Top 3 Plays for Healthcare PE

A discussion between two experts on where to invest in healthcare today

Ben Daverman
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Expert Roundtable

Top 3 Plays for Healthcare PE

Experts from Riverside and GTCR discuss where to invest in healthcare today

The Panelists

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Matt Malone, Privcap: We're going to talk about two growing sectors—behavioral health and addiction services, and healthcare IT—and, more generally, about consolidation as a strategy for private equity investors.

Ben, what's your take on the current state of investing in the healthcare market?

Ben Daverman, GTCR: I'd start by going back to the beginning of 2015, [when] we saw a lot of consolidation across a number of different sectors within healthcare. Some of that was driven by strategics and, more specifically, some of the structures that they've set up to be more acquisitive. And it's also driven by the public markets rewarding M&A activity. You combine that with the state of the debt capital markets in 2015 and it created a very active year for private equity in healthcare.

As we moved into the early part of 2016, on the private equity side you saw some choppiness in the debt capital markets, which I believe led to a slowdown in activity in the first quarter—although as we monitor the debt capital markets on a weekly basis, it does appear that some of the health has returned to that part of the market.

John McKernan, Riverside: In healthcare, we're seeing some of the consolidation trends driving opportunities at the smallest end of the middle market—sub-$100M in enterprise value. We've seen it a lot in dermatology. There's some consolidation going on in behavioral health. And what we often look for are providers that typically fall outside the scope of where a hospital system or an integrated delivery network are focused on acquiring, and to band them together and create a level of scale that can succeed, given the changing payment structures.

The House Judiciary Committee approved a bill to increase some federal grants to combat the rise of opiate abuse, which follows the passage of a more comprehensive bill targeting drug abuse by the Senate in March. But the behavioral health sector has been on private equity's radar for several years.

Ben, can you start us off by describing some of the major trends that have been driving that interest?

Daverman: Behavioral is one subsector that we are currently drilling down into within the services realm. And there are several reasons why. We are seeing the emergence of the benefit parity via the Mental Health Parity and Addiction Equity Act of 2008. So commercial insurers now must provide behavioral and medical benefits on equal terms; they cannot make behavioral [health coverage] stricter. As this is playing out, I think you'll see this impact more than 110 million insured people.

You also see the general expansion of the insured population via the ACA [Affordable Care Act]—

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that expanded coverage could be an additional 25 million people. It's our feeling in the market [that] you're seeing payers seeking quality and in-network providers within the behavioral segment versus others that historically may have been pursuing an out-of-network strategy. The payers are really starting to drive in-network adoption.

You're seeing increasing provider consolidation impact this space, as well. Providers are seeking to create multi-site or multi-acuity platforms with which to partner with these payers in order to create a "one-stop" shop. The result is a pretty active M&A market, and the trend should continue.

McKernan: There is an increasing recognition by payers—as evidenced by the focus on getting some of these behavioral healthcare providers in-network—of the ROI and tangible benefits that providing adequate mental health services has on the payers' bottom line. It started in 2008… and as the visibility into data has improved over time, you're seeing more and more metrics as to why providing adequate behavioral healthcare services can ultimately reduce the cost to treat a patient population over the long term.

Can you discuss the notion of the pendulum swaying from inpatient to outpatient and back to inpatient, and what impact that has in terms of the investment opportunity?

McKernan: We are interested in residential treatment centers as well as more intensive levels of inpatient care. A lot of the focus of payers historically has been how to drive costs out of the system and how to drive down reimbursement rates per day or per episode of care. And that created an environment where there was a bias towards trying to push care from inpatient to outpatient settings.

On a per-episode-of-care basis, that works and that reduces costs. But it's created this dynamic in the U.S. where there is a shortage of residential treatment beds, and there is a shortage of inpatient psychiatric beds in a number of counties where people that need the highest level of care and have the highest level of acuity are not able to obtain treatment.

Daverman: Both inpatient and outpatient models are pretty interesting and are case-dependent. We're drilling down within some of the subsectors of behavioral, such as various addiction-treatment models. We're seeing the opiate epidemic that's going on in this country.

We also are intrigued by eating-disorder recovery business models, given the lack of providers in that space and how that may evolve. And similar to other models that we've looked at—physical therapy and other areas—there's a de novo element to eating disorders, where not only can you acquire regional presence but you can also then build out adjacent facilities.

Lastly, we like inpatient psych facilities; within that there's a stable, growing patient base. And again, similar to the eating-disorder subsegment, there's a lack of providers in specific geographies.

Are there any subsectors or niches within the addiction-services world that are particularly compelling?

McKernan: One place we spent quite a bit of time on recently is high-end adolescent residential

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treatment centers. We've interviewed a number of referral sources that cite the lack of bed capacity. And you're seeing two dynamics at work here. One is that payers have done their best to compress reimbursement rates per episode of care, and perhaps per day, at some of these residential treatment centers, which has caused a tightening of reimbursement rates. That causes residential treatment providers to focus on cost, and their outcomes have suffered.

And there is a dynamic within the high-end adolescent treatment center where you have kids from wealthier families who may start with a depression or anxiety issue. And that depression or anxiety can manifest itself in substance abuse disorders. The starting point of the referral continuum is a psychiatrist or an outpatient treatment center. And what we've heard from those referral sources is that there are a number of patients who have severe enough depression, anxiety, or substance abuse disorders that the next step in treatment for those individuals is to send them to a residential treatment center. And that creates a significant opportunity for some of these treatment centers to expand and provide various levels of care to get people into the system to receive the treatment they need.

Let's move into our discussion about healthcare IT. Ben, what's driving investment and interest?

Daverman: [When] you combine the mandates around electronic medical health records, as well as the ACA, there's an interesting opportunity to invest in healthcare IT today. And specifically within software-as-a-service models that are particularly geared toward reducing cost within the system, either through efficiencies in workflows, RCM [revenue cycle management] solutions, or other billing solutions that create transparency across constituents and hopefully reduce redundancies.

Within healthcare IT, you have to drill down as an investor and look for niche subsegments. But what's nice about that is there are actually a lot of small companies that are emerging and getting traction in today's market. They have customers, and they continue to explore customers across a number of different constituents, including the payers that are starting to pay for data and recognize the value in buying data from some of these healthcare IT players.

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John, are there some subsectors within healthcare IT that Riverside is finding attractive, or at least spending a lot of time exploring?

McKernan: We are focused largely on niche healthcare IT subsectors that are often creating efficiencies within a particular vertical of providers that may be smaller than the overall EMR [electronic medical record] opportunity for hospital systems. And we spend the most time on investment opportunities that are converting legacy inefficient paper-based systems to automated software platforms that are more accurate, effective, and reduce costs to the healthcare provider and improve quality to the patient.

There are two [examples] that I'll briefly point out; one's a company that we owned from 2008 to 2012, Healthcare First. They sold what was effectively an automated billing solution to the homecare and hospice market. So instead of fill-

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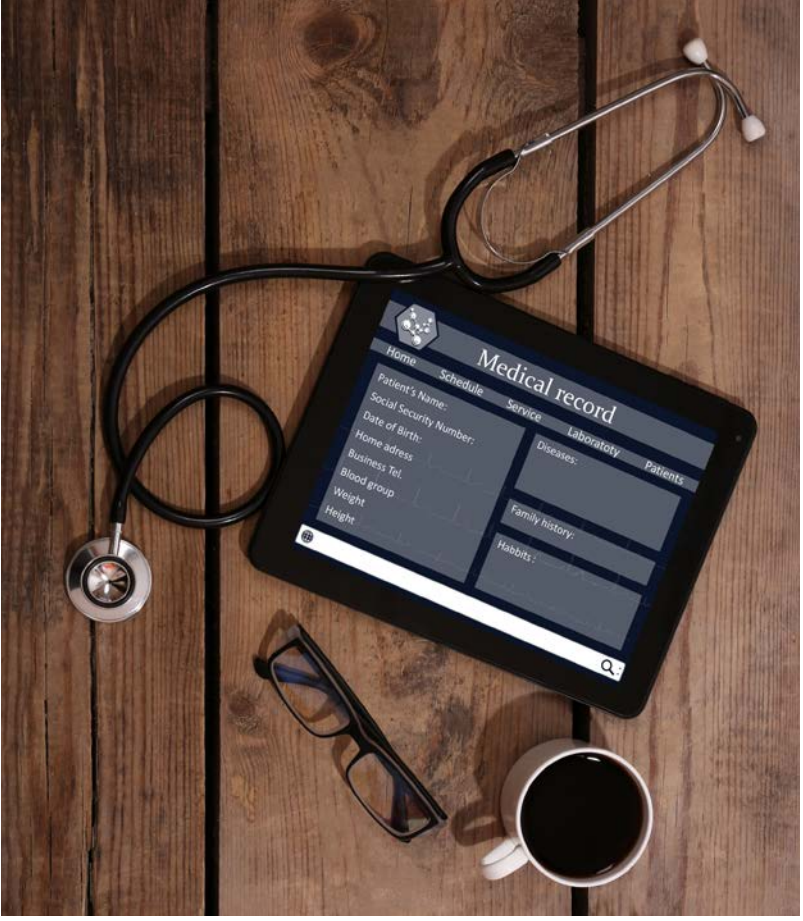

ing out Medicare forms in a paper-based format that are more prone to error, it was automated and looked a lot like TurboTax in the way you would fill it out and go through a decision tree to ensure that you're submitting the right claim and maximizing reimbursement.

The other example currently in our portfolio is a company we invested in, in 2014, by the name of Censis Technologies, which provides surgical-equipment tracking software to hospital sterilization departments. It transitioned processes that were typically manual and paper-based to an automated system that reduces costs by performing maintenance on surgical equipment on the basis of when it's needed and recommended, not on the ad hoc basis that's oftentimes created by paper-based systems, where things can get lost in the shuffle.

Ben, what's an example from your portfolio?

Daverman: Back in 2014 we invested in a company called Zyphon that connects labs and payers in order to help labs—which are their customers—send tests to the payers and ultimately get reimbursement. It's a software as a service platform, and upon that platform we are adding—both through acquisition as well as organic development—other products and applications to create this connection between the payers, the labs, the physicians, and the patients. We feel that we're creating significant value in the diagnostic area; that's ultimately going to be one of the major drivers in reducing costs within the healthcare system.

I want to touch on this notion of consolidation, which is a major strategy when it comes to private equity healthcare investing. John, can you talk about that strategy as it relates to Riverside?

McKernan: There is significant consolidation happening within the healthcare-provider space, including hospital systems acquiring physician practices and other specialties to try to gain more control over the costs and referral patterns.

What we're seeing is a handful of industries—dentistry is one, dermatology is another—that are outside of the typical referral patterns that you may see within a hospital base. And there are significant benefits to scale in those markets. What I mean by that is it's becoming very challenging for the one- and two-provider offices to compete effectively in the market because of increasing requirements for things like electronic medical records, increasing complexity around payment systems and payer contracting. And what that's creating is a dynamic where providers are looking to band together to benefit from the scale that some of these larger platforms can create.

What are the impediments to that consolidation strategy in today's market?

Daverman: The challenges are part of the market backdrop, [and] combined with the platform scarcity across some of these different subsectors, it creates a situation where some of the platforms in these spaces—dermatology being one of them—are going for premium valuations. And so the question that we're asking ourselves is, what size platform do we want to pursue? The size then correlates to the dollar premium that you're willing to pay to acquire the platform.

Markets like dental are still highly fragmented, and the follow-on activity can get done at pretty attractive multiples—significantly below the multiples currently being paid for the platforms. So that's really the challenge that we see: What's the right-size platform where you're minimizing the dollar premium that you need to pay to get in the business?

And lastly, another challenge is the compensation model. We spend a lot of time looking at this in order to make sure that the retention of physicians in these physicians' groups that we are acquiring is in fact attractive so they will stick around. Because at the end of the day, they are the valuable assets that are driving your business. ■