Introduction

Uncertainty, fear, hope, and almost every emotion in between loom large in today’s political and economic environment, and the same is true in the health IT market (which we define as healthcare software, health services and outsourcing, and digital health). On January 25th, the Dow Jones Industrial Average closed above 20,000 for the first time in history, climbing the most recent 1,000 points at the second fastest rate in history, 42-days, and notably, entirely since the election of Donald Trump. Does the bullish nature of the market correlate to that of health IT? Have health IT valuations risen or fallen due to the new administration and its policy implications? In other words, in the near- and long-term, will a shift away from much of the regulatory framework of the Affordable Care Act help or hurt health IT companies looking to create and unlock value?

We believe the next chapter for health IT is likely to perpetuate initiatives around value-based care but using dramatically different forces: the Trump administration is forcefully advocating free-market levers in healthcare and across all sectors, with a focus on de-regulation, price transparency, and patient responsibility. While the catalysts may change, the simple objective remains the same for investors and operators alike: generate strong financial returns for shareholders by building sound business models that align profit incentives across all stakeholders with superior health outcomes.

To begin, it is easier to assess the future with a solid understanding of the past. In this edition of the HGP HIT Market Review, we start with an assessment of historical trends by taking a deep dive analysis into valuation multiples for 266 M&A transactions from 2010 through 2016 categorized across 15 health IT subsectors. The findings are unbiased and unfiltered, yet only serve as a guidepost, since every transaction has a unique identity and circumstance.

After inspecting 2016 valuation trends in health IT, we will take a similar approach to predicting the new policy and regulatory environment, observing past programs and stated frameworks outlined by the key healthcare leaders in this new administration.
Health IT Sector Valuation Trends

HGP Statistical Analysis of HIT Sector Valuations

A Box and Whisker plot graphically displays the Median, 25th Percentile, 75th Percentile, Minimum, and Maximum; where points beyond 1.75 times the Inter-Quartile Range are shown as outliers. The Inter-Quartile Range (blue columns) is the 75th Percentile minus the 25th Percentile and serves to describe the variation in the range of outcomes. The raw data for this graph can be found on page 3.

The sectors were sorted according to decreasing median revenue multiple, and show a trend of decreasing IQR as median revenue multiple decreases. We can interpret this to mean that while companies that fall within sectors further to the right on the graph can expect a lower revenue multiple in a transaction, the transaction is also much more predictable. A company that falls within a sector on the left, however, cannot have as strong a confidence in their expected outcome. These observations follow a common theme in investment theory: that with greater potential upside, there is also greater risk and volatility.

The following summary provides additional context on the valuation trends within each sector, the statistical and intuitive significance of those trends, and a listing of representative transactions. The statistical significance of each sector varies depending on the volume, date, and variability of transactions within each. While these metrics may be used as a guidepost for expected outcomes, the end result often depends as much on seller and market fundamentals as buyer circumstances, and buyer circumstances tend to be extremely unpredictable. It is not uncommon for the clearing price of a transaction to be significantly higher than the cover bids. This usually occurs when a buyer has unique circumstances that justify a higher price than the rest of the buyer universe. Identifying those buyers and appropriately positioning in relation to them is part of the art of running a successful transaction process.
## 2 Health IT Sector Valuation Trends

### Sector Observations

<table>
<thead>
<tr>
<th>Sector</th>
<th>Observation</th>
<th>Representative Deals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pop Health</strong></td>
<td>With a median revenue multiple of 5.1x and standard deviation of 6.5x, Population Health Management trades at the top of our selected Health IT sectors. The category aligns with macro healthcare trends and value-based payment reform, which in turn supports a strong investment thesis. Because the space is relatively new, pop health companies tend to have technology and revenue model characteristics that lend to high valuations, especially when the mix is compared to other mature Health IT sectors, such as EMR and Infrastructure IT. The sector reports several outliers – dbMotion (Allscripts), Care Team Connect and HealthPost (Advisory Board), Wellcentive (Royal Philips) – all trading above 10x revenue.</td>
<td>HMS-Essette (2016), NantHealth-NaviNet (2016), Philips-Wellcentive (2016), Thoma Bravo-Imprivata (2016), IBM-Phytel (2015)</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>Content transactions demonstrate the highest standard deviation of all Health IT sectors. Upon further review of the data, lower valuations were realized by consumer content plays, such as Everyday Health, 1-800-Contacts, Drugstore.com, and eDiets.com. The premium outliers were experienced by sellers who deliver clinical content to healthcare providers, and particularly those with content that serves as a standard of care, such as Milliman Care Guidelines, ExitCare, and Health Language.</td>
<td>DTC: j2 Global-Everyday Health (2016), Care.com-Citrus Lane (2014), Walgreens-Drugstore.com (2011)</td>
</tr>
<tr>
<td><strong>Telemed</strong></td>
<td>We do not believe the data from M&amp;A transactions fairly represents the valuation range of Telemedicine targets. The limited sample size (4) and the diverse mix of companies within that sample do not fairly result in a statistically significant dataset. Furthermore, HGP is aware of a number of telemedicine and care management companies receiving much higher venture and private equity valuations than reported in this M&amp;A sample. As this market matures and as investment activity harvests into M&amp;A activity, we will gain more visibility into M&amp;A valuation trends, which we expect to be above the data reported in this sample set.</td>
<td>Teladoc-HealthiestYou (2016), Medtronic-Cardiocom (2013)</td>
</tr>
<tr>
<td><strong>Analytics</strong></td>
<td>The 19 reported analytics transactions generally trade in a tight range around 4x revenue. Outliers above the median include data warehousing vendors Explorys and Humedica, and below the median include vendors that operate in the more mature life sciences analytics space, such as Inventiv Health.</td>
<td>Quintiles-IMS (2016), Veritas-Verisk, nka Verscend (2016), Thoma Bravo-MedeAnalytics (2015), MedAssets-Sg2 (2014)</td>
</tr>
<tr>
<td><strong>Benefits Software</strong></td>
<td>Benefits Software transactions have experienced a wide valuation distribution. A number of deals trade in the 2-3x revenue range, which includes several transactions that are more distressed in nature. The data is somewhat skewed by several deals that traded at very high multiples, including HealthPocket and bswift, resulting in a mean much higher than the median. The limited number of transactions (12) in this category gives the data less statistical strength.</td>
<td>WEX-Evolution 1 (2014), Aetna-bsswift (2014), West-Health Advocate (2014), Towers Watson-Extend (2012)</td>
</tr>
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## Health IT Sector Valuation Trends

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<tr>
<td><strong>RCM Tech</strong></td>
<td>The 27 RCM Technology transactions contain an array of targets that address different structural needs within healthcare, ranging from basic connectivity to price transparency, bundled payments, and patient financial responsibility. Intuitively, one can imagine how transactions fall on the valuation distribution based on the innovation level of the product offering. Outliers include Executive Health Resources and A-Life, (Optum), Medical Present Value and Passport (Experian), CodeRyte (3M), ABILITY Network (Summit/Bain), RevPoint (Availity), and Brighttree (Resmed). There is a notable trend among RCM Technology outlier valuations: often the highest valuations are achieved when the transaction represents a non-traditional outside acquirer making a platform Health IT investment. This has also been a prevalent theme in the Benefits Management category.</td>
<td>Bain-Navicure (2016), Pamplona-MedAssets (2015), Change-Capario (2014), Experian-Passport (2013)</td>
</tr>
<tr>
<td><strong>HIM Software</strong></td>
<td>HIM Software is a relatively small set of 6 transactions that occurred between 2010 and 2012, making this category the least statistically relevant. For vendors in the HIM space, the best comparable sectors are EMR followed by Infrastructure IT.</td>
<td>One Equity-m*modal (2012), Lexmark-Perceptive (2010), Hyland Software-eWebHealth (2010)</td>
</tr>
<tr>
<td><strong>Infrastructure IT</strong></td>
<td>There is no one size fits all method to valuation within Infrastructure IT. Valuation ranges are highly dependent on the software delivery model (on-prem versus cloud) and revenue model (license versus SaaS). Despite the differences within the transaction set, the category has a relatively low standard deviation of 1.4x. Outliers include the sale of API Healthcare (GE), VendorMate (GEX), HealthLine (HealthStream), and Extension Healthcare (Vocera).</td>
<td>SympIr-CACTUS (2016), Halma-CenTrak (2016), Global Healthcare Exchange-VendorMate (2014), API-Concerro (2012), Infor-Lawson (2011)</td>
</tr>
<tr>
<td><strong>RCM Services</strong></td>
<td>RCM Services transactions generally traded within a tight range with a median and standard deviation revenue multiple of 2.1x and 1.2x, respectively. Very few transactions in the category traded over 3x revenue, with the exception of HealthDataInsights (HMS), SPI Healthcare (Conifer), MedSynergies (Optum), and Cardon Outreach (MEDNAX). The sector generally trades off of EBITDA multiples, and targets that realized the highest revenue multiples tended to have above market profit margins (30%+).</td>
<td>Atos-Anthelio (2016), MedData-Cardon (2016), Optum-MedSynergies (2014), Zotec-Medical Management (2013)</td>
</tr>
<tr>
<td><strong>EMR</strong></td>
<td>The 59 EMR transactions include a relatively balanced mixed of license (non-recurring revenue) and SaaS (recurring revenue) models, with license models trading closer to the 2x range and SaaS in the 3-5x range. Taken together, the median is 2.8x with a standard deviation of 2x. The category also includes several distressed transactions that traded below 1.0x revenue. Revenue model and architecture as well as site and specialty focus are likely indicative of where companies fall on the range.</td>
<td>Allscripts-NetSmart (2016), Quality Systems-HealthFusion (2015), Cerner-Siemens (2014), Vitera-Greenway (2013), ADP-AdvancedMD (2011)</td>
</tr>
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<tr>
<td>Teleradiology</td>
<td>Teleradiology also contains a small sample size (5), but the sample size produces consistent results. This relatively mature market segment trades in a tight range around 2x revenue.</td>
<td>MEDNAX-Virtual Radiologic (2015), Virtual Radiology-Knighthawk (2010), RadNet-eRad (2010)</td>
</tr>
<tr>
<td>(5 deals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median: 2.0X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IQR: 1.0X</td>
<td></td>
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<tr>
<td>CTMS</td>
<td>As a relatively mature category, CTMS transactions generally hovered in the 1.5-3X revenue range. The category has fewer transactions (7), which make the data less statistically significant. However, we interpret the tightness of the distribution range to be a reasonable indicator of valuation for the sector. Even so, there is no doubt that disruptive innovations in the data management of clinical trials could fetch significantly higher valuations as the entire sector seeks opportunities to innovate, and not just consolidate.</td>
<td>JLL Partners-BioClinica (2013), Genstar-eResearch (2012), Merge-StudyManager (2012)</td>
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<tr>
<td>(7 deals)</td>
<td></td>
<td></td>
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<tr>
<td>Median: 2.0X</td>
<td></td>
<td></td>
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<tr>
<td>IQR: 0.7X</td>
<td></td>
<td></td>
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<tr>
<td>Payer Services</td>
<td>Traditionally a services or tech-enabled service, Payer Services transactions generally hovered near the revenue multiple median of 1.4x, with the exception of Mediconnect Global (Verisk) and Alere (Abbott).</td>
<td>Wipro-HealthPlan Holdings (2016), ExamWorks-ABI (2016), Exlservice-Landacorp (2012), Verisk-Mediconnect (2012)</td>
</tr>
<tr>
<td>(13 deals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median: 1.4X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IQR: 0.8X</td>
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<tr>
<td>Consulting</td>
<td>Consulting transactions generally traded within a narrow range of 1-2x revenue (and cluster closer to the lower end of that range). Pure outsourcing tends to trade at the lower end of the range, and higher value services, such as Huron’s acquisition of Studer, trade at the higher end of the range. Revenue visibility is also a key consideration for a market that traditionally experiences project-based revenue.</td>
<td>Accenture-Kurt Salmon (2016), Evolent-Valence (2016), Huron-Vonlay (2014), Quintiles-Encore (2014)</td>
</tr>
<tr>
<td>(15 deals)</td>
<td></td>
<td></td>
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<tr>
<td>Median: 1.4X</td>
<td></td>
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<tr>
<td>IQR: 0.5X</td>
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<tr>
<td>Utilization Mgmt</td>
<td>Given the relatively low margins of this segment, UM businesses typically trade in the 1-2x revenue range. From a valuation perspective, the category often looks to payer valuations as a comparable set. However, new UM models, such as those focused on genetics, specialty testing, devices, oncology, and other areas of high cost or over-utilized care, may justify significantly higher valuations and trade on very different metrics.</td>
<td>Magellan-HMS (2015), Magellan-CDMI (2014), Universal American-APS (2012), AmerSourceBergen-TheraCom (2011)</td>
</tr>
<tr>
<td>(7 deals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median: 0.8X</td>
<td></td>
<td></td>
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<tr>
<td>IQR: 0.3X</td>
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Healthcare Policy Snapshot

Introducing the New Healthcare Administration

The common threads between the four key influencers in the Trump healthcare administration are de-regulation, price transparency, and patient responsibility. We are potentially entering a very different era from the Obama administration. Since enactment of the ACA, the health IT market has been undergoing more than five years of government mandates around technology adoption. HGP has described the health IT market like a game of policy Whac-A-Mole – vendors are constantly required to react to a steady mandate of feature requirements, alternative payment models, quality reporting, and compliance provisions. During the HITECH and ACA implementation era, we made the case that the health IT market behaves more like a policy-based economy than a market-based economy. The next chapter is likely to perpetuate initiatives around value-based care but using dramatically different forces: the Trump administration is forcefully advocating free-market levers in healthcare and across all sectors. Strong on rhetoric but sparse on details, plans for the future are uncertain. The best indicator of what to expect is the observation of past programs and an analysis of current frameworks outlined by the key healthcare leaders in this new administration.

Immediately post-election, worry surrounded hospital and health system appetites for Health IT purchases as they would understandably hesitate to make large purchases in the face of a changing regulatory environment. The Advisory Board Company noted that it has seen changing attitudes by providers, delaying and cancelling deals. It is likely that some Health IT companies will see purchasing hesitation for the immediate future until more certainty is seen in the regulatory environment. However, recent CIO surveys and general investor sentiment indicate that momentum continues to be strong except for certain pockets that face a particularly high degree of risk due to negative exposure to the likely positions of the Trump administration, as discussed in the following sections.
**Healthcare Policy Snapshot**

**The New Healthcare Guard**

**Donald Trump: POTUS**

Donald Trump

**Stated Focus:** Increase competition, Reform FDA, Modernize Medicare, State power over Medicaid, Remove individual and employer mandates.

**Stated Position:** “The Administration recognizes that the problems with the U.S. health care system did not begin with – and will not end with the repeal of – the ACA.”

- Greatagain.gov

**Donald Trump:** Responsible for key healthcare appointments, including HHS and CMS.

**Tom Price: HHS Nominee**

Tom Price

**Stated Position:** Runs the gov’t’s largest social programs, including Medicare, Medicaid, CHIP, Direct and indirect authority over FDA, CDC, and NIH. Funding is appropriated by Congress, the office controls implementation and oversight.

**Track Record:** Empowering Patients First Act (2015) calls for age-adjusted tax credits for those buying health coverage on their own; a one-time credit for starting a health savings account; state-administered high-risk pools for people with pre-existing conditions; tort reform; and allowing insurers to sell policies across state lines. It would also allow individuals to opt out of government plans such as Medicare, Medicaid, and the VA programs and take the tax credit instead to buy their own insurance and would allow small businesses to create their own national insurance buying groups.

**Stated Positions:** “It’s time for a better way to put patients, families, and doctors back in charge of medical decisions. President Obama and Democrats must put their pride and politics aside so that we can start over with a Better Way—a step-by-step plan to give every American access to quality, affordable health care.”

**Paul Ryan: Speaker of the House**

Paul Ryan

**Stated Focus:** Crafted a core Republican policy agenda, A Better Way, which serves as a blueprint for conservative policy programs covering all facets of governance, with a significant focus on healthcare reform. Reduce regulation and taxes. Greater flexibility and improve FDA clearance process. Build on 21st Century Cures.

**A Better Way:** More choices and lower costs. Our plan gives you more control and more choices so that you can pick the plan that meets your needs—not Washington’s mandates. Real protections and peace of mind. Our plan makes sure that you never have to worry about being turned away or having your coverage taken away—regardless of age, income, medical conditions, or circumstances. Cutting-edge cures and treatments. Our plan clears out the bureaucracy to accelerate the development of life-saving devices and therapies. A stronger Medicare. Our plan protects Medicare for today’s seniors and preserves the program for future generations. – A Better Way

**Seema Verma: CMS Nominee**

Seema Verma

**Stated Position:** HIP 2.0 under Governor Pence was unique in its emphasis on personal responsibility. Enrollees to the program were required to make contributions ranging from $1-27 a month that went into a Health Savings Account (HSA) like pool that could be applied towards personal wellness services. Receiving a $2,500 deductible health plan along with a $2,500 HSA like account was intended to incentivize enrollees to think judiciously about the choices they made.

**Paul Ryan:** Currently Speaker of the House, the House’s political and parliamentary leader. Previously Chair of Ways & Means Committee, the chief tax-writing committee of the House which also oversees Social Security and Medicare.

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**Seema Verma:** Under HHS, administers Medicare and, in coordination with states, Medicaid. Oversees largest health insurance payer in the U.S. and oversees CMS programs that shift payment models from FFS to value.

**Track Record:** Founder of consulting firm, SVC, which works with state gov’ts regarding public health, Medicaid and insurance policies. Under VP-elect, Mike Pence, developed a consumer-directed Medicaid plan called Health Indiana Plan (HIP).

**Stated Positions:** HIP 2.0 under Governor Pence was unique in its emphasis on personal responsibility. Enrollees to the program were required to make contributions ranging from $1-27 a month that went into a Health Savings Account (HSA) like pool that could be applied towards personal wellness services. Receiving a $2,500 deductible health plan along with a $2,500 HSA like account was intended to incentivize enrollees to think judiciously about the choices they made.
# Healthcare Policy Snapshot

## ACA: Cleaning House

Much of the new administration’s proposed changes to the ACA revolve around opening healthcare up to the free market, and as such we expect to see regulatory mandates and taxes repealed or amended. Value-based reimbursement, however, is at its base a push to make healthcare behave according to more traditional market dynamics, and will likely see continued support under the new Republican administration.

<table>
<thead>
<tr>
<th>ACA Provision</th>
<th>Likelihood of Repeal/Amendment</th>
<th>F&amp;S Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual and Employer Mandate</td>
<td>High</td>
<td>Potential to eliminate individual and employer mandates through the budget reconciliation process. This may preclude ACA’s incentives to maintain health insurance coverage through penalty mandates.</td>
</tr>
<tr>
<td>Cadillac Tax</td>
<td>High</td>
<td>This tax has never been popular and has been delayed to go into effect in 2020. Likely to receive bipartisan support from house representatives to reform and/or repeal this provision.</td>
</tr>
<tr>
<td>Public Health Exchanges</td>
<td>High</td>
<td>Considering only about 4% of Americans are registered on the health exchanges, President Trump’s administration will more likely dismantle the state level Public Health Exchanges model with structured legislative reforms to promote free market driven price transparency on insurance policies.</td>
</tr>
<tr>
<td>Wellness Program Incentives</td>
<td>Low</td>
<td>Trump administration will possibly amend the wellness and preventive care initiatives by linking the incentives to Health Savings Accounts (HSAs) which has been central to the Republicans’ health reform approach as they plan to expand HSAs for all Americans.</td>
</tr>
<tr>
<td>Medical Device Excise Tax</td>
<td>High</td>
<td>In June 2015, this tax had already been suspended until 2018 with 46 Democrats and 234 Republicans votes. It is nearly a certainty this suspension of the tax is made permanent.</td>
</tr>
<tr>
<td>Medicaid Expansion</td>
<td>Medium High</td>
<td>A sticking point for many states who have openly sought to defy the ACA, the Trump administration could alter the bill to give greater freedom to the states in choosing how to manage their Medicaid dollars.</td>
</tr>
<tr>
<td>Lower Prescription Drug Costs</td>
<td>Medium</td>
<td>Free market policies could revert efforts in controlling prescription drug prices. Proposals which sought to position the government to wholesale bargain with companies will likely be tabled. Furthermore, efforts to allow greater drug imports and transparency into drug costs could be abandoned.</td>
</tr>
<tr>
<td>Value-Based Reimbursement</td>
<td>Low</td>
<td>The new administration will be in charge during the first year of MACRA, the Obama administration’s overhaul of physician Medicare reimbursement. With MACRA, Medicare will double-down on the shift from volume-based payments to value-based care. Trump likely will support the continued move to value-based care, which, in part, pushes hospitals, health systems and other parts of the industry to operate more like retailers.</td>
</tr>
</tbody>
</table>

*Sources: Frost & Sullivan and PricewaterhouseCoopers.*
# Healthcare Policy Snapshot

## Trumpcare: Likely Core Principles

Trump’s healthcare plan will likely revolve around removing mandatory requirements and increasing incentives to pay for insurance. Additionally, in an effort to incentivize consumers to make educated decisions about their care, Trump will likely emphasize the use of Health Savings Accounts and encourage greater price transparency. He has already identified tax benefits as one way he will incentivize consumers to engage with their health, however detailed plans to create the necessary price transparency have yet to be revealed.

<table>
<thead>
<tr>
<th>Provision</th>
<th>Likely Action Plan</th>
</tr>
</thead>
</table>
| Structural Amendment to ACA | - Coverage for pre-existing conditions, and dependents up to age 26 covered by parents provisions will remain.  
- Remove the Individual and Employer Mandate, as no one should be forced to buy health insurance.  
- Reduce the growth rate of Medicare spending by implementing new taxes and fees. |
| Emphasize the use of Health Savings Accounts | - Expand Health Savings Accounts (HSAs) to all individuals, where the contributions would not only be tax-free but also accumulate over time.  
- Allow HSAs to become a part of a person’s estate and would be passed on to heirs without any penalty. |
| Making premiums tax deductible | - Allow individuals to fully deduct their premiums from their tax returns under the current tax system, facilitating a free market to provide insurance coverage to companies and individuals.  
- May abolish APTCs and let individuals use pre-tax money to purchase individual market insurance.  
- The aim is to provide people with an incentive to pay for coverage when they are healthy, and not make it mandatory. |
| Funding Medicaid through block-grants | - Dismantle State Health Exchanges and fund Medicaid all over the country through block grants. Under this, the federal government would give a fixed amount of money to states and let them fund their programs.  
- The rationale behind this is that state governments know best about their population and should have the sole authority on how the money should be spent and will fare better without federal administration overhead. |
| Health insurance companies to sell plans across state lines | - Allowing health insurance companies to sell their plans across the state lines - Any vendor that complies with the state guidelines can offer insurance plans in that state.  
- Objective is to promote a competitive environment, to optimize the insurance cost and customer satisfaction. |
| Increased price transparency | - The goal is to make individuals aware of the best prices for medical procedures, tests, drugs and devices.  
- How and to what effect it will be implemented is uncertain so far, thus impacts of these are unknown. |
| Free market for drug providers | - Trump believes that the cost of care could be reduced to a great extent if Medicare negotiates with pharmaceutical companies for drug pricing.  
- He wants to remove the existing barriers to entry and create a free market for drug companies. |
| Renegotiation of foreign trade deals | - Possible restrictions on global trade may result in tariffs or custom duties, which drive up supply chain and import costs of foreign drugs.  
- May boost US pharma if new deals include longer patent exclusivity rights.  
- May create a stronger market to sell US drugs overseas. |

*Sources: Frost & Sullivan and PricewaterhouseCoopers.*
Health IT M&A (Including Buyout)

Overview

HGP has observed a number of tangible and intangible company and transaction characteristics that typically define where a deal falls on the valuation distribution. Growth, profitability, and recurring revenue are the most commonly identified factors used to justify valuation multiples. Not all health IT companies capture premium valuations just because they operate in health IT. However, those companies that offer a combination of growth, address an unmet need, and fit into the vision of healthcare reform are seeing valuations significantly higher than historical patterns of activity. Premium value is also created when a seller fulfills the specific needs of a buyer at a specific point in time. Timing and serendipity are external factors that play a large and sometimes unpredictable role in the creation of value.

Health IT Revenue Multiples Distribution

Among the many business and market characteristics that drive superior valuations, the following are core components to healthcare IT businesses that have established themselves as outliers:

1. **SaaS Architecture and Delivery**
   - Single database enabling robust analytics
   - Delivery model that creates scale on the cost side, and recurring revenue on the top line

2. **Pricing Alignment with ROI**
   - Pricing methodology that aligns with customer ROI – the vendor wins when the customer wins

3. **Scalable Distribution Model**
   - Efficient distribution model (eg, customer acquisition cost < customer value)

4. **Data Rights**
   - Contract structures that contain explicit rights to data

5. **Reform-Centric Value Proposition**
   - Addresses healthcare structural flaws rather than take advantage of them in an effort to deliver sustainable change in a policy-based environment

6. **General Considerations**
   - Market leadership (or opportunity to lead) = favorable supply/demand characteristics at exit
   - Large and growing market opportunity, strong financial characteristics = recurring revenue and growth, inherent scalability if not profitability, strong management, size
Health IT M&A Activity

The following chart summarizes annual M&A activity since 2008, according to the Healthcare Growth Partners database.

After a record 331 transactions in 2015, health IT M&A activity continued at a record pace of 364 transactions in 2016, with total transaction value also setting a record at $44.4 billion. Total transaction value tends to be much more volatile than deal volume since it only takes one or two very large deals to skew the data and the majority of transactions do not disclose value, thus HGP looks toward transaction volume as a better indicator of deal activity.

Generally, sub $100 million companies have three valuation inflection points: proof-of-concept, growth scalability, and mature scalability (as illustrated on the following page). Proof-of-concept is value created when a company shows that its product can be successfully sold and deployed in a commercial setting. The proof-of-concept inflection point is generally of more importance to venture investors than it is to acquirers, as companies at this stage tend to be too immature to realize significant value through a sale. Growth scalability occurs when an earlier stage company begins to show profitability or at least scale at high levels of growth, although the organization is still small and lean. Mature scalability takes place after a company has matured to a level where it takes on real infrastructure, and the company begins to show strong profitability after building out a mature corporate organization.
Although the size of a company at each inflection point can vary significantly based on a company’s product or services and sector, the general rule of thumb in health IT is that proof of concept occurs at revenue of less than $1 million, growth scalability occurs in the $5 to $10 million revenue range, and mature scalability occurs starting in the $20 million revenue range.

Healthcare Growth Partners narrowed its transaction database to include 199 highly relevant transactions of Health IT Software companies with disclosed multiples since 2010. When analyzing valuation multiples based on certain criteria, findings show the key valuation drivers for health IT transactions. Therefore, the revenue multiples in the following tables serve as a better guide to demonstrate the variability in valuations based in certain criteria. It is important to highlight that the multiples below are based on trailing-twelve-month financials and the transaction value assumes 100% achievement of any contingent consideration (i.e., earnouts).

<table>
<thead>
<tr>
<th>HIT Software Transactions (2010-2016)</th>
<th>Number of Transactions</th>
<th>Median EV</th>
<th>Median EV/Revenue</th>
<th>Median EV/EBITDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HGP-Selected Transactions</td>
<td>199</td>
<td>$103.3</td>
<td>3.06X</td>
<td>12.8X</td>
</tr>
<tr>
<td>EV &gt;= $100mm</td>
<td>102</td>
<td>$313.6</td>
<td>3.80X</td>
<td>13.7X</td>
</tr>
<tr>
<td>EV &lt; $100mm</td>
<td>97</td>
<td>$19.5</td>
<td>2.40X</td>
<td>9.6X</td>
</tr>
<tr>
<td>Profitable Companies</td>
<td>116</td>
<td>$160.1</td>
<td>2.90X</td>
<td>12.8X</td>
</tr>
<tr>
<td>Non-Profitable Companies</td>
<td>15</td>
<td>$34.2</td>
<td>2.65X</td>
<td>nm</td>
</tr>
<tr>
<td>Recurring Revenue Model Companies</td>
<td>122</td>
<td>$155.9</td>
<td>3.86X</td>
<td>14.8X</td>
</tr>
<tr>
<td>Non-Recurring Revenue Model Companies</td>
<td>56</td>
<td>$54.8</td>
<td>2.01X</td>
<td>10.5X</td>
</tr>
<tr>
<td>Recurring Revenue Model Companies and EV&lt;$100mm</td>
<td>46</td>
<td>$20.7</td>
<td>3.24X</td>
<td>10.0X</td>
</tr>
</tbody>
</table>
Further focusing on the implication of transaction size and value, HGP analyzed 199 HIT Software and 65 HIT Services transactions since 2010 based on transaction size in the following table. As a general rule of thumb, transaction multiples expand as valuation increases. Higher valuations can also be attributed to the fact that larger companies are large because they have been successful — meriting valuations because of success, not exclusively size. Across both sectors valuations climb as transaction size increases until they peak in the $500-$1B range. Above $1B, valuations fall which is likely due to the maturity of these companies and the slower growth rate that comes with market and company maturity.

<table>
<thead>
<tr>
<th>HIT Software Companies</th>
<th>HIT Services Companies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transaction Value</td>
</tr>
<tr>
<td># of Transactions</td>
<td>195</td>
</tr>
<tr>
<td>Median</td>
<td>$103.3</td>
</tr>
<tr>
<td>Mean</td>
<td>$456.7</td>
</tr>
<tr>
<td>&lt;$30mm Transactions</td>
<td># of Transactions</td>
</tr>
<tr>
<td>Median</td>
<td>$11.7</td>
</tr>
<tr>
<td>Mean</td>
<td>$12.9</td>
</tr>
<tr>
<td>$30-100mm Transactions</td>
<td># of Transactions</td>
</tr>
<tr>
<td>Median</td>
<td>$49.2</td>
</tr>
<tr>
<td>Mean</td>
<td>$52.0</td>
</tr>
<tr>
<td>$100-500mm Transactions</td>
<td># of Transactions</td>
</tr>
<tr>
<td>Median</td>
<td>$220</td>
</tr>
<tr>
<td>Mean</td>
<td>$239.8</td>
</tr>
<tr>
<td>$500mm-$1B Transactions</td>
<td># of Transactions</td>
</tr>
<tr>
<td>Median</td>
<td>$720.9</td>
</tr>
<tr>
<td>Mean</td>
<td>$718.7</td>
</tr>
<tr>
<td>&gt;$1B Transactions</td>
<td># of Transactions</td>
</tr>
<tr>
<td>Median</td>
<td>$1670.4</td>
</tr>
<tr>
<td>Mean</td>
<td>$3073.1</td>
</tr>
</tbody>
</table>
Continuing the analysis on the prior page, HGP evaluated the distribution of transaction size by target enterprise value. HIT Software valuations experience a nice inflection above $30mm in value, which steadily climbs until approximately the $1B valuation mark. HIT Services multiples experience a similar inflection at $30mm, and a second inflection at $100mm especially with higher percentile transactions. The second inflection is in part due to a private equity universe that has expanded leverage capacity for larger transactions, which in turn drives up valuation multiples.

In 2016, Healthcare Growth Partners monitored 364 health IT and related services transactions, compared to 331 transactions in 2015. In terms of aggregate deal size, nearly $44.4 billion in transactions was announced in 2016, compared to $14 billion in all of 2015. The $44.4 billion number was skewed by several large transactions, including the $9 billion sale ($4.9 billion equity) of Alere to Abbot Labs, the $2.6 billion sale of Truven to IBM, and the $13.5 billion ($8.8 billion equity) acquisition of IMS by Quintiles. The median revenue multiple in 2016 was 3.8x for HIT Software, equal to 3.8x in 2015, and 1.7x for Health IT Services, also equal to the 1.7x reported in 2015.

Detailed annual trends can be found in the following table. It should be noted that multiple trends can be very volatile given the limited availability of data. Refer to Appendices A and B for a list of notable M&A and Buyout transactions in 2016.
It is important to note that transaction multiples are based on trailing-twelve-month financial information, assume the achievement of all contingent consideration, such as earnouts, and most EBITDA multiples do not include any adjustments for unusual items. It is also important to note that less than one-third of transactions contain a disclosed multiple, therefore the multiple data represents only a portion of the overall transaction activity.
Health IT Capital Raises (Non-Buyout)

The chart below summarizes quarterly private-equity and venture capital activity in health IT and related services since 2008, according to the Healthcare Growth Partners database. The data below and in this section does not include buyout private equity activity. In 2016, Healthcare Growth Partners monitored 481 capital raise transactions, with the majority (59%) occurring in the second half of the year.

HIT Investment Activity

HIT Investment Deals by Quarter

Refer to Appendix C for a list of notable non-buyout capital raises in 2016.
Healthcare Capital Markets

HGP tracks a basket of stock indices within health IT and closely related sectors. It is important to consider sectors outside of pure “HIT” because the universe of health IT and related services encompasses many companies that share similar characteristics to other healthcare sectors. What classifies a company in the universe of health IT and related services, and ideally creates a valuation premium, is a strong information technology and data component that creates scalability and competitive strength. This is particularly relevant to services organizations that use technology and data analytics to streamline their operations. With this in mind, HGP considered seven sectors when evaluating the performance of publicly traded companies – details of the components of these sectors can be found on page 21:

<table>
<thead>
<tr>
<th>Considered Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health IT (HIT)</td>
</tr>
<tr>
<td>HIT Services</td>
</tr>
<tr>
<td>Pharmacy Benefit Management (PBM)</td>
</tr>
<tr>
<td>Healthcare Services</td>
</tr>
<tr>
<td>Contract Research Organizations (CROs)</td>
</tr>
<tr>
<td>Payers</td>
</tr>
<tr>
<td>Payer Services</td>
</tr>
</tbody>
</table>

Despite ups and downs, the U.S. capital markets ended 2016 with an election-rally uptick. Of the HGP health IT and services indices, HIT performed the worst, with a decline of 16.6%. PBM took a sharp decline after the election, ending the year down 15.8%. Top performing indices were HIT Services and Payer Services, which gained 17.8% and 31.6%, respectively. The chart and the table on the following page summarize the performance of the HGP health IT and services indices in 2016.

HIT & Related Index Performance 2016
6 Healthcare Capital Markets

### HIT Index Performance Detail – 2016

<table>
<thead>
<tr>
<th>Index Description</th>
<th>2016 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;P 500</td>
<td>9.5%</td>
</tr>
<tr>
<td>NASDAQ</td>
<td>13.4%</td>
</tr>
<tr>
<td>CRO</td>
<td>7.5%</td>
</tr>
<tr>
<td>Payers</td>
<td>17.0%</td>
</tr>
<tr>
<td>PBM</td>
<td>-15.8%</td>
</tr>
<tr>
<td>HIT</td>
<td>-16.6%</td>
</tr>
<tr>
<td>Healthcare Services</td>
<td>-11.0%</td>
</tr>
<tr>
<td>Payer Services</td>
<td>31.6%</td>
</tr>
<tr>
<td>HIT Services</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

The Advisory Board Company (NasdaqGS: ABCO) -33.0%
athenahealth, Inc. (NasdaqGS: ATHN) -34.7%
Benefitfocus (NasdaqGM: BNFT) -18.4%
Castlight (NYSE: CSLT) 15.9%
Cerner Corporation (NasdaqGS:CERN) -21.3%
Computer Programs & Systems Inc. (NasdaqGS: CPSI) -52.6%
Connecture, Inc. (NasdaqGM: CNXR) -53.5%
Covisint (NasdaqGS: COVS) -24.0%
eHealth, Inc. (NasdaqGS: EHTH) 6.7%
Everyday Health (NYSE: EVDY) 74.4% (Last trade on Dec 5)
Evolent Health, Inc. (NYSE: EVH) 22.2%
Fitbit Inc. (NYSE: FIT) -75.3%
Health Insurance Innovations, Inc. (NasdaqGM: HIIQ) 166.4%
HealthEquity, Inc. (NasdaqGS: HQY) 61.6%
Healthstream Inc. (NasdaqGS: HSTM) 13.9%
HMS Holdings Corp. (NasdaqGS: HMSY) 47.2%
Imprivata (NYSE: IMPR) 70.4% (Last trade on Sep 15)
IMS Health Holdings (NYSE: IMS) 23.0% (Last trade on Sep 30)
Inovalon Holdings, Inc. (NasdaqGS: INOV) -39.4%
McKesson Corporation (NYSE: MCK) -28.8%
MedAssets, Inc. (NasdaqGS: MDAS) na (Last trade on Jan 27)
Medidata Solutions, Inc. (NasdaqGS: MDSO) 0.8%
MINDBODY, Inc. (NasdaqGM: MB) 40.8%
NantHealth, Inc. (NasdaqGS: NH) -46.5% (Since June 2 $14 IPO)
National Research Corp. (NasdaqGS: NRCI.B) 16.3%
OneView Group plc (AIM: ONEV) 77.5% (Since Mar 16 $2.66 IPO)
Orion Health Group Limited (NZSE: OHE) -37.5%
Premier (NasdaqGS: PINC) -13.9%
Press Ganey Holdings, Inc. (NYSE: PGND) 28.4% (Last trade on Oct 10)
Quality Systems Inc. (NasdaqGS: QSII) -18.4%
Roper Technologies, Inc. (NYSE: ROP) -3.5%
Streamline Health Solutions, Inc. (NasdaqCM: STRM) -11.3%
Teladoc, Inc. (NYSE: TDOC) -8.1%
Veeva (NYSE: VEEV) 41.1%
Vocera Communications, Inc. (NYSE: VCRA) 51.6%
WebMD Health Corp. (NasdaqGS: WBMD) 2.6%
# Healthcare Capital Markets

Following a record eight IPOs in 2015, health IT saw five completed IPOs in 2016, and two follow-on offerings. Completed IPOs include Tabula Rasa Healthcare, Inc. (NasdaqGM:TRHC) - $52mm, Oneview Healthcare PLC (ASX:ONE) - $46.5mm, Cotiviti Holdings, Inc. (NYSE:COTV) - $237.5mm, NantHealth, (NasdaqGS:NH) - $91.0mm, and iRhythm Technologies, Inc. (NasdaqGM:RTC). Filed but not completed IPOs include PointClickCare and Inventiv Health who withdrew its IPO. Follow-on offerings were completed by Constellation Healthcare Technologies, Inc. (AIM:CHT) - $46.4mm, Senseonics Holdings, Inc. (AMEX:SENS) - $45.0mm, and HealthEquity, Inc. (NasdaqGS:HQY) - $91.9mm.

Valuation multiples across the healthcare sector remain strong. The HIT, CRO, and Payer Services indices receive the most significant valuation premiums over the rest of the market.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health IT</td>
<td>3.2X</td>
<td>2.9X</td>
<td>3.2X</td>
<td>17.1X</td>
<td>13.1X</td>
<td>12.2X</td>
</tr>
<tr>
<td>HIT Services</td>
<td>1.1X</td>
<td>1.6X</td>
<td>1.3X</td>
<td>9.9X</td>
<td>9.1X</td>
<td>9.9X</td>
</tr>
<tr>
<td>CRO</td>
<td>2.7X</td>
<td>3.3X</td>
<td>2.8X</td>
<td>13.5X</td>
<td>14.6X</td>
<td>12.5X</td>
</tr>
<tr>
<td>Healthcare Services</td>
<td>1.1X</td>
<td>1.5X</td>
<td>1.4X</td>
<td>8.8X</td>
<td>10.2X</td>
<td>8.8X</td>
</tr>
<tr>
<td>Payer Services</td>
<td>1.8X</td>
<td>1.5X</td>
<td>2.5X</td>
<td>14.7X</td>
<td>14.9X</td>
<td>12.9X</td>
</tr>
<tr>
<td>Payers</td>
<td>0.6X</td>
<td>0.6X</td>
<td>0.6X</td>
<td>8.9X</td>
<td>9.1X</td>
<td>8.3X</td>
</tr>
<tr>
<td>PBM</td>
<td>0.8X</td>
<td>0.7X</td>
<td>0.6X</td>
<td>11.2X</td>
<td>9.2X</td>
<td>8.4X</td>
</tr>
</tbody>
</table>
## Healthcare Capital Markets

As discussed previously, HGP tracks seven indices across the health IT and services sectors. The components of each index are listed below. Each index is based on an equal-weighted portfolio.

<table>
<thead>
<tr>
<th>Sector Components</th>
<th>HIT Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altegra Healthcare Solutions, Inc. (NasdaqGS:MDRX)</td>
<td>Computer Sciences Corporation (NYSE:CSC)</td>
</tr>
<tr>
<td>athenahealth, Inc. (NasdaqGS:ATHN)</td>
<td>Xerox Corporation (NYSE:XRX)</td>
</tr>
<tr>
<td>Benefitfocus, Inc. (NasdaqGM:BNFT)</td>
<td>Huron Consulting Group Inc. (NasdaqGS:HURN)</td>
</tr>
<tr>
<td>Care.com, Inc. (NYSE:CRCM)</td>
<td>CBIZ, Inc. (NYSE:CBZ)</td>
</tr>
<tr>
<td>Castlight Health, Inc. (NYSE:CSLT)</td>
<td>Team Health Holdings, Inc. (NYSE:TMH)</td>
</tr>
<tr>
<td>Cerner Corporation (NasdaqGS:CERN)</td>
<td>DST Systems, Inc. (NYSE:DST)</td>
</tr>
<tr>
<td>Computer Programs and Systems, Inc. (NasdaqGS:CPSI)</td>
<td>Kforce Inc. (NasdaqGS:KFRC)</td>
</tr>
<tr>
<td>Connecture, Inc. (NasdaqGM:CNXR)</td>
<td>Navigant Consulting, Inc. (NYSE:NCI)</td>
</tr>
<tr>
<td>Covisint Corporation (NasdaqGS:COVS)</td>
<td>Accenture plc (NYSE:ACN)</td>
</tr>
<tr>
<td>eHealth, Inc. (NasdaqGS:EHTH)</td>
<td>Constellation Healthcare Technologies, Inc. (AIM:CHT)</td>
</tr>
<tr>
<td>Everyday Health, Inc. (NYSE:EVDY)</td>
<td>PBM - Constituents</td>
</tr>
<tr>
<td>Evolent Health, Inc. (NYSE:EVH)</td>
<td>BioScrip, Inc. (NasdaqGS:BIOS)</td>
</tr>
<tr>
<td>Fitbit, Inc. (NYSE:FIT)</td>
<td>CVS Health Corporation (NYSE:CVS)</td>
</tr>
<tr>
<td>Health Insurance Innovations, Inc. (NasdaqGM:HIIQ)</td>
<td>Express Scripts Holding Company (NasdaqGS:ESRX)</td>
</tr>
<tr>
<td>HealthEquity, Inc. (NasdaqGS:HQY)</td>
<td>Rite Aid Corporation (NYSE:RAD)</td>
</tr>
<tr>
<td>HealthStream, Inc. (NasdaqGS:HSTM)</td>
<td>Walgreens Boots Alliance, Inc. (NasdaqGS:WBA)</td>
</tr>
<tr>
<td>Imprivata, Inc. (NYSE:IMPR)</td>
<td>Healthcare Services - Constituents</td>
</tr>
<tr>
<td>IMS Health Holdings, Inc. (NYSE:IMS)</td>
<td>Amedisys, Inc. (NasdaqGS:AMED)</td>
</tr>
<tr>
<td>Inovalon Holdings, Inc. (NasdaqGS:INOV)</td>
<td>Brookdale Senior Living Inc. (NYSE:BKD)</td>
</tr>
<tr>
<td>Invitae Corporation (NYSE:NVTA)</td>
<td>Civitas Solutions, Inc. (NYSE:CIVI)</td>
</tr>
<tr>
<td>iRhythm Technologies, Inc. (NasdaqGM:IRTC)</td>
<td>Community Health Systems, Inc. (NYSE:CYH)</td>
</tr>
<tr>
<td>McKesson Corporation (NYSE:MCK)</td>
<td>Envision Healthcare Corporation (NYSE:EVHC)</td>
</tr>
<tr>
<td>Medidata Solutions, Inc. (NasdaqGS:MDSO)</td>
<td>Envision Healthcare Holdings, Inc. (NYSE:EVHC)</td>
</tr>
<tr>
<td>MINDBODY, Inc. (NasdaqGM:MB)</td>
<td>Genesis Healthcare, Inc. (NYSE:GEN)</td>
</tr>
<tr>
<td>Model N, Inc. (NYSE:MDN)</td>
<td>HCA Holdings, Inc. (NYSE:HCA)</td>
</tr>
<tr>
<td>NantHealth, Inc. (NasdaqGS:NH)</td>
<td>HealthSouth Corporation (NYSE:HLS)</td>
</tr>
<tr>
<td>National Research Corporation (NasdaqGS:NRCI.B)</td>
<td>Kindred Healthcare, Inc. (NYSE:KND)</td>
</tr>
<tr>
<td>Omnicell, Inc. (NasdaqGM:OMCL)</td>
<td>Laboratory Corporation of America Holdings (NYSE:LH)</td>
</tr>
<tr>
<td>OneView Group plc (AIM:ONEV)</td>
<td>LifePoint Health, Inc. (NasdaqGS:LPNT)</td>
</tr>
<tr>
<td>Orion Health Group Limited (NZSE:OHE)</td>
<td>MEDNAX, Inc. (NYSE:MD)</td>
</tr>
<tr>
<td>Premier, Inc. (NasdaqGS:PINC)</td>
<td>Quest Diagnostics Incorporated (NYSE:DGX)</td>
</tr>
<tr>
<td>Press Ganey Holdings, Inc. (NYSE:PGND)</td>
<td>Select Medical Holdings Corporation (NYSE:SEM)</td>
</tr>
<tr>
<td>Quality Systems, Inc. (NasdaqGS:QSII)</td>
<td>Team Health Holdings, Inc. (NYSE:TMH)</td>
</tr>
<tr>
<td>Roper Technologies, Inc. (NYSE:ROP)</td>
<td>Tenet Healthcare Corp. (NYSE:THC)</td>
</tr>
<tr>
<td>Simulations Plus, Inc. (NasdaqCM:SLP)</td>
<td>Universal Health Services, Inc. (NYSE:UHS)</td>
</tr>
<tr>
<td>Streamline Health Solutions, Inc. (NasdaqCM:STRM)</td>
<td>Payer Services - Constituents</td>
</tr>
<tr>
<td>Tabula Rasa Healthcare, Inc. (NasdaqGM:TRHC)</td>
<td>Alere Inc. (NYSE:ALR)</td>
</tr>
<tr>
<td>Teladoc, Inc. (NYSE:TDOC)</td>
<td>CorVel Corporation (NasdaqGS:CRVL)</td>
</tr>
<tr>
<td>The Advisory Board Company (NasdaqGS:ABCO)</td>
<td>ExamWorks Group, Inc. (NYSE:EW)</td>
</tr>
<tr>
<td>Veeva Systems Inc. (NYSE:VEEV)</td>
<td>Healthways, Inc. (NasdaqGS:HWAY)</td>
</tr>
<tr>
<td>Vocera Communications, Inc. (NYSE:VCRA)</td>
<td>Magellan Health, Inc. (NasdaqGS:MGLN)</td>
</tr>
<tr>
<td>WebMD Health Corp. (NasdaqGS:WBMD)</td>
<td>WageWorks, Inc. (NYSE:WAGE)</td>
</tr>
<tr>
<td>Payers - Constituents</td>
<td>CROs - Constituents</td>
</tr>
<tr>
<td>Aetna Inc. (NYSE:AET)</td>
<td>Charles River Laboratories International, Inc. (NYSE:CRL)</td>
</tr>
<tr>
<td>Anthem, Inc. (NYSE:ANTM)</td>
<td>ICON Public Limited Company (NasdaqGS:ICLR)</td>
</tr>
<tr>
<td>Centene Corporation (NYSE:CNC)</td>
<td>INC Research Holdings, Inc. (NasdaqGS:INCR)</td>
</tr>
<tr>
<td>Cigna Corporation (NYSE:CI)</td>
<td>PAREXEL International Corporation (NasdaqGS:PRXL)</td>
</tr>
<tr>
<td>Humana Inc. (NYSE:HUM)</td>
<td>PRA Health Sciences, Inc. (NasdaqGS:PRAH)</td>
</tr>
<tr>
<td>Molina Healthcare, Inc. (NYSE:MOH)</td>
<td>Quintiles IMS Holdings, Inc. (NYSE:Q)</td>
</tr>
<tr>
<td>UnitedHealth Group Incorporated (NYSE:UNH)</td>
<td></td>
</tr>
<tr>
<td>Universal American Corp. (NYSE:UAM)</td>
<td></td>
</tr>
<tr>
<td>WellCare Health Plans, Inc. (NYSE:WCG)</td>
<td></td>
</tr>
</tbody>
</table>
7 Macroeconomics

2016 Macroeconomic and Market Summary

In a year marked by volatility and political upheaval, global stocks rallied on signs of improving U.S. economic growth and aggressive central bank stimulus measures around the world. U.S. stocks led developed markets higher, particularly late in the year as investors cheered Donald Trump’s unexpected victory over Hillary Clinton in the presidential election. Economically sensitive sectors outpaced defensive areas of the market, highlighted by strong returns in energy, materials, and industrial stocks. Healthcare and traditionally high-dividend paying sectors lagged the overall market.

U.S. equities bounced back from a flat 2015 with the help of solid economic data and low interest rates. Stocks got off to a rocky start early in the year, retreating on worries about a decelerating Chinese economy, falling oil prices and a potential U.S. recession. But after China announced stimulus measures and the Federal Reserve said it would proceed cautiously on rates, stocks then proceeded to rise, with a notable hiccup following the U.K.’s surprise vote to exit the European Union in June. Another surprise – Republican Donald Trump’s win in the November presidential election – sent stocks higher on hopes his administration would follow through on campaign pledges to cut taxes, reduce regulations, and increase spending on infrastructure and the military.

The Dow Jones Industrial Average rose 16% to end December just shy of the 20,000 milestone. The S&P 500 Index and the Nasdaq composite gained 12% and 9%, respectively. All three indexes eclipsed previous all-time highs during the year. Other financial assets also did well; the dollar touched its highest level in almost 14 years against the Fed’s Trade-Weighted U.S. Dollar Index. After a double-digit decline in 2015, energy had the biggest gain among S&P 500 sectors, rising 27%. The price of U.S. crude oil rose 45% to just under $54 per barrel as OPEC nations finally agreed to curb production late in the year.

Health care was the only sector to decline. Pharmaceutical companies were hurt by pricing pressure and a dearth of new products. Concerns over the future of the Affordable Care Act also weighed on the sector. The information technology sector gained 14%, supported by semiconductor companies such as Nvidia, whose shares tripled as it unveiled innovative graphic chips. Tech bellwethers Apple, Alphabet and Microsoft had more modest results, rising 12%, 2% and 15%, respectively. S&P 500 earnings growth turned positive in the third quarter after five periods of contraction, according to data provider FactSet.

The U.S. economy continued to expand at a modest pace. Gross domestic product growth was revised to an annualized rate of 3.2% in the third quarter, up from 1.4% in the second quarter. The unemployment rate fell to 4.6% in November, down 0.4% from a year previous. Job gains averaged 180,000 per month for the year to date through November, roughly 20% less than in 2015. Still, with global economic conditions sluggish the Fed delayed raising the federal funds rate until December, a year after its first hike since 2008. Significantly, the central bank’s outlook for rate hikes in 2017 rose from two to three.
2016 Macroeconomic and Market Summary, continued

There were 112 IPOs in the U.S. in 2016 raising $23.1B, a decline of 37% in terms of capital raised and 36% in terms of number of IPOs, making this the slowest year for IPO activity by both deal number and proceeds since the global financial crisis in 2009.

For the IPO market in particular, the tone for both business and investor sentiment was set early in the year. The political uncertainty of the US presidential election was compounded by a host of other geopolitical factors, including the UK’s EU referendum and the Brexit result, Middle East tensions and the EU migrant crisis. From an economic and financial market perspective, dealmakers faced volatility in equity markets and oil prices, concerns of a slowdown in the growth rate in Mainland China and uncertainty over US monetary policy. Against this backdrop, unsurprisingly, many IPO candidates decided to be patient and prepare for 2017 instead of risk a listing amid such uncertainty.

Global M&A volume reached $3.84T in 2016, down 18% compared to the 2015 full year record high of $4.66T and the fourth largest year on record behind 2015, 2007 ($4.61T) and 2006 ($3.91T). The UK led the decline with a 48% drop to $222.3B, its lowest M&A volume since 2013, followed by China and US, down 28% and 21% respectively. US targeted M&A($1.72T) was down 21% compared to the record $2.17T in 2015, but 2016 is still the second highest year on record. 10 of the 15 $20B+ deals announced in 2016 were US targets.

The pace of venture activity declined in the fourth quarter with $12.7B being deployed to 1,736 companies. Overall, the annual total reached $69.1B funding 7,751 companies. Companies backed fell by 22%. Venture fundraising continued at a strong pace, however, with $41.6B of capital being raised for the year.

2016 U.S. Major Indices

![Graph showing the performance of S&P 500, Dow Jones, and NASDAQ from Jan-16 to Jan-17.](image-url)
Health IT Headlines

Overview

Notable headlines 2016 are outlined in the following pages on a quarterly basis. The headlines in 2016 illustrate the significant influence that policy and regulatory intervention has on the incentives that dictate health IT investment trends and innovation.

Q1 Headlines

The Speech Heard Around the Healthcare Industry
Despite widespread calls from industry groups and Congress for a delay, CMS in October stubbornly issued its final rule for Stage 3 of the Meaningful Use program, which is set to begin in 2018. Fast forward just three months and CMS is now telling us that MU will end sometime in 2016. CMS Acting Administrator Andy Slavitt told an audience at J.P. Morgan’s annual healthcare conference that the Meaningful Use program “as it has existed, will now be effectively over and replaced with something better.” He provided no details, promising that specifics would be released over the next few months on where the industry goes from here.

5 major HIT vendors launch interoperability effort
Five major healthcare IT vendors have agreed to adopt an interoperability framework consisting of legal terms, policy requirements, technical specifications and governance processes—fostering cooperation that’s designed to simplify system-to-system data sharing. The vendors—athenahealth, eClinicalWorks, Epic, NextGen Healthcare and Surescripts—are the first implementers of the Carequality Interoperability Framework, a collection of documents that will be used to create the structure for data sharing for their customers and to enable nationwide health information exchange.

CDC: Almost three-fourths of docs using certified EHRs
The percentage of office-based physicians implementing certified electronic health records climbed to 74.1 percent in 2014, up from 67.5 percent in 2013, according to a new data brief published this week by the Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS).

CMS plans to expand access to Medicare, private claims data
Under new proposed federal rules, the government will expand provider and employer access to Medicare and private insurance claims data in an effort to drive quality improvement in healthcare. “Qualified entities” will be able to provide or sell Medicare and private-sector claims data to providers, as well as confidentially share or sell analyses of claims data in order to support improved care, according to the Centers for Medicare & Medicaid Services (CMS). The new rules are part of the Medicare Access and CHIP Reauthorization Act.

Insurers could face pressure to cover more genetic testing
U.S. health insurers may be looking at some difficult decisions when it comes to whether they will cover an increasing array of genetic testing, according to a Kaiser Health News report. The ongoing debate about how far health plans should go in paying for these expensive tests was put in the spotlight by the recent announcement by Pennsylvania-based Independence Blue Cross that it will cover a complex type of genetic testing for some cancer patients. The test detects DNA mutations that might help decide a patient’s optimal cancer therapy. But only some of the information from genetic testing is useful in terms of making a difference in a patient’s treatment and prognosis, making decisions about paying for such testing a challenge for payers.
High-deductible health plans reduce care, but at a cost
HDHPs include any health plan that has a deductible higher than $1,300 for an individual and $2,600 for a family, the brief says. In the Affordable Care Act marketplace, almost 90 percent of enrollees have a plan that qualifies as an HDHP. HDHPs are also becoming more common in the group insurance market, as Kaiser Family Foundation research in September found that deductibles have increased 67 percent since 2010 in employer-based plan, according to the brief from Health Affairs. Research from the consumer-advocacy organization Families USA also found that nearly 30 percent of adults with deductibles of $1,500 or more per person went without needed care because they couldn't afford it.

CMS, AHIP release new quality measures for physicians
The seven new measure sets include metrics for accountable care organizations/patient-centered medical homes, primary care cardiology, gastroenterology, HIV/hepatitis C, medical oncology, orthopedics, obstetrics and gynecology. The announcement marks a major step in the transition from the traditional fee-for-service model that has long prevailed among medical providers. Reimbursement physicians for services may not be the most efficient way to provide quality care, but it's a straightforward metric to define, price and deliver. While improved quality of care provides an attractive philosophical underpinning for a value-based care model, it's very difficult for practices to take pragmatic steps toward improving their quality of care without knowing how payers define quality and how they intend to measure it.

IBM makes big bet on healthcare with Truven acquisition
On February 18, IBM Corp. announced that it plans to pay $2.6 billion for Truven. The acquisition is IBM's fourth major buy in healthcare during the past year, having previously bought population health management vendor Phytel, cloud-hosted analytics company Explorys and medical imaging software vendor Merge Healthcare. In total, the deals cost Armonk, N.Y.-based IBM more than $4 billion.

HHS OCR maps HIPAA Security Rule to NIST Cybersecurity Framework
The Department of Health and Human Services' Office for Civil Rights has released a “crosswalk” between the National Institute of Standards and Technology's cybersecurity framework and the HIPAA Security Rule to help healthcare organizations improve their cybersecurity preparedness. It maps the HIPAA Rule standards and implementation specifications to those of NIST, as well as other commonly used security frameworks—such as Control Objectives for Information and Related Technology (COBIT) and the International Organization for Standardization (ISO).

HHS touts 'historic' gain of 20M covered through Affordable Care Act
Among Americans ages 19-25, 6.1 million have gained coverage because of the ACA--2.3 million of them between 2010 and 2013 through the provision that allowed individuals younger than 26 to remain on a parent's coverage. The uninsured rate among black non-Hispanics and white non-Hispanics each dropped by more than 50 percent, while the uninsured rate of Hispanics dropped by more than 25 percent.

Health wearables market to hit $17.8B by 2021
The healthcare wearable device market is projected to hit $17.8 billion in revenue by 2021 as the industry undergoes what a new report describes as a big transformation. Digital health will be a driver in more efficient, affordable and wide ranging healthcare and wearables are pushing healthcare into the digital age, according to a new Tractica market forecast. The top device leaders will be fitness trackers and smartwatches. The 2015 wearables market saw a 139.4 percent growth rate, from 35.5 million shipments in 2014 to 85 million last year; that figure is expected to hit 560 million by 2021. The No. 1 device revenue generator is the Apple Watch, which, despite lower than projected unit sales, hit $5.5 billion in revenue for 2015.
Health IT Headlines

Q1 Headlines, continued

**Feds to test new Medicare Part B payment models**
Citing a new report that found prescription drug spending reached $457 billion in 2015, the federal government announced it will test new Medicare Part B payment models to try to tackle those spiraling costs. The Centers for Medicare & Medicaid Services (CMS) says its proposals will create incentives for patients and physicians to select lower-cost, high-performing drugs that are administered at medical facilities, as well as test new ways to reward positive outcomes.

**Senate bill imposes limits on FDA regulation of apps, software**
The Senate health committee on March 9 approved a bill that would exempt low-risk medical software and mobile apps from regulation by the Food and Drug Administration, so as not to stifle innovation by developers. The MEDTECH Act (S. 1101) will “make sure that uncertainty regarding the definition of medical devices, which dates all the way back to 1976, doesn’t deter companies from innovations such as Fitbits or watches that help people keep up with their health,” said Sen. Lamar Alexander (R-Tenn.), chairman of the committee.

**NQF issues new guidance on federal healthcare quality measures**
A partnership that aims to help the federal government select performance measures has issued recommendations on new quality measures for several federal healthcare programs, including the new Merit-Based Incentive Payment System (MIPS) and Medicare Shared Savings Program (MSSP). The National Quality Forum’s Measure Applications Partnership was established to take a coordinated look across federal programs to evaluate performance measures. The group announced it considered 60 performance measures for use in MIPS, which combines the Physician Quality Reporting System, the Value Modifier and the Medicare Electronic Health Record incentive program into one program.

**HHS: Affordable Care Act helped Medicare save $473 billion**
A report out Wednesday from the Department of Health and Human Services (HHS) shows that the Medicare program has spent $473 billion less from 2009 to 2014 than would have been spent if previous cost trends continued. If those trends are found to continue through 2015, the program could save as much as $648.6 billion, HHS says.

**OCR’s HIPAA audit letters already in the mail**
After a considerable delay, the HHS Office for Civil Rights has officially launched Phase 2 of its HIPAA audit program to assess compliance with the privacy, security and breach notification rules.

**Feds finalize mental health parity rule for Medicaid and CHIP**
The new regulations build upon the Mental Health Parity and Addiction Equity Act of 2008, which required private plans to provide mental health and substance abuse treatment benefits comparable to their medical and surgical benefits. Concerns have continued to arise, however, about whether health plans--particularly those on the Affordable Care Act exchanges--are actually compliant with the mandate.

**CMS anticipates big role for health IT in CPC+ initiative**
The Comprehensive Primary Care Plus (CPC+) initiative, a five-year model that will roll out in January 2017, comprises two primary care practice tracks that each boast unique care delivery requirements. It will span 20 regions and can accommodate as many as 5,000 practices, according to CMS. According to a frequently asked questions document provided by CMS, all CPC+ practices must have certified electronic health record technology, as well as “other infrastructural capabilities.” However, CMS notes that it will not prescribe technical specifications for any tool or enhancement, nor will it pay for any specific health IT vendor or product. Practices participating in Track 2 also will be held to a higher standard when it comes to use of health IT. As a requirement, they must submit a letter of support from health IT vendors with which they partner that "outlines the vendors’ commitment to supporting practices with advanced health IT capabilities." Such vendors must sign a Memorandum of Understanding with CMS.
Health IT Headlines

Q2 Headlines

Mixed news for first year of Medicare Shared Savings Program
It's been a bumpy road for Medicare Accountable Care Organizations, with only 97 of 353 Pioneer and Medicare Shared Savings Program ACOs earning performance bonuses in 2014, and new data show the MSSP achieved mixed results its first year, according to research published in the New England Journal of Medicine. The research found the ACOs that joined the program in 2012 cut spending by $238 million, but the second group of ACOs, which joined the program in early 2013, generated hardly any savings, with an average of only $3 less per beneficiary. Researchers further found that the $244 million in bonuses paid out to the first two groups essentially wiped out any Medicare savings generated by the first group's lower spending.

Jury awards Epic $940M in lawsuit against Tata, TCS
A jury has awarded Epic Systems $940 million in damages in its trade secret lawsuit against Tata Consultancy Services (TCS) and Tata America International Corporation (Tata), according to Reuters. The verdict awarded $240 million for benefits received by the defendants and a whopping $700 million in punitive damages.

Zika virus: Small local outbreaks likely in the U.S. soon, CDC official warns
More than 40 Senate Democrats banded together to demand that Majority Leader Mitch McConnell (R-Ky.), allow a Senate vote on the White House's request for $1.8 billion to combat the virus, the Associated Press reported. Without a vote being called, "Congress has failed to address a disease that has infected nearly 700 Americans in 40 states, Washington, D.C., and 3 U.S. territories," the Democrats said in a letter to McConnell. The AP said a vote was likely before the summer recess, but how much money Republicans are willing to authorize was unclear.

MedPAC wants to push insurers to curtail Part D drug costs
While the federal government currently reimburses insurers 80 percent of Medicare beneficiaries' drug costs that exceed a "catastrophic" level, the Medicare Payment Advisory Commission (MedPAC) will recommend in its June report to Congress that it cut that share of reimbursement to 20 percent. It also will recommend that Congress eliminate Medicare beneficiaries' 5 percent share of drug costs above the catastrophic threshold, the New York Times says.

CEO Stephen Hemsley: UnitedHealth will exit all but a few Affordable Care Act exchanges
Following mounting losses on its individual market policies, UnitedHealth Group plans to exit the Affordable Care Act marketplaces in all but "a handful" of states in 2017.

Healthcare No. 1 target for cyberattacks in 2015
Healthcare hit the No. 1. spot for cyberattacks last year, though no industry was immune from such incidents, according to an IBM cybersecurity report. Unauthorized access remained a leading cause of incidents in all industries, growing to 45 percent of incidents in 2015 from 37 percent in 2014. And in 80 percent of cases, attacks were carried out by insiders.

CMS MACRA proposal includes MU replacement
The Centers for Medicare & Medicaid Services' new proposed rule implementing the Medicare Access and CHIP Reauthorization Act, as it pertains to the use of electronic health records, varies considerably from physicians' requirements in the Medicare Meaningful Use program, allowing for streamlined reporting, reduced burdens and more flexibility. The rule, issued April 27, and slated to be published in the Federal Register May 9, creates a "Quality Payment Program" to replace the old reporting programs, including the Medicare Meaningful Use Program. The new program includes both the Merit Based Incentive Payment System (MIPS) and advanced alternative payment models, explained CMS Acting Administrator Andy Slavitt on a conference call. It also would replace the Meaningful Use program for Medicare eligible professionals with a program dubbed Advancing Care Information, he said.
Health IT Headlines

Q2 Headlines, continued

**FDA proposes guidance on using EHR data in clinical trials**

New draft guidance from the Food and Drug Administration covers deciding whether and how to use EHRs as a data source in clinical trials. The agency’s draft covers using EHRs that interoperate with electronic systems supporting trials, and discusses ensuring the quality and integrity of data collected and used. FDA will accept comment on draft recommendations for 60 days before developing final guidance.

**Revamped MEDTECH Act looks to exempt low-risk software from FDA guidance**

The new bill updates proposed legislation initially introduced to the Senate last December and is more granular in distilling which software should not be regulated by the FDA. Software intended to support administrative and operational functions for healthcare facilities, for instance, is excluded from regulation, as are tools to monitor wellness “unrelated to the diagnosis, cure, mitigation, prevention or treatment” of a specific disease or disorder.

**The 21st Century Cures Act Unanimously Approved**

The House Energy and Commerce Committee on May 21st unanimously approved the nonpartisan 21st Century Cures Act 51-0. The nonpartisan legislation will help to modernize and personalize health care, encourage greater innovation, support research, and streamline the system to deliver better, faster cures to more patients.

**Healthcare spending trend $2.6 trillion below original projections**

The passage of the Affordable Care Act (ACA) has partly led to a huge slowdown in U.S. healthcare spending, according to a new report by the Robert Wood Johnson Foundation and the Urban Institute. The study concluded that the U.S. could spend $2.6 trillion less on healthcare services for much of this decade than originally projected prior to the passage of the ACA.

Q3 Headlines

**CMS proposes MU changes, 90-day EHR reporting period for 2016**

“These changes include a proposal for clinicians, hospitals, and critical access hospitals to use a 90-day HER reporting period in 2016—down from a full calendar year for returning participants,” states the CMS announcement. “This increases flexibility and lowers the reporting burden for hospital providers.” The proposed rule also offers a variety of adjustments in objectives for Stage 3 of the program; providers must provide evidence on these objectives to qualify for incentive payments for Stage 3. The agency says it lowered thresholds for achieving objectives in response to industry feedback on provider IT capabilities, as well as the readiness of HIT vendors, and their patients and consumers.

**Slavitt to lawmakers: CMS could move MACRA start date**

The CMS could delay the start of the Medicare Access and CHIP Reauthorization Act payment reforms because stakeholders have indicated some physicians may not be ready by the current Jan. 1 deadline, said CMS Acting Administrator Andy Slavitt in testimony before the Senate Finance Committee. Slavitt said the agency is also considering shorter reporting periods, alternative ways of gathering data and additional ways to reimburse providers caring for chronic patients at a higher rate.
Health IT Headlines

Q3 Headlines, continued

Health spending in U.S. to rise 5.8 percent a year through 2025 according to CMS
Healthcare spending in the United States will likely grow by an average 5.8 percent per year over the next decade, a bit faster than the past two years, due to an aging population, rising medical prices and faster economic growth, according to updated projections from the federal government. The annual growth of health expenditures between 2015 and 2025 will be 1.3 percentage points faster than growth in gross domestic product, the Centers for Medicare and Medicaid Services (CMS) said in a report published in the independent journal, Health Affairs. The spending will represent 20.1 percent of the country’s total economy by 2025, up from 17.5 percent in 2014, the report said.

FDA takes ‘hands-off’ approach to fitness trackers, health apps
The Food and Drug Administration has released guidance on low-risk devices intended to promote general wellness, including mobile health and fitness apps. Under the final guidance, which contains “non-binding” recommendations for the industry, the FDA indicated that it “does not intend to actively regulate low-risk technologies that are intended only for general wellness use” and that the agency “encourages the development of general wellness technologies, such as fitness trackers or mobile apps, which can empower individuals to take a more active role in their health.”

Aetna’s ACA Exchange Exit
Aetna announced that it is halting its exchange expansion plans for 2017 and will stop offering policies in 11 of the 15 states where it currently operates. Aetna said its policyholders are turning out to be sicker and costlier than expected and, along with its peers, has criticized the federal program designed to mitigate those risks.

Study examines adoption of precision medicine programs in US hospitals
Only 29% of US hospitals conduct precision medicine programs, but 41% with more than 500 beds, 35% that are academic medical centers and 25% that are multi-hospital health systems use precision medicine, according to a study by HIMSS Analytics. Researchers surveyed 137 physicians, chief medical information officers, chief medical officers and biomedical and pathology directors and found that the integration of genomic and clinical data and clinical data systems integration are the most significant challenges organizations face when conducting precision medicine.

Plans for the Quality Payment Program in 2017: Pick Your Pace
CMS offers providers four “pick your pace” MACRA/Quality Payment Program options for 2017: 1) Submit test data only, which avoids a negative payment adjustment; 2) Participate for part of the calendar year, which qualifies for a small positive payment adjustment; 3) Participate for the full calendar year, which qualifies for a modest positive payment adjustment; 4) Join an Advanced Alternative Payment Model, which qualifies for up to a 5 percent incentive payment. The AMA has already issued a statement saying it “strongly applauds” the change.

CMS: Avoidable hospital readmission rates have dropped in 49 states
New data from the Centers for Medicare & Medicaid Services finds that almost all states improved on preventable hospital readmissions between 2010 and 2015, while readmissions declined 8 percent nationwide in the same period. The drops aren’t small, either; according to the data, the decline exceeded 5 percent in 43 states and 10 percent in 11. Across all states, hospitals averted about 100,000 readmissions in 2015 and a projected 565,000 since 2010.

Medical costs jump in August by largest amount in 32 years, CPI shows
The cost of medical care in the US shot up 1% in August, the biggest single-month increase since 1984, the Labor Department said. The prices consumers paid for prescription medications jumped 1.3%, one factor pushing overall consumer prices up 0.2%.
Health IT Headlines

Q4 Headlines

HHS clarifies cloud providers as business associates under new guidance
Cloud service providers become business associates (BAs) subject to HIPAA whenever a covered entity or its BA handles electronic protected health information (ePHI), according to new guidance from the Department of Health and Human Services Office for Civil Rights. Whether a contractor to a covered entity or subcontractor to a business associate, this status applies even if a cloud provider handles only encrypted ePHI and does not hold the key to decrypt the data, OCR says. That means covered entities and business associates are required to enter into HIPAA-compliant business associate agreements with cloud providers. The guidance calls cloud providers contractually liable for meeting the agreement’s terms, and directly liable for compliance with applicable HIPAA requirements.

Final MACRA rule is published
The Department of Health and Human Services has published the final rule for the Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program, revamping physician reimbursement to reflect quality and efficiency of care, and making changes to the Electronic Health Records Meaningful Use Program. The rule, designed to bring the industry into the realm of accountable and value-based care, comprises nearly 2,400 pages; HHS considered thousands of comments filed nationally after the proposed rule was first introduced in April.

CMS publishes final rule for 90-day MU reporting period in 2016, 2017
Eligible hospitals and critical access hospitals and returning eligible providers who previously demonstrated meaningful use are now allowed to report to any continuous 90-day EHR reporting period between Jan. 1 and Dec. 31 in this year and in 2017, instead of a full calendar year, according to a CMS final rule published Tuesday. The agency also recommended threshold reductions in modified MU stage 2 levels and in MU stage 3 for 2017 and 2018 in its proposed rule.

CMS figures out a way to pay PCPs for more time spent with patients and better coordinated care
CMS announces several nearly-finalized policies aimed at improving the way it pays for primary care, care coordination, and mental healthcare. New coding and payment changes will enable PCPs to bill more for more time spent with patients and on better coordinating care. Similar bumps in pay will be made to physicians who bill under the new Psychiatric Collaborative Care Model, which brings together psychiatric consultants, behavioral healthcare managers, and PCPs in a team-based approach that extends beyond the four walls of an office. CMS will also launch an expanded Medicare Diabetes Prevention Program in 2018, aimed at offering preventative services to all beneficiaries in an effort to reduce costs associated with the onset of the disease.

Trump upset will force healthcare leaders to rethink the future
Republican Donald Trump’s surprising victory will force a major shift in the healthcare industry’s thinking about its future. Combined with the GOP’s retention of control of the Senate and the House, a Trump presidency enables conservatives to repeal or roll back the Affordable Care Act and implement at least some of the proposals outlined in the GOP party platform. But there are divisions even among conservatives over issues such as Medicare restructuring and how to help Americans afford health insurance. And Senate Democrats almost certainly would try to use their filibuster power to block major ACA changes.

Trump finalizes choices for HHS, CMS leadership
President-elect Donald Trump has selected Rep. Tom Price, R-Ga., chairman of the House Budget Committee and a former orthopedic surgeon, to serve as HHS secretary in the incoming administration, according to a transition team official. Trump has also chosen Seema Verma, an Indiana health policy consultant, as CMS administrator, a source said.
Health IT groups praise Trump’s pick for HHS secretary
President-elect Donald Trump has chosen House Budget Committee Chairman Tom Price, R-Ga., to become HHS secretary, earning praise from stakeholder groups within the health IT industry. “[Chairman Price] has been an advocate for utilizing health IT to improve health outcomes for patients, while decreasing unnecessary burden on providers,” HIMSS said in a statement.

Here’s what HHS nominee Price has floated for replacing the ACA
Rep. Tom Price, R-Ga., who is President-elect Donald Trump’s choice to lead HHS, has repeatedly proposed legislation to replace the Affordable Care Act. His plans include offering consumers fixed tax credits to buy health insurance, expanding health savings accounts, capping employer tax deductions for health insurance, creating state-run high-risk pools and allowing some coverage restrictions for pre-existing conditions.

U.S. healthcare spending skyrockets to $10K per person
The rising cost of private health insurance, hospital care, physician and clinical services, and prescription drugs are a few reasons that in 2015 healthcare spending in the United States grew at a rate of 5.8% and reached $3.2 trillion.

21st Century Cures Act clears Congress, heads to president
The Senate backed the 21st Century Cures Act in a 94-5 vote Wednesday, and the measure now heads to President Barack Obama, who says he will sign it. The legislation includes $1.8 billion for the National Cancer Moonshot, $1.6 billion for studying brain disease research including Alzheimer’s, $500 million in new FDA funding and $1 billion for states to use to fight opioid abuse.
About Healthcare Growth Partners

Healthcare Growth Partners is an exceptionally experienced Transaction & Strategic Advisory firm exclusively focused on the transformational Health IT market. We unlock value for our clients through our Sell-Side Advisory, Buy-Side Advisory, Capital Advisory, and Pre-Transaction Growth Strategy services, functioning as exclusive advisor to over 90 health IT transactions representing over $2 billion in value since 2007.

Our passion for healthcare inspires us to not only create value for our clients, but to also generate broad, overarching improvements to the functionality and sustainability of health. With our focus, we deliver knowledgeable, honest, and customized guidance to select clients looking to execute high value health IT, health information services, and digital health transactions.

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Sources of Information:

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## HGP Transaction Experience

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# Appendix A

## Strategic M&A Highlights

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<th>Deal Size ($mm)</th>
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<td>Midmark Corp.</td>
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### Appendix A

#### Strategic M&A Highlights, continued

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## Appendix A

### Strategic M&A Highlights, continued

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# Appendix B

## Financial Sponsor Buyout Highlights

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<td>Accel-KKR</td>
<td>IntegriChain</td>
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<td>DocuTAP</td>
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## Appendix B

### Financial Sponsor Buyout Highlights, continued

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### Private Equity Highlights (non-buyout)

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<th>Target</th>
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## Appendix C

### Private Equity Highlights (non-buyout), continued

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<td>CHV Capital, EPIC Ventures, Kaiser Permanente Ventures, Leavitt Partners, Leerink Capital Partners, MultiCare Health System, Norwest Venture Partners, OSF Healthcare System, Partners Innovation Fund, Sands Capital Management, Sequoia Capital, Tenaya Capital, UPMC Enterprises</td>
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<td>Harbin Gloria Pharmaceuticals Co., Ltd</td>
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<td>UPMC, Laboratory Corporation of America Holdings (LabCorp), Envision Healthcare</td>
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<td>Eastside Partners, Martin Ventures</td>
<td>Jvion</td>
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<td>Hearst Health Ventures</td>
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<td>University of Pittsburgh Medical Center, Merck GHI</td>
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<td>Chrysalis Ventures, Francisco Partners Management</td>
<td>Connecture</td>
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<td>INVEST AG, The European Bank for Reconstruction and Development</td>
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<td>NanoDimension Management Limited, OS Fund, LLC, ATEL Ventures, Laboratory Corp. of America Holdings (NYSE:LH), Summation Health Ventures</td>
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<td>Bessemer Venture Partners, Flare Capital Partners, New Enterprise Associates</td>
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## Private Equity Highlights (non-buyout), continued

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<th>Target</th>
<th>Raise ($mm)</th>
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<td>Alibaba Health Information Technology Limited</td>
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<td>Towerbrook Capital Partners, Ascension</td>
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<td>Draper Triangle, Early Stage Partners, Fifth Third Capital Holdings, Health Velocity Capital, HLM Venture Partners, North Coast Angel Fund, North Coast Venture Fund, West Capital Advisors</td>
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<td>Somnoware Healthcare Systems</td>
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<td>Bain Capital Ventures, First Analysis Corporation, SSM Partners</td>
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<td>83 North, American Express Ventures, Heritage Group, The Social+Capital Partnership</td>
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<td>SAP Labs</td>
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# Appendix C

## Private Equity Highlights (non-buyout), continued

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<td>Bank Hapoalim BM, JK&amp;B Capital, Pitango Venture Capital</td>
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<td>Acadia Woods Partners, ARTIS Ventures, Buchanan Investments, LDV Partners, Ping An Ventures, Roche Venture Fund, UPMC Enterprises</td>
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<td>Lux Capital, Data Collective, Dolby Family Ventures, OS Fund, Comet Labs, Breakout Ventures</td>
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<td>Accel-KKR</td>
<td>ESO Solutions</td>
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<td>Bessemer Venture Partners, NEA and Maverick Ventures</td>
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### Private Equity Highlights (non-buyout), continued

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<th>Target</th>
<th>Raise ($mm)</th>
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<td>Intersouth Partners; Kayne Anderson Capital Advisors, L.P.</td>
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<td>Octopus Ventures, Kaiser Permanente Ventures, Index Ventures</td>
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<td>FirstMark Capital</td>
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<td>Romulus Capital; Krillion Ventures; Struck Capital</td>
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<td>CRG</td>
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## Private Equity Highlights (non-buyout), continued

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<th>Quarter</th>
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<th>Target</th>
<th>Raise ($mm)</th>
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<td>Kaiser Permanente Ventures; Endeavour Vision; Xeraya Capital Labuan Ltd; Asahi Kasei; Emergent Medical Partners; Hikma Ventures; Cota Capital; Mission Bay Capital</td>
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## Appendix C

### Private Equity Highlights (non-buyout), continued

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<th>Quarter</th>
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<th>Raise ($mm)</th>
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