Privcap/

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WEBINAR

Briefing

Investing in U.S. Healthcare

From the Privcap webinar:
"The Healthcare Private Equity Opportunity"

Tom Flynn
SV Life Sciences

Adam Blumenthal
Blue Wolf Capital Partners

Rick Zall
Proskauer

Investing in U.S. Healthcare

While there is increasing opportunity for private capital investments in healthcare, there are cumbersome rules and regulations that need to be understood

The Panelists

Tom Flynn
Managing Partner,
SV Life Sciences

➜BIO

Flynn joined SVLS in 2011 and is focused on healthcare services and HCIT services investments. Before joining SVLS, he was a partner at Ferrer Freeman & Co., a healthcare-focused growth capital investor. From 1996 to 2010, Flynn served on numerous boards, including Aerocare Holdings, Amerita, Inc., GeneraMedix, Genova Diagnostics, and PHNS, as well as Physicians Dialysis and Vitalize Consulting Solutions, both of which were co-investments with SVLS.

Adam Blumenthal
Co-founder and Managing Partner,
Blue Wolf Capital Partners

➜BIO

Blumenthal is co-founder and managing partner of Blue Wolf Capital Partners LLC, a private equity firm, and of the PE funds Blue Wolf Capital Fund II, L.P., and Blue Wolf Capital Fund III, L.P. He also serves on the board of directors of several Blue Wolf portfolio companies and is a member of the firm's investment committee.

Rick Zall
Partner,
Proskauer

➜BIO

Zall heads Proskauer's healthcare industry practice, which has more than 75 lawyers across the United States focused on corporate transactions and healthcare regulatory counseling, advising private equity sponsors, lenders, and healthcare operators in deal diligence, structuring, negotiation, and documentation of transactions.

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Privcap: What have been, from your perspective, some of the most important changes to the healthcare landscape that have presented interesting opportunities to put your growth capital to work?

Tom Flynn, SV Life Sciences: Regulation plays an enormous role in how we react and invest proactively in the industry. And in the last five years or so, we've had a couple of significant acts. We had EMR [electronic medical record] meaningful-use dollars provided to the healthcare system, which provided tens of billions of dollars for health systems and physician offices to implement EMRs and use them in a meaningful way. So for us, what that meant was there was a near-term opportunity to help those organizations select and implement EMRs. And now that plumbing has been laid, there are downstream opportunities to utilize the data that those EMRs are producing, creating opportunities for both further software investing as well as technology-enabled services investing.

And then we have the Affordable Care Act, which has been a huge deal. That has done a number of things, but changing payment models, bundled payments, holding providers accountable for the outcomes of care instead of just fees for services—that's pretty meaningful. As part of the ACA, we had mental health parity, which has created a lot of attention on behavioral care. So there are a number of impacts coming out of that, as well as healthcare exchanges in the benefits marketplace. So between those two acts, we feel like the federal government laid a blueprint for us for the next decade to exploit interesting opportunities in healthcare.

What are some examples of behavioral healthcare?

Flynn: We recently invested in a company that is acquiring and building inpatient psychiatric hospitals. In many cities in the U.S., for people who are at acute risk of hurting themselves or others, there are not enough inpatient behavioral beds available to get those patients stable. So that's us reacting to a facility supply-demand situation. But beyond that with mental health parity, I think employers and insurers are much more focused on providing adequate behavioral healthcare. There are some interesting studies out that suggest that the consistent utilization of, for instance, therapy improves as a result of telemedicine—where you don't require the recipient to leave their home and sit in a waiting room prior to getting therapy.

> **"If you look at the demographics of the aging U.S. population versus the expansion of the physician pool, there are persistent projections of physician shortages. So that creates a number of opportunities to deploy midlevel providers in various service models."**
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> –Tom Flynn, SV Life Sciences

And Adam, how important are these new regulations, such as the Affordable Care Act, in shaping the way that your firm invests in healthcare?

Adam Blumenthal, Blue Wolf Capital Partners: Certainly there are overwhelming advances in technology and in treatment that allow a huge movement of services away from hospital-based and toward outpatient-based. And that's not just because of cost pressure. That's because convenience and quality and customer experience all can work better for many less-acute conditions in an outpatient setting. So regardless of changes in legislation and

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> –Rick Zall, Proskauer

the regulatory environment, there is structural change in healthcare services and delivery, driven simply by new ways of doing things.

But there also is an overlay on that, which has two components: One is the new payment model. People are trying to figure out how to move to more value-based pricing and how to live within that regime. And that creates a whole set of opportunities to do things better. But a second element of the ACA was Medicaid expansion, and so there's a large population of folks who have insurance coverage, but for whom service delivery and their interaction with the healthcare system is essentially disorganized and chaotic. And if there's anything that is an underlying truth, it's that healthcare works better when it's consistent and coordinated and delivered in a rational way. And it's possible to spend a phenomenal amount of money and get terrible outcomes if you don't do that. The movement to take all of those folks and find ways to effectively deliver care—there's tremendous pressure to innovate and to build new things as a result of that change.

Let's go to Rick Zall from Proskauer. Would you say that as you help clients navigate all of these new rules and regulatory changes, it's really affecting their approach to investing?

Rick Zall, Proskauer: It's absolutely essential now to understand how the mix of state and federal laws and regulations affects a particular business. Certainly healthcare is among the most regulated [sectors], and there's a need for most national companies to understand both the federal and the state regulations and laws. It used to be that we would see people look at opportunities and ask whether there was any regulatory overlay. Now people understand that there are, of course, applicable laws and regulations, and they're changing on almost a daily basis. The question is how to assess where those laws and regulations are going to impact a business going forward. We try to crystal-ball that, based on what we've seen in the past—because history does tend to repeat itself—and help evaluate the risks.

Are there risks that are manageable that a particular business model takes into account? Has the company that might be the target of an investment set up a business model that's scalable, that won't run into obstacles going forward? And are those rules changing? We find we're spending a lot more time with that kind of risk-assessment process than before.

Would you say that it's even more challenging now to read several years into the future for how a regulatory regime might affect a private equity investment?

Zall: It's been very challenging for the last several decades, since the federal government got into the business of not only regulating but actually purchasing healthcare through Medicare and Medicaid. There was a period of time, right before the passage of the Affordable Care Act, when there was tremendous uncertainty about whether the rules would change or not, whether there would be a federal healthcare reform law or not. Actually, a lot of that uncertainty has resolved itself, even though there is still a question about how the Supreme Court will rule on subsidies for the [state healthcare insurance] exchanges. After 2010, when the Affordable Care Act was passed, there was greater certainty, greater predictability. Around the edges, there are a lot of ongoing changes, but investors can, by and large, assess the trends.... A lot of those things have settled a bit, and there's a consensus about what the framework is.

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Let's move to a discussion about deal flow. Why are you seeing sellers, or potential partners interested your firm? What are their motivations, and what do they see in you as a partner, beyond your capital?

Flynn: There are two things going on in our world. On the healthcare services side, we are generally growth capital and small buyout investors. We get interested in companies around the $3M EBITDA mark and go up from there. And on the IT side, we are investors who will invest in loss-making companies. We prefer not to, but our cutoff there is about $5M of recurring revenue. So those are our lower limits, to give you a sense of where we play.

I'll focus on the healthcare services side for purposes of our conversation. That market—at least at our end—is being driven more by liquidity desires by owners. So we tend to invest in a lot of founder-owned companies in healthcare services. Twenty years ago, there weren't that many private equity firms that would cash out an owner in part and then leave that same owner in place, running the business. That's routine today, so folks who have built a business realize that they've created wealth and are often looking to monetize some of that wealth through a recap transaction. And that, in turn, has been aided by the tremendous liquidity we see in the markets now. Debt is extremely cheap. Lenders have gotten increasingly aggressive since the financial crisis, and so even at our end of the market, you see leverage ratios at three, four, five times EBITDA, depending on the characteristics of the business.

Those folks might be looking for different things. One is a good partner. But for a founder who might have been working at their business for 10, 15 years, they may also be looking for a partner who can bring some additional operating talent to their business to help that business scale to the next level, who might also create a succession plan for the founder. And so one of the ways that we go to market on the healthcare services side is working very closely with executives-in-residence. We call them venture partners. Other firms call them operating partners, but they are proven healthcare services executives who have multiple successes, and we will partner with them looking for these types of founder situations, where our ability to introduce this venture partner potentially as a board member, potentially as executive chairman, potentially as CEO, can often be a differentiating characteristic to that founder as they think about scaling their business and ultimately creating a succession plan for themselves.

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> –Adam Blumenthal, Blue Wolf Capital

Adam, your firm looks for complicated deals that are more challenging than other firms might want to do. What is your sourcing platform, and how do you come across the opportunities in the healthcare space that are right for your firm?

Blumenthal: Well, the nice thing about looking at distressed and challenged and complicated situations is that often one can find them simply by reading the papers. And so two things that work well for us are, one, we've identified a couple of large health plans and payers who have had a lot of expansion as a result of the ACA; and, two, who also are experiencing a lot of cost pressures and organizational pressures.

And of course, those folks are eager, as they grow, to have aligned and thoughtful partnerships with people they know on the service-delivery side. So one strategy that we've been pursuing quite actively is looking at where they

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are growing, looking at some of the undermanaged delivery platforms in those areas, and seeing if there's a way to buy those assets, based on however they exist today, but go in there with a relationship that can start to drive volume and start to bring something more than the traditional sets of relationships that grow them. The other thing that has worked well for us is finding folks who are capital-constrained—systems that know their future is in morphing from really a hospital-driven paradigm to a network paradigm. And that involves sometimes [building] just alliances, but very often building new things.

What specific kinds of due diligence are needed—whether we're talking about a generalist GP or an LP thinking about co-investing—leading up to a private equity healthcare investment?

Zall: There is a long list, unfortunately. But as we've said, the industry is highly regulated. And so I would categorize this in a couple ways. One, there's general overall diligence into a company, which most investors want to find out about. The next level is more healthcare-specific in terms of whether the company has obtained and is in good standing with the authorities who have to license or accredit the service. For service providers or for medical device makers or pharma companies, there are gating issues in order for them to conduct their business. And we certainly go through a lot of information about what has been obtained and whether it's still current, whether there have been any regulatory audits that might have uncovered issues, and whether those issues were dealt with.

Beyond licensing, business arrangements are subject to a lot of scrutiny by both state and federal government. People have probably heard about the anti-kickback laws and the civil monetary-penalty laws that essentially restrict how healthcare companies deal with vendors and physicians—all designed to prevent fraud and abusive relationships. These are all potential showstoppers that need to be evaluated, as well as a company's overall compliance program. One of the challenges is that it's easy to put a compliance plan together and have it look terrific up on a shelf somewhere. The question that really needs to be evaluated is: What has really happened, and are there processes in place to really prevent the kinds of abuses that the government's looking for?

Another important area is payment. Obviously the revenue flows are critical to these businesses, and most of the businesses do rely on third-party reimbursement, whether it's from the government through Medicare or Medicaid or whether it's commercial payers. And for every kind of service, there are separate reimbursement rules. So kicking the tires on how a company's going about deciding what they're entitled to, how they bill and collect for it, is very important.

What are the top investment theses or plays you are most excited about in the current environment?

Blumenthal: The single most exciting thing that we're doing is building outpatient facilities in partnership with not-for-profit hospitals in communities that have a preponderance of Medicare and Medicaid. And a way to put that in really concrete terms is, if you live in New York City and you walk around Manhattan, if you got hit by a bus, it doesn't matter what part of town you're in, because you could walk into an urgent care center within 50 feet. And assuming that you didn't get hit too hard, they would deal with you in 45 minutes. [If the] same thing happens to you in Brooklyn, you're going to likely be in somebody's emergency room for double the average national wait times—six hours—and the insurance company is going to spend $2,000. In Manhattan, however, it could be dealt with for $400. So simply because of the expansion in Medicaid eligibility, the economics of operating in those kinds of areas has changed fundamentally.

Flynn: We talked about the EMR spending, so providers have much better access to data than they once did. And now they're turning to the utilization of that data in evolving payment models. So we're very focused on population health management and data-analytics software models on the IT side. And on the services side, one thing we haven't talked about is the enormous changes going on with the U.S. physician population. That population is increasingly female over time and is increasingly employed rather than self-employed. In fact, if you look at the demographics of the aging U.S. population versus the expansion of the physician pool, there are persistent projections of physician shortages. So that creates a number of opportunities to deploy midlevel providers in various service models to evolve the physician practice model to more of an at-risk model and not just fee-for-service, volume-orientated.

There's a lot of private equity activity in aggregation of specialists. We have to apply technology to these looming physician shortages, and so tele-health is one thing that we're spending a lot of time with. ■