received a benefit is less than a full year's benefit.
- Example 2: COVID-19 liabilities:
 - Due to the COVID-19 pandemic, sellers have numerous liabilities (e.g., deferred employer payroll taxes due in FY20 and FY21 and potential payback
 of PPP loans) that need to be considered for net debt. Payroll taxes are generally not included within net debt, but since the deferred taxes are in a
 form of extended liquidity, the seller should be responsible to cover the liability.



Some examples of net debt and debt-like items

Net debt

- Short- and long-term borrowings
- Accrued interest payable
- Finance leases
- Less: Cash and cash equivalents

Debt-like items

- Past-due accounts payable (AP)
- Taxation/escheatment
- Deferred revenue
- Commitments and contingencies
- Long-term provisions that will translate into a long-term level of fixed asset creditors
- Transaction costs/bonuses
- Overdue patient refunds/credit balances within AR
- Shortfall in risk-based capital
- Pension funding shortfall and other long-term benefit obligations
- Malpractice settlements
- Third-party payer settlements

Examples of off-balance-sheet items

- Factored, securitized and discounted trade receivables
- Financial instruments valued at fair market value
- Deferred capital expenditures
- Breakage costs on financial instruments
- Letters of credit/other credit commitments (e.g., surety bonds)
- Committed capital expenditures



Example of sell-side vs. buy-side net debt

| | Sell side | | | | Buy side | | |
|--|--|-------|-------|------------------|-------------------|-------|--|
| Currency: \$000 | On balance sheet Off balance sheet Total | | | On balance sheet | Off balance sheet | Total | |
| Financial indebtedness | | | | | | | |
| Term loans | 2,862 | - | 2,862 | 2,862 | 1,500 | 4,362 | |
| Accrued interest | n.q. | n.q. | _ | n.q | n.q | _ | |
| Total financial indebtedness | 2,862 | _ | 2,862 | 2,862 | 1,500 | 4,362 | |
| Cash and cash equivalents | (16) | _ | (16) | (16) | _ | (16) | |
| Net financial indebtedness | 2,846 | _ | 2,846 | 2,846 | 1,500 | 4,346 | |
| Other items that may be considered as indebtedness | | | | | | | |
| Management bonuses | _ | | _ | 314 | 473 | 787 | |
| Tax provisions | 348 | _ | 348 | 348 | _ | 348 | |
| Committed capital expenditures | _ | _ | _ | 58 | 240 | 298 | |
| Provision for anniversary bonuses | 228 | _ | 228 | 228 | _ | 228 | |
| Provision for severance payments | 263 | _ | 263 | 263 | _ | 263 | |
| Provision for impending losses | _ | _ | _ | 40 | n.q | 40 | |
| Acquisition-related contingencies | | _ | n.q. | n.q | n.q | n.q | |
| Legal matters | _ | _ | n.q. | n.q | n.q | n.q | |
| Tax matters | _ | _ | n.q. | n.q | n.q | n.q | |
| Total other items that may be considered as indebtedness | 839 | _ | 839 | 1,251 | 713 | 1,964 | |
| Net debt and debt-like items | 3,685 | _ | 3,685 | 4,097 | 2,213 | 6,310 | |
| Other considerations | | | | | | | |
| Operating leases | n/a | 2,360 | 2,360 | n/a | 2,360 | 2,360 | |
| COVID-19 funding | | _ | _ | n/a | 250 | 250 | |
| Trade AR due from affiliated companies | 54 | _ | 54 | 54 | _ | 54 | |
| Trade AP due to affiliated companies | 31 | _ | 31 | 31 | _ | 31 | |
| Patient credit balances and refunds | _ | _ | _ | 30 | n.q. | 30 | |
| Holding company guarantees | | _ | _ | n.q. | n.q. | _ | |
| Total other considerations | 85 | 2,360 | 2,445 | 115 | 2,610 | 2,725 | |

n.q. — non-quantified



Net working capital



Overview

What is net working capital (NWC)?

- Generally: current assets, less current liabilities, excluding cash, indebtedness and income taxes.
- All items identified in the net debt analysis, which are within current assets and liabilities, need to be removed from NWC.

Why is NWC important?

- **Modeling importance**: Change in NWC is a key component to derive free cash flow and, in turn, pay down debt.
- **Financing importance**: Understanding "peak to trough" inter- and intra-month NWC trends to assess revolver facility size.
- Valuation importance: Calculated enterprise value (EV) for a business typically contemplates a "normal level" of delivered NWC. Absent this concept, sellers could plunder corporate coffers between signing and closing through asset monetization and liability deferrals.

NWC peg overview

- Many sales and purchase agreements (SPAs) include an adjustment for the difference between a predetermined target NWC and a closing NWC, which is called the NWC peg.
- NWC target is typically set on a predetermined amount which will make buyer/seller whole, dollar for dollar, for any deviation in delivered NWC vs. a "normal" level of NWC (contemplated in EV of target).
- Locked box arrangements are becoming increasingly common.



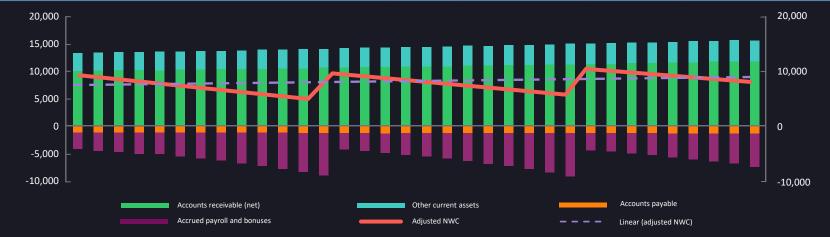
Peg example

Key considerations

Setting the SPA peg amount is a key consideration, as the difference between the delivered NWC and the SPA peg results in a direct adjustment to the purchase price.

For provider-focused deals, the main driver in NWC is accounts receivable and accrued payroll/bonuses, so it is important to understand the items, such as the timing of payroll and bonus payouts. The presented schedules show an example of how the timing of close (e.g., the NWC peg true-up date) can impact how the SPA peg is set and the corresponding purchase price true-up.

| Currency: \$000 | Dec22 | T3M avg. | T6M avg. | TTM Sep23 avg. |
|---------------------------------------|-------|----------|----------|----------------|
| NWC peg based on the applicable dates | 5,712 | 8,503 | 9,025 | 8,657 |
| Closing NWC at December 31, 2021 | 6,000 | 6,000 | 6,000 | 6,000 |
| True-up payment/(receipt) | 288 | (2,503) | (3,025) | (2,657) |



| Currency: \$000 | Oct22 | Nov22 | Dec22 | Jan23 | Feb23 | Mar23 | Apr23 | May23 | Jun23 | Jul23 | Aug23 | Sep23 |
|-----------------------------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
| Accounts receivable (net) | 11,104 | 11,160 | 11,216 | 11,272 | 11,328 | 11,385 | 11,442 | 11,499 | 11,556 | 11,614 | 11,672 | 11,730 |
| Other current assets | 3,663 | 3,682 | 3,700 | 3,718 | 3,737 | 3,756 | 3,774 | 3,793 | 3,812 | 3,831 | 3,851 | 3,870 |
| Total current assets | 14,767 | 14,842 | 14,916 | 14,990 | 15,065 | 15,141 | 15,216 | 15,292 | 15,368 | 15,445 | 15,523 | 15,600 |
| Accounts payable | (1,448) | (1,455) | (1,462) | (1,470) | (1,477) | (1,484) | (1,492) | (1,499) | (1,507) | (1,514) | (1,522) | (1,530) |
| Accrued payroll and bonuses | (6,516) | (7,102) | (7,741) | (3,000) | (3,270) | (3,564) | (3,885) | (4,235) | (4,616) | (5,031) | (5,484) | (5,978) |
| Total current liabilities | (7,964) | (8,557) | (9,203) | (4,470) | (4,747) | (5,048) | (5,377) | (5,734) | (6,123) | (6,545) | (7,006) | (7,508) |
| Adjusted NWC | 6,803 | 6,285 | 5,713 | 10,520 | 10,318 | 10,093 | 9,839 | 9,558 | 9,245 | 8,900 | 8,517 | 8,092 |

| T3M avg. | T6M avg. | TTM Sep23 avg. |
|----------|----------|-------------------|
| 11,672 | 11,586 | 11,415 |
| 3,851 | 3,822 | 3,766 |
| 15,523 | 15,408 | 15,181 |
| (1,522) | (1,511) | (1,488) |
| (5,498) | (4,872) | (5,035) |
| (7,020) | (6,383) | (6,523) |
| 8,503 | 9,025 | 8,658 |



SPA considerations



What does the SPA Advisory team do?

Whether buying or selling, we advise across each phase of the deal continuum:

| Planning | Advise on the appropriate pricing mechanism Advise on equity price bridge (e.g., cash, debt, working capital) |
|---------------------|---|
| Negotiation | Develop and support the client's point of view on equity price Participate in and support negotiation of key financial terms |
| Signing and closing | Advise and support closing readiness exercises and preparation of closing accounts |
| Post-close | Advise on preparation or review of post-closing schedule Provide dispute resolution |



Preparation of the estimated closing statement (closing accounts)

Process overview

- The estimated closing statement is prepared by the seller and generally delivered three to five business days prior to the closing date.
- The buyer generally has the right to review and comment, and the seller generally has an obligation to consider in good faith
 any appropriate changes proposed by the buyer to the estimated closing statement (but the seller is NOT obligated to revise
 the estimated closing statement).

| 3–5 days | Closing | Closing date | Closing date | Closing date | Closing date |
|--|---|--|---|---|---------------------------------|
| before closing | date | + 90 days | + 135 days | + 165 days | + 195 days |
| Estimated closing statement prepared by the seller | Cash paid at closing (based on estimated closing statement) | Final closing statement prepared by the buyer | Other party reviews and issues dispute notice | Disputes are settled or referred to arbitrator (neutral accountant) | Final "true-up" payment made |

Note: The timeline is for illustrative purposes only. The specific timeline will be defined in the purchase agreement.



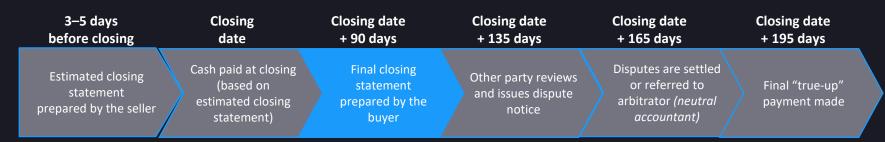
Preparation of the estimated closing statement (closing accounts) (cont.)

Process overview

- The final closing statement is generally prepared and delivered by the buyer to the seller between 60 to 120 days post-close.
- The seller generally has 30 to 60 days to review the final closing statement.

Key considerations

- The basis of accounting specified in the purchase agreement (the accounting principles)
 will govern preparation of the final closing statement.
- From a seller's perspective, deviations from historical accounting practices may result in unintended value shift. For example, a general accounting basis of "GAAP" provides ample opportunities for the buyer to chip on price.
- Although the final closing statement is in most instances prepared by the buyer, there
 may be situations whereby this is most practically done by the seller (e.g., carve-outs
 whereby the accounting function and/or systems do not transfer in connection with the
 deal). (This could be an advantage to the buyer.)



Note: The timeline is for illustrative purposes only. The specific timeline will be defined in the purchase agreement.



Preparation of the estimated closing statement (closing accounts) (cont.)

Process overview

- Selection of the arbitrator:
 - Often specified within the purchase agreement (e.g., "Seller and Purchaser shall submit all matters that remain in dispute with respect to the Notice of Disagreement to Ernst & Young LLP.")
- Submission of joint statement of facts/background of dispute:
 - Can be submitted jointly or separately by the parties
- Initial submissions by the parties:
 - Most often are "blind" simultaneous submissions
- Rebuttal submissions by the parties
- Questions from the arbitrator/possible oral hearing
- Arbitrator award issued and final "true-up" payment made

| 3–5 days | Closing | Closing date | Closing date | Closing date | Closing date |
|--|--|--|---|--|---------------------------------|
| before closing | date | + 90 days | + 135 days | + 165 days | + 195 days |
| Estimated closing statement prepared by the seller | Cash paid at closing (based on estimated closing statement) | Final closing statement prepared by the buyer | Other party reviews and issues dispute notice | Disputes are settled or referred to arbitrator (neutral accountant) | Final "true-up" payment made |

Sources of disputes

- Unclear hierarchy of accounting policies
- What is meant by consistency?
- Specific policies that are not very specific or are inconsistent
- Subjective areas not addressed
- Treatment of errors/items "consistently wrong"
- Hindsight period
- Access/process/timetable



Note: The timeline is for illustrative purposes only. The specific timeline will be defined in the purchase agreement

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Mentor Discussions

5:30 - 6:00

