Fixing America's Aching Backs, Bones and Joints: Orthopedic Care in the Digital Health Era

David Johnson (00:01):

Welcome to *House Calls*, where we have insightful conversations with investment bankers from Cain Brothers, a division of KeyBanc Capital Markets, Inc. I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of *The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All*. I co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of this dynamic healthcare industry.

This month, we're looking at a sector that has long been overlooked, but is now drawing a lot of attention, investment capital and business model innovation. Our article is titled *Fixing America's Aching Backbones and Joints: Digital Clinics Transforming Orthopedic Care.*

You'll hear the acronym MSK a lot during the show. It stands for musculoskeletal care, which no one wants to say fast. My co-author is Ricky Ng, a director at Cain Brothers focused on M&A and capital raising, with a particular expertise in orthopedics. Welcome to *House Calls* Ricky, where the bankers are always in.

Ricky Ng (01:17):

Hey Dave. Thanks for having me on the podcast. And I'm excited to dive into this topic here.

David Johnson (01:23):

Ricky, we had a lot of fun with this topic. I even wrote a song about it on our website. And so it turned out to be far more interesting and far reaching and even transformative than I would've initially expected.

So why don't you set the table for us? Give us a sense of the scale of MSK conditions, and why it's such a cost and quality challenge in U.S. healthcare. And once we have that as a foundation, we can dig into what these new companies are doing about it.

Ricky Ng (01:52):

So let's first define what MSK is. So MSK really includes your bones, your joints, your soft tissue and muscle. And it is a very serious issue. It's one of the fastest growing disease categories that impacts more than half of Americans.

And almost half of those that are affected with MSK will often lead to it being a chronic condition. MSK accounts for approximately 10% of all healthcare spending. And that's more than any cancer combined. And it's also the leading cause of employees days loss. And if you factor in total productivity losses, it can also lead up to five times more than the treatment cost itself.

So the interesting thing here is that despite these rising costs in MSK, there hasn't been a corresponding improvement in patient outcomes. Spending more money has not led to better outcomes, which means that the current system is not working.

David Johnson (02:54):

Yeah. I just want to amplify a couple of those points. "More money spent on MSK conditions than all cancers combined." Wow. And part of what drives up that cost so high is that aching backs don't only hurt the people who have them, they keep these people away from working. So the combination of the care cost and then the loss productivity is absolutely enormous.

It's easy to see, Ricky, how some of this increase in MSK conditions comes from aging, Baby Boomers like me. As you get older, your joints tend to ache a little bit more. But there's some nuances here too. Why don't you go a little deeper into the MSK world and reveal it for our listeners.

Ricky Ng (03:43):

Yeah. Yeah. Certainly, Dave. So, as you mentioned, MSK injury increases with age. That should be no surprise. There are ways to offset that by having a healthy lifestyle. But one thing is that there's more aging Baby Boomers that are more active, and as a result are prone to more sports related activity related MSK injuries.

And also in the workplace setting now, historically we're used to seeing MSK being an issue with certain active professions. But with COVID and the new remote work from home environment, there has been an increasing amount of MSK injuries really due to the workplace standard, which is your home office is not up to standards. And the employees are moving frequently less.

The downside of MSK is that even if it starts out as a small problem, it can eventually lead to a bigger problem if untreated. Employees will miss work, they become less productive, and require more expensive care. And their MSK issue will make them more vulnerable to subsequent injuries. Or the actual MSK issue can become a chronic condition. So, their quality life can be significantly impacted if it's not treated correctly.

David Johnson (04:59):

You got to love those aging Baby Voomer athletes. I've known four guys that have ruptured their Achilles tendon playing pickleball. Maybe if we got rid of pickleball, MSK costs in the country would go way down.

But that's also really interesting about the home offices and bad posture and bad chairs exacerbating these conditions. But when you got about half of the adults in the country with some type of MSK problem, it's going to start in a lot of familiar places.

So that means the root causes of this cost quality conundrum, particularly since these problems often start small and then magnify, is actually quite simple, isn't it?

Why don't you talk to us about the root causes. And that's going to lead into a nice discussion about where these new companies are pinpointing their attention to deliver better outcomes at lower cost.

Ricky Ng (05:48):

Yeah, David. So the issue here is very simple, as you alluded to. Much of MSK costs are really results from misdiagnosis, prolonged interventions, and unnecessary and ineffective treatments, with surgery being one of the biggest cost drivers.

In a 2019 study by the Journal of America Medical Association, there was nearly 2.5 million U.S. patients that were diagnosed with the lower back pain. And of those only 1.2% received surgeries. But those surgeries accounted for almost 29% of total spend. So just by preventing unnecessary surgeries could generate enormous savings.

David Johnson (06:32):

Yeah. And the research shows that where you go first with your problem makes all the difference in the world. You mentioned lower back pain, choosing wisely, which is the effort to try to eliminate unnecessary procedures, things you should never do, has on its list lower back MRIs.

Let's jump into this point about where people first go when they have a problem makes all the difference in the world in terms of outcomes, treatment, and then overall costs. Dig into that a little bit for us.

Ricky Ng (07:09):

Yeah, certainly Dave. And one of our interviewees, Airrosti, they did a very interesting study on this very topic. They commissioned Cohen to analyze over 2.1 million MSK episodes. And what this study really did is they looked at treatment costs associated with the patients seeing the first provider, and also any subsequent costs associated to that same episode. And that's what we defined as trailing costs.

And what the study shows is that the point of entry is very important. Seeing the right provider as early as possible will significantly lower the trailing cost because the patient's getting the right treatment early.

Unfortunately, a lot of people typically go to their PCPs for their initial diagnosis. And the PCPs often lack the right skillset to accurately diagnose the issue. And they would end up prescribing the wrong treatment. And that would lead the patient to not getting the right treatment for their MSK care condition. And that would result in this ballooning of their subsequent showing cost.

David Johnson (08:20):

Yeah, just a couple of observations to add onto that from our piece, Ricky. PCPs are where 70% of people with MSK problems go first. And as you said, they tend to over diagnose. So they're getting those lower back MRIs done. And they also often are just referral machines to orthopedic specialists, which then drives a whole other set of costs.

The other categories of places to go clinics, chiropractors, lower intensity places, diagnose the problem and then work at it through much less intense interventions. And that's a nice lead in to some of these innovative companies like Airrosti that we talk to and that are taking on this challenge.

And digital tech has come a long way to help them do this very effectively. So talk to us about why digital therapies are possible today. And how they're able to target the problem and then offer solutions for it.

Ricky Ng (09:21):

Yeah, certainly, Dave. Look, I would say number one, over the years there has just been a significant improvement in the technology, whether it's the telehealth capabilities, wearables sensors, tracking software. Two, I would say COVID has really accelerated the adoption in use of virtual care. Patients and providers are more accustomed to utilizing telehealth due to COVID. And there's just been numerous studies demonstrating that MSK virtual care is as effective as in person care.

But ultimately, it really comes down to making it more convenient for the patient and having a better patient experience. Through technology and in virtual care, workers no longer need to take time off from work to go to rehab. Or if they're at home, they don't have to find a babysitter to watch the kids while they go to the clinic. And it makes it very easy for a patient to see physical therapists via telehealth to get them diagnosed.

And with technology, there's better engagement and adherence rates with rehab, where you get to do your rehab exercises at the comfort of your home and at your own time.

David Johnson (10:31):

In our article, we broadly divided these new types of MSK companies into two categories. The first is hybrid model that has in-person clinics, physical clinics, and digital clinic offerings. And then the second which are virtual first and all digital clinic offerings. And we featured a company in each category.

In the first category, Airrosti, whom we've already mentioned does operate a true hybrid model but does have this very effective digital front door and digital aftercare.

Tell us about what makes a Airrosti so effective and how they're positioning themselves in this MSK marketplace.

Ricky Ng (11:14):

Yeah. And just as a quick overview, Airrosti has over 160 clinic locations in four states. And they also have a digital MSK solution called a Airrosti Remote Recovery or ARR that is currently available in 47 states.

Airrosti has a proprietary soft tissue treatment model, which is really a blend between PT and pain management techniques to help correct the underlying MSK issue. And they're really great at what they do. They pride themselves on fixing pain fast. And they have proven that they're able to do that on an average of three visits or less.

And one of the impressive thing about Airrosti is that from the very first patients they started seeing back in 2004, they started tracking outcomes. And now they have seen over 3 million patients, which they have tracked. And using those outcomes' data really help them improve and refine what they're doing.

Airrosti works primarily with self-insured employers and commercial health plans under a fee for service arrangement. And sharing those outcomes and cost data with their customers really helps them win in this market and demonstrate the efficacy in resolving these MSK issues.

So now when it comes to their digital offering, ARR, they really saw that as an opportunity to treat as many patients as possible. So they view it as an extension of their in clinic business.

Within ARR, Airrosti ships their remote recovery kit with therapy equipment with patients, and also delivers educational videos and tailored treatments, exercises via the ARR app. And through the app itself, Airrosti providers are able to diagnose the patients and also monitor and guide the patients throughout their treatment plans.

So Airrosti has done a wonderful job in combining both their in-clinic capabilities with their virtual capabilities, and really done an awesome job differentiating themselves in the marketplace and creating a very superb patient experience.

David Johnson (13:16):

Yeah. They started, as you said, in 2004 so they've got 18 years of hands-on experience in physical clinics. And they were able to translate that now into their digital offering. It's hard to believe that over time they won't become even more digital.

The second company we featured is a virtual first fully digital clinic named Sword. And that started much later than Airrosti. But they also have a very interesting story, have raised a lot of money, and are getting some real traction. Tell us about their business model.

Ricky Ng (13:54):

Yeah, certainly. So Sword Health as you mentioned, is a virtual first company that specializes solely within the MSK's care space. And it was founded in Portugal in 2015, and now it's based in Draper, Utah. They've recently raised a series defunding of $163 million, which puts them at an evaluation of at $2 billion.

And in our conversation with CEO and co-founder V Bento, they had a very deliberate approach when it came to developing their product as well as their go to market strategy. And for them, they really spent years building the technology, improving out their clinical model before even going to the market. And once that was done, there was a very fast adoption rate and they were able to win a lot of customers despite Hinge Health, who will talk a little bit about later, the other main player in this space, having head start.

And Sword, again, is a virtual first company. They have an AI powered digital therapeutic system that enables interactive physical rehab exercises from home. And it's also supervised by remote physical therapists.

And the interesting thing about this is V recognizes the seriousness of MSK and how costly it is. And he views technology as being the only solution that helps increase quality and direct access to patients while eliminating cost from system.

Similar to Airrosti, Sword works with self-insured employers and commercial health plans. But then for them, they rely on at risk contracts to really drive their growth. So V really puts the money where their mouth is. They charge a case rate for each patient. And after 12 months they compare their patient cohort with the control group. And if Sword isn't able to deliver the outcomes and the savings, they will reimburse their customers.

David Johnson (15:52):

I love that. And what V said to us, it sounds like a much bigger risk than it is. Because preventing just one surgery, which can cost tens of thousands of dollars, right? You can do an enormous amount of clinic work. So they're great. And I bet we can't find another single company in the entire history of the world that founded in Portugal and then moved to Utah. I bet they're a total unicorn in that regard as well.

Now you did mention Hinge, and they're the better known of the digital MSK clinic companies. Talk to us a little bit about them and their model, and the enormous market traction they're getting.

Ricky Ng (16:32):

Yeah. With Hinge, like I said earlier, they're the other player in this space. I would characterize them very similar to Sword in terms of the offering and revenue model. And I look at Sword and Hinge as 1A and 1B in the virtual MSK care space.

Hinge is the most valuable company within this space with a $6.2 billion valuation based upon their recent Series E funding of $400 million. And like I said earlier, they're the first mover in this space. So they're able to have over 600 employers and health plan customers. And given their head start, they've really done a great job building out their clinical care team that consists of physicians, orthopedic surgeons, physical therapists, and health coaches. And that helps manage the patient throughout their journey within the Hinge offering.

And Hinge also has done a really great job developing their technology portfolio. And from a strategy standpoint, similar to Sword, they're really focusing on deepening its MSK care capabilities. And you could tell through some of the acquisitions that they made, they have acquired a computer vision company for motion assessment, and also another company that does electrical pain release simulation.

So very interesting for them to start developing their technological capabilities even further within the MSK care space.

David Johnson (17:56):

One factoid I learned about Hinge, you mentioned that they have had over 600 self-insured companies that they work with. They've only lost one client. So clearly, the marketplace is speaking. Employees love this type of service, the quick access. And it also works, right? They resolve the vast majority of orthopedic complaints that come to them as the Sword. So tell us about any other digital MSK companies getting your attention.

Ricky Ng (18:25):

Yes. Sure, David. Another virtual MSK company that's interesting is Kai Health. And that company was founded in Germany in 2016. And they've recently raised $75 million in Series C funding.

What's interesting about Kai Health is that they view themselves more of a technology AI software company first, rather than a healthcare company. And they look to partner with medical providers to create their care teams, which is very different from Sword and Hinge Health's model.

Also unlike Sword and Hinge where they're focusing on MSK, Kai platform treats a range of chronic diseases, such as COPD and not just MSK. So it's interesting to see how Kai approaches MSK care differently than Sword and Hinge.

We've also seen other broader digital health providers entering into MSK care space. And these digital health providers are generally focused on treating other chronic conditions such as diabetes, hypertension, mental health. A few examples that come to mind are Omada Health acquiring Physera, as well as DarioHealth acquiring Upright Technology.

And this makes a ton of sense for many reasons. The total addressable market for MSK care is huge. So there's a lot of upside and runway. They have the same customer base with self-insured employers and health plans. And they're also looking to expand their product, offering into a one stop shop, providing a better product for their customers.

David Johnson (19:53):

Wow. Ricky, as you're describing this, I've got pictures of Lee Major's the "Bionic Man" running through my head. And this idea that in the future we'll have better living through engineering, the monitoring, we will be walking straighter, sitting upright and just living better because of all of this.

And it raises the question for me of what's going to happen to the more traditional orthopedic model? Orthopods are sitting at top of the pyramid. But if I'm looking at the tea leaves right, these new types of much broader MSK companies that diagnose and treat earlier are going to touch many more lives and could become the channels that determine not only who gets surgery, but where they get it. So how afraid should traditional orthopedic practices be about the emergence of this broader MSK marketplace offering that just touches so many people?

Ricky Ng (20:56):

Yeah. David. So as these virtual MSK care companies evolve, they're going to be more integrated with the employer's healthcare ecosystem. And they're going to play a significant role in directing the patients to the right treatment providers. So, if you're an orthopod, that's something that you need to be aware about. It's not something that's going to happen overnight, but definitely something you should be cognizant of.

And as these virtual MSK care companies move towards the top of the funnel, if you will, in directing the patients, it's beneficial to start partnering with some of these virtual care companies such as the Sword and the Hinge Health of the world to just be involved as part of their ecosystem.

David Johnson (21:39):

Yeah. That's just great. I think you're right. It's all going to blend together, become much more patient centric. And I think the good news for American consumers is that with all these added capabilities, we can all have much greater certainty if we're directed to surgery that we actually need it. It won't be any more of these unnecessary surgeries or diagnostics and so on. So we can focus on getting the right care in the right time, and the right way and at a much lower price, the right price as well.

Well, Ricky, this has been a great discussion. It's been a fun project to work on with you. So I thank you for that. But as you know, I can't let you get away without making a big and bold prediction about healthcare in some form or another over the next three to five years.

Ricky Ng (22:25):

Yeah. David. Thanks for putting me in the hot seat. So my view is that in the near future, the hybrid and the virtual MSK companies would be moving to the top of funnel, which I said earlier in terms of serving as the initial point of diagnosis for the patient. Look, I wouldn't be surprised to see these virtual MSK care companies directing more than 25% of their surgeries to orthopedic surgeons.

Also in the near future as these virtual MSK care companies develop and become more accepted in the marketplace, there won't be a difference between virtual care and in clinic care. I view, whether if it's a hybrid company or a virtual care company, both companies will look to build out both capabilities. Companies will look to build out their virtual presence as well as their in clinic presence.

And ultimately, it's a better offering and experience for the patients. They get to decide on how they get diagnosed and where they get treated.

David Johnson (23:20):

Well, you heard it here first folks. Traditional orthopedic practices should be afraid, very afraid that they're going to lose control of the patient funnel. And the idea that just like there's no more telebanking it's just banking, we're not going to have any more telehealth or virtual health. It's just going to be healthcare.

So Ricky, you gave us two for the price of one. Thank you very much. And thanks for the great discussion. I encourage our listeners to read the article, *Fixing America's Aching Backs, Bones and Joints: Digital Clinics Transforming Orthopedic Care* to learn more.

In the meantime, stay safe, stay healthy, and keep doing what you're doing to make all of our healthcare systems kinder, smarter, and more accessible and affordable for all.

Fishing for Returns in Turbulent Waters: Healthcare Investors Adapt to New Competitors and Greater Risk

Dave Johnson (00:02):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets. I'm your host, Dave Johnson, the CEO of 4sight Health. And the author of *The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All*. I co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry. This month, we're doing something a little bit different. Usually, we examine sectors from the perspective of CEOs and founders who are leading innovative businesses driving transformation throughout the healthcare industry. This month, we've decided to talk to some of the people behind those leaders, namely the funders from private equity and venture capital firms. Our article is titled *Fishing for Returns in Turbulent Waters: Healthcare Investors Adapt to New Competitors and Greater Risk*. And my co-authors this month are Stacy Guffanti and Mike Elizondo, both directors at Cain Brothers focused on M&A and capital raising. Welcome to House Calls Stacy and Mike, where the bankers like you are always in.

Stacy Guffanti (01:16):

Hi, Dave. Great to be here with you.

Mike Elizondo (01:18):

Dave, nice to be with you again.

Dave Johnson (01:20):

We're going to have some fun today. So our article focused on this topic because these are such interesting times in healthcare's capital markets, particularly the investment side of it. And we wanted to investigate a thesis that we collectively developed about how private equity and venture capital investors are responding strategically to the dynamics at play in the current market. So first, to kick it off, let's talk about the role that PE and VC play in driving changes in healthcare businesses and within the sector overall.

Mike Elizondo (01:55):

Dave it's, as we reflect back, an incredible transaction environment that we've had since the national response to the pandemic started a little over two years ago, which is incredible to say at this point. Something that Stacy and I have spent a lot of time talking about over the last two years has been what's changed. A common observation that many in the market and the sector make has been with the telehealth industry. Through necessity, particularly in the early days of the pandemic, providers, and importantly, consumers, needed to find ways to provide care and access care respectively. And this caused an acceleration of adoption of telehealth, both on the supply and on the demand side. I think the takeaway from that is that the pandemic in many ways caused people to change, but allowed people to change.

And I don't think it's too dissimilar in other areas of healthcare, in particular in areas that Stacy and I spend a lot of time in, in payers and value-based care. So as we talked to our interviewees, I'd say there was a general consensus of the need for long-term change, in particular, the idea of value-based care having been around for a long time. But I think there's now really broad-based support from all stakeholders, a payer, a provider and the consumer, to achieve that goal. Interestingly enough, one of

our interviewees discussed in some ways the concentration of investment capital moving towards disruptive models. Not only from the venture community, but also from corporates really investing in ways to disrupt their own businesses to stay relevant in many ways.

Dave Johnson (03:38):

I sure hope you're right, Mike. And I also hope we didn't have a selection bias in who we decided to interview, leaning hard on the value theme because that did come through loud and clear. And I also really like this distinction that COVID not only caused or triggered the need for innovation, that it allowed people that have had innovative products on the sidelines for a long time, to actually demonstrate their effectiveness. So remarkably fruitful time in that sense. Silver lining to the COVID tragedy generally. Stacy, anything to add to what Mike observed?

Stacy Guffanti (04:12):

So I agree with all of what Mike said. And Dave, I completely agree with you, in terms of thinking about some of the silver linings that has come from COVID. I do believe that the pandemic is going to have a longer-term impact for the healthcare industry. And a lot of the innovation that we're seeing right now in healthcare that investors, both PE investors and VCs are chasing, is really reflective of this, whether it's in value-based care, mental and behavioral health, or moving care to the home. These are all themes that investors are very much focused on right now.

Dave Johnson (04:50):

Digging a little deeper into the current market dynamics as they've evolved over the last couple of years, Mike, why don't you talk about how these shifting dynamics are shaping opportunities for investors?

Mike Elizondo (05:01):

Dave, I'm going to focus on the HealthTech area because that was really the focus of our interviewees of this article. We mentioned at the top the velocity of investing has been outstanding. And in 2020 and 2021, venture capital fundraising increased from 2019 to 2020, 50% increase. And 2021 saw a double on top of 2020's level, so we're talking about incredible, and in many cases, unprecedented amounts of capital coming into the picture in these specific segments. From a HealthTech standpoint, saw nearly 1200 deals, nearly 40 billion in aggregate dollars invested. And importantly, noting that there were a significant portion of that $40 billion invested were in transactions where there was over a hundred million dollars put to work in that investment. So, we've seen sizes increase of these rounds to really support the tremendous growth that investors see.

There's a couple of private transactions that I would highlight. Devoted Health is a tech-enabled Medicare managed care company. In September, they raised 1.15 billion, with a B, dollars in a series D round, valuing the company at nearly $13 billion. But the time the investment the company served, approximately 40,000 members, which is a good size MA plan. It's not a terribly large MA plan if you look and you compare it to the Uniteds and the Anthems and the Humanas of the world. A couple weeks

later, VillageMD announced an investment by Walgreens for $5.2 billion. The valuation wasn't disclosed, but Walgreens upped their stake to 63% in that company.

Why is this happening? We spent a lot of time discussing that with our interviewees. And there's a number of elements, but one externality that they all observed was really the entrance of more traditionally generalist or even technology funds moving into healthcare investing. There's always been funds that would invest in both technology and healthcare, but there was always a distinction between those groups. What I would say now is we've seen a little more direct intervention from nontraditional healthcare investors into the broader investing landscape. Which certainly is, according to our interviewees, causing some of this rapid deployment of capital, rising valuations and record level of investment happening in this sector.

Dave Johnson (07:38):

Eye popping numbers, right? And of course, there's a supply/demand impact here on investment. And are there too many dollars chasing too few deals? And is that having an impact on these valuations? So Stacy, given the activity, given our initial thesis, particularly as it focused on private equity investors and the fact that we thought they might need to move upstream to find opportunities with earlier stage companies. Also, I think we discovered happening to some extent with venture investors as well. Could you just talk about our thesis and the grounds for it, the evidence for it and how we're coming out?

Stacy Guffanti (08:21):

Yeah. And that thesis I would say, was really formed following a number of conversations we had more broadly with middle market PE firms, really over the last year. Where a lot of those conversations focused around the types of investments that they were looking to make, where historically a lot of these middle market PE firms have been focused on positive EBITDA companies. And I would say over the last year, that conversation shifted where those investors said that they would be willing to get in earlier pre-profitability, so long as they could really see a path to profitability over the course of their investment period. And you really saw this as you think about just valuation metrics over the last year. I would say the conversation moved from EBITDA multiples to looking at revenue multiples in ARR. So it's definitely been an interesting year I would say, just given everything going on in the market.

The second observation that we had as we were developing our thesis is that the market is just moving faster. So the number of companies that start doing, I'd say smaller capital raises, and then a year later they're reaching unicorn status, has been really incredible. So our thesis was that not only are investors moving earlier, but that they're being forced to make quicker decisions doing less due diligence as a result of that. And part of this I would also add, is that with these earlier stage companies, PE firms are generally not taking control positions. So it's a bit of a different focus than as you think about some of the historical control investments that they've made.

Going back to our broader thesis though around PE investors moving upstream to find opportunities with earlier stage companies, one good example of this is Welsh Carson Anderson & Stowe. Last summer Welsh Carson, which is the leading PE firm focused exclusively on healthcare and technology, announced that it was launching Valtruis, which is really a unique portfolio company that invests in partners with healthcare companies whose mission is to realign and transform healthcare through value-based care. And so, they committed an initial $300 million to this platform back in August.

And since that announcement, they've invested in Cricket Health, which is a value-based kidney care company. Wayspring, which is a value-based care entity that's focused on substance use disorder, as well as a couple of other investments in home-based primary care with U.S. Medical Management and Oncology Care Partners. So really, four investments over the last year or so. And we've seen other PE firms taking different approaches as well, whether it's creating funds that are specifically intended to invest in earlier stage opportunities that have smaller check sizes. Those were just some of the observations that we had going into this that helped develop our thesis.

Dave Johnson (11:24):

Really, really interesting. In many ways, I look at investors as a leading indicator of where the market's ultimately going to go. And when you start digging into companies like Welsh Carson and what they're doing and how they're segmenting their investments, it really does send some signals, some pretty powerful signals. But as always, it's important to test theory with real world evidence. So Mike, why don't you talk to us about some of the firms and people that we interviewed to check out our thesis and refine it as we engage with them?

Mike Elizondo (12:02):

Yeah, absolutely. We're really fortunate, Dave, to have really great relationships with these firms. We really consider to be top tier and on the cutting edge. Folks that have a lot of understanding of the past of healthcare and how that'll really help to shape its future. First we spoke with Jim Elrod of Vestar Capital Partners. Vestar was founded in 1988 and has invested over $7 billion in healthcare companies since its founding. Unique Fund does both management buyouts as well as growth capital investments.

And one of those recent investments was in a Colorado based company called Friday Health Plans, which has been disrupting the ACA exchange insurance market. And in a lot of ways, we've talked a lot about the consumer here today on this podcast, really putting the ACA consumer first with a really novel, unique benefit design and network design. We also spoke with Srdjan Vukovic of Newlight Partners. In healthcare, Newlight really has been one of the firms that has been at the forefront of value-based care, and most notably being an early investor in a value-based care leader really recognized across the market. And Oak Street has invested over $6 billion in over a hundred companies in its 15 year history.

Dave Johnson (13:24):

Thanks, Mike. And Stacy, why don't you fill us in or round out our lineup card here with the other two investors that we had conversations with?

Stacy Guffanti (13:32):

Yes, thanks Dave. So we spoke with Lauren Brueggen of Heritage Group. Heritage has partnered with some of the most leading healthcare companies in the industry. Their model is unique because they are backed by both payers and providers. They have over $700 million of assets under management. And then the last investor we spoke with was Scott Rosen from Transformation Capital, it is a growth equity fund focused exclusively on healthcare IT and healthcare services companies.

Dave Johnson (14:01):

And out of those conversations, we really saw three themes emerge. And we'll take those individually. So let's hit the first one addressing increasing levels of uncertainty and competition in the markets. How did our investors view that, Mike? Shed some light.

Mike Elizondo (14:17):

Dave, I would say one of our theses here was around valuation. And then there was really no challenge, candidly, to that valuation, which hits on uncertainty and competition. There should be a relationship between those. But there were a couple of general consensus items behind the reasons for that. One, certainly interest rate, environment, lots of capital seeking investments. I don't think that's necessarily exclusive to healthcare, that's just the market broadly speaking. The addition, as we've talked about, of more generalist and technology investors, all of our interviewees remarked in one way or another just chasing investments has become more challenging as the valuation levels have increased. And particularly, one of our interviewees commented really at the earlier stages, that really leaves very little room for foot faults or "mistakes" early on in investment.

And those elements when you're getting into valuation levels that earlier and earlier stage companies are getting to and the amounts of capital they're raising, you really need a smooth glide path to that growth and bumps are felt a lot earlier on than perhaps they had in the past. We did have a fair amount of discussion on generalist and nontraditional healthcare investors spending time here. What was interesting is some of our interviewees discussed how these investors, without understanding some of the history in healthcare, the historical backdrop, may ultimately be figuring out in a couple of years that they've bit off more than they could have anticipated. In particular, relating to the myriad of rules and regulations and the levels of rules and regulations for that matter that exist in healthcare, but may not exist in the broader technology sector, for example.

I'd say it was noted also by one of our interviewees, that technology investors have historically come into healthcare, but generally speaking, that's when technology has struggled as a broad sector. Although, that's not the case in the current environment, healthcare and technology have been very successful. Where is this ultimately going, is really going to be exciting to watch and predict. But frankly, I have a history in FinTech, Dave, and it seems pretty similar candidly to the convergence of financial services and technology that happened 15, 20 years ago. I think that's where we've been heading and probably continue to go. All that considered, I thought it was particularly interesting that despite the current environment, there was not a broad-based change in our interviewees viewpoints of their theses in the sector. In fact, I would say there seemed to be a broad view that this period of time has

actually emboldened their theses. That despite this market environment, it's really solidified their conviction. They may become more expensive, but they weren't deterred from deploying capital and they won't sit on the sideline during this current environment. I found that resolve to be pretty remarkable.

Dave Johnson (17:25):

Well, buckle up. I think you're right, there's still a huge amount of sorting out that has to work its way through the market place in many respects. Many of these individual sectors are still quite immature, in the sense of just too many players. And we haven't really established who the winners are. And companies are having to take some bets. And you really did get the sense that it's more harrowing and they're falling back on their expertise and their instincts maybe to a greater extent than they were even two or three years ago, measure twice and cut once. And out of that, Stacy, we saw, I think, our second theme emerge, which was the importance of alignment between investors and entrepreneurs in the company. So talk a little bit about that, the dance between investors and entrepreneurs and how they find one another. And what types of marriages work and maybe more importantly, which types don't work.

Stacy Guffanti (18:26):

Yeah, Dave, it was interesting to hear some of the commentary around the management teams in this environment and in working with earlier stage companies than these traditional middle-market private equity firms are used to working with. I would say though, the one broader point that really all of the investors agreed on, is management and aligning management is very important for a successful outcome with the investment. And generally, the way that you do this is through a meaningful equity rollover from management as part of the investment. And so this continues to be an important piece as you think about putting together term sheets for these types of investments. All that said, I did think it was interesting to hear some of the commentary around trying to find the right management teams in this environment. And particularly, the competitiveness that's been driving up the valuations.

So, the first observation was around just accepting management as is in this frosty environment. One of the interviewees commented on how it's challenging in this environment to be able to make leadership changes as part of the investment. So you're really entering the investment knowing that you, meaning you as the investor, are going to need to fill capability gap. And you know where the management team and the areas where the management team may be lacking and where you're going to need to bring in your own resources to help fill that gap. The second observation was around some of the valuations and the high valuations we're seeing. And that there's certainly management teams out there who want to maximize value today. But then there's the teams who are really focused on finding the right partner in an investor, a partner that can really bring more than just capital, but that they can really bring, whether it's a network of connections or healthcare expertise in the particular sector.

And this really can push a company right to the next level when you're thinking about the investment horizon and when that investor exits, it's actually a better outcome over the longer-term for the management team. And that, I would say, is really the differentiator for the more traditional healthcare investors who we spoke with that they really understand the nuances of healthcare and can help an

early stage company overcome challenges just using their experience in the space. The last interesting comment I would say that Jim Elrod had made, is really around the board in making sure that the board has like-minded people on it. And that there's really enough room on the board for real industry experts. And so I thought this was a really interesting point as you think about developing term sheets for investments in earlier stage companies, is really putting a lot of focus on the composition of the board and making sure that you have room in there for experts.

Dave Johnson (21:26):

Jim really is a grizzled veteran, I'm sure he'll love hearing that term, when it comes to the ups and downs of investing through the years. And one thing that struck me about his comments was his observation that we're back to an era where, he used the term bootstrapping. Really working together with the companies to really bring them up to the next level in a much more hands-on, active way. Great observation, Stacy. And then the final theme we focused on was the emergence of value-based care and consumerism. And honestly, Mike, I was a bit surprised at how proactive our investors were in pushing these themes. What's your take on that part of the conversation?

Mike Elizondo (22:15):

Yeah. I think everyone recognized the road to value has been a long and arduous road and will continue to be a tough road. But that they are pretty committed to continue to push us in that direction. And candidly, sometimes seemingly needing to pull us there. Healthcare clearly is a sector with a lot of entrenched interest and it takes time to break those interests down. We've seen and talked about how the pandemic did that in many respects. Srdjan of Newlight made a really interesting comment really around policy. He remarked that generally speaking, the policy around improving healthcare has been reasonably good. And that their job really as investors or the investor community, should focus on implementing that policy. I think as I reflected on that comment, it seems that sometimes we find a lot of ways to try to resist policy change. Obviously, that can be pretty counterproductive to end-goals. So I thought that was a really interesting observation by Srdjan.

One element that was often forgotten with a value-based care by definition includes, is the consumer. Our interviewees were very focused on end-market being the consumer, or at least including the consumer in that. I always like to use the sandbox example of healthcare between three folks playing in that sandbox of financing source, typically a payer, a hospital system and a physician. There wasn't room for the consumer in there. I think they're all recognizing that the consumer needs to be able to play in that sandbox too. We also talked a lot about where value-based care will be implemented, and clearly, Medicare broadly, whether Medicare Advantage or DCE, now the ACO REACH program, really has been the sub-sector where value-based care has been the focus.

But we also spent time talking about two other areas where value-based care is moving, specifically populations and specific subpopulations within broad segment thesis. So for example, Medicare subpopulations like a PACE and I-SNP and culturally focused MA, social determinants of health. Those specific subpopulations that are beneath the overall Medicare thesis. And secondly, employers.

Particularly, those self-insured employers that are looking for spot solutions within employer populations. So cardiology, urology, women's health, oncology, kidney care, MSK, there's a myriad of examples. This is something Stacy and I have observed over the past 12, 18, 24 months. And it's been one of the talking points, so it was good to hear the interviewees generally see the same trends that we've been seeing.

Dave Johnson (25:06):

Great. So we had the three themes, so let's step back from that a little bit and just look at the big picture. So we see that investors are feeling the heat a little bit. They're moving upstream and searching for value with a little less certainty than they might have had in the past. Having to take on a little more risk than they otherwise would, given the competition from generalist investors and the high valuations that have emerged and continue to emerge.

But at the same time, they seem to be leaning into their strategies. And as you said Mike, not pulling out of the market, actually in many respects doubling down. So as each of you look forward into the industry, do you think these patterns will continue the search for value in harder to find places, or at least earlier places? Generalist investors continuing to come in, and at big enough scale, to change and push up valuations. And obviously, the give and take of the marketplace as it determines market fitness and picks winners and losers. How do you see this all playing out over the next one, two, three years? Stacy, why don't you start and then Mike, you can add on to that.

Stacy Guffanti (26:22):

Yes, Dave, it's a great question. I do think that we will see this continue, although I think that there could be some correction coming from the valuation side. But just taking a step back, we're in a very interesting time right now. We've been talking on this podcast about what we've been seeing in the healthcare investment market. But then when you think about the broader backdrop of everything happening in the broader world economy right now with Russia and Ukraine and concerns around China, there's the US midterm election coming up this year. There's a lot going on both internationally, domestically, and then within healthcare. We've seen a valuation correction already happen in the public markets in healthcare. Private markets generally follow usually with a bit of a lag. So it is likely that we'll see some bit of a correction here. I thought it was an interesting comment that Rock Health observed thinking about some of these funded companies as they look towards the later rounds, that they could feel pressure to sustain the growth and really the revenue goals that were priced into early-stage valuations. And that the risk of having down rounds, as we go out into the next year or two, may increase. And I think this is interesting because it could lead to more consolidation amongst some of these earlier stage companies. And we've seen a bit of this happening already in the space. For example, Unite Us over the last year has acquired two earlier stage companies, NowPow and Carrot Health in the SDoH sector. All of that said though, the broad takeaway that I had from talking with the investors is that they are moving earlier, and that there's certainly a lot of uncertainty in today's market. But that they're really sticking to what they know and remaining disciplined, which can be really, really hard right now in this marketplace. And all of that said, there's still a lot of capital out there. Healthcare is an industry that needs to change. The current healthcare spend is unsustainable, so I do think we'll continue to see a lot of activity in the healthcare marketplace over the next couple of years.

Mike Elizondo (28:33):

Yeah, Dave, I totally agree with what Stacy remarked here. I think particularly if you look at companies that had received funding in the past two years, it's going to be incumbent on them to continue the growth here. And I think you're going to see a refinement of strategies. You're going to see those strategies that are working really bubble to the top. Because I do think the end-markets, whether that's an employer, whether that's directly to a consumer, whether that's a health plan, whether that's a health system, I think they're receptive to change. And I think that's an important and catalyst to always remember that they are willing now to change, whereas perhaps in the past it was much harder, as we discussed earlier. They've been allowed to change now because the world was turned upside down on them for a period of time.

Dave Johnson (29:21):

Yeah. It's really a remarkable time, and as you just look at these valuations, and Mike, you just alluded to it, if you're an entrepreneur and you get a high valuation, that's great on day one and then you have to start earning it. So if we're collectively right that we're in the early stages of a sorting out process of some sort, then there probably are some down rounds in the future of some of these companies. Whereas others, the ones that break through, could see spectacular rises in valuations and market share and everything that goes with it. So it just feels like there's more variation and potential outcome than maybe we've seen in more recent times, pre-COVID times. So that, of course, gets us to my favorite part of the show where each of you gets to make a big, bad, bold prediction about healthcare in some form or another over the next three to five years and what's going to happen. So who wants to go first on that?

Mike Elizondo (30:15):

I'm willing to be the guinea pig here, Dave. So I think you're going to continue to see a lot of focus, both in the employer market, as well as in the government market, around focusing on specific populations as part of overall solutions. I think becoming really good at a, I guess it's a little bit of a misnomer to say, an end-to-end solution for a very specific problem. I think becoming very good and solving holistically, whether that be urology solution, a women's health solution, I think that that is going to be something that is going to be very valuable here in the future. And I think a lot of companies are trying to figure that out. And then I mentioned FinTech earlier, I just continue to see the parallels between FinTech 15, 20 years ago. I think HealthTech is going to become an everyday word for us as we continue to move forward.

Dave Johnson (31:09):

Good. Get on board the pop health train, omni-channel solutions, get it all together. So Stacy, what do you see happening?

Stacy Guffanti (31:17):

Yeah, Dave. So I think the last time I was on with you, the bold prediction I gave you was around consumerism. And I do believe that we will start to see more and more companies and solutions out there that put the member and the consumer in the center, similar to how it's done in other industries.

And I agree with Mike that we'll see further penetration of value-based care in specialty areas. But one other area that I would say will be interesting to watch is really around rural healthcare. I think there's a lot of opportunity in this market, although it's challenging to be truly scalable.

However, we're starting to see companies take a go at this market with Main Street Health, for example. But I think the rural healthcare market will be interesting to watch because there is a certain level of distrust around more traditional healthcare organizations in rural markets. Whereas there's actually a lot of trust around retailers, whether it's a dollar store or a retail pharmacy like CVS, there's Amazon out there. So I think it's going to be interesting to see how there's a little bit of a blurring of the lines between what some of the retailers are doing and coming into healthcare and how that all plays into, particularly the rural healthcare segment, I think is going to be interesting to watch.

Dave Johnson (32:33):

Yeah. And you didn't mention Walmart, but they're obviously going to be a big player in that arena as well. And I think you could argue almost no sector of American society needs more effective access and orientation and service provision than rural populations. Thank you, Stacy and Mike, for such a terrific discussion. I do encourage our listeners to read our article, *Fishing for Returns in Turbulent Waters: Healthcare Investors Adapt to New Competitors and Greater Risk*, if you'd like to learn more. And there's a lot to learn. In the meantime, stay safe, stay healthy and keep doing what you do to make our healthcare system kinder, smarter and more accessible and affordable for all.

Stacy Guffanti (33:16):

Thanks, Dave.

Mike Elizondo (33:17):

Thanks, Dave.

Looking Back, Looking Forward: A Golden Age of Healthcare Innovation?

Cain Brothers' President Rob Fraiman and Dave look back on 2021, another remarkable year in U.S. healthcare investment and M&A activity, and debate the trends and market dynamics driving industry investment and innovation in 2022 and beyond. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson (00:01):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, a division of Keybanc Capital Markets. I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable care for all. I co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry.

Dave Johnson (00:30):

This month, we're reflecting on 2021, another just remarkable year in US healthcare and thinking about 2022 through the perspective of the investment and capital markets communities. Our article is aptly titled, Looking Back, Looking Forward a Golden Age of Healthcare Innovation? My co-author and one of my favorite people is, Rob Fraiman, the president of Cain Brothers. Rob, welcome to House Calls, where the bankers like you are always in.

Rob Fraiman (01:01):

Dave, it's a pleasure to be here and always a pleasure to talk with you on these podcasts and to listen to your podcast with my colleagues.

Dave Johnson (01:08):

Free advertising, got to love it. So Rob, we decided to use a question mark at the end of our subtitle. Let's talk about why 2021 left us with that somewhat uncertain feeling. First of all, 2021 was another brutal year for frontline healthcare workers coming off of 2020. How did you see the industry and particularly, the financial sector respond to the challenge of the pandemic?

Rob Fraiman (01:34):

Well, first of all, the question mark at the end of our title, I think is probably something we did out of modesty. There are so many points of view these days in every part of our world and the political world and whatnot, where people are making bold statements. I don't think we can really assess whether this is a golden age of healthcare innovation until it's in the rear view mirror. So that's why the question mark, along with lots of other things about what's going on in the US these days.

Rob Fraiman (02:02):

I have to say, I think that the frontline healthcare industry had obviously and continues to have into 2022 another exceptionally difficult and challenging time. Obviously, Omicron led to incredibly high hospitalization levels once again. But now coming two years in, it also led to continued burnout at every part of the economy, but certainly every part of the healthcare profession. In particular, you have to feel for the frontline healthcare professionals who are working in hospitals and clinics and nursing homes and any place else where they're touching patients, where they're having exceptionally difficult times. That of course, has led to labor shortages, it's also led to a remarkable resurgence in, for instance, the healthcare staffing industry, to try to address some of these labor shortages.

Rob Fraiman (02:53):

Now, you've got the supply chain issues obviously continuing on affecting every industry, certainly including healthcare. And then of course, the mental health challenges that are probably going to continue for many years. But we're seeing it now not just in the elderly of course, but the other end of the spectrum and tragically for children and adolescents. So all of these things have led to a particularly difficult time in the industry and yet the industry, in so many ways as we'll talk about today, really stood tall and the people who are on the front lines continue to work in a remarkable way. But also, as we'll

discuss the people who provide capital and help drive innovation in the industry really doubled out their activities.

Dave Johnson (03:41):

I agree with you. Obviously, the frontline professionals are the ones that ran into the fire. Their heroic efforts and courage and resilience under just the toughest conditions was really remarkable to watch, continues to be remarkable to watch. And at the same time, as the industry confronted these issues relating to staffing, supply chain and so on as you described, there were a number of really innovative solutions that came to the foward to address the problem, the finest aspect of American innovation at work, quick responses at scale to big problems.

Dave Johnson (04:16):

So let's talk about 2021 and the remarkable year was for capital raising investment and M and A. The digital technology sector in particular, attracted dramatic amounts of capital, had record high valuations. Almost 30 billion in funding in 2021, which was double the 2020 level. And the 2020 level was double that of 2019 so we've seen a fourfold increase in digital tech investment in the last three years. So what are some of the forces contributing to this increased investor interest and these very high valuations, Rob?

Rob Fraiman (04:54):

Many of these things would've happened, Dave, under any circumstances and they certainly were starting. These are trends that have gone on not just for years, but actually for decades. But I think in hindsight, we'll look back at this period of time as we looked at the NASA space race to the moon in the sixties or even world war II. And you think about the technology, the innovation, the industrialization. In this case now it's digitization of this industry is on that scale, like a war-like effort that was accelerated of course by the pandemic.

Rob Fraiman (05:34):

So you've got digital health tools that have been out there for a while, but which became not just interesting, but necessities for both clinical care as well as with the financial side of the industry. And it's both for episodic and for chronic care that we saw that happening. I'd say that the treatment of chronic conditions became or is and has been particularly important. Diabetes, heart disease, mental health, as I mentioned earlier, musculoskeletal issues, the ability to use various digital health tools during the pandemic for all of these things accelerated, which was super exciting to see.

Rob Fraiman (06:11):

And then of course, you've got that combining with what the tech industry has been driving us towards for such a long time. More active consumer engagement and tools to help us take care of ourselves one way or another, sometimes just taking care of our mental health. And then finally, I'd say that, there's this increased need for digital and IT solutions to manage providers and payers accelerating trend of migrating from free for service to risk based payment models. So all of those things came together at a

dramatically more robust pace since 2020. And I think we'll look back at this and say, that was a remarkable time.

Dave Johnson (06:52):

War footing. Very interesting way to put this into perspective. We've all experienced a lot of changes in disruption in our life but one thing you touched on, Rob, really resonated with me, and it's the treatment of chronic conditions and the spotlight that COVID placed on health equity. And the fact that we saw differential rates of disease contraction, hospitalization and death in low income communities, inner city and rural.

Dave Johnson (07:22):

And because of that, we saw some new tools, some new urgency put into this whole concept of health equity. I just wonder if you could bring those two trends together, the digitization of healthcare delivery and its opportunity to make access both easier and more affordable as we as a country grapple with these longstanding issues that are disproportionately affecting lower income Americans and in a way that I think shocks most of us. Could you just touch on those two threads a bit?

Rob Fraiman (07:56):

I'll certainly try. Look, it has always been an unfair playing field for our society in terms of access to healthcare, whether it was walking into a doctor's office or a clinic or an urgent care center or the emergency department. The pandemic obviously has impacted people in certain communities, certain age groups, socioeconomic categories in a more profound way. That's a fact, we see that in the numbers.

Rob Fraiman (08:26):

And so we certainly think that the entities out there, whether they are existing health systems and providers, payers, or as we're talking about here, these innovators have a new imperatives during the pandemic, driven partly by the pandemic to try to address that. And technology can be an amazing solution. But on the other hand, we've got lots of people in the US who don't even have access to that technology. Obviously, the infrastructure need for broadband, for instance, to do a telehealth visit or to engage if you have kidney disease to engage in a virtual solution is dependent upon whether you've got the access in your home to the equipment. Meaning, the line in your house or the computer or the smartphone, which many people of course, don't have.

Dave Johnson (09:14):

So with that as a backdrop, I think the question on everyone's mind is, will the level of investment in US healthcare continue at the current level or even greater levels? We're probably at the end of the longest bull market in history. What's your view on investment activity in healthcare going forward?

Rob Fraiman (09:35):

Well, it's probably driven in part by the broader economy. Your comment about the longest bull market is certainly relevant. I think if we had done this, we probably did do this interview two years ago and three years ago. And I might have said at the time that, G, I don't know if this economy can keep growing like this. And I'm not just talking about the healthcare economy, I'm talking about the overall US economy. But here we are at the end of the day, in an industry that is, as I said, trillions of dollars, if we can make minor changes, small changes to reduce cost, to make care delivery more efficient, to make medical record keeping more ubiquitive, to provide access to a broader group of people, as we talked about a few minutes ago.

Rob Fraiman (10:17):

Those are things that will absolutely continue to attract massive amounts of investment from venture capital, to private equity, to family offices, to large corporations regardless of what the economy looks like, regardless of where interest rates are, regardless of where inflation is although certainly, that has a big impact. I think that this is the reason, frankly, Dave, that you and I got involved in the healthcare industry, among other reasons 30 plus years ago, was because we knew that it was an industry that was going to and will continue for generations to provide opportunities for growth, for innovation, for capital investments, and frankly, hopefully for making things better.

Dave Johnson (11:01):

Well, so we've been talking about value based care and risk sharing models between providers and payers for over a decade. Progress has been slow and the benefits mimic for all involved, but what are you seeing that indicates meaningful change here? Because I think you and I both agree that we may not be at a tipping point yet, but we're certainly starting to scurry up toward the adoption of more fundamental change in payment and delivery than we've seen up to this point.

Rob Fraiman (11:28):

Yeah. Look, and it's still just a very small percentage of the overall addressable market, meaning the market for individuals seeking healthcare, just a tiny percentage of it is met today by value based care or risk models. I would argue that it's been going on for longer than a decade. I think back to when we used the phrase HMOs back in the early nineties and that was really all about shifting risk as well. And here we are, 30 years later having a similar dialogue. Look, I think that, what the missing link then was information technology, was IT solutions. And maybe there weren't good motivations to move to that model, but I'd say, the main thing was, people just didn't know how to do it.

Rob Fraiman (12:17):

Today, as we look at it, we do have the technology solutions to enable providers and payers to engage in discussions and contracts with one another that do pass risk from the payer to the provider. And I do believe there is ample evidence that in doing that, you can reduce cost in the system and achieve better outcomes. Frankly, it's true in every part of the healthcare economy. It's not just providers and payers, it's true, for instance, in the medical technology world where you see med tech companies that are incorporating outcome measures into total cost contracting arrangements. That's a remarkably innovative way for a medical device company like a Medtronic or somebody for them to think about this with the patient populations that they're serving.

Rob Fraiman (13:03):

And then the last point is, all around the healthcare industry, you've got these other trends that we've been talking about and they're pervasive in every part of our lives. It's about consumerism. It's about personalized devices. Those devices may not just be your phone. They can be in your ears. They can be on your eyes, in the form of glasses or things like that. Obviously, you have artificial intelligence and data analytics that just are moving along at warp speed. All of those things today in the 2020s, are prevalent in a manner that was absolutely unthinkable when people really first started to talk about value based care decades ago. And so I find that incredibly exciting, that it is here and still massive work that needs to be done, but that is the period of time that we're in right now.

Dave Johnson (13:51):

Thank you for taking me back down memory lane. I remember the nineties pretty well. Everybody talked about trying to get higher up the food chain and own a bigger part of the healthcare dollar but turned out we didn't really know what managing risk entailed and the difference between now and then, I think, is as you're saying is, we now have the data and the systems to track value and much more meaningful ways link it to outcomes.

Dave Johnson (14:19):

So much of the activity in the nineties was about preventing care access to save money by having gatekeepers stop individuals from getting care, now is driving a lot of the activity. I think now the real focus is on, how do you drive a better outcome at a lower cost? And there are many tools to make that happen.

Rob Fraiman (14:38):

And of course, the government got involved and it had to, it's the largest payer of course. And you look at MA, you look at the DCE, Direct Contracting Model. These are places where CMS, over just the last 10 years or less that you've had these programs that the government got behind and passed risk from the government fee for service model to a value based model. So once it started to happen there in a material way, then of course, you had all sorts of and we will continue to have all sorts of companies, large and small, all types of investors, large and small saying, I can do this. This is actually absolutely where it's moving.

Dave Johnson (15:17):

Well, let's talk about 2022 and what's been going on since we're now almost two months into the new year and the pace of transactions hasn't slowed at all, there've been lots of big deals. We've seen many of healthcare's high flying IPO classes of 20' and 21', although, decline in value. How would you characterize where we are right now? And what's the rest of 2022 going to portent for the industry and particularly, the investment side of the industry?

Rob Fraiman (15:48):

Innovation takes a lot of things, but if I had to boil it down and way over simplifying, it takes remarkable ideas and it takes the tools which includes capital to implement them. It also includes, of course, as we're talking about in this conversation, Information Technology and so forth. And so that's the reason that I think that we are in this period of healthcare innovation, this golden age. Is that, we have both those things. We have the tools as we've been talking about with the investments that have been made over the last 20 years in the IT infrastructure, the digital infrastructure, the consumer digital infrastructure, B2C and B2B in this country that is prolific and profound and it is now being harnessed in the healthcare industry.

Rob Fraiman (16:37):

And then what you have is, the people who provide capital, whether it's very large companies, both for profit and tax exempt or of course, as we've talked about institutional capital, venture capital and private equity or public institutional capital. I'd say as a sidebar that, the high flyer, I think that's how you refer to IPO classes, those stocks, many of them are down 40, 60, 75% from their high watermark. But when I look at absolute values of a number of companies, and I'm not going to really get into the names of various companies here. But when I look at the absolute value that they are trading at the total market capitalization, I still believe that those reflect very attractive valuations.

Rob Fraiman (17:22):

Now, if a company's gone from a $15 billion market value to a $5 billion market value, well, that's not so good for a lot of people. But what I look at is, it's $5 billion of a fair and attractive valuation for a company that doesn't make money yet and is trading off of a future revenue, multiple and so forth. And I would argue that it is and I would also say that in my 35 years of investment banking career, there have been more periods of time where companies could not raise capital in the public market and vice versa. So I look at it and say, for the right companies to go public and complete an IPO, whether it's an underwritten IPO or a stack merger, is actually something that's a unique opportunity for the right companies. And if it's not, then guess what? There is more capital available from these other sources that I've been talking about probably than ever before.

Rob Fraiman (18:16):

So I think that they will continue to be there. I think that they will continue to invest in chronic care and mental health solutions in diabetes and cardiovascular care and oncology and as well as of course, primary care. And then that other point, Dave, that we talked about earlier in the conversation, which is, health equity. And I think that some of the use of technology for social determinants of health types of business models, whether for profit or not for profit are obviously critical to this. So all in all, I'm very optimistic about this trend continuing and that's why we named the piece what we did.

Dave Johnson (18:53):

Well, that's fascinating about the availability of capital and how over the course of the last 30, 35 years, there have been more periods when it's been harder to get capital than easier. And I can't think of a good company right now that doesn't have multiple ways to get the investment funding it needs. That being the case is remarkable and we should note it.

Dave Johnson (19:16):

There's also always the question of execution and market fitness. And there are so many companies competing in these verticals across the space that will see some winners and some losers. And one thing I'd like you to touch on before we wrap up is, what's going on in terms of industry consolidation and M and A and how do you see that playing out not only this year, but into the next couple of years as well?

Rob Fraiman (19:41):

Every period of time where there's innovation happening and change, there are going to be winners and losers. There's probably half a dozen companies that are out there that are doing new model of kidney care and using different approaches. The end objective is the same, which is, keep people out of dialysis centers, keep them out of the dialysis chair, so to speak. Just as the primary care businesses that are out there or the companies that are doing chronic care management, their goal, when you really get down to it, is just to keep people out of the hospital. Keep people out of high cost care settings in lower and actually frictionless care settings is what it's all about.

Rob Fraiman (20:18):

But by definition, there probably is not a need for six or eight or 10 or 15 companies in each one of these verticals. So some of them will succeed, some of them won't, lots of them will consolidate or be consolidated. Meaning, they'll merge with one another if they can get through some of the social issues and all that and the relative valuation issues. Others will just be acquired by larger players. And that's the healthcare economy and the capitalist system at work here. I think that we'll continue to see that, the dialogue that we are privy to and really honored to have with players in every part of the healthcare industry would indicate that CEOs and boards see it that way. They see it as a very, what I'm going to call, target rich environment. And that's very exciting, does it mean every deal that people want to get done will? Of course, they won't because there's just too many different moving pieces out there.

Rob Fraiman (21:13):

But I think that we'll continue to see, I'd say, record breaking levels of investment activity and M and A activity this year 2022, and probably for the foreseeable future. Because it is the logical extension of this period of innovation and new company formation and new business models. And some will work really well and others will be an interesting idea that are ahead of their time. And some of course, will just fail. All of those will lead to more activity at one or another.

Dave Johnson (21:46):

Well, Cain Brothers bankers have been very busy and will continue to be very busy for the foreseeable future, which is great. Robert, I can't let you go without asking you to make a big, bold prediction about the future. So as you look out over the horizon, what's your crystal ball tell you is happening?

Rob Fraiman (22:05):

Well, Dave, as you know, obviously, my perspective, as you just pointed out, is that of an investment banker of a healthcare industry. So I tend to think about those types of things. And I look at you with the

greatest respect as somebody who's actually a visionary for what's happening in the healthcare industry. From my perspective, what we're going to see is more nontraditional healthcare entities for profit and not for profit and more private equity firms, for instance, play an active role in large transformational deals.

Rob Fraiman (22:38):

And the reason for that is multifaceted but one of them that has changed since you and I had our last conversation a year ago is, the intense antitrust group, over vertical integration in every sector, but including in healthcare. And this is the real deal both at the FTC and the department of justice, where we're going to see large strategic deals come under pressure. For example, looks pretty likely that the DOJ will seek to block the acquisition that I think it's a $12 billion acquisition announced 13 or 14 months ago of change healthcare by Optum. Looks like that's going to have some major challenges if it's able to be completed.

Rob Fraiman (23:20):

And the other end of or different spectrum, the FTC last week blocked the merger in Rhode Island of two leading health systems, Lifespan and Care New England. These are companies like Change Healthcare or systems like Lifespan Care New England that they may choose to just go it alone, wait it out, wait until there's a different way through trust environment. But given all that we've been discussing here about innovation and the need for capital. I think that we're going to see these types of entities that are shut out of doing deals that they thought made the most sense, seek alternative ways of making these deals happen.

Rob Fraiman (23:56):

And to me, that means not a traditional vertical or horizontal integration, but rather finding alternative sources of capital. Or, as I said, players that are not traditional healthcare companies, whether it's the big four tech companies or whether it's Walmart or whomever, I think those types of players can invest heavily in the healthcare economy in this country and will do so more and more in the next couple of years. That's really what I'm expecting to happen.

Dave Johnson (24:24):

That is such a mind blowing concept in a way. A PE company takes over the Mayo clinic or something like that or Walmart gets into the insurance business in a big way. Those really are big market changes that could alter fundamental supply demand dynamics with everything that represents. So we'll be on the lookout and first one of those that happens, I'm sure we'll be writing an article and doing commentaries about and so on. Just makes it a really interesting time to be in healthcare and to be thinking about where it's all going.

Dave Johnson (25:01):

Rob, as always, just thanks for this great discussion. I encourage our listeners to read Rob's and my article, Looking Back, Looking Forward a Golden Age of Healthcare Innovation? To learn more. In the

meantime, stay safe, stay healthy, and keep doing what you're doing to make our healthcare system kinder, smarter, and more accessible and affordable for all. Thank you very much.

Rob Fraiman (25:26):

Thank you, Dave.

The Many Roads to Value Part IV: Building The Last Mile to the Patient

On our last talk on the road to value, Cain Brothers' Managing Director Bryan Cloncs and Dave cross the digital bridge to patient communication and connection, and gaze toward the future of true patient engagement and tech-enabled consumer-focused healthcare. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson (00:01):

Welcome to House Calls, where we talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets Incorporated. I'm your host, Dave Johnson, the CEO and the author of The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of this dynamic healthcare industry. Today, we're concluding our four-part series called All Roads Lead to Value, with the final leg in that journey titled Building The Last Mile to the Patient. My co-author, Bryan Cloncs, is a Cain Brothers managing director focused on mergers and acquisitions, particularly in the healthcare information technology space. Welcome to House Calls, Bryan, where the bankers like you are always in.

Bryan Cloncs (00:58):

Thanks, Dave. Pleasure to be with you and excited to have a discussion today.

Dave Johnson (01:03):

Perfect. Well, let's get to it. As I mentioned earlier, this is the fourth article in our Road to Value series. In our first article, we looked at how health systems are building out their service platforms to manage risk-based contracts. In our second article, we talked about the middleware companies that are enabling risk-taking for physician groups. In the third, we focused on bringing value-based care to rural America. And in this article, we look at how providers are beginning to connect with patients more directly through various digital technologies. Let's start by talking about something that should be blindingly obvious but remains a blind spot for a lot of healthcare providers. Why is the patient so important on the road to value?

Bryan Cloncs (01:48):

Yeah, I mean, ultimately, if you think about value-based care, there has to be an effective way to engage patients and consumers and members. And that's blindingly obvious, to put it in your words, but it's

easier said than done. And we're at a place here in the transition to value-based care. I think everyone would agree that that train's left the station and that's where healthcare's moving. It's not a one-size-fits-all approach. And that's where we're starting to see a lot of innovation and traction with regard to provider usage of this type of solutions.

Dave Johnson (02:30):

Let's dig into the dysfunction a little bit before we get to the solutions. So there was a great article a few years ago that was written by Sarah Kliff when she was still at Vox and before she moved to The New York Times. And the article was titled Unpaid, Stressed, and Confused: Patients Are the Healthcare System's Free Labor. And in it, she discusses how difficult it was to get the healthcare system just to meet her basic needs. So talk to us a little bit about that article and what Sarah's getting at when she said it's not even meeting our basic needs.

Bryan Cloncs (03:06):

Yeah. It's a great article, and it really highlights the burden of patient coordination with respect to managing the healthcare system and, ultimately, the ensuing frustration that we all, to some degree, have experienced. And I think her main sort of focus was, historically and arguably up until modern day, that healthcare relies on patients to coordinate the in-betweens, the follow-ups, the reschedules, so on and so forth, and are viewed really as free labor. There should be a better approach to the patient consumer and, ultimately, engagement, helping them achieve their healthcare objectives.

Dave Johnson (03:54):

Yeah, it's so interesting because we're not talking about the holy grail of patient engagement here, where patients are supported by a network of capabilities that allow them to make smarter choices in real time about managing their health, lifestyle choices, healthcare choices, and so on. All we're really talking about is a level of administrative simplicity, right? It should be easy to schedule an appointment. It should be easy to get lab results. It should be easy to have a follow-up chat with your physician if you need to talk to him or her. That's engagement 1.0, and the industry really hasn't been there in a meaningful way. And I don't know if anybody's ever studied it, but it'd be fascinating to see how much, quote-unquote, "free labor" goes into things like scheduling appointments, paying bills, dealing with administrative complexity.

Dave Johnson (04:51):

So that's here, and we're working on the problem. And we were working on the problem a couple of years ago and then came COVID. COVID has been an accelerant to healthcare transformation in many ways, but perhaps no area has been more affected than the adoption of digital technologies. It was like the healthcare industry had tried everything else to connect with patients and couldn't succeed, and then COVID came and made it absolutely necessary to do that in digital and virtual ways.

Bryan Cloncs (05:21):

Yeah, I mean, look, I think you're spot-on. And by and large, we're still taking baby steps toward a more meaningful patient engagement, particularly if you line up other industries that are really consumer-

focused. But within healthcare, there has been some policy changes during the pandemic that have helped to advance the ball, so to speak. And so if you think about some of the telemedicine easing, if you will, regarding oversight and licensure and even, to a certain extent, data rights and transferability particularly as it relates to the pandemic, and supportive diagnostic testing and reporting, a lot of the red tape has been cut, and the genie's out of the bottle.

Bryan Cloncs (06:10):

So engaging patients during the COVID months has become extremely vital to maintaining a level of communication between the patient and that patient's healthcare provider. A lot of folks, as has been widely reported, have put their individual healthcare requirements and needs on the back burner, and physicians and other clinicians have been somewhat boxed out. And so a logical way then to help rebridge that communication channel is to have a digital outreach that's bidirectional, that patients can communicate back into the healthcare delivery system and vice versa, depending on what those patient needs and responsibilities are.

Dave Johnson (07:02):

Another interesting factor, Bryan, that's happened during COVID has just been the sheer amount of investment in digital health tech. It's probably going to top out at around $30 billion this year, which is three times the level of 2019. So talk to us about what's going on with the investment in digital health tech and how that's beginning to unfold in real time and the promise it offers to take this big lumbering industry and enable it to connect meaningfully, at least administratively at first, with consumers.

Bryan Cloncs (07:40):

Sure. Look, at the end of the day, competition can be a very good thing, and that's what we've seen within healthcare tech. You have what I classify as big tech companies coming into healthcare and trying to innovate and advance the ball to get more of a consumer experience. And a large part of this stems from the ongoing transition to value-based care. And ultimately, the payers and the providers are more aligned than ever. And there's full awareness and recognition that there are incentives under value-based arrangement that require engaging and improving outcomes at a more cost-effective manner or approach, and all that stems from communication and patient engagement. Those are sort of the key fundamentals, if you will, that are driving investment dollars into this particular sector. If you're a payer or a provider or a non-tech company, you're leaning heavily on those capabilities to move into the next generation of care delivery or member support.

Dave Johnson (09:00):

Glen Tullman, the CEO of Transcarent, and before transparent, Livongo, likes to say that great software eliminates the need for navigators and all of the friction and added costs they bring. And it feels to me that Glen's onto something here, that what a lot of this digital tech is doing is allowing consumers to connect directly with caregivers in ways that eliminate friction, make life easier, simpler, so on. Do you think he's right about that? And if he is, what sort of impact is that going to have on the traditional business models?

Bryan Cloncs (09:38):

I think it makes sense, and great software can really bridge the divide, if you will, to a certain extent, right? I mean, ultimately, healthcare's very personalized. And so there's going to be a component always that revolves around the user. It's important to make sure that consumer has a voice and their individual needs are met. And so those are some of the challenges as it relates to software development and usage and why engaging that patient in a manner that's significant and meaningful to them will ultimately move the needle. And so if you can solve that puzzle and create a dynamic platform that allows for that patient to feel engaged in a manner that's suitable for them, you're a step ahead of the competition, by and large.

Dave Johnson (10:36):

You don't have to outrun the bear. You just have to outrun the other providers and payers that haven't quite gotten up the digital learning curve as fast. Well, let's put some meat on the bones here, Bryan. We profiled four companies in the article. Let's talk about the first three, WellHealth, Radix, and Odessa, and what they bring to this new evolving digital marketplace.

Bryan Cloncs (11:00):

Sure. So these companies are digital patient communication-based vendors. And so at the core, they're similar in terms of what they offer and the value they generate. They certainly all differ with respect to their IT and their AI codes and their data sets, etc., as well as how they go to market and their in-market focus, right? Some of these focus on health systems or IDNs. Others focus more prominently perhaps on physician practices and specialties. And some have longer histories than others, right? Odessa is a company that's only been around for a few years. But in any event, the value prop that they offer stem from patient engagement, certainly, and how do you measure that? Well, one effective measure that gets providers' attention are reducing no-show rates. And that's a solution that folks want to solve for, certainly.

Bryan Cloncs (12:00):

However, there are a lot of use case. Again, they're all focused on delivering desirable results, on behalf of providers, to patients and ultimately looking to make the patient experience better while capturing data in responses in a useful and optimal manner and really looking to extend those results across a broader platform. These use cases vary but are centered around, for example, patient intake, utilization management, including broader marketing campaigns to subdemographic folks, be it, for example, diabetics. And then they're also able to then communicate with that subset in a manner that these folks want to be engaged or communicated with. It could be mobile phone. It could be e-mail and so on and so forth. But there's certain factors within these outreaches that can be constructed directly from the electronic medical record system as it pertains to certain conditions or treatment plans or medication refill and adherence reminders, etc. And then it also extends to scheduling appointments and follow-up and rescheduling as well as inpatient surveys.

Dave Johnson (13:25):

Wow. There's a lot going on. And the power to tailor an individual experience using digital technologies through these various point solutions really, I think, does have the potential to make life easier, not just in general, but as you were just saying there at the end, Bryan, with specific subgroups. That gets us

though to the fourth company we profiled and did a deep dive on, Memora Health, and their ambition's a little bit bigger than the other three. They compete with WellHealth, Radix, and Odessa, but they aspire to be an omnichannel, almost a backbone solution. We interviewed their CEO, Manav Sevak, who presented at the Cain Brothers Conference in October, really interesting guy, really interesting company. Bryan, talk to us about Memora Health and their big ambition and what they hope to do.

Bryan Cloncs (14:23):

Yeah, absolutely. So Memora, their offering does compete with some of those other companies that we had referenced in terms of offering use cases and other digital communication and engagement solutions. However, they are providing more of a digital infrastructure across the patient experience and the underlying data exchange back into the medical records. So they're effectively developing a digital platform that connects all patient-facing technology to manage the experience and improve the engagement while pushing and pulling data back to and from the EHR.

Bryan Cloncs (15:04):

One of the underpinnings here is then recording or capturing patient preferences and maintaining those on a go forward basis. And so, again, this comes back to the individual experience. As I was alluding to earlier, some folks want to interact with a chatbot, some folks want to speak with an individual. And so when a patient is looking to see where their next appointment is online, they have all the other important or related options as it relates to what else their visit or post-visit will entail.

Bryan Cloncs (15:51):

And so it really is that omnichannel solution or approach to comprehensively engage the patient and then help to manage that patient's experience from beginning to end. There are a number of disparate IT vendors across the clinical, financial, and admin portions of healthcare system. And ultimately, Memora is looking to serve as that single source of truth and digital infrastructure management on behalf of the patient.

Dave Johnson (16:24):

In many respects, healthcare is boldly going where many industries have already gone before, which is direct connection with consumers. I mean, I think about it when I go on the Marriott website, and I can get any room that I want from the equivalent of a student hostel to a presidential suite. I can rent a car. I can order flowers. I can create a unique experience for myself. And it's all done through this very elegant omnichannel platform. And we are so far away from that, even on the basic administrative services. So when you think big picture, Bryan, about patient engagement, and we're really struggling to get patient engagement 1.0, this administrative simplicity that we've spent most of our time talking about today, what does engagement 2.0 and 3.0 look like to you?

Bryan Cloncs (17:14):

Yeah, it's really, in my mind, weaving in some of those wellness activities and applications. And so if you just step back and look at the various IT solutions that are selling into consumers or that consumers are interested in, right, the Fitbits of the world, etc., there's the opportunity to more comprehensively look

at the picture and identify what's meaningful to an individual consumer and then overlaying that with their specific geography or wherever they may be at that point in time. And there's just a lot of components, right? If you think about an area that investors are very active in as it relates to this, it includes social determinants and behavioral type solutions. And a lot of that can be just mental health and wellness. And so there's certainly a big leap if you think about patient engagement 2.0 or 3.0 versus today. But ultimately, it is to round out the picture in totality.

Dave Johnson (18:23):

Wow. How active is this market going to get this, and how fast do we get there?

Bryan Cloncs (18:27):

Yeah, look, I still think we're in the relative early innings on the digital patient engagement front. There's been tremendous amount of innovation and companies that have been at this for a number of years. However, from a user perspective, patient consumers want more and expect more. And now healthcare providers recognize that this is a must. We didn't really hit on this yet, but healthcare providers are viewing patients certainly in terms of the patient health responsibility component, but also as an important piece to remain competitive in the market. This is a market share opportunity, and consumer satisfaction will ultimately carry the day.

Dave Johnson (19:11):

I agree with you that it's still early innings, but at least we know what game we're playing right now. I think for a long time, healthcare didn't even know whether they were playing baseball or basketball. Well, Bryan, this has been a really fun discussion. And you know I can't let you get away without asking you to make one big bold prediction for 2022 or beyond. So what's your big bold prediction?

Bryan Cloncs (19:32):

Well, I was going to lead with the Knicks make the finals, but I think that's going to be well beyond 2022.

Dave Johnson (19:40):

Jets in the Super Bowl and Knicks in the NBA Finals, which one comes first.

Bryan Cloncs (19:44):

Yeah, but truth be told, that's too bold. So I won't even go there. But really, the way I see the market is that it's made up of services and tech vendors in terms of better supporting patient and consumer engagement. And I think there's going to be as much of a convergence going forward, whereby services providers will continue to invest and enhance their investment in technology companies, in many instances, buy them outright. It could be from a competitive or differentiation solution standpoint where they want to own that tech. And I also see technology software providers continuing to partner with, and in some instances, build out services capabilities. I do think in many instances, not all, software and services certainly go hand in hand. And I suspect, going forward, we're going to see more of that, frankly.

Dave Johnson (20:44):

That's such a great observation. I do think the tech companies are going to start delivering care. I mean, Amazon Care is an example of that, right, a tech company that's getting into the care business. And if you're a traditional provider or payer, you probably should be a little bit afraid, maybe even very afraid. Yeah, great prediction. I think that one's spot-on. I encourage all of our listeners to read the series, All Roads Lead to Value, and in particular, Bryan and my article, Building The Last Mile to the Patient. In the meantime, stay safe, stay healthy, and keep doing what you're doing to make our healthcare system kinder, smarter, more accessible, and affordable for all.

Bryan Cloncs (21:24):

Thanks, Dave. Really appreciate it.

All Roads Lead to Value Part III: Making Inroads in Rural America

In rural America, market dynamics for healthcare providers are exceptionally challenging. A number of promising public and privately funded initiatives show great potential, however, in implementing better primary and comprehensive care through value-based arrangements. These programs and businesses offer hope for improving health and quality of life for millions of Americans living in medically under-served rural communities. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson (00:00):

Welcome to House Calls, where we talk to investment bankers from Cain Brothers, the division of KeyBanc Capital Markets, Incorporated.

Dave Johnson (00:08):

I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of *The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All*. I also co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry.

Dave Johnson (00:31):

Today, we're continuing our road trip with our series of article titled "All Roads Lead to Value." We're taking the scenic route on that journey today with a piece entitled "Making Inroads into Rural America." My co-author, Colby Kittrell, is a Cain Brothers director in the firm's corporate M&A advisory practice. Welcome to House Calls, Colby, where the bankers are always in.

Colby Kittrell (00:55):

Good to speak with you today, Dave. Look forward to discussing the potential for value-based care in rural America.

Dave Johnson (01:02):

Back roads and blue highways as it pertains to healthcare. This is the third article in our series. In our first piece, we looked at how health systems are building out their service platforms to manage population health and risk-based contract. That's the clear direction that payment is moving. In our second article, we talked about middleware companies that are enabling risk taking for physician groups. So companies that actually help bring about the value-based payment and contracts that are more and more en vogue.

Dave Johnson (01:32):

Now in this article, , we're focusing on bringing value-based care to rural America. Let's start by talking about the characteristics of rural America that make help healthcare delivery, in general, and value-based care, in particular, so challenging. Give us the overview.

Colby Kittrell (01:49):

Sure. Before getting into the challenges, I think it might help to briefly touch on what has led to the success of population health management platforms in more urban settings. While there's been various clinical models, technology, and so forth, that has enabled these companies to change healthcare. I see a couple things they do have in common is they serve dense populations and have the ability to manage risk pools with larger patient base, as well as a larger pool of physicians and providers. Whereas, in rural America, you have patients in areas that are more sparsely populated, which makes it tougher to manage those patients and benefit from economies of scale, technology and clinical innovation, as well as the challenge of drawing from a smaller pool of capable providers. Then on top of that, you have sicker patients with less access from a shortage of services. That makes our formidable challenge to overcome to improve health in this segment. Not surprisingly, there hasn't been much investment or attention on bringing care models or value arrangements to this population.

Dave Johnson (02:52):

The sad thing is when you look at the outcomes, we actually see fairly significant declining life expectancy in rural America, compounded by all of the factors that you talked about. A book that we both recently read really brings this home. It's called "The Hospital: Life, Death and Dollars in the Small American Town”. What struck me most about that book wasn't its principal focus, which was how a rural hospital and its management team struggled to stay sustainable under very tough economic headwinds. There's a lot of that in the book.

Dave Johnson (03:32):

But what really caught my attention was the dramatic mismatch between the services people in the community needed and what the hospital and the overall healthcare system offered. There was plenty of money to amputate a foot for somebody who had diabetes, but very little money to provide the care management that would've prevented the need to amputate the foot in the first place, not enough mental health services, access to much basic care, very hard to get particularly primary care.

Dave Johnson (04:04):

When you think about it, it's these basic services left unattended that trigger the more serious acute interventions needed later on. So I think much of what we're trying to do in healthcare, broadly, both in urban markets and rural markets, is think in a more progressive way about how to meet the basic healthcare needs of people so they're healthier and more productive, and won't need as much of the

acute care services that the system always seems willing to offer. Any thoughts about that pattern, Colby and where we are, and where we need to go?

Colby Kittrell (04:41):

Yeah. I think you covered a lot, Dave. I agree with what you had to say. Unfortunately, that hospital, along with many others across the country in rural areas, has to devote much of its budget to high-cost specialists and acute procedures. And as result, it is not well-positioned to treat the root causes of chronic illness, such as mental health or substance abuse disorders, illnesses that are widespread in rural America. Unfortunately, they aren't treated before they cause serious harm or death, then unnecessarily costing the system too much money. This mismatch is unlikely to change, given the need for hospitals to focus on the remaining solve and managing their fragile bottom line, which requires a focus on treating patients in the hospital, not through effective preventative care.

Dave Johnson (05:28):

Colby. I sometimes wonder if we could do it any worse than we currently do it, in terms of resource allocation and getting the right services to the people when they need them. But on that score, I've believed forever that you really can't improve the delivery in care until we change the way that we pay for care. Medicare advantage, despite having some issues, does in the ultimate equation, pay for outcomes, capitated payments to care for specific groups of people.

Dave Johnson (06:00):

Yet, while MA continues to make big strides nationally, both in terms of its popularity, enrollment is way up, but also in terms of the outcomes it generates and the services it provides, the program has been much less successful in rural America. According to a Drexel University report, beneficiaries have been switching back to Medicare at twice the rate of people in urban markets. Tell us why people in rural America just aren't taking to Medicare Advantage the way they are in the rest of the country.

Colby Kittrell (06:32):

I think consistent with what we discussed earlier regarding some of the challenges in rural America, the switch back to Medicare fee-for-service is driven primarily due to low satisfaction with care access in those Medicare Advantage plans. Patients, many times, only have one or a couple choices when it comes to care options so you see seniors switching back to fee-for-service so they can find better alternatives, even if it costs more money.

Colby Kittrell (06:56):

Additionally, higher out of pocket expenses resulting from high utilization in those populations creates dissatisfaction and also contributes to switching back to fee-for-service. If there was a way that seniors could get better preventative care, more attention and care coordination, this problem of switching back to a higher cost program could be reduced. That is what we talk about with some of the innovative companies in our paper in what they're trying to achieve.

Dave Johnson (07:23):

So, it's basically individuals in rural communities making the best of a bad situation. Medicare Advantage appears to offer a lot of benefits, but the access limitations, the lack of competition, the limited service offering mean that they often are just back with traditional Medicare, for better or for worse.

Dave Johnson (07:42):

Now, interestingly like much of inner-city healthcare for lower income neighborhoods, healthcare in rural neighborhoods is paid for largely by the government through Medicaid and other types of rural-focused programs. That means governments have a stake in doing this better. Some state governments have been taking really bold steps to address this mismatch between service need and service delivery by dramatically changing payment formularies. Maryland, Vermont, Pennsylvania, all received waivers enabling them to institute global all-payer budget with caps. Tell us about these types of programs, how they work, what they're trying to accomplish and how they're doing.

Colby Kittrell (08:30):

Despite all the challenges we've been speaking about, it is encouraging that attempts are being made by policymakers to design new programs that seek to improve the root cause of poor health and rural America. As you mentioned, Pennsylvania and Vermont are two examples of states using all-payer global hospital budgets to provide financial support for rural safety net hospitals, embarking on a transition to value-based care. Four years ago, Pennsylvania designed their global budget payment system to help rural hospitals invest in population health services. This funding enabled those hospitals to redesign their overall services and embrace outpatient and behavioral health services and other lower cost care options.

Dave Johnson (09:14):

I guess what you're saying is that in states like Pennsylvania, they say, "Here's the revenue." It's not going to go up or down based on the number of healthcare interventions you have. We're just going to provide you a global budget and you use that global budget in the best way possible.

Dave Johnson (09:31):

So there isn't the incentive as there is in most of the rest of the country to drive as much volume through the hospital as possible. The revenue's going to come in anyway. So the opportunity is for hospitals and other healthcare organizations in the community to go to these primary care services, which cost less in an effort to drive down demand for acute care services and also to eliminate unnecessary services, and we all know there's a lot of unnecessary care delivered.

Colby Kittrell (09:59):

That's right. Dave, I'll talk about a new program that addresses that in a similar fashion for primary care physicians through capitated payments, which provide predictable revenue and help sustain those physician organizations in those communities.

Colby Kittrell (10:15):

As you mentioned previously, Vermont also has the all-payer model, which they launched about five years ago, and it enables ACOs in that state to receive payments that reflect aligned incentives and quality measures. All 14 of Vermont's hospitals and half of primary care providers in that state do participate in the program. Unfortunately, despite the well-intentioned attempts, that program so far has failed in a lot of ways to align financial interest seamlessly because hospitals bear the financial risk for the program while participating primary care providers can choose to still operate under fee-for-service or value-based arrangement, and specialists continued to operate in a fee-for-service. While a lot of work to do, I think both of these still are trying to accomplish the goal of better preventative care coordination services.

Dave Johnson (11:03):

Let's get into that program that you briefly mentioned a moment ago. The community access rural transformation model, or CHART (always need a good acronym). How does that program work? Again, I think the constant theme we're hearing here is the importance of primary care in managing the overall health of populations.

Colby Kittrell (11:25):

Yeah, the CHART model, it's a voluntary payment model that, again, is designed to meet the needs of rural communities and is set up to test whether they can align financial incentives and use technology to promote more effective delivery of healthcare and do it on a broader scale. So more specifically, this model aims to increase financial stability for rural providers through the use of new ways of reimbursing providers that deliver them upfront payments or investments and give them revenue predictability through capitated payments that pay for quality and patient outcomes, but also pay on a per member, per month basis, which gives these providers predictability in revenue. The investment seeks to enhance beneficiaries' access to care services also by ensuring that more rural providers remain financially sustainable for years to come and can offer important additional services, such as those that address social determinants of health, as well as other important factors that contribute to overall health and wellbeing of patients.

Colby Kittrell (12:25):

This program will be done through two tracks. The first is a community transformation track where they'll have designated lead organizations responsible for working closely with model participants. Those lead organizations will receive upfront payments and ensure that access to care is maintained. They also have an ACO transformation track where CMS is going to select up to 20 growth-focused ACOs to receive advanced payment as part of joining the MSSP, Medicare Shared Savings Program. Building on the success of the ACO investment model, or AIM, the advanced shared savings payments are expected to help CHART ACOs engage in value-based payment efforts that will improve the outcomes and quality of care for world beneficiaries. Both tracks are slated to begin later this year, early next year, and we're excited to follow progress.

Dave Johnson (13:15):

Almost by definition, these programs are going to do a much better job of front-end primary care. They really have to, otherwise they run the risk of spending too much money on acute services.

Colby Kittrell (13:27):

They really intend to give the primary care physicians more revenue and more economics to be able to provide the necessary preventative care services that they otherwise might not to this patient population that's in need for much better preventative care. So that's the goal and we're hopeful that we'll see meaningful progress in more preventative care services delivered and better care coordination, and ultimately, a reduction in overall cost and healthier populations.

Dave Johnson (13:58):

Well, it's certainly a big opportunity. Not surprisingly, the marketplace is coming up with several creative innovations for business models that can address these real challenges in health status, access, and so on, in rural healthcare. We profiled three of them, Aledade, Main Street Health, and Caravan. Between them, they're a good example of how markets organize to achieve specific goals, really based on value.

Tell us what these types of innovative for-profit companies are doing in a market driven way to support rural physician groups and improve care delivery on the front lines.

Colby Kittrell (14:40):

Many have heard of Aledade, as you mentioned, who has expanded quickly by partnering with independent practices in many larger markets, but also often in hard-to-reach rural areas. They look to establish value-based contracts and enable smaller rural providers to benefit from the scale that Aledade brings through his technology and practice management that allows these smaller practices to better identify at-risk patients, higher risk patients, and intervene at the appropriate time, and also provide better preventative care. These primary care groups are then able to share in the cost savings that they generate and also benefit from better clinical outcomes.

Colby Kittrell (15:20):

Earlier this year Aledade also announced that they are partnering with regions Blue Cross/Blue Shield of Oregon to enable more effective care management, including a focus on individual with chronic conditions while transitioning these providers from a system of being paid for volume to one that they are paid for better outcomes. Again, this will focus on rural populations in Oregon.

Colby Kittrell (15:42):

Another interesting company is Main Street Health. They recently received startup funding to focus exclusively on rural America. They are trying to solve the problem of access of both primary care and working on bringing value-based healthcare solutions to that population. Their first program attempts to make it easier for rural seniors to navigate Medicare and access care where they need it the most and they are doing so by partnering with rural primary care providers, pharmacies, urgent care clinics, to offer what they are calling their extra access program. This solution comes back to what we talked about at the beginning of our discussion around rural Medicare members leaving Medicare Advantage due to these access issues.

Colby Kittrell (16:23):

You also mentioned Caravan Health, another company that is focused on bringing and helping sustain value programs in rural America by helping hospitals, ACOs and other organizations capture more revenue that is available to them, which, as you know, and as we discussed, is important to making these programs financially viable.

Dave Johnson (16:43):

Absolutely. So those are companies on a little bit smaller size, earlier stage, and so on. But then we also have the big retailers that operate in rural America now, Walmart probably being the most prominent. They see opportunity in healthcare as well, and potentially could be a real game changer in delivering better primary, chronic and preventive care to all of rural America. Talk to us about Walmart and their clinics and their various approaches and why it's in their interest to invest in this type of really basic healthcare service provision.

Colby Kittrell (17:20):

Yeah. I think Walmart, for example, has recognized climbing healthcare costs and limited access to medical treatment in this population and particular challenges that they face. I know they recently selected two rural sites in Georgia because, similar to many rural locations, those communities continue

with higher rates of chronic disease than the average US town, as well as a storage of primary care physicians. Walmart believes it can fill a gap of customers who lack healthcare coverage and those who scrape by a plan with high deductibles and out-of-pocket costs. Their goal is to replace visits to primary care physicians with more routine stops at a clinic. A little bit different approach than, for example, CVS with their minute clinics, which offer more basic treatment for the occasional strep throat or your infection, for example,

Dave Johnson (18:12):

Well, and where there's Walmart, there's certain to be a Dollar General not too far away, and even in greater numbers. So Dollar General would serves towns even smaller than the ones Walmart typically serves, just hired a new chief medical officer and is invested in a telehealth and a pharmacy business. Again, these retailers like Walmart and Dollar General, know their customers. They have a trusted presence in their communities. They're delivering convenient, low cost, primary care, optometry, dentistry, low-cost medicines, chronic care management. Is there anything not to love about what the big retailers are doing?

Colby Kittrell (18:50):

No. I think it's great. Dollar General has stores that are located primarily in rural America and three out of four people live within five miles of one of those stores. So they definitely have an opportunity to solve part of the access problem.

Dave Johnson (19:05):

Yeah. Big challenge, big opportunity. We've seen a lot of success and investment in enhanced primary care companies operating in relatively underserved, urban markets, still a relatively new phenomenon in rural markets, but all of the same problems, all the same opportunities. How optimistic are you about the prospects for rural communities to improve overall health status through the multiple types of interventions that we've discussed today, new payment programs from the government, hopefully better and more Medicare Advantage program offerings, private offerings through innovative startup companies, big retailers, seeing an opportunity? Put all that together, where are you these days? Is the glass half full, half empty or filled with arsenic?

Colby Kittrell (19:55):

I'd say more half full. Definitely encouraged to see more private and public efforts to address these issues that we've been talking about. But I think you hit it before. A lot of the change will have to come from companies that people in those communities trust, like a Walmart, for example. But I think technology will have to play a big part to expanding more capabilities to local doctors and also technology delivered directly to the patient, such as remote monitoring, to help them manage their health given their remote locations.

Colby Kittrell (20:24):

But overall, I'm definitely encouraged to see a lot of progress over the last couple years and look forward to seeing hopefully an acceleration of investment from both the private and public standpoint over the next couple years.

Dave Johnson (20:36):

Yeah, it would be great if we could just be a little bit smarter about how we allocate our resources. In some ways, to me, the challenges in rural America are easier to see then they are in urban America. It's pretty stark. So maybe that offers an opportunity for these directed interventions, particularly in various types of primary care and mental health services, and so on, to show real results that can be translated into other rural communities and more of broadly, into the healthcare market as a whole.

Dave Johnson (21:09):

So anyway, great conversation Colby, but I can't let you go without getting you to make a big, bad, bold prediction for either the rest of the year or sometime into the near future. So what, from Colby Kittrell's perspective, what's a big, bold thing that's going to happen in healthcare that maybe most of us aren't seeing?

Colby Kittrell (21:29):

Yeah, I think over the next 12 months, you'll see a significant acceleration of funding and announcements for more rural startups, similar to Main Street Health that target many rural markets across the country.

Dave Johnson (21:43):

Awesome. So the back roads and blue highways are going to get a lot busier and overall that will be good. I hope that's true.

Dave Johnson (21:50):

Colby, thanks for the great discussion. I encourage our listeners to read our whole series, but particularly this article "Making Inroads into Rural America". In the meantime, stay safe, stay healthy, and keep doing what you are doing to make our healthcare system kinder, smarter, and more accessible, and affordable for us all. Thanks so much Colby.

Colby Kittrell (22:10):

Thank you.

Moving Healthcare Home and Beyond: A Conversation with Paul Kusserow, Chairman and CEO of Amedisys

As part of Cain Brothers' 8th annual Healthcare Conference, Dave Johnson interviewed Amedisys CEO, Paul Kusserow, on his unusual approach to healthcare leadership and his company's remarkable turnaround story in the dynamic home health sector. Cain Brothers is a division of KeyBanc Capital Markets.

Rob Fraiman (00:01):

Welcome to House Calls. My name is Rob Fraiman and I'm President of Cain Brothers, a division of KeyBanc Capital Markets. In late October, Cain Brothers hosted our eighth annual Healthcare Conference. For the second year in a row, we streamed that conference virtually to our audience of over 600 senior executives from the private equity, venture capital, corporate and institutional investor

communities. Frankly, if you're anything like me, you're anxious to engage and network with industry friends and colleagues in the live format and I can assure you that we intend to be back in New York City in person for our 2022 conference next October 20th through 22nd.

Rob Fraiman (00:41):

For this month's House Calls, we're providing you with a chance to hear one of the terrific conversations that took place between our regular House Calls podcast host Dave Johnson and Paul Kusserow, the CEO of Amedisys. Their conversation ranged well beyond Amedisys' home healthcare industry and even the healthcare economy. They discussed leadership, employee burnout and retention and how to remain optimistic and to build careers in troubling times of the pandemic and political divisiveness. It was an enlightening and fun discussion. So now, I'll let Dave Johnson take it away with Paul Kusserow.

David Johnson (01:18):

Good afternoon. I'm David Johnson, the CEO of 4sight Health. Our company 4sight Health is a thought leadership partner with Cain Brothers. It is my honor and distinct privileged to interview Paul Kusserow this afternoon, the Chairman and CEO of Amedisys, one of the nation's largest home and hospice companies. Paul, welcome to the Cain Brothers' 2021 Healthcare Conference.

Paul Kusserow (01:40):

Well, thank you very much, David. It's a privilege to be here. Appreciate it.

David Johnson (01:44):

Well, this is going to be a fun conversation, so let's start with your background and approach to leadership. Henry Kissinger was once asked how someone would like to introduce him and his response was, "Just the usual superlatives," and you certainly have many superlatives, particularly in your educational background. At the same time, that background is most unusual for the CEO of a publicly traded company; bachelor's degree in theology from Wesleyan, Rhode Scholar with a master's degree in literature from Oxford. And believe it or not, you wrote a thesis on TS Elliott's poetry. Talk about a labor of love.

David Johnson (02:20):

Then you jumped out of academia into strategy consulting at McKinsey. I bet that gave you whip flash, TS Elliot to McKinsey. You moved out McKinsey and led strategy at big companies, Humana and Tenet among other organizations, before becoming Amedisys' CEO relatively late in life, late in your career, not late in life. So you're a true Renaissance man, as I would define it, and so many questions here. I'll give you two. First, how did you develop so much passion for healthcare? Secondly, how has your unique academic training influenced your thinking on organizational development and leadership broadly?

Paul Kusserow (03:00):

Sure. I grew up in Northern Vermont by the Canadian border in a small little town of about 400 people and my mom was an academic. She taught at the university there, but also she was a visiting nurse. When I was a kid, we would go out to the farms in Vermont and I would watch her take care of a lot of these folks. They were all just wonderful people and I really saw how important it was to go to people's homes to take care of them to really understand their lives. And she made a lot of people's lives better, so I feel really good about. I wasn't expecting ever to be in healthcare. When I left McKinsey, I went into

the publishing industry and worked for the Readers Digest and National Geographic and got involved in the outdoors business after National Geographic bought a kayak and canoe company.

Paul Kusserow (03:56):

And at that point, we were about to sell the company. When we sold it, I asked my wife where she wanted to go and she said, "Santa Barbara." I said, "Wow. Okay, done," and we moved to Santa Barbara and I quickly got bored. There was only one company in Santa Barbara, it was Tenet healthcare. So I went to work as head of strategy and then moved into M&A business development, ran the venture fund, so that's where I got into healthcare.

David Johnson (04:23):

When all else fails, go to healthcare, I guess.

Paul Kusserow (04:26):

Yeah, exactly. You're right.

David Johnson (04:28):

Yeah. How did your academic training get you to think about leadership and organizational development?

Paul Kusserow (04:36):

If you boil it down, what motivates people and what motivates organization? And I learned a lot of this from McKinsey. If you get the right strategy, if you communicate the right strategy and you start to execute altogether, it creates a sense of community and a sense of belonging. Where I really got quite interested with storytelling, particularly in how healthcare, which I think is particularly interesting. There's a theologian, a very famous one, called Karen Armstrong, writes out of England, and she said, "At some point, everybody has to be the hero of their own story." And frankly, what I saw and see in healthcare and in the people that are out doing healthcare is they're heroes and I think where we have unlocked a lot of our potential is the fact that we tell the story of what we do, how important it is what we do. 65,000 times a day, we're going into someone's home and we're helping them live the best life they can. In hospice, they're people who are actively dying, so at very crucial times in their lives.

Paul Kusserow (05:46):

It's so important, I think, to go, to have your people go in with the understanding that they're caregivers, that they're interacting with people at very crucial times in their lives and they're making a huge difference to those people and their families. I think if they understand that and they understand that that's what your company's trying to do, again, it unlocks this sort of nuclear type energy that you've just split some atoms and you just get incredible outcomes, incredible stories, so we're really a company of storytellers and of caregivers. I guess what I've done that's really unlocked a lot for me is I assume everybody in this company, we have 22,000 employees, and I say everyone's a caregiver and everybody in some way or another is helping those people we're visiting 65,000 times a day who are vulnerable, who need us and we're providing care.

Paul Kusserow (06:39):

The big riddle they give to me all the time is, "Well, I'm just in accounting, and then I say, "Okay, let me tell you how accounting is important to what happens in that patient." "Well, I'm just receivables," or "I'm just purchasing," but once they understand how they all fit in and how they're important in the whole context of the company, what they do is it releases an incredible energy. I'll use another quote, Thoreau, "The mass of men lead lives of quiet desperation," and I think in a lot of environments, people do. My role and my job is to have people understand that they are not those people leading lives of quiet desperation, that they're out there doing God's work out there, they're working hard, they're taking wonderful care of people, they're putting themselves out there and it's a real privilege for me to be associated with such people.

David Johnson (07:30):

Boy, that's such a profound set of statements that you just made, Paul. It's really easy to measure return on investment, profit, expenses and so on and I think most companies kind of set up the way they organize around those very measurable traits, but the one thing we really can't measure is the human potential fully unleashed, right, and what you're talking about is unlocking that potential in a way that people come to work excited every day, they believe in the just cause of the company and that has the potential to return orders of magnitude higher than more traditional investments. And yet, it's the one thing that's kind of tough to measure and harness. I know you're a big believer in the Golden Rule too, so why don't you talk to us a little bit about how you apply the Golden Rule in the cut and dry business world?

Paul Kusserow (08:23):

Yeah. Well, I mean, the Golden Rule simply is treat others the way you yourself want to be treated. A lot of times with the old sort of patriarchal structures of hierarchy and corner offices and all the geometry that we live our corporate lives in, it's enervating. I mean, it sucks the life out of you. We go to places that are not meant to be living, they're... I don't know. My belief is if, and this is where I spend most of my time now that I have really talented folks working with me, is I spend most of my time out in the field and have been... Since COVID S dissipated somewhat, I was in Maine last week, for example, and was in eight care centers there. My job really is to have our folks understand and to take what they tell me and to go out with patients, to go to referral sources, to go to meet with the employees, to go out on visits, watch what they do.

David Johnson (09:27):

Wow.

Paul Kusserow (09:27):

And by doing that, I learned from the market. I'm learning from people in the market and that's key. I mean, so by taking these learnings that I find on the real poor level of caregiving, I bring them up to the corporation and we have this model of listening in our company that we reemploy and try to drive changes that we need to do, so we're very, very market driven, but also it's the Golden Rule in a lot of ways because we're trying to learn from our patients and our caregivers and we're trying to apply their knowledge and learning back. And in a way, that respects them and it produces better care, so it is very circular. I think the interesting thing... So I've been here now about seven years and you mentioned I'm an ex McKinsey guy. So when I first came here, I tried something very different than what you normally do when you're an ex McKinsey person, which is take your watch, Dave, tell you what time it is, do a fancy chart and charge you a million bucks for it.

Paul Kusserow (10:29):

So what I did is I left for two months. When I first showed up here, the company was in significant trouble. I went out and I visited thousands of patients, caregivers, offices, referral sources, doctors, hospitals, SNIFs, senior living and I started to listen for themes. There were very simple themes that came back, three themes that we've always operated our company on. We don't alter from those three things. First is provide the best clinical care you can. Second is take the best care of people, better than anybody out there. Third, give those people the best tools there are in the business. If you start with clinical care, and we've gone from about below a three in star scores, it's up to five, which is a C minus. And right now, we're the highest in the industry. We're about 4.6 stars out of five. We have over 330 care centers and only three are below four stars.

Paul Kusserow (11:37):

Now, what that does is, one, it shows we really care about quality. It's been a massive transition, but what the other thing it does is quality attracts quality. So when we deliver all this quality, it's attracting quality people who want to work for a place that puts care first. The second thing is quality matters in growth. When you put quality first and you're in a provider business, you'll grow probably over the normal growth rate about between three and 5%. So home health is already growing at about 6% a year; hospice, 7%; personal care, somewhere around 10%. And incrementally on top of that, when you have high, high quality, the referral sources who are all doctors, discharge planners, case managers, they'll look at the quality scores and they'll say, "This is where we're sending them."

Paul Kusserow (12:34):

It's really this wonderful, virtuous circle that's being created here, where you work, work, work for quality, you take great care of your employees who deliver that quality, you value them, you give them the best tools so that they can't get better tools elsewhere and then you start to push that flywheel and it starts to really get going. Some of the tangible results we've seen is our margins went through the roof. I mean, on both businesses, we produce the highest margins because we have the highest level of productivity amongst our caregivers. I mean, we've seen over the past five years, 9% a year on the same base employees, growth and productivity because we say, "Take care of those patients. Do the best you can," and we provide tools in which they can do it.

Paul Kusserow (13:24):

And tools of efficiency, tools that cuts down extra workloads, paperwork, documentation, all this sorts of stuff, data, protocols, all that, so for us it's a great thing. And also, the executive team and me, I get up every morning saying, "I'm not trying to sell cigarettes here or whatever, I'm out there trying to make sure every single day we produce better and better quality patient outcomes, that I have better, happier employees that deliver this care and that they have exactly what they need in their hands," and that's been our strategy and the results have been phenomenal in terms of what we've been able to evolve as a company.

David Johnson (14:02):

Yeah. You talking about the circular nature and the beneficial nature. In some ways, Paul, your first couple of months, where you're spending your time now, which is getting out to the field, it feels like you're circling back to the very beginning of your life where your mother, the caregiver, was going to the farms in Vermont and getting realtime feedback and helping people. I don't know why it is that American businesses gets away from that. I mean, I just happened to have finished reading Simon

Sinek's latest book, The Infinite Game, and he basic describes two types of managerial mindsets. One is finite, like you're in a sports contest, where there's winners and losers, there's the end of the game and so on. Infinite, which is you're actually just playing to stay in business or playing the long game.

David Johnson (14:55):

And he said most companies operate with a finite managerial mindset and they create artificial metrics and they're inwardly focused, but the handful of companies that have this infinite mindset organize around a just cause, just like you organize around on this just cause of how do we deliver the best possible care, and we do that by treating our own people in the best possible way. Quality attracts quality. You've already talked a little bit about unleashing people power, but could you talk... And when you took over, I think Amedisys' stock was at $11 bucks a share and that it got as high as $325 earlier this year.

David Johnson (15:34):

Just talk about how you take a company that was clearly struggling, infuse it obviously with this incredible vision that you've already spent some time talking about, but then move from turnaround, to sustaining, to growing and what it takes to do that because you've turned a company doing what many would consider kind of a dead end business, in some respect, home health, into a growth juggernaut and you've done it the way you've described, but talk to us a little in more detail about that process, where you arrived, to where you are now.

Paul Kusserow (16:11):

Yeah. I mean, when I came into the company, it was doing very badly, paid a huge fine to the government for violations and was put on a CIA and so the DOJ was in there and the OIG was in there. And we had massive turnover with our employees. We were focused on way too many things outside of home health. I guess what I just did, as I said, I went out into the markets and I really spent a lot of time just thinking about since I was a first time CEO, but I also had something that it couldn't get any worse. As I went around and understood, I understood the one thing as I was going around, we weren't good at sales, we were okay at operations. We had a lot of things wrong, but the one thing we always did is we took good care of people.

Paul Kusserow (17:08):

What we started with was that and we were always a clinically based company, so we just focused around our area of strength, which I believe is the right thing. And then what we did is we built these loops, these feedback loops, into our business, which would just say what... and then we would make definitions on these, saying, "What is good care? How do we get to good care? What is good operations? How do we get to good operations? What is good growth? How do we represent to the market what our products are and how can we get the best possible outcomes? We created more or less a sense of belonging. The other thing is, frankly, from my perspective, is my job is just being a facilitator. I mean, my job is to keep feedback loops going and going and to make sure that people feel they have a voice in this company and they feel their piece of the company and their piece and participation in the company is essential, because it is.

Paul Kusserow (18:06):

Once people understand that this will is a company built for the people, by the people, for the patients, by the caregivers, once they understand that, then we created this whole level of participation, this

whole level of caring. That's what I think we've created is something that's relatively unique. But in order to do that, you can't be a typical corporate stiff. I mean, I can't be sitting in a suit and a tie with a secretary sitting out front and having a parking space with my name on it. It just doesn't work. So what you have to do is you have to serve these people and in serving them, they'll serve you back and that's also a Golden Rule. And that's what we do. I mean, the interesting thing about our company, we're just people. 22,000. We have no assets. So all we have to do every day is create better gravitational pull to keep these people in.

Paul Kusserow (19:02):

I'm coming to the belief now that what's really driving our company, what the key metric to this company is turnover. I see this every week, I see turnover stats. I talk to all these people who stay and leave. We brought our turnover down from about 40%, which is about average in home health, it's now down to 18% and 18% is too much. The point is people vote with their feet, but the economics of people staying and people feeling valued and people becoming more productive as they stay and take care of people, it produces these incredible economics, so we're really a staffing company. I mean, if you look at it, we have nurses and we deploy nurses to take care of people over an episode or over a visit. In order run a company that's pure people and somewhat a little technology, you have to create a gravitational pull that really wants them to be part of the club and the one thing people want, particularly nurses, is they want a sense of belonging and they want a sense of voice. And if you can provide that, you'll do very well.

David Johnson (20:10):

You serve them and they serve you back. No, that's so powerful.

Paul Kusserow (20:14):

Yep.

David Johnson (20:15):

Speaking of finite games, you might remember, particularly since you grew up in Vermont, the 1980 game where the USA played the Soviet Union in Lake Placid, not far from where you were growing up, and that right before the game Herb Brooks said, "IF we played the Soviet team 10 times, we'd probably lose nine, but this is our time," and then they started the sticks. I bet you're feeling that way about home care post COVID. You've made the acquisition of Contessa and the industry's come to this blindingly obvious conclusion that hospital-at-home saves money, fewer days in care, better customer experience, fewer complications and we've known that since basically the seventies, but now suddenly hospital-at-home is hot, there's all kinds of proof that we don't have to get basic care in hospitals, there are virtual ways of doing things. So you must be feeling like the US hockey team, this is your time now. Talk a little bit about the market and how you're feeling about things.

Paul Kusserow (21:17):

No, I mean, if you look at other healthcare systems, the one difference between... and then you look at their costs and their outcomes, you look at Switzerland or some of these other places that everybody holds up, we have much more institutionalization. And the interesting thing is if you look at how we've changed as a society and as a healthcare provider, if you looked at the eighties, you were in acute care, it was episodic care, it was medically driven and it was institutional. So people would show up with acute illness and they would get it solved in the centralized, institutional, medically driven places. The

issue you have now is 86% of the population is chronically ill and you can't use the old acute care model because it's all structured towards acute care. Don't do hospitals. Should they be out there? Absolutely. But should they be the predominant type of care? No.

Paul Kusserow (22:13):

When you have people living 10, 15 years with chronic illness, the way you do that is very, almost 180 degrees different in terms of care delivery. You want to keep them in place, you want to help them manage their disease, you want high touch at low cost and I think COVID has certainly accelerated the desire for people to be out of institutions and into the home. I don't know if that logic that I just described drives it, but fear is driving a lot of that, particularly when you see some of the issues that occurred in SNIFs, but you look at all the other post-acute areas that are capital intensive because they're place based, and you also have another factor, which is really fascinating, our average patient is about 77. The leading edge of the baby boomer is now 75. The baby boom generation, it's between about 57 and 75.

Paul Kusserow (23:08):

They call it the pig and the python, but this is a tsunami that's working its way through and it's now hitting that place where people make choices. And if you look at baby boomer preferences, the preference the baby boomers want is they want an age in place, they want to stay at home. And remember, baby boomers are 20% of the population and 55% of the wealth and health has become their primary concern. So you've got all this interesting demographics and psychographics and then you have the whole cost version of this. On apples to apples, we're a third of the cost of a SNIF, so that's why you're starting to see Kindred being bought by Humana, all these places starting to... start to figure for that baby boomer population in Medicare Advantage, which is outgrowing fee for service.

Paul Kusserow (23:57):

They want a centralized place, they want to have a home offering, which is what people desperately want. If you look at the AARP data, 95% of the people want to live and die at home. And as you know, baby boomers are incredibly influential population because they have the money and they also have that pig in the python, so I think we're in for an incredible 10 to 15 years as the baby boomers pass through because economically it makes sense, demographically it makes sense, psychographically makes sense, consumer wise it makes sense. I think we're in the best place we could possibly be, so I'm incredibly lucky. If we're not going to break the bank in Medicare, people should be in the home, particularly when they have chronic disease, which, as I said, 85% of the people.

David Johnson (24:46):

Yeah, makes sense to me. How does Contessa fit into this? How are you thinking about that?

Paul Kusserow (24:52):

Contessa, we made the acquisition in August and I think it'll change our company entirely. Contessa does a couple things really well. It takes care of higher acuity people that would normally go to a hospital and it brings them home. It takes care of people that would normally go into a SNIF and it brings them home. It takes people that would normally go into institutional palliative care and brings them home. The majority of what they're doing now, they have seven systems they're working with, the Marshfield Clinic, Mount Sinai, all these other places that are... Henry Ford was announced last week, but basically what this does, and the great thing about it, is because they're able to deliver care so

efficiently in the home is they can go back to the plans and give the plans delegated rates for DRGs in the hospital that are 80 to 85%, and so the plan is like, "Oh my God, you're going to do it for this. That's amazing."

Paul Kusserow (25:46):

The other thing is they make these hospitals JV partners and basically the DRGs they deal with are medical DRGs that the hospitals lose money on. So when they do a JV, because their MLR is less, that these hospitals actually get profits when before they were losing money. Obviously, that helps the hospitals drive this business. The other thing is the consumers, when given a choice between hospital-at-home and going in through the ER generally, into the hospital, 90% pick home. Outcomes are better, rehospitalizations are reduced by 40%, patient satisfaction is in the nineties, so that's what you get. And also, our total addressable market, our TAM, just doubled, so it's a wide market. Secondly, they take full risk on everything. So not only if you're a plan and you go in, this is full risk, this is a 60 day, 90 day risk, so we're in the risk business. We're almost in the insurance business for doing this.

Paul Kusserow (26:50):

And we have actuarial functions now. We have claims processing and analytical functions. We have underwriting functions.

David Johnson (26:56):

Wow.

Paul Kusserow (26:56):

So we can take risk in the home and we want to move that risk based element so we can, again, bet on ourselves and take care of and capitate in the home. The third thing, which is phenomenal, they do is because they take care of sicker patients, they had to build a platform of care which incorporated all the different types of care in the home at a very high acuity level. So we now have this platform that can have home health, hospice, personal care, consumer care, infusion, DME, all these things can now fit on a platform which can apply to that individual patient. Now, when you take all this in and you and input it in our core business, it's extraordinary. What this allows us to do is tell very different stories, it totally expands our marketplace and it also partners us with hospitals that really want to free up some capacity and want to make money where they previously hadn't been able to make money before and plans want to be able to push people at home because they get delegated risk that's fully insured.

David Johnson (28:03):

I thought for a while that there was more opportunity to manage risk in the post-acute space than there is even in the acute care space.

Paul Kusserow (28:14):

Yes.

David Johnson (28:14):

And when you combine it sort of the inefficiencies in the post-acute space with what you're describing, 80% of people needing some form of chronic care management over a prolonged period of time, with the ability to do what you're saying with hospital-at-home, it really does become a prototype almost for

how a capitated company can work under a full risk environment. I think many people believe we're not really going to change the way we deliver healthcare until we change the way we pay for it, but if you're suddenly delivering much better outcomes with happier clientele, more efficiently, more conveniently, for less money, your ability to bet on yourself should be pretty profound.

Paul Kusserow (29:04):

Yep.

David Johnson (29:04):

Am I missing anything there or is that the-

Paul Kusserow (29:06):

No. The reason why I think they sold to us, they had more options probably at higher prices, but the reason why they sold to us was because we give them nurses and nursing care for these folks as they're going to be expanding, it will require very much having really skilled, good nursing in the home and that's what we're good at. So the symbiosis that's going to happen there, I think will be extraordinary. It'll allow them to grow much faster and go into markets where previously they'd have to wait until they were able to hire nurses. You do need MPs and RNs for sure in these markets.

David Johnson (29:39):

And what about the cultural fit? It sounds like they must have valued your culture if they had other suitors willing to pay more.

Paul Kusserow (29:48):

I think culturally we're all aligned. The great thing I love about these folks, it's a small business and it's a small company, but they're all ex corporate people in a lot of ways. I mean, Travis, the CEO, came out of Vanguard and Aaron, the COO, came out of Aspire, so what I really like is they're entrepreneurs who worked well in corporate environments and chose to be entrepreneurial and there's a real can-do attitude and I think that culture combined with our culture has really invigorated our culture in a lot of ways.

David Johnson (30:20):

That's fascinating. I'm on record as saying that healthcare will change more over the next 10 years than it has in the last hundred, it's a pretty provocative statement, but the basis of that is really twofold. One is that the business models enabled through the digital tech revolution and so on are finally going to free up corporate purchasers, self-insured companies to really get value in exchange for their healthcare purchases, which up until this point really hasn't happened. The second is as we're getting more and more genetic knowledge, we will be able to identify disease earlier and earlier, so imagine a time in the not distant future where we're doing full genetic, epigenetic and proteomic profiling along with other longitudinal studies and we'll be able to say, "Hey, Paul, if you don't do anything else over the next four years, you're going to get Alzheimer's. But if you take these kind of lifestyle interventions, we can [inaudible 00:31:20]."

David Johnson (31:20):

I think we're going to witness personally a fairly large shift in resources out of treatment, into prevention to do much earlier disease identification and intervention, sort of more lifestyle interventions, and people will live longer, they'll live better and so on. That's kind of what I think is going on here. We're obviously at the very early stages of that. I'm just curious, do you think I'm out to lunch or is that directionally where you think we could be headed over the next 10 years, that... Yeah, go ahead.

Paul Kusserow (31:49):

I agree. I think that when I think of Amedisys and what we're trying to do is my focus is I believe we shouldn't be a post-acute business, we should also be a pre-acute business. I believe that the data's out there. We own about 20% of a home health and hospice AI company called Metalogics and it's a predictive model. It brings in huge amounts of data, but we can predict when somebody is ready for hospice, which means fundamentally we're predicting time of death. We can predict how to take the most efficient care of people. Where I see the world's going to need to change, frankly, is the Medicare Advantage markets. And when I was at Humana, that's why we started Humana At Home. And when I left, they've certainly pumped that up and it's doing... with the acquisition of the largest company out there, Kindred, and I believe what we can do is if we can use those predictive models to understand... Because we can also predict readmission.

Paul Kusserow (32:44):

So if we can predict readmission, we should be able to predict initial visits. I think the whole idea is what does it take to reduce initial hospital visits and then you back up more and more. The other thing is I believe that some people really don't take good care of themselves, particularly in the United States, particularly with obesity. So one of the things we've seen is tremendous results with drug adherence. So if they do med adherence in their drugs, I know in rehospitalizations, you'll reduce them by close to 50%. I believe that as more and more medicines are out there, even if people don't change the way they eat or drink or exercise, that if they adhere to some of these meds, they're going to really keep people better at home. And chronically ill people need consistent delivery of meds. The problem I have that I always believe is the ultimate question, is healthcare a right or a privilege?

Paul Kusserow (33:38):

I believe if we ever treat it as a privilege, like a driver's license, everybody always uses that analogy, "You got to do it right or you shouldn't get on the road." At some point, but there's all these other societal issues and all these other things, at some point, people have to understand when they're abusing themselves and the healthcare system and that's where I'm most worried. I mean, I live in Tennessee, which is part of the diabetes belt and the heart attack belt, and there's just a lot of people who completely don't care about what they do to themselves and then expect everybody to do the patch patch, work on them. That sort of acuity needs to be pushed out of the system and people like that really need to get some education and try to see what we can do about it. The other thing is I just joined a very interesting company, [inaudible 00:34:23] Crescent company, called Pure Foods and that's medical foods.

Paul Kusserow (34:27):

I think that since food is a big issue with us and getting the right food, these folks deliver really nutritious by disease state food to Medicaid folks who can't afford good food and also are doing it in Doles and some of these other places. I think it's going to follow the way you want. I think it will have to be

subsidized, but subsidizing some meals to send to somebody and having them take good care of themselves versus showing up in the hospital 10 times a year and that's where the plans have to kick in.

David Johnson (35:00):

Well, I haven't met anybody yet who thinks we need to spend more than 18% of our economy to provide great care to everybody in the country. And by the way, I love that phrase pre-acute care. So to me, it's not really a question of the money, there's enough money there, it's how we're choosing to spend it.

Paul Kusserow (35:14):

Yes.

David Johnson (35:14):

So how we ultimately shift resources out of acute and specialty care into the types of things you're describing, I think it's the $64,000 question. We got a bunch of investors on this call. I need you to comment on valuations and what's going on in the market and does it make sense and is this a bubble, isn't it a bubble? What's your take on all of this market frenzy, the high valuation, all of funding flowing into healthcare? What does it mean and where does it lead?

Paul Kusserow (35:42):

Yeah. I also sit on the board of Oak Street, which has a huge valuation, I think justifiably so, and then Pure Foods and then Amedisys and we've brought our valuation up from, I think 400 million to five something billion or $6 billion now. I believe that, at least in my businesses, there's too much money in private equity at this point, they're justifying overpaying for pretty good medium sized companies to establish toeholds, so I believe this is the time to be an investment banker. The Bible says there will be lean years and there will be fat years. All you investment bankers, these are the fat years. And I think it's easy to know where to go. I think anything that drives efficiency within the system, anything that moves things outside of institutions, so that's where the government's going to go, that's where the payers go, anything that fundamentally helps an MA plan and also anything in Medicare, I think, is huge because that's the really profitable part of the payer world.

Paul Kusserow (36:41):

The other thing that's important is payers run the world now. In the eighties, hospitals did. It's now payers because they have the money and the information and the patients. We've living in a payer dominant era. You look at lifetime value of members, that's what we did at Humana all the time. How do you keep a member fundamentally out of an institution, in the home and take care of them through using more efficient techniques to make sure their care is monitored and they're kept out of institutions? I think that's where the world is going to. I think home health does that really well. I think hospice care is about a third of the cost of hospital care, maybe even less, and also people want to die at home, personal care, taking care of activities of daily living and social determinants, is very inexpensive for some of the things it delivers.

Paul Kusserow (37:33):

It's better to be lucky than good, as I always tell myself and everybody around me. We're in an extraordinarily good places. I also think ASCs, specialty ASCs, are going to be great places to play. I think the consumerization of healthcare, basically, there's not going to be enough caregivers out there. First,

I'd try to figure out how to grow more caregivers. But second of all, when I go out into the field and I go out into a patient's home, I always see family hanging around and they're never included in the care plan, but they all are out Googling it and understanding what does mom or dad have and then how can we help?

Paul Kusserow (38:12):

I think the AARP says there's over $70 billion in free care giving by loved ones. Yet, it's completely disassociated from the care plan, the care EMR, EHR, whatever it is, so I think there's going to be a much more melded deputization of non-skilled caregivers that I think is going to drive a lot of these outcomes, so that's going to be very interesting. How do you translate a lot of things because there will not be enough docs, there will not be enough nurses? It's going to be a real problem.

David Johnson (38:47):

Wow, that's so much to unpack there and we're getting a little bit close to time. I'm thinking about your thesis at Oxford on TS Elliott and his famous poem The Wasteland, where he said the world will not end in a bang, but in a whimper.

Paul Kusserow (39:03):

Yes.

David Johnson (39:04):

I'm wondering how you think the overbuilt, disconnected, fragmented US healthcare system will end? Will it be in a bang or in a whimper? How will we go through what will be a jarring transition for so many?

Paul Kusserow (39:21):

I also have another quote that I love as well from The Wasteland is, "I shore these fragments against my ruins." It's the king saying, "I got to build a collage out all this garbage sitting out there, how am I going to do it?" I think that's what we're going to do. I think the idea is there will be a significant deinstitutionalization of care. It will rely on more technology, it will rely on increasingly lower levels of acuity. If somebody's sick, they should have a great hospital to go to and that's necessary. You talk to the guys at HCA and they say, "That's what we do. The other stuff, that's not our world," so there is going to be that focus, but there's going to be a lot less beds. There should be a lot less beds. Look at the Contessa, what I just described to you. If we can use technology and really good protocols and bring in the whole group of people, we can drive costs out and then a lot of people out of these institutions.

Paul Kusserow (40:18):

Again, if you've been in a SNIF, that's the last place in the world you want to see mom or dad, so we do SNIF-at-home. How can we make that a reality? So I agree with you entirely. I think healthcare in the next five to 10 years, with the technology that's out there, particularly with the predictive analytics that are out, I think it's going to drive a lot of change and particularly pushing it out. But again, we're going to fractionalize and fragment, so I also think there will be care coordination opportunities for having the right people come in at the right time for the individual patient. I think there's going to be extraordinary opportunities there.

David Johnson (40:54):

Wow. Do you think we'll reverse this depress saying trend we're on where we spend more per capita on healthcare, but have lower life expectancy than other developed countries? Will this combination of forces, technological, social financial and just the native genius of American innovations, will that be able to combine in healthcare and give us a brighter future... in the way we really want it, right, which is we want a better, healthier population for less money? We want to be able to pay people more money. We want to be able to invest in more productive industries. And as long as healthcare is a bigger and bigger drag on the economy, it prevents us from doing that. Do you think we can make that kind of reversal, Paul? We're going to hold you to this, but-

Paul Kusserow (41:39):

Okay. No, my cynical view is no because I spend a lot of time in Washington and the most powerful people, and if I'm Congressman Paul, one of my largest employers is certainly going to be a hospital system and there's a lot of economics that are associated with that. So I look at that, I look at the amount of money going to hospitals and I look at their increases every year and I look at the cuts that are going on everywhere else, and I don't get it, but I understand there's a lot of political pressure. Eventually, the political pressure though will be so in intense, I believe, that it's going to break the Medicare/Medicaid bank. And at that point, I think then, that's why I say these fragments, that will cause things to explode and I think they'll reassemble in much less institutional, much less capital intensive areas.

Paul Kusserow (42:31):

Because again, it's a lot of its behavioral. I mean, 80% or 90% of all the issues are behavioral, so you don't need a building to change somebody's behavior. You just don't. I think the technology and the caregivers that are out there, the customization, the ability to use technology to customize care is where it'll go. I think what we'll do is probably leapfrog Europe and some of these other places because I think there will be blowups. Everybody looks at Geisinger and Kaiser and all these other places, they're anomalies, but the reason they work is they have both the healthcare providers and the insurers together. Marshfield Clinic, where we work with Contessa, is a phenomenal example that in rural health. I like those combinations because they very sparingly use their own hospital systems. Steward Healthcare for a certain while was a for-profit, a Cerberus deal, where they were doing that in Boston, which I thought was very interesting.

Paul Kusserow (43:27):

I hope CMS pushes more things out like ACO experiments, a lot of these things out there that really tries to say the hospitals are the brand, they're the hub. I think what ACOs tried to do is not have hospitals abuse the hub and I think what they did is abuse the hub. Because right now, hospitals are built as a catchment system. They own the docks, which pushes into the hubs and causes more expense, So that's got to be broken up.

David Johnson (43:51):

Yeah. Yeah. I guess we got to go to the health systems and tell them that payers rule the world. They must not have gotten that memo yet.

Paul Kusserow (43:57):

No, I... But they do. I worked seven years at Tenet and I worked five years at Humana and I loved both experiences being in the hospital business and providing care. But after I left Humana, I was convinced,

considering where healthcare's going, considering where patients are going, considering where demographics are going, we're in for a payer dominated world.

David Johnson (44:18):

All right. Well, usually at this point, Paul, I ask my guest for a big, bold prediction, but I feel like this entire conversation has been one big, bold prediction, so I guess I'll end by just asking you if you have one piece of advice to professional in the healthcare industry, whatever part of it they're touching, what would it be?

Paul Kusserow (44:42):

Well again, and I'm going to look like a nerd, but I was just presenting to my board our strategy and the first page in the strategy was a quote from the ancient philosopher, Greek philosopher, Heraclitus and it says, "The only constant is change." He also was the guy who said, "You never can step into the same river twice," and I guess the whole idea there is where there's change, there's tremendous opportunity. Where there's consistent change, there's consistent tremendous opportunity. I believe that with the economic forces that are going to try to do this, with the demographics that are pulling up, there will be tremendous opportunity to generate opportunities to bring down cost and I also believe that in long view there will be tremendous opportunity to aggregate care, and so we have coordinated care. Because in our business where we have most of our problems is when there's a gap in care, when somebody doesn't get picked up from the hospital and go into the home, that they have two days or so, which is rare for us, but then they go back to the hospital.

Paul Kusserow (45:48):

I think there's a uniformity that data can provide. And once you find ways to get people to want to participate in that uniformity, I think there will be some really interesting ways to really drive behavioral change. I'm excited.

David Johnson (46:04):

What I take from your big picture is [inaudible 00:46:06] to healthcare professionals of all stripes out there is go run and jump in the river, right? Go swim with the change.

Paul Kusserow (46:14):

Yes. Yeah. Follow the guide. Don't work against the current, but let the current take you along and you'll be phenomenal.

David Johnson (46:20):

The metaphor police are going to come in here any second. I told everybody it was going to be fun and it has been and we can't thank you enough. Keep slaying dragons out there, man.

Paul Kusserow (46:29):

It's fun. It's fun.

David Johnson (46:30):

Thank you so much.

David Johnson (46:31):

Wow, wasn't that great. Thanks for listening. Once again, that was Paul Kusserow, the dynamic CEO of Amedisys. We hope you enjoyed Paul and my conversation. I'll be back again next month with another great conversation with a Cain Brothers banker. In the meantime, stay safe, stay healthy and keep doing what you do to make our healthcare system kinder, smarter and more accessible and affordable for all.

The Many Roads to Value Part I: What is a Health System Supposed to Be?

In 2020, vertically-integrated tax-exempt health systems outperformed traditional health systems financially, and offered more evidence of the advantages of value-based payment models in an increasingly consumer-driven marketplace. Cain Brothers' Director David Levine talks with Dave Johnson about five models innovative health systems are pursuing on the road to value. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson (00:00):

Welcome to House Calls, where we talk to investment bankers from Cain Brothers, a division of KeyBank Capital Markets Incorporated. I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I coauthor a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry. For the next few months, we're going on a road trip with a series called All Roads Lead to Value. The first leg of that journey is titled, what is a health system supposed to be. My co-author David Levine is in the driver's seat on this piece. David is a director in the firm's health systems M & A practice. Welcome to House Calls, David, where the bankers are always in.

David Levine (01:00):

It's great to be here. Appreciate it, Dave, and look forward to the conversation.

Dave Johnson (01:04):

Yeah, we're going to have some fun. All right, David, let's talk about the Genesis of this article by starting with the title of our four-part series, All Roads Lead to Value. It comes from the old saying, all roads lead to Rome. In doing just enough research to be dangerous, we learned that that saying originated in the middle ages, centuries after the fall of Rome. At the time, the Maximus was actually a geographical reality. Most of the major cities and roads in Europe had been built by the Roman empire. One of the things I found fascinating was that to this day, those Roman era cities remain among the largest and most economically vibrant in Europe. And many of their major roads still do lead to Rome. So that just shows you the hold that history can have over us, even to the present day.

Of course, the saying now means that certain ideas or places or solutions are so central and inevitable that every decision you make, action you take or road you follow leads to the same destination. This is what's happening in healthcare. The concept of value is becoming all encompassing as the industry shifts toward risk-based contracting, greater accountability and consumerism. Providers,

notably hospitals, have built their business models on fee for service payment, which incentivizes volume over value. So the issue becomes not whether, but how health systems should adapt. So to start our conversation, David, let's pose a hypothetical question to hospital CEOs. I know it's one you like to ask. What is a hospital supposed to be?

David Levine (02:50):

It's a great question, Dave. And we've heard a lot of the industry, everyone talks about being at an inflection point. You know, this is the road to value is a long inflection point. It's been going on for a while, but we see investment after investment announcement across varying healthcare platforms, both from within health systems, external private equity firms and the like. And it's just begging that question over and over. What are hospitals supposed to do? How do we compete in this new world? The per unit costs are too high in the hospital settings, value pays for keeping people out of hospitals and healthy. So this question is really top of mind when we talked to a lot of our clients.

Dave Johnson (03:34):

Very well put, David. Interestingly, the COVID pandemic has turned out to be an accelerant in the shift to value. Tell us why.

David Levine (03:43):

So it's an interesting dynamic. Obviously COVID kept people away from the hospitals. And so it moved the idea of really caring, not for the disease, but for the person even more into the limelight. And that's really what happened during COVID. Hospitals and anything that the continuum of care really centered around, how do we care for the person and not the disease because no one was coming into those doors. The importance of social determinants of health, population health and the durability of integrated models, capitated payments games versus the fee for service historical model, which didn't work in that COVID environment, all those things really came to light.

Dave Johnson (04:24):

I know that you've done some deep research into volume patterns at traditional hospitals and hospitals with insurance plans associated with them. What did you find?

David Levine (04:36):

So we'll take a step back and kind of look at EBITDA margins and we'll just stick with that metric for a second because it's a pretty good indication of performance. But you can look at EBITDA margins across all health systems, health systems both with and without insurance arms and in 2020, for those that were all that not-for-profit health systems that had reported data on a revenue weighted basis, EBITDA margins were roughly in that 7 to 8% margin range, maybe a little bit lower for health systems with insurance arms versus without.

But when you strip out the care's dollars that all those hospitals and health systems received, the resulting EBITDA margin really stands apart. The ones with insurance arms, EBITDA margins fell to the around 6% range, so only about 2%. But hospitals and health systems without an insurance arm, their EBITDA margins fell almost 5%, if not more, depending on the scenario. So a real differentiation in performance. When you think about, as we move to a new value world, as you're incentivized to keep patients out of the hospital setting, if you think about the care's dollars as a representation of that, margins dropped dramatically for those that are not taking on that risk.

Dave Johnson (05:50):

Well, it makes sense, right? Because insurance comes upfront and per member per month payments. And obviously if you're doing procedures, payment comes for those as you do them or after the fact. So if you've got the upfront dollars to offset ups and downs in treatment volume, presumably you would weather a storm more effectively. But that longer term trend that you described, which is a declining need for procedures inside hospitals really speaks to a need to diversify revenue sources. So given that reality, how should health systems and hospitals adapt to the evolving market environment? In our article, we discussed five quote unquote roads to value. The first of those is regional consolidation. Tell us about that strategy and why it makes sense for some health systems.

David Levine (06:50):

Yeah, absolutely, Dave. It's a great question and I think probably best described through an example. So if you think about a recent transaction that was announced with HCA, some or a few of their hospitals in the Georgia market to Piedmont, that one really highlights this trend. So HCA is among the nation's most efficient hospital operators and they do a great job, but they tend to exit markets where they lack sufficient scale to compete effectively. And there are regional health systems like Piedmont who have a strong market presence, and they're the ones who are buyers for those types of hospitals. And they look to increase their regional scale and that increases Piedmont's ability to undertake and manage those risk based contracts. You become a more efficient operator as you have more scale in a given market. There's obviously advantages with local payers and just the overall ability, again, as we move down this road to value, to take on more of that value element and that risk as you have more and more of a presence of any local one market.

Dave Johnson (07:54):

HCA certainly knows what it's doing. They actually made so much money during the pandemic that they gave back their care sellers, which almost no other health system, certainly not many, maybe not any not-for-profit health systems did. So let's talk about the second road to value, which is health systems that desire to directly embrace risk-based contracting. They do this either by acquiring or affiliating with a health insurance plan. Let's dig into that. Give us some insight.

David Levine (08:31):

Yeah, absolutely. If you think about health systems, you know we talked a little bit about margins for health systems with and without an insurance arm. And there are a number of health systems. Take for example, Sentara with large Virginia based health system. And they have a fairly sizable insurance arm called Optima health. And they've been in that business for quite some time. There are a handful of other health systems around the country that have been in the insurance industry for quite some time, taking on that element of the healthcare continuum and that portion of the risk. And so there are those that are in the business today and continue to do well and have to adapt as the world changes. And then there are those health systems that are getting into the business for the first time in different ways. As we talk about the road to value, obviously everyone zeros in on Medicare Advantage.

So let's stick with that for a second. You look at Medicare Advantage, take a health system like Cone Health in the Greensboro North Carolina market. They took the ownership route. They developed their own Medicare Advantage health plan called Health Team Advantage. And they've been doing a great job in that market. That's one path. Other health systems, and we can stick with the North Carolina market, take Duke. They formed a joint venture with Blue Cross Blue Shield of North Carolina to form Experience Health. And that's a new Medicare Advantage plan jointly owned by both of those,

Duke health system and Blue Cross Blue Shield, North Carolina, to offer that product in that market. Or take a third way, maybe a little sort of a step back from that and more of a co-branding element, take Montefiore in New York and Oscar Health. And they've co-branded a Medicare advantage plan in that market. So there are a number of different ways that health systems are doing that, all with the mindset of looking to embrace risks and take it head on as this world changes to value.

Dave Johnson (10:22):

Really good point. There are many different ways to take on this type of contracting risk, but at the end of the day, all the roads lead to some form of vertical integration. And you see with some companies, Kaiser Permanente, for example, they're actually more health insurance company than they are a delivery system. So we're seeing it from the other side too that health insurance companies, particularly traditional health insurance companies, are figuring out how to provide care so they can sort of play in the vertical integration game as well. So the market really is coming at risk-based contracting from both sides. So road number three is one where health systems employs strategic partnerships to enhance their service platforms. This strategy provides a rationale for the diverse range of joint ventures that we're seeing in the marketplace. Post acute care to home health, to food and nutrition, to telehealth and so on. What's going on?

David Levine (11:22):

Yeah, this is an interesting one and one that I know we've talked about before. But as you think about value, in order to help manage that person, that person is not just coming in for one type of thing. You have to manage across the entire continuum of care and no health system, in our experience that we've found to date, does everything across the continuum of care in the best possible way. There are companies out there that do provide certain areas of care across that continuum. They are experts. That is their sole focus. Their sole purpose is to provide that level of care across certain sub verticals within the continuum of care. Take urgent care, take home health, for example. There are operators like AccentCare who recently formed a joint venture partnership with Fairview Health Services up in the Minnesota region. Large multi-billion dollar health system. They have their own home health and hospice business line.

As a multi-billion dollar health system, they can't focus on everything and the smaller business line that they have for home health and hospice is such a core element of caring for a person in that value based world, but that's wasn't their area of expertise. So they sought out a partner who's sole focus was home health and hospice, and they aligned that partnership with AccentCare. On the urgent care side, similar situation, just different industry, Trinity Health. Trinity Health sought out an urgent care partner whose sole focus is that sub vertical. And they formed a partnership with Premier in the urgent care space. And that's what we see health systems doing. Advocate Aurora recently made an investment in Foodsmart on the nutrition side, or Senior Helpers also in the home health side. They're looking to partners who have an expertise that the health system doesn't have for that level of care in a value-based world.

But to loop it all together, you need that clinical visibility across that continuum. So if you don't have the area of expertise in one service line, you find the partner that does, but you wrap it around your full continuum of care. So you have that visibility across the patient, across that person, across that covered life so that you're able to provide that value based care. And that's really an interesting thing that we're seeing more and more of as we progress in this kind of environment.

Dave Johnson (13:37):

Well, it just makes so much sense, right, David. But it's not really a new strategy except to healthcare systems who have traditionally wanted to be all things to all patients, but are discovering they really can't do that. You know, for example, when I go into our local Target store, what do I see? A CVS pharmacy. Target got out of the pharmacy business and partnered with CVS because CVS was better at it and then ends up being just a great thing for both sides. And I think health systems are waking up to the fact that it's better to divide and conquer and have companies be a part of your platform in a cohesive way so you can do a better job for customers. Why not? Like Target did what it did with CVS, why shouldn't health systems do the same thing for their customers? It brings us into this whole concept of brand. And as you move into the consumer oriented businesses, brand becomes intensely important. So let's talk about what a brand does for a health system and how do brand aware companies use their new service offerings to strengthen their market positions?

David Levine (14:48):

Yes, it's a great question, Dave. And I think it kind of crosses over into the area that we just explored around having partners that provide certain areas of expertise, but when you elevate that discussion, it's what am I? What am I as a health system to all those around me? And that's really that brand component that you just brought up. What is my organizational identity, if you will, and how does that get communicated to our customers? What's my value proposition in a consumer based world? And it's got to be consistent and seamless across my entire platform. And obviously, the bigger the platform, the harder that is to implement. But it's just so important to ensure that there is that consistency across the brand. So if you go out and find a partner, you want to make sure that they're still delivering on that brand that you have in your marketplace.

Let's take an example again. The Cleveland Clinic. They spent a long time and a ton of work around their branding and how they distinguish themselves on a truly global basis, not just in the US healthcare, but around the world. And it's backed up by time and time again proven practices. And I think that that's such an important element. They've established themselves as "a patient's first brand" emphasizes their clinical expertise. So when you think of Cleveland Clinic, you automatically think of clinical expertise providing complex care solutions, and they've developed that brand over time. And I think that that's going to be such an important element in that road to value. When you think about consumerism, you think about brands.

You mentioned Target just a second ago, Dave. They have a certain brand recognition in a certain market and that's what more and more health systems are going to be doing. And then as they take on partnerships, so the Cleveland Clinic on a digital basis partnered up with Amwell, a Boston based telemedicine company to launch that digital health platform, but they need to do it in such a way where it captures, it continues the brand that the Cleveland clinic has established. So we're going to just see more and more of that as we move into more of a consumer-based world.

Dave Johnson (16:47):

Wow. So much to unpack there. I amplify what you're saying, David, by saying that when you've got a great brand, it not only answers the question, what are we, it also answers the question, who are we. It provides a why, as well as a what. A purpose for the organization. So when you were describing the Cleveland Clinic and everything they've done to truly put patients first, it becomes almost a guiding principle for people on the front lines to determine, okay, what should I do? Well, we always put patients first. What does that mean now? And it works its way back bottom up through the entire organization and becomes a self-reinforcing principle, incredibly powerful. And I think too many health

systems have been in the what business and not in the why business, despite a lot of very lofty statements of purpose and mission and so on.

Our final road to value, David is one where health systems established themselves as segment experts. For example, MD Anderson has become synonymous with cancer care, not only in their home Houston market, but as they partnered with other health systems outside of Houston. Why don't you talk a little bit about that segment expertise strategy and give us maybe a lesser known an example or two of how that is manifesting itself in the marketplace.

David Levine (18:18):

Absolutely. So I think that me being based in New York, it's more known to me, maybe a little bit less known nationally, but they certainly do have a national reputation. That's the hospital for special surgery in New York that's built a gold-plated reputation for providing very, very high-end bone injury, joint replacement, orthopedic type care. And it's really become a destination for that type of orthopedic care. And I think as we talked about this whole theme around the road to value and that you can't be everything to everybody. And so one of those options in this road to value is, let's be something really specialized to those that need it. Let's be something for somebody, not everything to everybody. And that's what I think some of these health systems that have that certain area of expertise, we'll see more of them move and really just zero in on that. In this value world, let them be that expert. And so I think that that's just another path on this road to value that somehow that some health systems may take.

Dave Johnson (19:16):

My favorite segment expert is the Shouldice Hernia Center in Toronto. They have become the world's experts on hernia treatments to the point where they have reunions for people that got their hernias done at the same time and so on. And so when you think of hernias, you think of Shouldice. And how powerful is that, when you're the hospitals for special surgery. Joints R Us or MD Anderson as the leader in cancer care, you automatically have goodwill built in the marketplace that steers volume your way. And again, it's back to our last strategy. It often provides a why both for yourself and for those looking to purchase your services in the marketplace.

Awesome. Well, we've taken five roads to value. We're not saying these are the only roads to value or that they're exclusive. In fact, most health systems will employ a combination of these strategies. But what we are saying is that it's time for hospitals and health systems to proactively reposition themselves to compete in markets shaped by consumerism, price competition, and value based metrics on outcomes, cost, quality, and consumer experience. Hospitals and health systems, providers overall, need to be much more accountable for the care that they deliver and the prices that they charge for that care. How do you think hospital CEOs should frame this strategic debate within their organizations to move it forward and achieve a positive result?

David Levine (20:51):

It's a great question. And I'll frame up a few questions that I think we're hearing, we're talking to some CEOs and how they're thinking about it. And again, there's no one answer. There's no one size fits all. But CEOs, boards, they need to be asking themselves, what are we really good at? Who are our customers? How can we improve patient access and outcomes? What legacy are we building from and towards? It goes back to, you mentioned the mission elements a lot of these health systems have. Mission is so critical in the health system world that we live in. Eat, live and breathe, non-for-profits, they're all about mission. That's what drives them. And so you think about that. You think about what legacy, what's their mission that they're building off of? What roads are already there? Historical and

new roads that they're building, what are the relationships to the patients we served? How do we align their purpose into value, and ultimately accelerate this transformation that we're seeing.

It's obviously taking a lot of play out on the road to value, but as I mentioned early on, investment after investment, announcement after announcement that's being made in the healthcare space is just pushing this more and more towards this value based world. And so I think we're going to see more and more of that. And so these are some of the questions that I think hospital CEOs need to be thinking about as they explore their options.

Dave Johnson (22:11):

I'm so glad you brought up this concept of mission. I think the worst thing an organization can do is say it does one thing and then actually do something else. So, many health systems say they put patients first. I actually believe that Cleveland Clinic really does, and that's incredibly powerful, but many say they put patients first and actually don't. They're chasing volume or looking to optimize margins or it's not doing ultimately what's in the best interest of the patient. And I think what the road to value ultimately means for the healthcare marketplace is doing what's right for the consumers of health care services in America. And in many ways, we've ended up with the system because of the perverse price incentives that optimizes revenues to some extent at the expense of patient care.

And that just can't really happen anymore. We ultimately have to do the right thing for consumers. So when we're talking about value and consumerism and risk-based contracting and accountability, partnerships, all these other things that we've discussed, there are many ways to get to the final destination, but that destination is value and is truly serving your consumers in the best way possible. But I can't let you get away without asking you particularly given the discussion we've just had to give us one bold prediction for the coming year or beyond in healthcare. What's something you're seeing that maybe others aren't?

David Levine (23:48):

My wish my prediction could be that we see all the health systems taking road A, B, C, D or E but that's obviously not going to be the case. I'm not that much of a fortune teller to say that's the road that we [inaudible 00:24:00] obviously a number of options in front. But I do ultimately think that with the disintermediation of fee for service and value based care, it's going to cause continued consolidation in the hospital industry. That's not the bold prediction, but maybe I would say the top 25 health systems, they're going to control I think more than 75% of the revenue that's generated in that hospital setting within the next 10 years. I see that happening. Whatever road health systems decide to take, ultimately we see a further consolidation and there's going to be fewer and fewer major players and those major players are going to be controlling more and more of the revenue that's generated in the hospital setting.

Dave Johnson (24:39):

Do you think we'll see the emergence of truly national health systems as this consolidation unfolds?

David Levine (24:44):

I think we will. There are those that exist today. And I think that they'll continue to be more and more of it, especially as you can bring on operational expert partners for specific things. You can then set focus on bigger picture things, elevate the discussion at the executive level and focus on really, how do we provide all of this, this road to value? How do we provide the best patient experience across our

platforms, which involves so many other component parts to it? I think that's why we'll just see more and more of that at the national scale.

Dave Johnson (25:19):

I think you're right. But as that happens, it's going to break down what I believe is a myth that all healthcare has to be local. It has to be delivered locally, but there's nothing that prevents a national system from standardizing procedures in such a way that they can deliver great care in local markets all over the country. We certainly see it in so many other aspects of the American marketplaces. So I think it's going to come to healthcare too, and we'll see some other myths probably destroyed along the way as well.

Well, David, I can't thank you enough. This has been a fun, wide ranging discussion. I'd encourage our listeners to read the article that supports this discussion. What is a health system supposed to be? In the next three articles and podcasts from this series, we will explore how other industry segments are making their individual road to value journeys. In the meantime, stay safe, stay healthy, and keep doing what you do to make our health system kinder, smarter, and more accessible and affordable for all.

Medicaid, Motherhood and America's Future: Giving Birth to Better Maternity Outcomes

Medicaid funds almost half of all births in the U.S, yet the overall maternal mortality rate is dismal. Cain Brothers' Christian Pesci and Women's Health USA's Andrea Balogh join Dave Johnson to discuss innovative models and value-based reforms that are improving care quality, safety, experience and cost for millions of new mothers and their babies. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson:

Welcome to "House Calls," where we talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets, Inc. I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of "The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All." I coauthor a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry. This month, we're discussing maternity in the Medicaid population. In ways large and small, Medicaid babies are America's future. For the most part, aggregate statistics relating to Medicaid births in America are dismal, but there are pockets of great practice and promising innovation. That's where we'll turn our attention today in this podcast. Our article is entitled "Motherhood, Medicaid and America's Future: Giving Birth to Better Maternity Outcomes." My coauthor is Christian Pesci, a managing director in Cain Brothers's corporate M & A advisory practice. We're also joined by Andrea Balogh, division president and general counsel, Women's Health USA. Welcome to "House Calls," Christian and Andrea.

Christian Pesci:

Good morning.

Andrea Balogh:

Good morning.

Dave Johnson:

Here are a couple of facts that were a surprise to me, and I think a surprise to many readers and listeners, too. Medicaid covers almost 50% of babies born in America. At the same time, America ranks last among the world's richest nations in maternal and infant mortality. In fact, America's maternal death rate is twice as high as the next closest affluent nation. That grisly statistic doesn't come near to capturing all the harm created by premature birth, low birth weight babies, and inadequate pre and postnatal care. So my first question for both of you is why does that happen in America? Andrea, why don't you start in setting the stage for our listeners, and then Christian, you can follow up.

Andrea Balogh:

Sure. I mean, I think there are a number of reasons why this occurs. The buzz phrase that everybody says, there's the lack of access to care, but I think it goes a lot deeper than that. There is care available at every level, but it's not well coordinated. And I don't think that as a country, we've done a good job of figuring out the best way to reach every patient where they are. And by that, I mean that every patient has their own set of unique challenges, particularly in a Medicaid population, that may not, for instance, very simply be able to get time off from work to go to the doctor. They may not have a ride to get there. They may not have childcare to watch their child to go to the doctor. And these simple things need to be solved in order to ensure that women get proper prenatal care, which will have a positive impact on improving those rates. And that's something that as a country, we really need to work towards.

Dave Johnson:

Christian, anything to add to that?

Christian Pesci:

Yeah, I completely agree with Andrea. I mean, it's about prevention, right? And doing that early is what will reduce costs of the system going forward.

Dave Johnson:

Yeah. And drive better outcomes, right? Because the future, we want healthy babies that can achieve their highest potential in the country. So that's helpful context, and Andrea, as you said in our article, which I thought was a very, very powerful quote, "Pregnancy is not a disease. It's a natural part of life. We have to stop paying for it like it's a disease." What do you mean by that statement? And how does this quote unquote disease mindset shape the care given to Medicaid mothers and babies? And what does it say about how the American healthcare system chooses to allocate resources for Medicaid obstetric services?

Andrea Balogh:

I don't think we've done a good job as a country, really, figuring out what pregnancy care should look like. Doctors are reimbursed on a fee for service basis, whether they're paid one uniform rate for the

entire episode of care, but there's a total lack right now of coordination between the obstetrician... We don't bring social workers into the mix to be able to attack those social determinants of health that make it very difficult for people to access care. We don't yet have a system where physicians, hospitals, and all specialists that are involved in the care are sitting at the table together discussing and developing a coordinated system of care.

Right now people are just reimbursed for providing the care, as opposed to saying, "All right, what does the pregnancy episode entail? What challenges does each patient face? How do we attack those challenges and ensure that they're getting the care that they need, and that they are accessing care at the right times and in the right setting to ensure the best possible outcomes?" And so we can't treat pregnancy as if it's cancer, and you only wait until something acute has gone wrong before you call the system. We need to be reaching out, coordinating that care, bringing everybody into the mix and figuring out what patients need, rather than just assuming that they'll contact us when they need care.

Dave Johnson:

Andrea, maybe we could follow up on that a bit. I want to talk about the money, because in many respects it feels like there's more than enough money in the system to do the type of coordinated care that you're describing. A lot of it goes to neonatal intensive care units, and very expensive procedures related to complications at birth, and so on, many of which would disappear if we did a better job on the coordination. So talk to me about the money.

Andrea Balogh:

We've got the payers on one side of the table, and the providers on the other, and in each of those conversations, depending on which provider it is, are unique conversations. So a payer will first have their discussion with the hospital system to say, "All right, here's your reimbursement for the following procedures. Here's what you get reimbursed for a NICU stay in neonatology," et cetera. They'll have a separate conversation with the obstetrician to negotiate what they'll be reimbursed, but nobody ever sits together at the table and talks about what the total cost is, what's involved at each and every stage from diagnosis of pregnancy all the way to 60 days, to 120 to a year postpartum, where you would be bringing in a pediatrician. There isn't a venue yet where everybody is sitting down and discussing, what does each element of this cost?How do we deliver better care? How do we take costs out of the system? And how does everybody benefit from that?

And how do we reward each person, each entity in this process in this care compendium to be thinking about quality, access, and lowering costs? Everybody's incentives need to be aligned. There's a lot of work being done right now by different companies trying to do that, but we're just not as far along as we should be. And the other thing that I think never gets thought of are social determinants of health. How do you bring a social worker into the equation so that when you're in particular talking about that Medicaid population, that a social worker who is far better equipped than a hospital system or even a physician, is out there reaching the patient and trying to take away the barriers that they have in terms of accessing care appropriately and figuring out what it is that's going on at home that might lead to a bad outcome.

Oftentimes it is food insecurity. It is living in an unsafe or unclean home environment. These are things that lead to complications at birth and lead, also, to hospitals having concerns around discharging a baby to a home environment that they know may not be safe or clean. So how do we bring social workers and community health workers, all of whom have allocations from the state, whether it's the Medicaid agency or some other agency within the state, that wants to help? Everybody's got a lot of money to throw at this, but until we're all sitting at the same table with the payers, whether it's a state

Medicaid that's paying, managed Medicaid, or a commercial payer, until we're all sitting together as the care provider, the social work providers, and the payers for this care, we're not going to be able to solve the problem.

Dave Johnson:

Yep. Such a great, great point. All the emphasis goes to the component parts in a separate and independent sort of way, without the focus on the desired ultimate outcome, which is a healthy baby and a healthy mother.

Andrea Balogh:

Everybody's got to be comfortable, too, sharing information with one another. It shouldn't be mysterious or voodoo what the hospital costs are, what the OB's costs are, what the NICU costs are. Everybody should understand every element of it. And that's a technology challenge that there are plenty of companies out there that thought of how to solve it, are ready to solve it. But everyone has to get comfortable with the notion that the data needs to be transparent so that everybody can say, "This is what I can add to the mix of making this better."

Dave Johnson:

Yeah. I think this is a good point to shift the discussion away from the problem, which I think we've done a nice job of defining, toward what some of the solutions are. And Christian, why don't you tell us why maternity services are so appropriate for value-based payment strategies that focus on better outcomes ultimately? Tell us what you think.

Christian Pesci:

Yeah, look, I mean it's insane. When you look at it, CMS has a goal to convert half of Medicaid and Cura services to value based reimbursement by 2025. And we're a pretty long ways away from that happening. When you think of an event like maternity, that's something that could really move the needle in the right direction, is people look at value-based care, particularly around Medicare Advantage side. I have a massive pool of people, I have a defined event, I have a life period, and they're not changing jobs. So I get to control them for this entire period of time, and I have enough information and data around to influence behavior and reduce costs of care, and drive to lower cost settings. When you look at women's health, you have a massive amount of Medicaid births, half of all the births in the United States are from Medicaid mothers. Now, the question is, how do you get in front of that population?

I'd love to hear Andrea's view on it. Everyone always talks about what are technology that can fix things, but it's really sort of simple blocking and tackling to help manage it. You've got this massive population, you've got a defined event, and you have the ability to shift costs from unnecessary over-utilization of certain services during pregnancy. Then you look at the timing of it as it relates to getting in front of that birth, and getting in front of that mother, so that the first time that they're not interacting with the healthcare system is when they're seven months pregnant showing up to the ER. I think that's a big thing. And then if we're going into the hospital setting, the ability to shift to lower cost setting, healthier births and lower risk pregnancies that can be done in a birthing center, then thinking about the unnecessary use of NICUs for healthy babies.

There's so many pieces that fit in terms of being able to handle this and shift this to a value-based environment, the tricky thing is how do you connect that from the physician prehospital through the hospital. And that's going to take really solid coordination around with the hospitals, the payers, and

the physicians. And we're not there yet, but at least as you think about sort of the different steps along that risk pool and that opportunity, you can at least control the upfront with the physician. The big question is going to be how do you shift that focus? So when they're going to the hospital, there's a real comprehensive view of not just obviously focusing on getting the best outcome, but making sure that you're doing it in a cost effective manner.

Dave Johnson:

Right. Good points, Christian. Andrea, this isn't a theoretical question for you. You live in this world every single day and your organization, Women's Health USA is on the front lines, putting in place the very kind of coordination and information sharing you were describing, so that Americans doctors can deliver babies more effectively. So talk to us about your company and what you do and the experience and the successes. They're impressive.

Andrea Balogh:

Thank you. Women's Health USA formed back in 1997. We are a management partner to women's health practices around the country. And we're partnered with practices back in the East Coast and also in the Southwest, where I currently reside. We've spent a very long time building our organization and working with our physicians to help them deliver the best care possible. Our goal is to remove all business impediments to the physician in terms of how they run their practice, so that they can focus simply and solely on the quality of care that they deliver to their patients. And we work with them in terms of figuring out what's the best way to reach their patients. How do we change and evolve with the population as it's evolving? How do we meet our patients now on social media, and provide them with the information that they're looking for there? For many of our physicians, they're just starting to understand that younger patients are looking not just to be able to make an appointment on the internet at 2:00 in the morning, but to get some information. How do we provide and put information in a user-friendly manner into patients' hands that demystify any sort of women's health, medical care that they're looking for?

How do we ensure that as our practices grow and evolve over the years, that we're bringing in physicians and care extenders, mid-level providers that match what their community looks like? How do we make sure that the providers that are servicing our patients look like our patients, and provide that warm and safe environment that is necessary. Oftentimes people are scared of physicians, and they don't access care because they're afraid to bother the doctor. How do we solve for that? We've spent a lot of time thinking about that recently. Do we bring in care coordinators so that there are more affirmative reach outs to our patients to see how things are going? How did the visit go? Is there anything, any complications, anything that you forgot to ask? Let us get that information back to you. If you're not feeling well, you don't have to wait until 8:00 in the morning the next day when the doctor gets back in the office. Call at 9:00 at night, and somebody will pick up the phone. Come to one of our urgent care centers when you're not feeling well, don't dial 911.

Don't go to the ER, there are better ways to access the system. Call us. You're not bothering the doctor. If you feel like something is going wrong, we will get you in. We will make sure you have a ride. We will make sure someone is there to watch your children. We spend a lot of time just really thinking about how do we remove those impediments and reach our patients where they are. We've talked about other things, like for some of our large employer groups, where their employees are accessing our physicians for care, what do we do in terms of perhaps setting up clinics onsite? Can we do belly checks in a conference room to see our patients if they only have a 15 minute break and they can't take two hours out of their day to come to the office?

There are a lot of things that we spend a lot of time each and every day thinking about, and working with not just our physicians, but the payers in the community and starting to work with the hospitals as well to improve that care. We've had tremendous success in all of our markets, and I think we will continue to grow with this model. Our physicians like it, they went into medicine because they want to heal people. They want to help. Obstetricians love to deliver babies. They love to deliver healthy babies. There's nothing more joyous in the world for a physician than to bring a new baby into this world and see the smiles on the faces of their patients and their family. That's the whole game for them. And we've got to continue to remove any barriers for our physicians that get in the way of that, that get in the way of the patient coming in and achieving that outcome that they so desperately want. It's a lot of hard work, but it's a lot of gratifying work.

Dave Johnson:

Yeah. Good for you. Proactive, hands-on, holistic, patient-centric, and the good results just follow. Really, really impressive. Christian, we also featured the OB Hospitalist Group in our article. Talk to us about how they're improving the quality and safety of hospital deliveries.

Christian Pesci:

Yeah. So OB Hospitalist Group, or OBHG, is really just innovative, super interesting company. CEO there, Lenny Castiglione, is very impressive and has just really differentiated that business. I mean, there's really no one else out there like them. And they took what was a real problem that health systems are having, and built a very large business around it. OBHG, I mean, their focus is really ensuring that high-risk maternity patients receive consistent quality care from dedicated hospital-based OB/GYN. So today they're in over 33 states, 200 plus hospitals, and over a thousand physicians, and it's the largest employer of OB/GYNs in the country. Traditionally, nurses are the first line of maternity care for expectant mothers who arrive at the hospital, and the focus then is nurses communicating with the OB/GYNs to make sure that someone's in here, delivery is imminent, you need help.

So this way, every patient coming in, they're seeing a highly trained OB/GYN whose focus has been around managing more complex births and emergencies. And so hospitals have really turned to OBHG, not just for the more complex patients, but really potentially for all labor and delivery patients, because they've been able to show that, "Hey, we improve quality. We improve patient experience, and we're reducing costs for the hospital." So really interesting company that's continuing to gain traction as health systems continue to look at how do I partner versus employ necessarily to really drive the best outcomes?

Dave Johnson:

Terrific. And the results are what you'd expect, fewer complications, healthier babies, fewer issues with the mother postnatal, and so on. The other group we featured in our article, Christian, was Erie FQHC, Federally Qualified Health Center in Chicago. And like the two other companies we've discussed, their focus is also on how do we drive the best outcomes? And they do it from a community-based health center perspective. So they were originally founded on the west side of Chicago to help immigrant populations. And over time have become one of the largest companies managing births in Illinois, not just Medicaid births. So they look at their operations from a holistic perspective. They try to get actively involved with the mothers in their prenatal care, manage their process throughout birth, and then after birth and help the mothers and now the new baby, become permanent members of their health system.

They work with large hospitals, like Northwestern here in Chicago, where they have physicians on staff to provide some of the later stage services like OB Hospitalist Group. And it's just very

impressive to see an organization living within the Medicaid payment scheme, which is terrible in Illinois, no other word for it, really, but able to marshal resources in a holistic way so that they can do the types of things that Andrea described. The care coordination, have the focus on the mother, getting her what she needs, solving her problems, and taking that all the way up through birth and afterwards. So yet another good example, and if we get enough of these popping up around the country, we can actually, I think, shift the direction and begin to reverse these Medicaid statistics relating to motherhood and birth that we talked about at the beginning of the show. Christian, last question, before we go into our wrap up round, tell us about how technology is helping to make better maternity care possible.

Christian Pesci:

I'll start off, and I want to get Andrew's views. Andrea lives it, versus I just study it and work around it and listen to people talk about it a lot. When you think about the right way to leverage technology within healthcare, think of it as combining technology with care delivery, in a sense of does something increase access? Does it improve the navigation of care? And then, how does it help in terms of driving to better outcomes? And then, in turn, lowering costs? Within the maternity episode, let's start at the top, right? How do you identify within the problem? How can you leverage technology to make sure that you know what's happening, so you're not discovering that someone's pregnant six months in, right? So what are the tools and technology that can drive that? And then within that, in terms of navigating care, I think it's easy.

It's simple technology, right? Everyone's got a phone these days. It's how can you send automatic updates? Hey, have you done this? Have you seen the doctor? Have you checked this? Have you taken this medication? Just sort of simple reminders. And we're seeing this across everything, not just within maternity, that helps just stay close with that patient and guide them along the path. And to me, I think that's really where it is, but Andrea, I'm curious your view. I know we've talked about in the past, but it's not just technology alone, right? We need to have social services, particularly as you think about Medicaid population, combined with that. So I think you can use the technology in the front to identify and then help sort of support. But this is still a very human interaction situation to reduce the cost.

Andrea Balogh:

Thanks, Christian. I mean, technology is important. It does, as you say, help identify issues. But what needs to happen is that the technology needs to be utilized, right? The doctor needs to get that information fed back to them to say, this is what's going on with the patient. And the patient needs to be encouraged to utilize the different technology resources that are provided to them. It is all well and good to develop wonderful apps that patients can access. But I think what really needs to happen with those, is those need to be explained to the patient and why it's important to access the app by someone in their physician's office, whether it's the physician themselves or a nurse practitioner that's assisting with the provision of care. The patient needs to understand, and it needs to be demystified for them, why we're asking them to check in on an app or to use things like some of the remote tools that are being developed now, like remote fetal monitors.

I don't think you can just as either a payer or a technology company, send that to a patient in a box and expect they're going to be able to utilize it. The physician needs to be brought into that conversation, and needs to be an advocate for that so that if I'm pregnant and I'm going to the doctor's office, I will trust my doctor. If he says, "Look, Andrea, we want to get some better monitoring of what's going on during your pregnancy. I'm going to take this tool out of the box, and you and I are going to go through how you use it together. And I'm going to show you how easy this is to use, and I want you to

try it before you leave the office. And I want to show you the information that it transmits to me as your care provider, so that I know what's going on."

If someone demystifies this particular element of technology for the patient, you have a much greater chance that the patient is actually going to use it. So it goes back, I think Dave, to kind of the early parts of our conversation of care coordination, and really making sure that we're not just throwing things at patients and assuming that they're going to use it. We're not just grabbing data and assuming that it will be helpful, but we're figuring out how do we make the patient comfortable with the information that we're asking them to share with us, with the technology that we're asking them to use? How do we use that data to go, "Okay, there must be something going on at home that is causing whatever I'm seeing, low birth weight or failure to thrive, whatever it is. I'm using that data, then, to send a social worker out, to go check out what's going on at the home, and working then with their resources to solve for the problem." It really does come down to, I wouldn't say simple coordination because coordination is hard, but I think technology brings an important element to it. But as Christian said, it doesn't supplant human interaction, which is really the crux of medical care. It always has been. And it always will be.

Dave Johnson:

You both made that point very articulately, that the relationship with the patient is first and foremost, and if there's trust and engagement, then the technology can augment the experience for everybody. If there's not engagement and trust, then the best technology in the world won't necessarily improve the outcomes. So you really have to do both, and probably first really work on that relationship part of the equation so that everything else can fall into place.

Well, I got to say what a great discussion. When you just think about the sheer numbers of half of the babies being born in America being funded by Medicaid, there may not be a more important issue in healthcare in terms of trying to improve our statistics, to make sure the highest percentage of these babies get off to a good start in life so that they can become productive members of society and reach their full potential. So I really want to thank you both so much for shedding light on this issue, which is right before us, but I don't think gets anywhere near enough attention. So thank you. But before I can let you go, we have a tradition here on our Cain Brothers podcast of asking our guests to make a bold prediction for the future of healthcare. So Andrea, we'll start with you. Make your bold prediction on what do you think we're going to see in healthcare over the next three to five years?

Andrea Balogh:

With so many people leaning in on this issue and so much desire to solve it, I believe that we have the right people involved. We have the will to solve it, and I think that if we all have the patience to recognize that there isn't a five minute solution to this, that with all of the smart people thinking about this, with all of the passion around the issue, and with all of the economic support to solve the issue, we will get there. And my belief and my fondest hope is that we get there in less than five years.

Dave Johnson:

Awesome. Christian, what's your prediction?

Christian Pesci:

I don't know if this is a bold prediction or not, but in order to be successful in a value-based world, you need scale. And in order to have scale, you need this coordination. You need to have all the tools. I think you're going to see it just a continued acceleration of consolidation within the industries, but not just

within doc groups merging with other doc groups, but really going fully vertically integrated. We're talking about this, health systems have been evolving over the years, and I think it's just going to continue to happen in a value-based world, where you look at these massive towers that are being built, and just the amount of money that's going into care for the sick.

I think you're going to see the continued outsourcing within those hospitals, where it's almost like large retailers today, right? You walk into whatever, you name it, fancy department store, and it's little pockets of people operating within that of other folks. And I think that's the right way it should be. And I think you're going to see that from the health systems, and I think they're going to be more fully integrated on the value-based care side of things. And the only way they can do that is really by partnering, versus being the ones employing and owning, and...

Dave Johnson:

Well, I hope both of you are right, because staying on the status quo path is not a desirable outcome for the United States of America. I'm taking optimism away from our conversation today, and encouraged by the companies that we featured in this article that are on the front lines of improving the quality of the birthing process all over the country. So let's hope they get bigger and have better outcomes. So thank you both, Andrea and Christian, for sharing your insights today. I encourage our listeners to dig into the article, "Medicaid Motherhood and America's Future: Giving Birth to Better Maternity Outcomes." It's worth your time. And in the meantime, stay safe, stay healthy, and keep doing what you do to make our health system kinder, smarter, and more accessible and affordable for all.

Stigma vs. Science: Overcoming Opioid Addiction with Evidence-based Treatments and Services

Though the COVID pandemic dominated headlines, substance abuse and opioid-related deaths spiked dramatically in 2020. Cain Brothers' Director Erika Haanpaa talks with Dave Johnson about the distinct challenges of opioid addiction and new treatments and services creating hope for a better future. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson (00:00):

Welcome to House Calls, where we talk to investment bankers from Cain Brothers, a division of Key Bank Capital Markets, Inc. I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I also co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry. This month, we're exploring America's ongoing opioid addiction problem. Recent CDC data reveals that addiction and overdose deaths actually have worsened during COVID. Given this grim reality, we have focused our attention on advances in opioid addiction treatment that show great promise. Our article's title is, "Stigma Versus Science: Overcoming Opioid Addiction with Evidence-based Treatments and Services." My co-author is Erika Haanpaa, a director in the firm's M&A practice. Welcome to House Calls, Erika, where the bankers are always in.

Erika Haanpaa (01:11):

Thanks, Dave, it's great to be here.

Dave Johnson (01:13):

Well let's jump in to this topic. Before COVID, most considered opioid addiction, overdose, and death, to be America's biggest health crisis, then COVID arrived, and it was almost as if everyone forgot about opioids. Let's start with the current state of the opioid addiction crisis. With the new CDC numbers, how bad was 2020 in terms of addiction trends and overdose deaths?

Erika Haanpaa (01:39):

It's really a problem that has gotten worse over the timeframe of COVID. We've gotten the data from the CDC on overdose deaths through September of last year, and what we've seen is with each month through the pandemic, the year over year increases in overdose deaths have been continuing to grow, right? So, when we looked at May, for example, of last year, we have seen an 18% increase in overdose deaths. By the time we got to September, which is the most recent, that 18% turned into 28.8%, which is just incredible. If you look at opioids alone, you're above 36%, in fentanyl, which we'll probably get into at some point, is 55% year over year. We've set a new record of LTM overdose deaths every month since the pandemic started.

Dave Johnson (02:33):

Wow, so much of these increases in addiction deaths link, I'm sure, to isolation, loneliness and the despair that have risen from social distancing, lost jobs, and lifestyle shut down. What other pandemic-related factors have influenced addiction and overdose increases?

Erika Haanpaa (02:54):

You touched on some of the key issues that we've all dealt with over the past year, and then when you about people that have substance-use disorder, there've been other challenges that have exacerbated the problem. For example, if you think about border closures and the shutdown, there were significant disruptions in the supply chain, and I'll hearken back to some of the stories I've read and heard about from the prohibition, and when substances become harder to obtain, they tend to become stronger and more lethal and more caustic in many ways, so we certainly saw that happening. We've seen a decrease and closure of many harm-reduction programs such as needle exchanges, and then there was some disruption in addiction treatment programs, some programs shut down, a number of factors that caused these rates to increase.

Dave Johnson (03:41):

More demand, more powerful substances, less ability to mitigate, really is almost a perfect storm of causes that are pushing up these addiction episodes and deaths. You mentioned fentanyl earlier, what is it and talk about how's it spreading?

Erika Haanpaa (04:00):

Fentanyl is a synthetic opioid, and it is 50 to a hundred times more potent than heroin or OxyContin. It is a prescription used in patch form in medical settings, but it's also finding its way more and more into both opioid- related products and non-opioids, so stimulants such as cocaine, amphetamines, are increasingly being tainted with fentanyl.

Dave Johnson (04:25):

What other challenges complicate opioid addiction?

Erika Haanpaa (04:29):

It's tough, there are a number of challenges, I think, that complicate any addiction, the way it impacts one person, what works for one individual, may or may not work for another individual. For many of the folks that have been diagnosed with a substance-use disorder, about half of them have also been diagnosed with a mental illness, according to data from SAMHSA. Anecdotally, I would not be surprised, I'd say, if that number weren't much higher. We've gone a long way in easing the stigma, and getting more and more folks to search out and obtain some form of treatment, or counseling, for mental health issues, and it seems to me that we're not quite there yet when it comes to addiction, folks are still hiding that, I would surmise, a bit more, than they might other mental health issues.

Dave Johnson (05:17):

I really admire that you have characterized addiction as a disease and recovery as a process, and I want to shift to our discussion toward treatment here in a second, but just to keep our listeners on track, you mentioned SAMHSA as a data source. Could you just tell us what that is?

Erika Haanpaa (05:38):

SAMHSA is the Substance Abuse and Mental Health Services Administration, it's a government organization, and they collect data and fund grants and provide opportunities to treat mental health and substance-use disorder issues.

Dave Johnson (05:54):

So let's discuss the evolution of addiction treatment. If you think back to the eighties, first lady Nancy Reagan famously advised, "Just say no," to drugs and alcohol, would were it that easy, once someone's addicted, it can be very difficult to say no. So explain the dynamics of addiction to our audience, and the ways in which new treatment methods are rising to address those dynamics.

Erika Haanpaa (06:22):

Yeah, it's funny, I remember growing up in the nineties, maybe, with the commercials of someone cracking an egg and saying, "This is your brain. This is your brain on drugs, any questions?" and frankly, as a kid, I was like, "Well, a lot of questions." I'd say, a lot of the conversation and recent history around addiction, hasn't fostered open communication, and folks have been curious and tried it without having the information of how addictive, and what types of impacts these things can have on their lives, and livelihood.

We've gone through the more recent legislative battles in and around prescription opioids, and the fact that those had been marketed as perhaps being less addictive than they turned out to be. And, a problem that had been exponentially smaller decades ago, who has continued to grow at a tremendous pace, we're evolving today, and there's room for greater dialogue, and people to seek out different treatment options versus only going to the first one they see, or know about, or can get into, and there's room for education and communication to help improve outcomes, and help reduce this stigma so that folks can seek treatment, and move along their path to recovery.

Dave Johnson (07:46):

That's been one of the failings of the healthcare industry broadly, is that it tends to just have one approach and doesn't recognize individual differences. Could you just talk to us about the three broad

categories of treatments for opioid addictions and all addictions, why they're evolving the way they are, and their promise for really providing better solutions to people struggling with this disease?

Erika Haanpaa (08:13):

I think when we look to put this into three, broad buckets, I would say you have the sobriety-based programs, which include residential services, detoxification in-patient services and alike, and there's a wide range of counseling and wraparound services in many of these programs, but the sobriety-based programs are the programs that people go into, and they are detoxing and working on their path to recovery. And then the other option, and this one is mostly related to opioid addiction because, unfortunately, we don't have medications that can be used for every type of addiction, but in opioid addiction, you have Medication- Assisted Treatment, and that is where you have a medication that helps reduce craving, doesn't produce a high, and helps individuals return to their daily lives, so methadone, or buprenorphine, those types of molecules are provided as a part of the treatment to help assist someone on their path to recovery. And then third, it's really a hybrid of the two, where you can have a mixture of sobriety-based, inpatient residential program, as well as an outpatient aspect, that offers Medication-Assisted Treatment.

Dave Johnson (09:27):

So what other treatment innovations show promise?

Erika Haanpaa (09:31):

One thing that the pandemic, though it's created a lot of hardship, it's created a lot of opportunity as well, for all of healthcare really, we've seen the uptake in tele-health for all providers, and we've seen tele-health in these situations as a effective tool for group therapy, counseling, and for the MAP program, prescribers can prescribe Suboxone via tele-health, and help someone start their path to recovery via that route. We've seen the relaxing of regulations to allow individuals to have take-home doses of methadone more easily that makes it easier for somebody to comply and continue along treatment... This isn't necessarily tied to the pandemic, but overall lack of access in rural communities is a problem, we've seen mobile clinics where an RV might drive out to a community one day a week, and treat the individuals in that area, that's something I've seen, it was being done in Colorado, and more states are releasing Medicaid waivers, to broaden the scope of services allowed and covered for individuals covered by Medicaid that have substance-use disorder.

Dave Johnson (10:44):

Well, Erika, as you described, there's enormous amount of positive activity occurring in the sector. It's particularly encouraging that the government is nudging individuals in Medicaid toward newer and better treatment alternatives, as demand increases, companies emerge to meet that demand for these new forms of treatment. Which companies do you see as leaders?

Erika Haanpaa (11:09):

So I think we're getting to the point where we have a number of decently sizable regional players across the treatment landscape, and there is significant opportunity for continued expansion across all providers. One of the larger players in this space is [inaudible 00:11:28] ARC, which does Medication-Assisted Treatment. I think they're in a little more than half of the states in the country, and they've historically provided Medication-Assisted Treatment outpatient programs, and they're moving into a broader continuum of care, and offering services beyond focusing on MAT.

Then from there, we have a number of providers that are in, call it 15 to 20 or fewer states, and there's opportunity to increase access and scale across the market, because once you take a step down from there, you have thousands of subscale, regional providers, or one to two site locations, and an opportunity to really broaden the continuum of care, and what consolidation can really do in this space, is help a provider have much more information on what's working. That type of information really means a lot and goes a long way, and a challenge that we've seen in addiction treatment, is that once someone leaves your program, for example, if you are offering only one option along the broader spectrum of care, if they leave your program and do not find success, you may or may not know if they ran for another program, and when we look at the future, the providers that are offering a full continuum of care, take a more holistic approach, and help a patient find what will work for them.

Dave Johnson (12:50):

You're bullish on the sector.

Erika Haanpaa (12:52):

I am bullish on the sector, I'm bullish on the fact that the providers we have offering treatment today, they are taking very clinical approaches, they are understanding what's happening, not only from the addiction side of things, but they're looking at the overall health, mentally and physically for the patients, and helping them find a path to recovery and what'll work for them, and what works for one person, isn't what necessarily will work for another.

Dave Johnson (13:22):

That's great, and I think a nice place to land for our interview on that hopeful note. Of course, Erika, I can't let you go without asking you to make a big and bold prediction, so what do you see happening in healthcare, and maybe specifically in the addiction sector, that others may not, what's your perspective?

Erika Haanpaa (13:46):

I think we've come a long way in addiction treatment, and I think we're on the cusp of seeing more cooperation, payers, providers, stakeholders across the care continuum, if you will, and as more and more folks are touched by and understand the impacts, and the options, and really see the opportunity, not only from a business perspective, but the opportunity to get people back to their normal, everyday lives, and find a path to success.

Dave Johnson (14:19):

That's good to hear, Erika, it's been a real pleasure talking to you and having this discussion on our article, Stigma Versus Science: Overcoming Opioid Addiction with Evidence-based Treatment and Services. I encourage our listeners to read the article if you want to learn more about this really important topic. In the meantime, everyone, stay safe, stay healthy, and keep doing what you're doing to make our healthcare system kinder, smarter, and more accessible and affordable for all. Erika, thank you so much.

Erika Haanpaa (14:49):

Thanks, Dave, it was great talking to you.

Health Systems Embrace Platforming and Innovative Financing Strategies

To compete in dynamic, consumer-centric markets, not-for-profit health systems must build broad, asset-light service platforms, despite the limits of traditional financing. Cain Brothers' Co-Head of Health Systems M&A, Dave Morlock talks with Dave Johnson about innovative capital formation tools that support strategic growth and investment flexibility. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson (00:01):

Welcome to House Calls where we talk to investment bankers from Cain Brothers, a division of Key Bank Capital Markets Incorporated. I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of the Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I coauthor a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry.

This month, we're looking at how not-for-profit health systems are deploying innovative capital formation strategies to build out their service platforms. Our article is entitled Health Systems Embrace Platforming and Innovative Financing Strategies. My coauthor is Dave Morlock, a managing director and co-head of the firm's health system M&A practice.

Welcome to House Calls, Dave, where the bankers, like you, are always in.

Dave Morlock (00:58):

Thanks, Dave. I appreciate it. It's great to be with you again, as always.

Dave Johnson (01:03):

So Dave, this article has a long history. A year ago, almost to the day, we finished writing an article on adaptive capital formation, and I think we even recorded the podcast for that article.

Dave Morlock (01:14):

We did.

Dave Johnson (01:16):

Then something called COVID happened. That's a good reminder of how fast the virus has spread and how much impact the pandemic has had on healthcare delivery. Writing the article a year ago, of course, we had no expectation that the world would suddenly shut down and everything we wanted to say about health system strategy would seem irrelevant, at least for the time being.

The amazing thing, though, is here we are a year later is how resilient healthcare markets have been. We've seen the types of deals you and I were contemplating a year ago actually accelerate. So the topics of platforming and capital formation are more relevant than they've ever been. Let's hold off on speculating why that is for now and dig into the underlying concepts.

So, first question, Dave, let's talk about platforming. What is it, and why is it key to healthcare strategy now?

Dave Morlock (02:19):

Well, that is a great question. The definition of platforming and what does it mean to have a platform in healthcare probably depends on who you're talking to. 10 people can come up with 10 slightly different definitions.

From my perspective, it's a matter of getting the right business lines and the right assets in your portfolio and have them aligned with the type of company that you want to be, right? We often say asset-light. Maybe the phrase is asset-right. You need to strategically think about do you want to be a Total Cost of Care company, or do you want to be the kind of organization that takes care of patients and problems sort of on the backend and downstream from the top line revenue. And in each of those instances, you've got a unique set of assets, business lines, risks, capital formation strategies, et cetera that all have to fit together into the right type of platform.

Dave Johnson (03:26):

Outside of healthcare, we see platform companies all over the place, hotel industry, obviously the retail industry. A lot of those are focused ultimately on consumers and meeting consumer needs, something healthcare historically hasn't been terribly good at.

To what extent do you think platforming is an intermediate stage to consumerism in healthcare or maybe even in some ways, a first stage?

Dave Morlock (03:56):

I think it's a facilitator towards the move of consumerism. Traditionally, healthcare providers have been focused on what's best and most convenient for the providers as opposed to delivering the right care in the right place at the right time in the lowest cost fashion. I think platforming or moving your platform away from an asset heavy, brick and mortar, we're all about the hospital and move it toward a digital consumer-centric, convenient platform and access for what's best for the patient and what's best for the community. I definitely think that's the right direction for folks to go.

And if you're moving in that direction, you then have to start thinking about things like the social determinants of health. It's not just consumerism. It's social determinants of health. It's wellness. It's prevention. It's how do you keep people out of the hospital which is turning the business model on its head from how do I generate volume in my emergency room, in my ORs, and in my beds?

Dave Johnson (05:07):

Such a great point. We often say that we're not going to change the way we deliver healthcare until we change the way we pay for it. And what you're describing are these new payment models that are dramatically shifting risk onto providers and to some extent, onto payers as well or payviders in many cases. And in that world, a hospital visit is not a revenue opportunity. It's a cost.

Dave Morlock (05:33):

That's right.

Dave Johnson (05:34):

Elaborate on that a little bit.

Dave Morlock (05:37):

If you are responsible for the total cost of care and the top line dollar that comes in, if there's typically a $20,000 inpatient admission that you've been chasing after in a fee for service environment, all of a sudden that 20K is money to be saved by keeping the patient out of the hospital, and that creates, in essence, a medical arbitrage. And that's why you see all of this investment money flowing into companies and platforms around taking risk, value based care, and in upstream with the insurance dollar, as opposed to downstream in a volume-driven fee-for-service mechanism. If a traditional health system that's been very hospital focused doesn't eventually shift its focus, then I worry you'll just be commoditized, and it's then an economic race to the bottom. And the only way to really solve that when you're in a commodity business is huge, huge scale. And that's still a very hard space to be in when you're talking about such thin margins in a capital-intensive environment.

Dave Johnson (06:53):

Well, it sure is, but you're right. Quite honestly, most of healthcare is commodity. Maybe that's turning into a high volume, low margin business which works against sort of the idea that a lot of health systems historically have had that if we own and control all the factors of production, that's how we optimize revenue and profits for our company.

So let's get into the heads of health system administrators and deal with the schizophrenia.

Dave Morlock (07:22):

Well, it's difficult to be all things to all people and do that really well, right? There's a draw on management time and attention, and there's also a draw on capital allocation. There's always more capital needs than there's actual capital to go around when you're in a health system.

Think about a health system that, over time, has developed, for example, a home care and hospice business, right? So you get a large multi-billion dollar, multi-hospital system and they decided years ago, we're going to get into the home care business. And they've sort of built this thing up over time. Now, their CPA can't point on the financial statement to the spot that says, "Here's your equity position in home care," right? They get it. It's not on the balance sheet, but interestingly, an economist would look at that and say, "You have a ton of capital that's tied up in that business, right? It may not show up on your balance sheet, but it's definitely there if you were to go into the marketplace and sell that business to somebody else."

And it's sort of that economist view of the world versus a CPA's view of the world that some health system CFOs need to shift their thinking and think about the amount of capital that's actually locked up in these ancillary business lines.

Dave Johnson (08:50):

It's so true. And everything about sort of the way healthcare has operated in the country has really amplified the acute care episode, and that applies to capital too because the go-to mechanism for funding for not-for-profit hospitals has been tax-exempt bonds. But as we point out in the article, it doesn't really align very well with the types of products, services, and technology that health systems need to incorporate and have to operate these seamless tech platforms that ultimately interact with consumers.

So let's talk a little bit about the limitations of current capital formations and why we're starting to see not-for-profit health systems start to embrace capital formation strategies more typically associated with for-profit companies.

Dave Morlock (09:42):

You're right. Look, the traditional not-for-profit, tax-exempt bond issues, those are fantastic for building hospitals or building new bed towers connected to the hospitals. They make sense for brick and mortar, long-term physical assets, but they don't work for building physician networks. They don't work for the development of the IT platform necessary in order to shift to a consumer perspective and things like that.

So we're starting to see many not-for-profits augment their capital formation strategies in a creative way like joint ventures. So they sell stakes of ancillary business lines into joint ventures. Does a variety of things. It raises capital. It's a way to tap into that equity capital that I referenced a few moments ago, that the economist would tell you is sitting there on your balance sheet, even though you can't point to a line item and say, "There it is." It's a way to tap into that capital. And now you've got cash that you can flexibly apply to physician networks, consumerism, IT, et cetera. That's that's one approach.

We also see health systems that are availing themselves of taxable debt more often than they used to. The prevalence of municipal bond issuers shifting to the taxable market over the course of the last two years has been pretty significant. Now, part of that is the spreads between taxable and tax-exempt debt are pretty narrow. So when you look at that price difference between those two forms of capital compared to the additional flexibility that it creates, it's worth the price difference.

I think that the traditional approach of looking at the cost of capital and saying, "Tax-exempt bonds are the cheapest cost of capital. Therefore, that's the most logical direction that we should move for capital formation," I actually think that's a thing of the past. I think you need to think through what's my full suite of capital raising opportunities? Could be tax-exempt debt. Could be taxable bonds. Could be selling real estate and taking long-term leases. Could be selling stakes of ancillary business operations like home care or urgent care. All of those are legitimate capital formation strategies.

And the thought is, "What's my opportunity cost if I can raise this capital? How can I invest it?" That's really where your focus should be, not just on the absolute lowest cost of capital.

Dave Johnson (12:28):

We're throwing a lot of financial concepts at our listeners right here, so I'm just going to stop and explain a couple of things. The reason tax-exempt bonds are fantastic, to use your word, for assets like hospitals is that they have a use requirement. They can only be used for a nonprofit purpose, and they have restrictions regarding the term of the debt related to the asset life of the building or equipment being financed. Therefore, a building with a 30-year, 40-year life lends itself to a long-term tax-exempt bond issuance for a nonprofit purpose, and it can carry a very low interest rate.

When you get into these other types of areas like physician practices and technology, they either are taxable in nature to begin with, therefore, they aren't for a tax-exempt purpose, or they tend to have very short asset lives and therefore, tax exemption doesn't really work very well.

Also, spread relates to the difference in the interest rate between a taxable instrument and a tax-exempt instrument. And the taxable market is so much larger and deeper than the tax-exempt market, that those spreads can get very narrow, and there are even times when taxable debt is less expensive than tax-exempt debt. That's really important.

And then on the capital formation side, probably the biggest difference between a for-profit and a nonprofit company, or actually two big differences, one on the for-profit side, they can issue stock, right? So people can invest and get equity, and that's a huge source of funding not available to tax-exempt entities, and tax-exempt entities make up for that to some extent by carrying large cash and

investment positions on their balance sheet which is also another source above and beyond some of the ones you've listed.

So as we're looking at these health systems getting larger and more sophisticated, they aren't just doing the kind of plain vanilla tax-exempt bond to finance a hospital. They're actually thinking systematically about the entire enterprise and how to generate the highest return on investment across all these different platforms. And that just lends itself, as you were saying, Dave, I thought you made the point really well, to sort of multiple forms of accessing capital, each with their own cost and benefit, and then applying those in ways that generate the highest overall return for the company.

Dave Morlock (15:08):

That's a great summary. I was a CFO earlier in my career at a major academic medical center, so sometimes, crusty old finance guys like me tend to use too much jargon and lingo, so...

Dave Johnson (15:21):

No, no, you weren't at all. It's amazing that you're such a nice guy for having been a CFO who spends 90% of their day saying no to people, right, so...

Dave Morlock (15:31):

... being skeptical is a great tool for a CFO. [inaudible 00:15:35] while you're being skeptical.

Dave Johnson (15:38):

There you go. But for me, I've walked the fine line between skepticism and cynicism every day. I really work at it.

Dave, let's get into some examples. Tell us about M Health Fairview and AccentCare. For those of you don't know, M Health Fairview is the new brand name for what we are all used to calling Fairview, and it recognizes the University of Minnesota health affiliation which is an integral part of Fairview.

Dave Morlock (16:04):

Sure. So Fairview is this fantastic health system in a wonderfully vibrant community in Minneapolis. Multi-billion dollars of revenue, several hospitals, several thousand physicians. It's really a fantastic healthcare organization. They had, as part of their business portfolio, a home care and hospice business. That was an important element of the continuum of care, but it's arguably not a core part of their functionality. So what they elected to do was seek an operating and capital partner to grow the home care business, to provide the management bandwidth and attention to that business that Fairview itself internally couldn't generate on a consistent basis day after day.

And so they ultimately set up a joint venture arrangement with AccentCare. AccentCare as a national home care and hospice company. Great organization, super high patient quality and safety scores, excellent financial outcomes along with those patient care outcomes. The two organizations came together, set up a joint venture. That joint venture then acquired a majority stake of Fairview's home care and hospice business. The joint venture then has a governing board with representatives from both organizations to monitor the economic outcomes, as well as monitor patient care issues, medical directorships, et cetera.

So it's the kind of thing that freed up capital for Fairview. It freed up management time and attention for Fairview and long-term goal is it'll improve operations for that particular business line for

them while they still maintained a foot in the strategic portion of the continuum of care related to home care.

So I think that was a great example, deciding what's the right platform that we ought to be involved in and then how do we execute a capital strategy and operating tactics in order to get on that correct platform?

Dave Johnson (18:23):

So when the dust settles, they end up with some cash, right, that they can use toward other strategic needs. Maybe more importantly, they end up with a strategic partner that really knows how to run this business well. And if they do it well, they can plug these assets into a platform, which is what we're talking about, that kind of seamlessly connects the post-acute care operations with the acute care operations and really, I think results in a better experience for those people needing access to the system, both through the acute care component of it and into the post-acute care.

Is that a fair way to think about it?

Dave Morlock (19:07):

Very fair. Absolutely.

Dave Johnson (19:08):

All right. The Welltower and Jefferson transaction, also a really interesting one for somewhat different reasons, but some of the same reasons as well. So let's dig into that a little bit.

Dave Morlock (19:19):

So that's a slightly different example in that Welltower is not a care-providing company in the way that Fairview and Accent were both care providers, just in sort of different spots in the platform. Welltower is a real estate investment trust, and they and Jefferson Health announced a joint venture that really integrates clinical and financial strategy.

So what Welltower did was acquire some of Jefferson's real estate assets. That creates investment capital for Jefferson to fund certain other clinical activities, academic activities. Gives them a chance for dollars to address social determinants of health, and that growth capital is also going to help Jefferson accelerate their expansion in outpatient clinical services, right? So shift the platform, the acute care setting to the outpatient setting, the ambulatory patient-facing portion of the platform.

And then Jefferson can then support Welltower in some of their other activities they do in the Philadelphia market, like senior living, senior assisted living, independent living, memory care, those kinds of things. So it's really a win-win partnership for the two.

Dave Johnson (20:34):

Awesome.

The other thing I like about Welltower is they're a, for all intents and purposes, a really enlightened landlord. They own, as you said, long-term care facilities, congregate facilities all over the country, but they also have a number of partnerships with organizations like CareMore to try to improve the resident experience.

So by virtue of partnering with Welltower, Jefferson not only gets capital, which always happens with retransactions, they also get an owner that has a positive perspective on how healthcare is evolving

and brings some ideas and relationships to the table that wouldn't otherwise be there. And so synergistically, I think this is an example where just like the Fairview and AccentCare transaction, where one plus one equals three or four, maybe even five.

We've got several other examples in the article, so we encourage people to read it and get smart on both platforming and alternative forms of capital financing to really underlie some of these new platforms that are emerging.

One last thing before I get your prediction, we've had quite a year, and I think most healthcare professionals would say that COVID has accelerated the pace of change toward value-based care delivery, virtual care delivery, platforming, and these alternative forms of capital raising that we've talked about that aligns so nicely with platforms.

Dave, you want to just talk about the post-COVID healthcare world, why we aren't going back to the way we were doing it before, and what you think we've got ahead of us?

Dave Morlock (22:19):

Well, listen, I think moving into the platforming direction, tele-health, the delivery of acute care in the home setting with the right personnel and the right monitoring, I think all of that benefits communities. It benefits individual patients and society as a whole and will ultimately deliver clinical outcomes that are better than the clinical outcomes we deliver now and at a lower cost.

I just think that's a really good thing for healthcare consumers and enlightened health systems that move in that direction and for the health systems that their strategic perspective is hunker down, double down on the way we've always done it. And I'm going to keep cutting five to 7% out of my operating budget every year because my fee for service reimbursement keeps getting ratcheted down. I think those health systems are going to be in a race to the bottom. So it pays to be forward-thinking as a health system in this regard.

Dave Johnson (23:24):

Does that result in more consolidation and the emergence of these more comprehensive care delivery companies, I guess?

Dave Morlock (23:33):

I think it does. Whenever we've done these kinds of podcasts together, you always ask for a prediction at the end, right? So I-

Dave Johnson (23:41):

Give it to us.

Dave Morlock (23:42):

... [crosstalk 00:23:42].

Dave Johnson (23:42):

Give it to us.

Dave Morlock (23:42):

I work with CEOs and boards. So from my perspective, the focus needs to be beyond 2021. So this is not a set of predictions on the next nine months. It's a little farther into the future. And because I like working with you and talking with you so much, Dave, I'm going to give you two-for-one predictions.

So prediction number one is that Medicare Advantage is going to continue significant growth in the value-based care space. Now, I don't think we're going to have Medicare for All in the foreseeable future, but I do think we're going to have Medicare Advantage available to many more. All right? And that shift is going to create a battle ground between payers, private equity, and health systems in the race to align and consolidate physicians. So that's prediction number one.

Then prediction number two is that in five years, I think the top 20 health systems are going to control two-thirds of the hospital revenue in the country. The additional consolidation is going to be a response to the commoditization of the hospitals. They're just going to have to grow and scale.

Dave Johnson (25:00):

Wow. Those are big predictions. I'll one up you on MA. I think MA not only will grow, but over the course of the next four to five years, it will ultimately migrate to the exchanges. So people will be able to buy them directly on the exchanges which will make the exchanges more robust and bring tighter pricing and so on to that marketplace, particularly as I think we'll see the government step in and provide reinsurance and some other things to allow for tighter pricing.

But I'm kind of with you on the consolidation piece. We're starting to see the emergence of truly national players and super regional players. And it's hard to not believe that that won't continue as marketplace kind of gets more and more focused on managing risk and also managing this transition of not only providing great acute care services, right care, right time, right place, right price, Dave, like you'd said, but from a risk perspective, starts thinking more holistically about the individual and preventing disease, promoting health, managing chronic illness when it appears and really trying to keep individuals healthy and out of the hospital as much or more as treat them efficiently and effectively when they're in the hospital, so buckle your seat belts.

Dave Morlock (26:22):

That's right.

Dave Johnson (26:23):

Thanks again for a great discussion. I encourage all our listeners to read the article.

In the meantime, stay safe, stay healthy, and keep doing what you do to make all of our healthcare system kinder, smarter, and more accessible and affordable for all.

The Many Flavors of Healthcare's Not-For-Profit/For-Profit Partnerships

Investors and sponsors increasingly look for M&A and JV opportunities with not-for-profit health systems and plans, even as NFP organizations seek outside funding for their strategic and financial goals. Cain Brothers' M&A practice Director, Stacy Guffanti talks with Dave Johnson about the rise of healthcare's not-for-profit/for-profit partnerships. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson (00:00):

Welcome to House Calls, where we talk to investment bankers from Cain Brothers, a division of key bank capital markets, Incorporated. I'm your host, Dave Johnson, the CEO of 4sight Health and the author of the customer revolution in healthcare, delivering kinder, smarter, affordable care for all. I coauthor a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry. This month, we're exploring the innovative ways that not-for-profit providers and payers are joining forces with for-profit entities, including private equity investors to support their mission and strategic growth objectives. Our article has the title, "The many flavors of healthcare's not-for-profit, for-profit partnerships." My coauthor this month is Stacy Guffanti, a director in the firm's corporate M and A practice and a fellow Colgate alum. Hello, Stacy, welcome to House Calls where the bankers are always in. And how about those [Raiders 00:01:04]?

Stacy Guffanti (01:06):

Hi Dave, it's nice to be here and always good to be talking to another Colgate alum.

Dave Johnson (01:11):

I hear admissions are really up this year. I think it's because the school's done such a great job on COVID and got national press for it, but it could be the hockey team.

Stacy Guffanti (01:20):

Yeah. Well, I'm sure the hockey team has something to do with it, but no, I agree. I actually think Colgate has been definitely a leader as you look at the colleges across the board in terms of how they've dealt with the COVID situation.

Dave Johnson (01:35):

Yeah, impressive. Onto our article and you and I got to dig into a fascinating topic, our inspiration was the Cain Brothers conference in October, where there were several panel discussions on arrangements between non-profit and for-profit organizations. First, Stacy, let's talk about the big picture. What is it that's driving these new types of not-for-profit and for-profit arrangements. They seem to be happening with greater frequency and greater scale. Why do you think that is?

Stacy Guffanti (02:13):

Yeah, Dave it's a really interesting question. As you think about not-for-profits and for-profits, there are certainly differences. So there's obviously the difference in tax status, but they also have different governance models that drive decision-making and timing. They have different accounting processes and strategies around capital formation and more often than not I think there also is a view that the missions are not aligned between the not-for-profit and a for-profit, but at the end of the day, they share a desire for value creation and growth. And it's important to understand that if you're a not-for-profit, but you're not generating any profit margin, then you're really not meeting the mission. And that's what makes not-for-profits and for-profits in my mind, more aligned than one may think.

Dave Johnson (02:59):

Yeah, the old adage, no margin, no mission actually applies to both types of companies. One thing I've always found interesting about Cain Brothers is the firm seems to be agnostic with regard to whether a

firm is for-profit or non-profit. It really is trying to look at the business fundamentals and figure out how to drive the greatest value ultimately for customers.

Stacy Guffanti (03:26):

Partnerships and JVs and healthcare are obviously not new, but we're in a unique position to be able to advise both types of companies on these types of transactions. Part of the reason why I think they're happening more frequently now is driven by the market environment. So valuations for assets are soaring, even in a COVID world. We're seeing people looking through the impact from COVID and focusing more on long-term value and multiples are staying strong. The markets for acquisitions and consolidations has become costly and competitive, and then health systems and insurers, they're striving to improve outcomes and control costs for not-for-profits, even if they have the right playbook in terms of wanting to build scale, becoming more competitive and pursuing growth. There's often a capital constraint. And so combining forces with for-profit entities can help them achieve their financial goals and ultimately their mission.

Dave Johnson (04:21):

Well, that was a terrific explanation of what some of the driving forces are. And it is really interesting. So let's put some skin on the bones here and dig into our case studies. The first that we looked into was Welsh, Carson, the huge PE firms investment in CareSource and Ohio based regional health insurance company. Stacy, why don't we start by having you tell us something about CareSource.

Stacy Guffanti (04:51):

CareSource is even mission based, not-for-profit health plan. It's been a national leader in Medicaid, managed care and other government programs for over 30 years. Serves over two billion Medicaid and other government program beneficiaries in Ohio, Georgia, Indiana, Kentucky, and West Virginia. And it's by far the largest Medicaid plan in Ohio. The company is led by a CEO Erhardt Preitauer. And Erhardt and the board really understood how important growth in scale is for the company, but they needed access to outside capital to achieve this growth. And with our help, they partnered with Welsh, Carson, Anderson and Stowe last summer.

Dave Johnson (05:31):

Stacy, what was Welsh, Carson's motivation for this transaction?

Stacy Guffanti (05:37):

From Welsh, Carson's perspective, they really saw an opportunity here to invest in a Medicaid managed care organization that was a not for profit. And I think that there's real advantages to being a not-for-profit in the Medicaid space. There are states that prefer working with not-for-profits and CareSource is one of only a small few that had the size and the scale that they do.

Dave Johnson (06:01):

So how does the for-profit element of the investment one, structurally take place and then two practically, how do the returns spin off to the various parties as growth occurs?

Stacy Guffanti (06:16):

Yeah. So it's part of this transaction CareSource formed a for-profit management services organization. And Welsh, Carson committed equity capital to that MSO, which is owned by the not-for-profit. I wouldn't say that's unique in healthcare, particularly as you look at physician groups, which tend to use an MSO structure fairly frequently, but it is rare for a not-for-profit in the managed care sector to form a for-profit MSO for which it's not the sole owner. And in this deal, Welsh, Carson will be a minority equity holder and CareSource will be the majority holder. The reason why this structure is important is because it did not require CareSource to convert to for-profit status or diverge away from its long held mission orientation. And really the MSO, like you said, is a vehicle to help the health plan grow with government programs.

Dave Johnson (07:18):

Yeah. Pretty remarkable that Welsh, Carson's is willing to take a minority position, speaks to the trust that must exist between the leadership of the two organizations and the working relationship they're developing.

Stacy Guffanti (07:29):

Yeah. I think the relationship piece here is really important. And I think as you look at some of the other case studies that we're going to talk about today, the relationship pieces is probably one of the most important things in these partnerships and the relationships are not built in months. They're built over years. In Welsh, Carson has a strong track record of doing partnerships like this and working with not-for-profits. In the past, they invested in InnovAge, a national pace provider. That was a not-for-profit that converted to for-profit. And they also recently did the JV with Humana around partners in primary care. And I think that's one of the biggest challenges when you're going out and trying to do a JVs who is the right partner and what do they bring to the table?

Dave Johnson (08:17):

Yeah. Everybody's learning some new dance steps here and the transactions are complex. Let's listen to a clip from CareSource CEO, Erhardt Preitauer, when you asked him about how the company was dealing with the complexity.

Stacy Guffanti (08:32):

I guess this question is more directed to Erhardt. As not-for-profit, what were the key goals and requirements for any partnership?

Erhardt Preitauer (08:39):

It's really understanding how important our mission is to us and understanding how that impacts how we look at our members, how we make our decisions, the time horizons, the legacy of the company. And so again, having the perfect partner, Tom, Welsh, Carson was incredibly important for us. In fact, it was critical. It was not something that we could overcome. And there was a lot of technical elements under that as well in terms of the deal and the structure and lots of questions around control and how money moved around and a lot of that type of stuff that we had to sort of work through. But the biggest piece is really just understanding the business and understanding the mission and understanding why that's a valuable thing as we go out and get beyond the states that we're in today.

Dave Johnson (09:39):

I think you're right, Stacy. That's something we see in all of these partnerships is this clear desire to drive better performance and create value grow in the right way. So why don't we go next to some JVs between large not-for-profit health systems, Fairview and Trinity Health and for-profit post acute care companies. What can you tell us about these transactions?

Stacy Guffanti (10:05):

So AccentCare partnered with the not-for-profit health system fairview health. AccentCare is a national leader in the post-acute space and provides home health in hospice services into the second transaction is Premier Health. So they formed a JV with a not-for-profit health system, MercyOne, and Premier Health is a national urgent care provider. And it's really one of the pioneers of the JV urgent care model.

Dave Johnson (10:33):

Yeah. I think a good way to look at this is thinking of Fairview and Trinity, the two big health systems here and MercyOne is a component of Trinity as really bundles of capabilities. And there's just no way either organizations going to start from scratch and build a post acute care business line equivalent to either what AccentCare or Premier Health is doing. So by bundling those post-acute services into the overall service lines for these big health systems, they get the benefit of an experience player working seamlessly within their platform, uniform electronic medical records, reasonable allocation of resources, so on and so forth. And that again, overall complex, but at the end of the day, they do it because it drives better overall outcomes at a lower costs with better customer experience.

Stacy Guffanti (11:33):

So I completely agree with you. I think that health systems today are motivated by a growing need to manage quality and costs at every step of the care delivery process. And so being able to partner where the partner can bring in an expertise that you don't, makes a lot of sense as you think about the overall outcomes that you're trying to achieve. I also think that doing a JV arrangement enables the health systems to just deploy capital more strategically and more efficiently is another reason for doing these sorts of arrangements.

Dave Johnson (12:15):

And I guess the great thing is that if you're a customer of Fairview or Trinity, you don't really care, but AccentCare or Premier Health is running the post acute component of it.

Stacy Guffanti (12:28):

Yeah. And I think that what's really important is that these partnerships are extremely important for how the health systems really connect with their communities.

Dave Johnson (12:39):

Yeah. Well, we've got a clip here of your colleague, Dave Morlock interviewing Sherry Shapiro, the chief strategy officer at Trinity and Sherry does a great job of putting this in into context. Let's listen.

Dave Morlock (12:54):

So Sherry, what are the motivations at Trinity with the leadership group [inaudible 00:12:59], around exploring partnerships in these non-acute areas?

Sherry Shapiro (13:03):

Yeah. I find it really interesting that the name of this panel is talking about ancillary business lines, because I would say for us, as we've worked through our strategy and our vision going forward, we really find a lot of these partnerships are poor. We wouldn't call them ancillary business lines. However, we recognize that we may not have all those capabilities or expertise internally. And so in order to continue to have them as core to our business, we want to find like-minded and culturally aligned partners that can bring that expertise. And we can go to market together to provide those services for the people we serve.

Dave Johnson (13:42):

Wow. Spoken like a chief strategy officer. Hey Stacy, before we go to our last case study, why don't you just give us your thoughts on what are the keys for success for these types of for-profit not-for-profit arrangements?

Stacy Guffanti (13:57):

I think that the biggest thing that makes these arrangements successful is culture alignment. I'd also say governance is critical. There's oftentimes real issues that the need to be worked through. And I think trying to figure out what some of the showstoppers are early on is important. And then also just being as transparent as you can throughout the process just makes it go a little bit smoother. And then I think you need the right incentives in the deal to make sure that you truly have a partner. And then the last thing I'd say is just a similar values and similar mission oriented thinking.

Dave Johnson (14:35):

For our last case study Stacy, we looked at the arrangement between Brown & Toland, a very successful physician group based in San Francisco. And Altais an independent subsidiary of the not-for-profit blue shield of California. Altais is a health services company that provides physician groups with tools, technology, and support services. What can you tell us about this transaction?

Stacy Guffanti (15:01):

So the Brown & Toland transaction with Altais, is a really good example of what we're seeing happening right now between providers and payers. So we're seeing major health insurance companies getting into the business of owning primary care practices. So payers believe that disruptive primary care can really reduce healthcare costs and provide better patient outcome. For the Brown & Toland deal that hits on a lot of these things. Brown & Toland has a strong history of being physician led. Most physicians are under contract. They've had an MSO structure to provide administrative and practice support, and Altais is a technology and physician services company created to deliver next generation level support for physicians so Brown & Toland physicians will get more tools, more processes to help them deliver care. In Brown & Toland, were also gets the funding and the support they need to grow their footprint statewide.

Dave Johnson (16:01):

So the way to think about it, I think is Brown & Toland is already a high performing physician organization. And the capital and technology that Altais provides should allow them to go to this next level of performance. We now have an audio clip from Brown & Toland CEO, Kelly Robison, talking about how the organization will assess the long-term success of this partnership arrangement with Altais. Let's take a listen.

Kelly Robison (16:30):

I think the short answer for me and Jeff and I talk about this a lot. We use the word expectations. We expect in five years, not we hope or we're working towards that we expect physician gratification, healthcare outcomes, and patient satisfaction to be significantly higher five years from now than it is today. That's our goal and mission and what that how we will measure whether this partnership has succeeded. How we get there is equally important.

Dave Johnson (16:58):

We've covered a lot of ground, Stacy. We've looked at different types of transactions. We've seen how important cultural alignment and governance are, shared vision, supporting mission and strategy, financial alignment, incentives. Ultimately though these arrangements will succeed or fail. Really just like Kelly Robison suggested are they able to deliver better outcomes at lower costs with better customer service. Thanks for walking us through this, but I can't let you go before I ask for one bold prediction for 2021 or beyond. What's going to happen in healthcare that will knock everybody's socks off?

Stacy Guffanti (17:37):

Dave, I guess what I'd say is my bold prediction is that we're going to see a significant acceleration in the consumerization of healthcare over the next couple of years. We've been talking about consumerization healthcare for a while now, so that's not new. However, we've all been living in this COVID pandemic for the last year. And one big implication I think it has on everybody is it's forced people to really think about their health and the healthcare system and consumers, especially the millennial generation are going to be demanding better experiences in healthcare companies that target the consumer and put them front and center will be the winners.

Dave Johnson (18:18):

That's a great prediction. I think the marketplace is making a huge bet on just what you're saying that consumer led healthcare will be a driving force in reshaping the marketplace environment. And I don't think healthcare will go back to the pre COVID way of doing things. Thank you, Stacy for this great discussion. I encourage our listeners to read the article Stacy and I wrote, The Many Flavors of Healthcare's not-for-profit for-profit partnerships. If they'd like to learn more, you'll definitely learn more and it'll be [dangerous 00:18:52] so that your next zoom cocktail party. In the meantime, stay safe, stay healthy, and keep doing what you're doing to make our healthcare system kinder, smarter, more accessible, and affordable for all.

Stacy Guffanti (19:02):

Thanks so much, Dave.

The Worst and Best of Times: Investor Perspectives from Cain Brothers' Healthcare 2020 Virtual Conference

Cain Brothers' President, Rob Fraiman discusses how healthcare Private Equity and growth investors navigated an unprecedented year, and why they are optimistic about growth and a better healthcare system in 2021 and beyond. Cain Brothers is a division of KeyBanc Capital Markets.

Dave Johnson (00:02):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, the division of KeyBanc Capital Markets Incorporated. I'm your host, Dave Johnson, the CEO of 4sight Health and coauthor of The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care For All. I coauthor a monthly leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry. This month, we're looking back at 2020 and forward to the future of US healthcare, through the perspectives of leading investors from private equity and venture capital. Our article is entitled, The Worst and Best of Times: Investor Perspectives from the 2020 Cain Brothers' Virtual Healthcare Conference. and my coauthor is none other than Rob Fraiman, the president of Cain Brothers. Rob, welcome to House Calls: Where the Bankers Are Always In.

Rob Fraiman (01:01):

Hi Dave.

Dave Johnson (01:02):

Rob, it's been quite a year. You and I actually did the first 2020 House Calls' podcast together right after the JP Morgan conference in January. 11 months later, we're here again, older, wiser, and considerably more socially distanced.

Rob Fraiman (01:19):

We are indeed Dave. I'd say the only thing that we could have predicted back in January when we were recording that and when we were out in San Francisco, is that we were going to have a very difficult election season. And that of course has proven to be true, but everything else that has happened since the pandemic began, I would say is of course completely unparalleled and certainly was not predictable to most of us at that time.

Dave Johnson (01:50):

Yeah. Worst and Best of Times: From an Investors' Perspective, really covers it. Everybody pulling back in March and here we are at the end of the year with the valuations like I've never seen before in my career, a rollercoaster kind of year.

Rob Fraiman (02:07):

For sure. And I'll bring it right down to the level that we operated at our business at Cain Brothers. Which is, we're going to finish the year with a record performance, over a record performance in 2019 and 2018 as well. But I could never have forecasted it, I did not forecast it. So as I look at every month in March and April and May, June and even through the summer, what we saw was that our business, which I'd say is a small microcosm of the overall level of the healthcare economy and the [deal 00:02:43] economy was down at that point in time. And in the second half of the year, there has been just an extraordinary resurgence which ultimately has led not only to these levels in the stock market that you're talking about, but also private equity valuations, and also strategic M&A transaction activity and private equity and venture capital investment activity.

Dave Johnson (03:05):

Well, there'll be a lot of postmortems on 2020 over the next couple of months especially in the healthcare industry, which has had a year like no other. We don't need to go over ground that many others will cover, but we do have an interesting vantage point that not many pundits or commentators do explore. And that's the story of healthcare in 2020 from the perspective of private equity and venture capital investors. Our inspiration for this discussion in our article came from the Cain Brothers conference in October, where top investors gathered on panels to talk about how their firms had weathered the COVID storm and how they were looking at opportunities and trends in light of COVID and beyond. So, first of all, Rob, let's talk about the conference itself. Which really has become perhaps the most prominent full investor conference. And congratulations again to you and your team for putting it on. What was it like to host your first ever virtual conference in 2020?

Rob Fraiman (04:12):

Well, look, we were fortunate. We've got a great team at KeyBanc that knew what they were doing from a technology perspective and our three and a half day event came off flawlessly from that perspective. We were able to grow then pretty significantly. We ended up having close to 800 attendees over the three and a half days, and we doubled the number of private company presentations. So we did just about 90 presentations, all private companies. That's one of the unique things about our bank. There are no publicly traded companies, unlike most of the other investment conferences out there. We also had some really interesting keynote discussions. We're fortunate to have Bruce Broussard from Humana and some terrific small panel discussions that were largely oriented towards joint venture activity. What's going on between private equity and in some cases not-for-profit health systems and so forth, which we see as one of the major themes happening in the industry. And then behind the scenes, we had over 350 one-on-one meetings that we arranged. We had demand for twice that amount, but ultimately we were delighted with the turnout and the feedback that we received.

Dave Johnson (05:28):

Do you think you'll take any of this virtual capacity in the next year's conference as something we can all meet in person?

Rob Fraiman (05:36):

I think we definitely will. I think that the virtual element will in some way become a permanent part of the conference. Of course, we all miss the ability to interact with people in the hallways or over meals during conferences, that's why people go to them. But I think that the virtual presentations, the one-on-one meetings, not only will we continue that at next year's conference, but frankly we're already leaning in and planning to do more of it in January when we won't be in San Francisco for JP Morgan. And we've got some unique themes that we're putting together to conduct a whole host of meetings over the course of the month of January with our clients.

Dave Johnson (06:18):

Let's move to the PE and Venture Investor panels. And despite the different approaches of PE and Venture Investors, both groups had similar responses to 2020 and are optimistic about US healthcare going into 2021. It's hard not to be optimistic with some of these valuations, but let's listen to one of your guests, John Maldonado of Advent International.

Speaker 3 (06:47):

First thing we did, we created the war rooms. This was across the portfolio, not just healthcare, right? What is the impact going to be? What's going to be the hits of cash flows? What are the leverage multiples look like? How are we going to get through this? Depending on whatever state recovery you predict, that took us from March to April, then we were stabilized, where we needed liquidity, we got it. And it was a what next? And we created this win room concept, which is okay, how do we go from, we might have lost time. Now, some number of our portfolio companies took a year back in terms of the five-year plans that we have for them. How do we get back on the front foot? So again, we've flipped these war rooms to win rooms with the concept of how do we think about disproportionate share gain as the market comes back? How do we think about digital enablement? How do we think about finding consumers in ways of... Patients in ways that we weren't before?

Dave Johnson (07:39):

War rooms to win rooms? Rob is that what you saw as well?

Rob Fraiman (07:43):

We did for sure. March 13th, the environment changed for everybody. What we saw is a very rapid decline in activity. And I'd say that, that really continued as John and others said, for at least six weeks, where people were looking inward and where it was pencils down on activities, both live transactions, many of which were well into the late stages of negotiation and documentation. And that didn't really pick up again until people began to have a sense of what their portfolios look like. So companies that were exploring transactions or raising capital, or had some sense of what the impact of COVID was. And I'd say that as we got to the end of the second quarter, we began to see some signs that there would be renewed activity in the market.

Dave Johnson (08:36):

Rob was there a trigger event, or was it just a kind of gradual shift in perspective momentum optimism that sort of triggered the second half of the year? Was there any big event or was it more of a slow gradual ascent?

Rob Fraiman (08:53):

I don't know that there was a single event other than the fact that the initial wave of the virus, which of course took many large cities down a very, very dark and tragic place, we began to see that improve dramatically. And when that happened, there came to be a point of view that we could control this to a certain extent. And frankly, I can't explain the stock market, Dave, I really don't profess to understand what drives it other than optimism. And there was optimism that we were at some point going to get on the other side of this and that ultimately led investors and led companies, both buyers and sellers to begin to say, "Hmm, there is some light in the tunnel. Let's get back at it."

Dave Johnson (09:40):

Well, also a lot of stimulus, fiscal and monetary policy working together, the US economy overall probably has come through at least to this point in this good shape, as any other country in the world, save China, which did a severe lockdown. So I think there was a feeling too, that the going off the cliff economically wasn't going to happen even though pockets of the country were suffering terribly.

Rob Fraiman (10:09):

Well, I'd certainly say that you're right. Stabilization is often something that gives people the point of view that you hit bottom. And while you may flat line for a while, eventually it begins to go up. And of course in the healthcare industry, we're both part of the solution and of course there was a big part of the problem, that the problems from a business perspective that were exposed by the pandemic, but also people started to look at, "Okay, well, this is where the solutions need to come from as well." And not just with regard to vaccines and therapeutics, but also with regard to treatment and care patterns and care delivery.

Dave Johnson (10:47):

One thing we heard from both panels was the longer-term focus on value and solving in Nancy Brown's words, undeniable problems. So there's clearly uncertainty in the marketplace. As companies were going through this, investors were going through this, they were really pretty focused on the longer-term while addressing short-term concerns. Let's listen to what Julia Carr from Blackstone said about their focus during the crisis.

Speaker 4 (11:19):

That's where it comes down to the strength of the business and the business model and conviction on long-term performance of the business, right? Because IPO is a point in time, as you said, it's multiple years for us to sell down our stake. And so we better feel really good about the company's ability to deliver on that continued performance. And that goes back to our underwriting process, right? When we're looking at an investment is like, how sustainable is the performance of this business? What can we do potentially to improve it?

Dave Johnson (11:47):

So, Rob, what's your reaction to Julia's observation?

Rob Fraiman (11:50):

Well, Julia was talking about IPO's, but I would actually broaden the comment to talk about any types of transaction activity that involves long-term investments and whether that's by a private equity firm or a venture capital firm, or of course, a strategic investor, a company that's buying or investing in another business. And I think that the shock of COVID caused people to have to figure out what their longterm point of view was and is. And once they had that vision and that conviction, they were able to look at investing in businesses with renewed vigor. And so back in the second half of this year, we saw valuations that didn't see any material diminution. And in many cases, valuations multiples, continued to grow and I'd say that's because people were looking at the long-term impact. They sort of gave 2020, or they used a golf phrase, a Mulligan year. They just said, "Okay, you're going to have to sort of restart. We might've lost a year in the company's development, but we can look beyond it because we see where we think this business is going longer term."

Dave Johnson (12:58):

Rob, I know when I play golf, I need all the mulligans I can get. So I'm glad the industry gets one for 2020. And that takes us to our second panel, which brought together Venture Investors. Jill [Drew 00:13:11] kicked that discussion off by asking about the unbundling of hospital-based services and their redistribution through new channels. Marty Felsenthal of Health Philosophy Capital talked about virtual technologies and how robust their platforms are becoming to meet care needs and new holistic engaging ways. Let's listen to what Marty has to say.

Speaker 5 (13:36):

We absolutely believe the pandemic has been a great accelerant. And what really excites me about the sector is that I think it's really healthcare's best equivalent, for lack of a better word, to Amazon. I mean these platforms, Teladoc and D-Lab, American Well, Doctor on Demand, they are healthcare without the bricks and mortar. They are going from, in the same way that Amazon went from books to CDs, to DVDs, to televisions, these platforms, which have not exclusively locked up distribution channels, similar to an Amazon who hasn't exclusively locked us up as consumers online, they've gone from tele urgent care, moving to longitudinal virtual primary care, to behavioral health care, to dermatology, to chronic care management, to post acute care management. Whatever time, we think it's going to lead to better, faster, cheaper care for everyone and align with what's our mission that I just mentioned, which is A More Affordable, Sustainable Consumer Friendly Healthcare System. So we think it's not only here to stay, we think it's really important for our country in our healthcare system.

Dave Johnson (14:51):

Yeah. Better, faster, cheaper, more affordable, more accessible, the real promise of what Venture Investment offers the healthcare marketplace and more importantly, healthcare consumers. You want to just touch on so many of the themes that Marty brought up in his comment there.

Rob Fraiman (15:08):

It's always been the Holy Grail to deliver better care for lower cost. That will be one of the things that will be completely sustainable, in my opinion, from the pandemic, as Marty said, the acceleration of these trends. So whether it's primary care and companies like Oak Street and ChenMed, Canon, Village Empty and Iora, all of which are using both technology, but also using risk models, which rely on frankly, really strong technology and artificial intelligence, whether it's home health care, behavioral, as he and others have mentioned. And then of course, we've got to talk about what's the impact on life sciences and the use of tools and diagnostics that are critically important in not just treating a pandemic, but treating chronic disease in this country. In every one of those types of categories, we're going to see continued and probably accelerating development of new models using underlying technologies that are consumer friendly. And of course we choose a lot of science as well.

Dave Johnson (16:15):

Yeah, really, really exciting. So the panel moved to the discussion of big tech and big retail. Let's talk about that for a moment. Ambar Bhattacharyya, from Maverick Ventures, actually thinks that big tech, Amazon, Apple, Microsoft, Google, missed a once in a generation opportunity by not making more inroads during COVID, because that was a time, if they had made the investments, where consumers would adapt new behaviors and new delivery channels. So a swing and a miss there. On the other hand, the big retail players, such as Walmart, CVS Walgreens seemed to be well positioned for a transformative impact. At least according to Nancy Brown from Oak.

Speaker 6 (17:01):

I think that the conversation merged a little into other players, like Walmart and companies like Walgreens and CVS and others that are retail players that have... It's a different question than tech infrastructure, it's all about access. It's all about the fact that they are actually where consumers are living their lives. They're out and they're going shopping and doing the things that they need to do. And they are many times a brand that people trust in locations that don't have a lot of other access. So I think what's been really nice is, this is the year. In some cases, again, maybe the third or fourth model

for Walmart and some of the others, having worked with Minute back before it was owned by CVS. And we've all been around these retailers for a long time, but they're really coming into their own. They're creating substantial footprints, I should say, real clinics that can make a difference, and adding telemedicine and playing real roles.

Dave Johnson (18:02):

So big tech, big retail trust, access, convenience. Rob lots for you to sink your teeth into here.

Rob Fraiman (18:12):

I'm not going to predict who is going to do it best among all of those big tech, big retail. At the end of the day, what people are craving and need is good healthcare. The companies that can deliver it, whether it's virtually and or in person. And it will be both. That's going to be, who's going to be able to deliver healthcare most affordably with the most efficacious delivery in this country. If you look at my daughters, the millennial population, they look at healthcare as simply, how do you help me get better or stay well? And they're not interested in doing it in the way that requires them to only have a singular path going to your primary care physician, waiting for the appointment and all of that.

And I think that it's going to take more time. This is accelerating it, as I said before, but there's these other generations begin to come into their own and to replace the baby boomers. I think we're going to see maybe all of the above, all of those big tech and big retail are the winners. And lots of others, because some people have to start with a whiteboard. And that's where the Oak Street and ChenMed come in. They started with a blank board and said, "How can we do it better?" And now we're seeing that.

Dave Johnson (19:35):

I saw a demographics statistic that kind of blew my mind this week, Rob. It said, "By 2025," so five years from now, "Boomers like you and me will only be 8% of the US workforce. Gen X and Y, the millennials will be fully two thirds and higher of the US workforce." That feels like the pace really could pick up from here. I mean, they're the group that taught us to get in the cars with strangers and rent strangers' houses.

Rob Fraiman (20:04):

Well, look, our population is growing and there's a massive portion of our population that doesn't have access to affordable or good healthcare. And of course, the pandemic and the economic crisis that has arisen during the pandemic is shining a light on that as never before. If it's generationally or geographically, or socio-economically easier to gain access to good, cheap, as Marty said, healthcare, then that's going to be a winner. And so it's not just the generation, I think that's critical, but my gosh, there's so many parts of the country where people have to drive enormous distances to get to a caregiver and so forth. We have to solve those issues. And that probably is where the big box and big technology companies really come in because they're so pervasive. So I think all of those things are really going to help. And gives me great hope about what our healthcare system looks like in five or 10 years because of these converging factors.

Dave Johnson (21:06):

It's so fascinating how the big companies see healthcare as a target rich environment, 20% of the economy, lots of room for improvement. And in that focus on big tech and big retail, sometimes we miss

the 900 pound gorilla in the healthcare space, United Healthcare. And that was a point Ambar Bhattacharyya from Maverick made when he talked about their influence.

Speaker 7 (21:32):

I've done some tech investing as well over my career. And over the last five, six years, every board meeting has a question of, "So how does Amazon effect our business?" I think the equivalent in healthcare for the next five years is the question of what is the United Health or Optum doing to affect our business? And my personal opinion is that I think the way that United and Optum are playing their shifts, they are playing them beautifully, is that they're setting themselves up to be a national health system, international provider for not just virtual by the way and I think a lot of offline things too. And so I think that, that's a new form of competition for a lot of these regional health systems. It's a new form of competition for a lot of local providers. And I think the real opportunity and risk for a lot of these existing providers is, how do you stay one step ahead of what Optum and United are doing? And so I think my hope is that actually pushes innovation faster.

Dave Johnson (22:37):

So is United, Optum, Amazon in healthcare, and if they are, what does it mean?

Rob Fraiman (22:43):

I think that Ambar's comments are right on and what United and Optum are doing is transformational. Optum is the largest employer of physicians in the United States. Not only the largest commercial insurance company, but they also are the largest employer of physicians. They have the second largest surgery center company, one of the largest urgent care businesses and so forth. So I certainly agree that every healthcare provider and payer should be carefully thinking about what United and Optum are doing. But I also think that some things that have come out that we've seen this year and that we talked about a lot at our conference in fact, have to do with some of the more traditional health systems, hospital and health systems that we see innovating better than they have before, out of necessity, of course.

But we see more joint ventures like Fairview Health System in the upper Midwest, which we advised on a partnership with a private equity owned, large home health company called Accent Care. Or like Care Source, a tax exempt, very large Medicaid health plan, headquartered in Ohio, but with Medicaid plans and a number of states that partnered with a private equity firm, Wells Carson. I think we're going to see more and more of that and whether it's horizontal or vertical or both, we have to redefine the boundaries of how to achieve those objectives that Marty Felsenthal talked about just a few minutes ago in that quote that you played.

Dave Johnson (24:14):

Such a great point, Rob. And I think what's happening is, the industry is starting to shift away from, how do I optimize performance under these convoluted payment formularies and reimbursement, and so on? To really focusing on outcomes, how do we deliver better care, pure errors, more prevention, better wellness? And when companies start focusing there, instead of how do I optimize the payment machine, they begin to be less concerned about owning and controlling everything and more concerned about, okay, what am I really good at? Where do I need the partner? What can I outsource to drive these great outcomes? And I've sensed, throughout our talk today, doesn't surprise me at all that you're optimistic going into the future. And you know, I can't let you go without making a big bad prediction for 2021. So what are you thinking? What's your bold prediction for next year?

Rob Fraiman (25:15):

Well, I'll make one for next year and then I'll make one for five years though. For next year, what I would say is something that lots of other folks have said, which is, when we do get back to a place where we can return to a somewhat normal work environment, I think that we're going to find that our workforce is greatly distributed. Not just our healthcare workforce, but our financial services and lots of other industries. I think we're going to have people that are going to work virtually for quite some time. And it certainly has changed my views as a manager. I had always felt previously, "You have to be in one of our offices in New York or San Francisco or Cleveland or Chicago." And I don't feel that way anymore.

The big bold one somewhere way down the road, think about the antitrust movement that's going on right now with big tech. We were just talking about Optum and United. I think that, five plus years from now, you'll probably see the government step in and say that those two companies have to be divided up. They're so big and they're doing the right things. I'm not saying I support that at all. I happen to think it would probably be a mistake, but some under some administration at sometime my guess is, you'll see that happen.

Dave Johnson (26:24):

Well, we've got an incoming HHS secretary, assuming he gets confirmed and Xavier Becerra, who's the one that engineered the big antitrust suit against Sutter. And that could become a model for going after some of the concentrated market power in regional markets and then nationally as well. Pretty interesting prediction. I think you're right about that one. Well, Rob can't thank you enough. And it's always just an absolutely fascinating discussion. I hope our listeners take time out to read the article, Rob and I wrote, The Worst and Best of Times: Investor Perspectives from the 2020 Cain Brothers' Virtual Healthcare Conference. We've tried to synthesize a lot of great thinking. Some of which you heard today. In the meantime, Rob, and all of you listening, have a wonderful holiday season. Stay warm and let's hope 2021, we're all back and seeing one another again. Thanks very much.

The Future of Clinical Trials: Decentralized, Diversified, Efficient and Fast

The race to develop a COVID-19 vaccine has put the clinical trial process under the microscope. Cain Brothers Managing Director, John Kerins, talks with Dave Johnson about innovations in clinical trials that reduce the barriers to participation, improve the diversity of patient populations, and accelerate the development of safe and effective vaccines.

Dave Johnson (00:00):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, a division of Key Bank Capital Markets, Inc. I'm your host, Dave Johnson, the CEO of Foresight Health and the author of the Customer Revolution in Healthcare, delivering kinder, smarter, affordable care for all. I coauthor a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry. This month, we continue our focus on COVID accelerated change across the healthcare industry with a fascinating article entitled The Future of Clinical Trials: Decentralized, Diversified, Efficient, and Fast.

To dig into that story, I'll be talking with my coauthor on the article, John Kerins. John is a managing director in the firm's corporate M&A Advisory practice. He joined Cain Brothers in 2015 and has over 10 years of experience in a variety of merger and acquisition capital raising and strategic advisory transactions, which include the minority recapitalization of RedCard by Pantheon Capital Partners, the sale of iCardiac Technologies to ERT and the recapitalization of Steward Healthcare System with Medical Properties Trust. More recently, John has immersed himself in the complexities of global pharmaceutical manufacturing, which is confronting its own particular challenges in the COVID era. Welcome to House Calls, John, where the bankers are always in.

John Kerins (01:37):

Thanks, Dave. Great to be back with you and looking forward to the conversation.

Dave Johnson (01:41):

John, let's dig into our meaty topic from this month. The recent Rock Health Report on venture capital investing came out for the third quarter. And first of all, it's just been a remarkable year, record year, in venture funding overall. Rock breaks it into three categories, venture funding, virtual care, wellness funding, and clinical trials. Before writing this article, I might've been surprised that clinical trials merited its own category, but that's definitely the case. So John, I know this has been an unusual year in clinical trials. What's been going on?

John Kerins (02:18):

As you'd expect after COVID hit in mid-March and many countries went into some form of lockdown, general participation in trials dropped off significantly. Existing trials continued, but there was a big slowdown in patient visits, blood draws, tissue sample collection, and the like. We've seen a nice kind of bounce back. If you look at the big publicly-traded CRS, they've all talked about kind of a return to normalcy in terms of patient visits throughout the third quarter. The other aspect here though is more focused on existing trials. There has definitely been somewhat of a pause on new trials. The exception being COVID-related vaccines and therapies obviously have been accelerating over the last few months in terms of new trials.

And there's over 300 active globally at the moment, but we did see a number of pharma companies pull back on initiating new trials. One, there was a concern about recruiting patients in this environment and then two, new protocols needed to be developed around, what do you do if you have a patient in your trial for a new asthma medication that becomes COVID-positive and how do you handle that patient? How do you test for it regularly and make sure that you've got a safe environment for that patient to participate in trial?

Dave Johnson (03:33):

Set the stage for us by describing the traditional process of vaccine development, focusing, especially on clinical trials and why they are so important.

John Kerins (03:43):

I think that the average American knows a lot more about the clinical trial process than they did in, say January or February of this year. It's in the popular press, it's on the news each night. And I think it's been an interesting education for the general populace. Just thinking about all the work and costs that go into bringing a drug to market. Once you've got an initial vaccine candidate and you produce that in a

manufacturing facility, you first need to test it in a preclinical setting, which typically testing on animals. And then you really need to take that through three primary phases of clinical development.

Phase one is focused on safety. Phase two is focused on efficacy and then phase three is the broader test around clinical effectiveness and testing for clinical end points. There's also phase four trials, which will come into play when you're looking at kind of comparing the effectiveness of a drug against other drugs in the marketplace or longer-term testing. We're all anxiously awaiting development of these vaccines. A number of them are in phase three development at the moment and have been moving through fairly quickly, but it takes time. There's a lot of safety protocols and measures in place. We want to make sure that they're safe, but they're also effective before we distribute them widely.

Dave Johnson (04:56):

And as we've seen, this as a really complex process and two of the vaccines, Moderna, and then just this week, Johnson and Johnson have to go on pause for a while. They tried to see why certain side-effects emerged in the trial. So let's talk about these clinical trials, how they've been done historically.

John Kerins (05:18):

Sure. A lot of clinical research in the last few decades has been conducted in large academic research institutions, as well as dedicated clinical trial sites. In some ways there's been a decoupling of the practice of medicine and clinical research. And what that's actually led to, is a decline in participation, both in terms of the number of patients in the US that are enrolled in trials, as well as physicians that are participating as a primary investigator on a trial. It's a theme that the FDA is actually concerned about. You want to make sure that they've got an adequate pool of participants in the trial. So if you find 100 patients who might meet that initial criteria, oftentimes only about 4% of those patients will actually randomize or roll into a study. So you need to reach out to a fairly broad universe of potential participants to get to qualified participants in the trial.

So that has always been a pain point for pharma. They're looking with partnering with their CRO partners, as well as other pharmaceutical outsourcing companies to try to address some of these pain points. How do we improve patient recruitment? How do we improve patient retention? One of the worst things that could happen to a pharma company during a trial is for you to participate for two years and decide this is just too much of a burden. I don't want to participate for the third year of a trial. Their data sets are complete, they've lost the value per participant in the trial. So they're also focused on how do we eliminate the friction points for patients? How do we encourage physicians who have good personal relationships with many of their patients to get involved, help to identify the right patients, keep those patients engaged. And I think some of the solutions around this idea of a decentralized model... so going away from the academic research center and the dedicated clinical site to how do we either bring the trial to the patient's home or into alternate settings that are closer to home.

Dave Johnson (07:11):

In some ways we'd expect clinical trials to be more active rather than less active. And yet this decoupling of research from practice has created several, you call them pain points or barriers, to driving clinical trials or having the level of clinical trials with the effectiveness we're hoping for. And so the solutions, I guess, first and foremost involve recoupling the practice of medicine with research, making sure that that patients and their physicians wherever possible can engage in trials together. Let's dig into some companies on these three broad topics, making it easier for physicians to participate in research, eClinical trials, and then at home visits. I think you can make it come alive by talking about the types of companies that impress you and where they're putting their effort and resources to develop these

individual market segments. So on the first one, getting physicians involved, recoupling that relationship between practice and research, I know you're impressed with the company Elligo. Why don't you talk to us a little bit about what they're doing and how they represent this broader movement to get more practicing physicians involved back again in research?

John Kerins (08:31):

Yeah, it's a really interesting company. They're certainly trying to solve one aspect of this kind of decentralized model, and as you said, trying to enable the physician's office to be a clinical site to participate in clinical trials and recouple medical research and the practice of medicine. Pretty interesting platform. If you go back and there's still many doctors that participate in clinical trials, they moonlight in it. It's a side gig for them. It's a nice ancillary revenue stream that isn't subject to reimbursement. But oftentimes what happens is that a young physician is very engaged in clinical research early in their career. And they find that it's really burdensome to participate in clinical research. There's technology investments that need to be made. There's a lot of regulatory filings and paperwork that needs to be addressed. And just a lot of protocol around engaging in clinical research in your office.

So what's occurred is a lot of these physicians have given up on clinical research. Elligo is essentially trying to come in and saying, we will be your outsourced clinical trial research division to make participation in trials, really easy for both physicians as well as their patients. And so they bring technology suite, they bring educated labor force that can serve as clinical study coordinators. They also bring the relationships with the pharma companies who are looking for patients and through that technology suite, they can eliminate a lot of the pain points for the physician, but also create a really attractive solution, both for pharma companies, as well as patients.

So from the patient angle, you mentioned this earlier, Dave, if you went to your family physician's office or your dermatologist, and you've been dealing with an ailment and they recommend a trial that might address it, your willingness to participate is going to be much higher, especially you know the doctor personally, you've got a relationship there versus just responding to an ad. That has historically been a lot of what clinical research is about is trying to find people with a certain affliction and convince them to participate oftentimes with a doctor that they've never met before.

So it's certainly a different touch point in terms of trying to bring a patient and get them engaged in a trial. So I think it's pretty interesting from a practical consideration. Typically, your physician is also in your community. You're not having to drive into an academic research center. You're going to your local doctor's office, which is pretty attractive to the patient as well. From the pharma company perspective and even the CRO perspective, your ability to get to the right patients quickly is definitely aided. Elligo and some of the other companies in this space... there's another company called Objective Health that offers a pretty similar model. Right now, very focused on the GI market. They're able to access the EMR on kind of a blinded fashion, but to identify patients within the existing practice that might qualify for an upcoming trial. And so very quickly get to 100 people that might be in the network that already qualify.

And then working with the physician office to make outreach, see if they would ultimately qualify to randomize into the study. So lots of nice kind of aspects. It's a win-win-win across the provider, the patient and the pharma company, but pretty elegant solution. And one that I think is going to gain more traction. Elligo has a network now of over 600 physicians working with a variety of different physician practices from kind of small couple doc offices to large multi-specialty physician groups. I think we're going to see more and more traction in this space.

Dave Johnson (12:16):

Maybe you could shift the focus slightly and talk now about how we're using technology to do all of these things much more effectively.

John Kerins (12:26):

There was an emerging theme, I would say 12 months ago that dovetailed with this idea of decentralization. How do we make trial participation easier for the patient? There was some general kind of positive feedback from pharma. They were interested in it, but similar to some of the broader themes of how is COVID accelerating a trend since February and March enabling virtual visits for trial participants. Clearly there were limitations in the second quarter about ability to travel. We saw a lot of the big CROs reporting that overall patient visits were down in the second quarter. A number of companies were trying to solve the solution with essentially a more sophisticated and kind of turbo-charged tele-health visit. So we think about the normal tele-health visits that you and I might encounter if we've got a sore throat, interact with the primary care physician. Here, the idea is a little bit different in that you're going to be enrolled in a trial for three years.

I could justify sending out a technology box to your house that has an iPad, blood pressure cuff and a pulse oximeter that are Bluetooth enabled. Other peripherals that can measure your vitals so that these virtual visits are a little bit more sophisticated and comprehensive relative to a tele-health visit. There're companies like Science 37 that recently raised around the capital here. Another business called THREAD that raised some capital in the last few months, both of those companies experiencing incredible demand and inbound interest in their virtual offerings. CROs, drug manufacturers are all trying to figure out how they could partner with companies like THREAD and Science 37 to enable virtual visits. So it's a pretty exciting time. I think this trend would have played out over the next four to five years. There would have been a modest adoption. It may have been more focused on certain therapeutic categories that lent itself to a virtual visit, but COVID, like a lot of things, has certainly poured fuel on the fire and accelerated that change.

Dave Johnson (14:32):

Yeah. John, one point you've referenced in your description of Elligo, I think makes for a nice transition to talking about diversity that researchers have in the participant pool, the need for doing that's become glaringly obvious as we wrestle with COVID and its disproportionate impact on people from low income communities, particularly black and brown individuals, as well as older individuals. So the ability to reach into these groups and get them to participate with trust and confidence in study trials is really important.

John Kerins (15:10):

I think we've all seen a number of accounts in the popular press, particularly around the vaccine trials, where the drug manufacturers are making a concerted effort to make sure they've got a diverse patient population who's participating. This is partly a function of who's being impacted by COVID as you suggested Dave, but it's also something the FDA wants to see. The FDA is not going to look favorably on a phase three study that is only done on participants just in China, right? They want to have a broad population that has ethnic, hereditary, diversity, different genotypes, and then even just geographically diverse in terms of the environmental factors. So you think about something really simple, like a new allergy medication, certainly geographic diversity, someone who lives in Seattle versus Atlanta, Georgia is going to have a very different hay fever season, right?

Then there's much bigger implications around the hereditary and specific genotyping within that patient population. The FDA really values diversity, particularly as it evaluates safety, as well as efficacy.

It's not uncommon to see different levels of efficacy across different patient populations. So as broad as possible as representative of sample sizes, they can attain. That's really what they're looking for. And that's why I think the decentralized trials are pretty exciting in terms of encouraging this participation.

Dave Johnson (16:31):

It almost gets you into the realm of personalized medicine doesn't it?

John Kerins (16:35):

In some ways it does. It does. I think kind of multifaceted in terms of what's driving participation, but you know, whether it's your doctor locally participating in a trial, the fact that 75, 80% of your visits might be able to be handled virtually and making it really easy to participate and then even bringing the trial to the home. Right?

Dave Johnson (16:58):

Yeah. Well, you mentioned earlier that Science 37 has had a big raise. Maybe you could talk a little bit about them and we've also had some discussion on this third group, the at-home, and maybe you could discuss a couple of the companies there because I think that rounds out our kind of three part model for describing how these compounding effects are really going to lead to better, more cost effective clinical trials. So I'll let you talk about some of the exciting companies that you're seeing and working with.

John Kerins (17:31):

Absolutely. Science 37, THREAD, Clinical Inc., are companies that all receive some kind of new capital over the last six to eight months, all in which the developing different types of solutions that build upon some of the existing technologies. So we talked about earlier the last five years, there's been a lot of adoption of patient reported outcomes on your smartphone, but then how do you then couple that with a more of a tele-health solution to enable visits? All those companies are seeing just tremendous demand for their services. And they're all trying to refine their model and customize it for each of the trials. You're never going to eliminate all visits to a clinical site, but a lot of people believe, depending on the therapeutic category, for example, like an asthma or COPD study, pretty good trials that will allow for at-home participation, 75, 80% of your visits could be virtual.

In contrast, if you need to be infused with a medicine in an ambulatory care center, maybe an oncology study that may not lend itself to an at home model as much, but there's a number of studies that certainly would, a lot of interest in it. And I think that it goes back to that point about patient recruitment and patient retention. As a perspective patient in a trial, if I know that 75, 80% of my visits can be done remotely, that's attractive. I'm willing to sign up to that. Three-year commitment. It's less of a burden on me. So eliminating that point of friction. Same idea on patient retention. If you're a patient in a trial eliminating some of those friction points with the hope that you stick with it and you see through the trial to its completion over the three years. So that's a pretty interesting model.

Dave Johnson (19:14):

What about that last mile problem? How do we make it easier on patients to get and provide the services and information that the trial needs?

John Kerins (19:25):

It's a big interesting question. And there aren't the easiest SIM solution, but there's some interesting companies out there that are trying to address it. You think about eliminating 75, 80% of the visits to a clinical site. It's really exciting, but you know, pharmacological study, you need to be drawing blood regularly. You need to be taking tissue samples. Those are essential to understanding the impacts of the drug, the efficacy of the drug. So that needs to be happening with some kind of regular cadence. Some groups that have approached it by suggesting you go to your local Quest or LabCorp office. I think there's a pretty interesting group of companies though, that are saying, can we go into the patient's home to handle blood draws, either with infusion nurses, phlebotomist, or actual nurses or doctors that are part of the trial team they're going to visit patients.

You think about compromised patients, geriatric patients that are a little bit more home-bound bringing the trial to them. And I think particularly you think about blood and tissue samples, you can't eliminate that from a trial and that's that last mile issue that the industry is wrestling with. I think it's an interesting intersection with some healthcare services companies. A lot of our listeners will be familiar with I mentioned that the idea of infusion nurses, even life insurance companies that might employ a group of phlebotomist to go out in the home, some of those organizations are partnering with CROs they're to solve for this right now. So pretty interesting group of companies that are trying to find a way to bring the trial to the home.

Dave Johnson (20:54):

One of the things we've discovered through COVID is that hospitals really can't run without patients. And it turns out clinical trials really can't run without patients either. And this has been a fascinating discussion about how innovation and technology are helping to accelerate clinical trials generally. And then specifically with regard to a COVID vaccine, getting us one faster than we might ever have expected. So, John, thank you so much for this discussion. You know, I can't let you go though, without having you make one big, bad, bold prediction about the healthcare marketplace in the next three to five years. So what do you think we're going to see that maybe others don't?

John Kerins (21:34):

I do think this theme of de-centralization is an interesting one. I think we will see increased participation in clinical trials, partly result of some of the broader education that's going on in the marketplace right now. I think that it may be an interesting twist for pharma in that they've spent the last four or five years really battling pricing pressures in some way, this is an interesting PR event for them. I think there's a greater appreciation of the cost of developing and bringing a new drug to market. It's complex. It takes a lot of time. It takes a lot of money. So I do think from just a broader PR perspective is an interesting moment in time for pharma. But I think that we will likely also see increased trial participation because of this just broader edification in the marketplace.

Dave Johnson (22:22):

This goal of getting a COVID-19 vaccine essentially within a year is every bit as ambitious, I think as the challenge John Kennedy laid before the nation in the sixties of getting an astronaut to the moon within the decade and the same elements are coming together, science, innovation professionals kind of across the spectrum, and we're seeing all kinds of new ideas, new business models emerge. So I think you're right. We'll start thinking about the world as pre-COVID and post-COVID. And while there's a lot of pain right now, I think in the post-COVID world, we'll see some new ways of doing things that will really accelerate progress. And that's pretty exciting. Thank you, John, for this fantastic discussion. I encourage

our listeners to read our great article, The Future of Clinical Trials: Decentralized, Diversified, Efficient and Fast if they'd like to learn more. In the meantime, stay safe, stay healthy and keep slaying dragons.

John Kerins (23:23):

You as well. Thank you so much for the time.

Podcast: The Future of Hospitals in Post-COVID America (Part 2) – The Policy Response

Dave Morlock, Managing Director at Cain Brothers' Health Systems M&A Group, and Bart Plank, the firm's Co-Director of Healthcare Public Finance, debate the future of hospitals in markets challenged by social determinants of health and fiscal and operational pressures.

Dave Johnson (00:00):

Welcome to House Calls, where we talk to investment bankers from Cain Brothers, the division of KeyBanc Capital Markets, Inc. I'm your host, Dave Johnson, the CEO of 4sight Health and the author of the Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I also coauthor a monthly thought leadership article with the rotating [inaudible 00:00:24] senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of this dynamic healthcare industry.

This month, we continue our discussion of the future of hospitals and post COVID America. In our first article, we talked about the market response to COVID accelerated disruption. In this follow-up article, we discussed the policy responses needed to support hospitals in low-income communities, particularly rural and inner city communities. This month, we continue our two part series, The Future of Hospitals in Post COVID America. In our first article, we talked about the market response to COVID accelerated disruption. In this follow-up article, we discussed the policy responses needed to support hospitals in low income communities already under great fiscal and operational pressure. COVID has only made that worse.

To dig into this meaty subject, I'll be talking with my two coauthors on the article, Dave Morlock and Bart Plank. Dave Morlock is a senior banker in the firms, Health Systems and M&A group. In a past life, he was also CFO for the University of Michigan Health Systems and CEO of the University of Toledo Medical Center. When it comes to hospitals, Dave certainly brings a knowledgeable and notable perspective. Just as knowledgeable is Bart Plank, the firm's co-director of healthcare public finance. Welcome to House Calls gentlemen, where the bankers are always in.

Dave Morlock (01:59):

Thanks Dave. Appreciate you having us on.

Bart Plank (02:02):

Yeah, it's a pleasure to be here, Dave.

Dave Johnson (02:04):

Great. Well, let's dig into it. Setting the stage. It's September 2020. The COVID pandemic has been with us for about six months. I remember early on, March, April hearing the Cain Brothers bankers were

getting a high volume of inbound calls from clients, looking for answers and advice. In your conversations with hospital executives, what's the level of uncertainty, pessimism, or optimism that you're hearing right now.

Bart Plank (02:34):

Most of my hospital executives, I would say at this point, are cautiously optimistic. When you think about where they started, really, it was almost like getting prepared for war and not really knowing what you were exactly going to be fighting. First, operationally. Getting as much PPE as you could. Starting to figure out how you were going to admit patients. All the things that hospitals were trying to do in the immediacy operationally was also being run in parallel with what I would call balance sheet protection. We saw a real rush for people to increase or get new lines of credit. Most of the losses that were incurred while active surgeries couldn't take place were really overcome by the significant amount of capital injected by the government in the various programs.

I think what we're seeing now is that elective surgeries in a lot of facilities are returning to their prior run rate levels. The biggest challenge operationally that hospitals are seeing now from that perspective is just how many procedures you can do in a COVID environment in a given day. Looking forward, I think there's a healthy fear of what will happen in the fall, but I think hospitals are feeling much more ready and knowing what they will be facing.

Dave Johnson (03:53):

That's encouraging to hear Bart. Dave, what's your take?

Dave Morlock (03:56):

I spent my time talking with health system CEOs primarily, and then CEOs of big physician groups and also CEOs of health plans that are connected to our own by health systems. Generally, what I'm hearing at this stage, folks, are to echo what Bart said, cautiously optimistic about things going forward. Many of the forward looking CEOs are actually pretty happy about the drive towards some of the consumer in digital platforms like tele-health and those types of things. What I find interesting is the CEOs that generally look at this situation and say, "All of the fundamentals that existed before the pandemic are still here and they're going to exist after the pandemic." We've also seen some organizations, and these generally are smaller hospitals in smaller health systems, say under a billion, five or so in revenue who oftentimes have historically said, "Come hell or high water, we're going to stay independent."

Now they've actually seen what high water looks like, hell and high water, and they don't like it. We're starting to see a lot more conversation around consolidation from folks who previously had thought, that's way out into the future, if that ever happens. We're also seeing some big health systems who are actually using the pandemic as a catalyst for being aggressive and trying to grow and saying, "Look, we've got the combination of enough balance sheet strength or enough access to capital that this is an opportunity for us to go out and seize the day, and try to grow through acquisition."

Dave Johnson (05:47):

Yeah, it's a pretty dynamic time. That gets really to the heart of this discussion about what is the future of hospitals? We've been putting our heads together to discuss both how COVID has affected health care in general, and then hospitals specifically. When we examine the landscape broadly, we saw the circumstances and the outlook for specific hospitals were very different depending on the marketplace. In the first articles, we focus primarily on the M&A market, which is largely bigger systems looking to get bigger and gain market share.

They're tending to focus on dynamic markets that generally have healthier populations, favorable payer mixes, strong balance sheets. We're not too worried about that group. They have the opportunity and the resources to position themselves by adopting digital technology, enhancing service lines, consolidating, transitioning over time to value based care. And if they can't do it, shame on them.

On the other hand, when you look at low-income markets and those tend to predominate in inner city and rural communities, it's much tougher. Dave, why don't you just talk to us about what the reality is like for hospitals in rural and inner city markets that are under much more pressure?

Dave Morlock (07:14):

Yeah. I'm a huge fan of the use of market forces to drive positive change. However, requires that you've got a functioning market in some of these unfavorable market areas. Another way of saying that is places where the social determinants of health are not in the best of circumstances. Many of those hospitals and hospital leaders, and boards are in a catch-22.

They see the drive to reduce the cost of care. They see the downward pressure on revenues. At the same time, they've got patient populations that they're taking care of with difficult circumstance in their social determinants of health, which runs counter to driving down utilization, reducing costs, and pushing care into the lower cost settings.

At the same time they're getting the revenue pressure, they don't have the resources or the market forces to create the impetus to make the changes necessary so you get caught in this downward cycle. It worries me that it is a potential public health crisis in the making, frankly.

Dave Johnson (08:29):

Yeah. Bart, what would you add to Dave's comments in terms of the challenges confronting hospitals in lower income communities?

Bart Plank (08:38):

To come at it from a little bit different perspective, my area of focus in investment banking is tax-exempt financing for hospitals. What we've seen since the pandemic, if you look at the rating agencies that evaluate a hospital's ability to pay back debt, its the hospitals with the weaker balance sheets, that were in the tougher markets, were the ones that were going to get downgraded. You think about COVID as really exacerbating a precarious financial position for these facilities.

Dave Johnson (09:11):

Yeah. Let's dig into social determinants of health a bit. As we've seen COVID has hit people with chronic conditions disproportionately, and it's kind of ripped through the various types of communities that we're talking about. Inner city, rural, older people, people with, with comorbidities and so on. These are the very places that have the most challenged hospital facilities. What's the right way to think about investing in social determines of health while we're trying to right size the acute care and hospital footprint?

Bart Plank (09:53):

It's going to be a really heavy lift. I think it's going to take a significant amount of investment, entrepreneurial-ism and really some visionary programs to try and figure out how you can break this curve, where we have large areas of the population that don't have access to the appropriate nutrition, don't have access to the appropriate education, exercise. Population where the children are not in

school, so the parents are probably having difficulties with their own occupation. Where diet and nutrition may be a little bit of an afterthought in terms of what can be afforded.

That will be a challenge because they do require hard work to remedy. It's going to be far more difficult, I think, to see it happen than for us to talk about it and just say, people need to eat better, and exercise, and be happy.

Dave Johnson (10:47):

How about that? A system where people pursue wellness and try and stay out of the hospital, that's our goal. Well, Dave, you've lived this on the other side. One of the distinguishing characteristics of American healthcare is that providers get paid different amounts of money for doing the same thing based on the type of facility they are and whose making the payment. Whether it's a government payer or a commercial payer and so on. Talk to us about payer mix and how it, in some ways obstructs the ability of the system overall to achieve the very kinds of objectives that Bart was laying out for us.

Dave Morlock (11:30):

Well, as we used to say, "God bless payer mix." I've worked in a couple of different, big health systems in my career. I've been on each side of the payer mix spectrum. It makes a world of difference in your financial situation, in your resources to invest in your mindset. I've seen analysis done where solid financially performing organizations, if you take their payer mix and simply replace it with a payer mix of a struggling hospital, 50 miles down the road with a different payer mix profile, even if you use the original hospitals' payment contracts, they shift from a money-making enterprise to a money losing enterprise. Then you're right in that strained environment that we talked about a few minutes ago in that downward spiral.

What's interesting from the investment perspective, ultimately to see the investment improve social determinants of health in the value based care. You've got to have a situation where the providers are tied into the insurance premium. To the top line of the revenue, rather than being paid on a piece by piece basis or a widget basis, which is another word for fee-for-service medicine. Not being paid to do stuff to people, but rather being paid to keep people healthy.

It's healthcare, as opposed to sick care. In order to get the investments in social determinants and in value based care, you've got to have skin in the game and the top line insurance premium dollar.

Dave Johnson (13:23):

Are you seeing evidence that's happening?

Dave Morlock (13:25):

We are. We're seeing evidence that it's happening. The problem is it's a slow moving transformation. But look, the reality is American healthcare is highly regulated and it's extremely political. The vast majority of congressional districts around the country, you'll find that the hospital or the health system is the largest or one of the largest employers. If you start making policy changes that may over the long run, make a lot of sense, but may create initial pain for many of those hospitals and health systems, people come out of the woodwork to lobby against that change. You're a jobs killer. You're not supportive of the elderly, or the poor, or other vulnerable populations. There aren't many politicians that sign up to be known as a jobs killer or anti vulnerable.

Dave Johnson (14:25):

Dave, thanks for that. When I look at healthcare right now, I think most of the services that people go to providers for are relatively routine. We know what to do, probably 80% of the time. From a services perspective, healthcare is relatively mature. When other industries mature, they tend to decentralize the lower costs, become more convenient, and improve the customer experience. We're certainly seeing some of that in healthcare.

You see the rise of urgent care centers and home care apps and so on. But we're also seeing a number of places continuing to double down on the centralized high cost method for delivering care, primarily through hospitals. In some respects, healthcare here is immature from an organizational perspective. That it really should be more decentralized than it is. Then it's exacerbated by some of the places most in need of change are the ones with the weakest balance sheets, and least ability to transform.

Bart Plank (15:45):

Yeah. I think we've danced around this a little bit in some of the prior comments, Dave. But when you think about it, we should have a completely different model than we had 50 or 60 years ago. You think about these facilities designed to basically take care of every problem you could imagine. From open-heart surgery, neonatal ICUs to a Steptoe coming into the emergency room. As our payer mix has changed and reimbursement has changed, healthcare has become more expensive. How do we make those big brick buildings less needed or repurpose them?

If you take heart disease, for example, we know so much more today, how to prevent heart disease than we did 50 years ago. So the need for heart surgery should go down. If you can advance that with your population. It's like the hamster on the wheel. You're spinning around because you're just getting more and more procedures. It's terrific that we can do more for more people, but obviously that requires more cost in the system. If we can agree to play some of those resources to prevention, that's where we can really make a difference.

Dave Johnson (17:02):

You're right Bart. We're getting much better as an industry, keeping sick people alive longer. Wouldn't it be great if we could flip that around and prevent people from getting sick in the first place or discovering it early?

Bart Plank (17:18):

Yeah.

Dave Johnson (17:18):

Dave, how do you think about this paradox?

Dave Morlock (17:20):

Yeah. There are a lot of things that line up to keep the status quo in place. Whether it's politics, and it's lobbying, it's concern about what do you do when you've got that 50 year old brick-and-mortar behemoth in town. You don't want that thing shuttered up and closed. It's hard to pivot or turn that battleship when you're in that spot. I also think that in the healthcare industry, healthcare people love to talk to other healthcare people. There's maybe less cross industry pollination that impacts care delivery models, and drives change. I literally saw the other day an ad for a virtual conference around innovation in care delivery models. It was six major health system CEOs, and one lobbyist who is a

former major health system CEO. I thought to myself, I don't think those seven people are going to drive the innovation in American healthcare.

Dave Johnson (18:35):

Let's pivot from the bad news, or at least the old news, and start talking about some of the promising solutions we've seen, because we made some effort in the article to look at some of these medically underserved markets and find places that are thinking different about the problem. I think all of us believe that top down, one size fits all solutions aren't going to work. The right solutions need to be put in place for the communities that work for the people in those communities.

Let's start by discussing what we termed regional transformation plans. We see them in both urban and rural markets. A dramatic example, we all encountered a couple of years ago was when Mission Health, a very strong regional health system in North Carolina chose to sell itself to for-profit HCA, which took a lot of people in the marketplace by surprise. I can think of any number of strong nonprofits, some that would have wanted to add Mission to their portfolios. But one of the things that came out of that was the creation of a $2 billion foundation, the largest per capita foundation in the country. It's going to focus almost entirely on social determinants of health for people in Western, North Carolina, truly potentially transformative.

Former CEO of Mission, Ron Paulus gave a talk on that sale and its implications at the Cain Brothers Conference a couple of years ago. More recently four hospitals in Chicago, South Side, all safety net hospitals, all struggling all with lousy quality ratings announced that they wanted to merge and form an altogether new health system where they would take their four hospitals, repurpose them to some other use end up with one or perhaps two modern house [inaudible 00:20:52].

But then a whole network of ambulatory and clinical care outlets, a unified electronic medical record, more emphasis on prevention and so on. Instead of the State of Illinois funding for declining hospitals, it would be investing in a community health network that would actually serve the needs of the people on the South Side much more effectively than what they're receiving today. Dave, what do you think of these types of transformational efforts?

Dave Morlock (21:29):

Look, I love to see that kind of stuff. The story in Asheville remains to be seen how it plays out over time. Whether it creates the transformation that we all hope that it's going to create, but the idea of taking huge cash balances off of the not-for-profit balance sheet and putting them into a foundation that spins off spendable dollars every year to impact the social determinants while the hospital still exists. All of those nurses are still working there. The doctors are still there in town. Just happens to be owned by a for-profit HCA.

The care is being delivered and they were able to unlock that cash sitting on the balance sheet. I think it's a fantastic idea. It does call into question, places that have 10% and 12% EBITDA margins, and 350 to 400 days of cash on hand, than to sit there and say, "Well, it's a mission-driven organization." And you think to yourself, is it really? How does that play out given those numbers? Because it feels like perhaps the citizens in your community are paying too much for healthcare.

Dave Johnson (22:53):

Well, Bart, let's shift our focus a little bit and talk about what's going on in the market. In the last couple of months, we've seen three noteworthy transactions. Walgreens put a billion dollar investment in the VillageMD, which is an enhanced primary care clinic. They're going to open clinics and hundreds, if not thousands of Walgreens around the country. [inaudible 00:23:21] , which really focuses on dual eligible

populations. Medicare, Medicaid eligible did a public offering and as last time I checked is training in a market valuation north of $10 billion, even though they haven't paid any money yet. That's more than most of the big for-profit chains. There was also the announced merger of Teladoc, the telemedicine company with Livongo that digital care management company. When you put those two together, the implied valuation was $44 billion.

That's bigger or about the same size as HCA, the largest of the for-profit chain. It feels like the market is sending some pretty strong signals that the future isn't in bricks and mortar, but it's in the companies that harness digital platforms that are consumer centric that use retail models, focus on wellness and prevention and not exclusively on treatment, or if they do treatment, they do it in asset light ways. Bart, what's your take on all this? What's going on?

Bart Plank (24:44):

Yeah. I'm not an equity research analyst, Dave, but the market is going to incentivize entrepreneurial-ism and processes, procedures, technologies that are going to incite change. That's what our country has been about forever. Encouraging people through innovation that has a financial reward at the end of it. When you think about the acute care side, those investors know what's being provided. I think investors then say, the big risk I faced there is what happens when the reimbursement rules change again. It's these newer companies with newer technologies that I think are going to attract the capital. I think the challenge for them as how do you demonstrate profitability? How do you demonstrate that things that you're doing that may be difficult to measure are truly creating value for the end user? Whether that's a physician group, a managed care company, an individual. I think that's where you'll see those valuations get challenged.

Dave Johnson (25:47):

Healthcare has the possibility to have completely new delivery models that aren't weighed down by these legacy costs. That could change supply demand dynamics. We're seeing some big players making some big bets on this. But you still got the overall industry, which is still very asset heavy, but wants to do better. Dave, one of the approaches I know you like are global budgets, particularly for challenge marketplaces.

Done right, this can be a way to reward hospitals for outcomes and not activity because there's revenue coming in and hopefully incentivize the type of transformation we've been talking about, away from excessive, acute care treatments and more into prevention and promotion, chronic disease management, integrating behavioral and physical health and so on. Why don't you talk to us a bit about global budgets, how they work, and what you think are their long-term prospects.

Dave Morlock (27:00):

Yeah. Thanks Dave. I think for the areas where market forces are not positioned well to drive the kind of change that we need. I think we need to be thinking about, as a country, the idea of global budgets. Examples like the Pennsylvania Rural Health Model, the Regulative Medical Economy in the State of Maryland, et cetera. Create some of these global budgets. It's functionally like capitation where there's dollars on a per person, per period of time basis. Then you have to drive better health outcomes and lower cost health outcomes for those folks, as opposed to the traditional fee-for-service model. What that will allow some of these neighborhoods to do is focus their dollars on prevention, primary care, on addiction care, behavioral health, and some of those things that under a traditional fee-for-service model, just don't pay well enough for folks to really invest their dollars.

Global budgets used in the right pockets, I think can make a lot of sense. America is a pluralistic society. A one size fits all model isn't going to work. People waving their arms around saying, "Well, we need this Medicare for all." I don't think that's going to solve our problems one bit. Just like people that wave their arms around and say, "Well, all we need, it's just market forces and you get out of the way of the market." I actually don't think that's going to work either. You've got to have some kind of a combination that makes sense around the various regional areas in order to really achieve the best outcomes for America.

Dave Johnson (28:51):

That's such a great point, Dave. I think the purists on either side push you one way or another, and ultimately there are our fatal flaws in purest approaches. We need to get the formula right. I'd also argue that often left out of this discussion is the community's role. We also need to think about how do we help communities promote health and wellbeing. A lot of the times that's not dollars and cents so much. It's just creating a culture that propels that type of thinking forward. I'm curious, as you look forward to the future of healthcare, are you optimistic? Pessimistic?

Bart Plank (29:35):

I'm an optimistic person by nature. I think that all the tools that we have out there and all the science that we have, and I think that will hopefully lead to a better system across the country in good markets or bad. I want to emphasize the most important thing is that everybody has access, but how can we encourage people to make good decisions so that the system isn't weighed down by things that are unnecessary and really so that people can just live healthier lives. I think that really comes down to an individual level. Then how can the government, how can existing healthcare systems, how can the private sector create programs and incentives that make people want to not smoke. That make people want to get regular exercise. That make people make better nutrition choices. I think that's where we're going to get the real bang for our buck because when you look at a lot of these chronic diseases that we're treating, we can certainly do a lot better.

Dave Morlock (30:42):

Healthcare is one of the top debated and discussed topics in a variety of forums. Talking about the future of America and healthcare. I think that's a great thing. There is a lot of public equity money and a lot of private equity money flowing into healthcare, trying to create new models. I think that is a huge positive for the future of healthcare. I think there are these examples of things like the Pennsylvania Rural Health Model for areas where maybe the private equity money isn't as plentiful. I think the combination of all of these things, I think it's a big positive for healthcare over the course of time. I'm incredibly optimistic.

Dave Johnson (31:32):

Wow. Well, you guys got me pumped. I can't let you go without asking for your one big bold prediction for what's going to happen in healthcare over the next two to five years. Bart, why don't you go first and then Dave, you can bring us home.

Bart Plank (31:48):

I think, as we talked about earlier, one of the reasons why a lot of the hospital systems have made it through at least, this first six months or so of COVID with balance sheets intact, is all the money that's come in from the government. But all that money is going to have to get paid back. We've got a

Medicare and Medicaid system that's clearly broken. Where, we continue to kick the can down the road. We need reimbursement change. I don't think the politicians will do that. I predict that we'll need it and they won't do it.

Dave Johnson (32:21):

Status quo, it's okay. Morlock.

Dave Morlock (32:27):

I love being on these podcasts with you, Dave. I'm going to give you two for the price of one. Two bold predictions. The first is that we will have, not Medicare for all, but Medicare advantage available to most, which I think will have the impact on health care that shifting from traditional pension plans to 401(k) plans had for retirement savings. It will be the shift from defined benefit to defined contribution, and functionally will be the privatization of Medicare. That's prediction number one. Prediction number two is that all of this turmoil will continue to drive consolidation at the hospital and the health system level. I think the top 25 systems in the country will own 60% of the health system provider revenue in the country in five years.

Dave Johnson (33:29):

You two are coming down on different ends of the equation here with regard to payment reform. We'll see how it plays out. Well, thank you both so much. This has been a blast and I hope the audience will look at both articles about the future of healthcare. I expect this will be a topic of active conversation at the Cain Brothers Conference in October, along with a couple of other small matters, like the pandemic and the presidential election. We definitely live in interesting times, but for now stay safe, stay healthy, and keep doing what you're doing. Make our health system kinder, smarter, and more accessible and affordable for all. Thank you both very much.

Podcast: The Future of Hospitals in Post-COVID America (Part 1) – The Market Response

The Co-Heads of Cain Brothers' Health Systems M&A Group, Carsten Beith and James Moloney, discuss Black Swans, Gray Rhinos and the Future of Hospitals in Post-COVID America.

Dave Johnson (00:01):

Welcome to House Calls, where we have the great privilege of having conversations with senior bankers from Cain Brothers, a division of KeyBank Capital Markets. I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of The Customer Revolution in Healthcare, delivering kinder, smarter, affordable care for all. I also co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of this dynamic healthcare industry. This month, we start a new two-part series on The Future of Hospitals in Post-COVID America. In our first article, we'll be looking at the likely market responses to COVID accelerated disruption.

To cover that daunting topic, I'll be talking with my two co-authors on the article Carsten Beith and Jim Moloney. Carsten and Jim are Managing Directors at Cain Brothers and Co-Heads of the firm's Health Systems M&A practice. They're both great friends and frequent collaborators with us on thought

leadership. So I can say without reservation, this is going to be an absolutely fascinating discussion. Carsten, Jim, welcome to House Calls, where the bankers are always in.

James Moloney (01:24):

Thank you, Dave.

Carsten Beith (01:25):

Morning, Dave.

Dave Johnson (01:26):

Let's get into it. Some people would call COVID a black swan, meaning an unpredictable, unforeseeable high-impact event. I'm not sure that's really the case because we should have been able to predict that a global pandemic could happen and the industry should have been prepared to respond, but clearly it wasn't. And as a result, COVID has hit both society at large and hospitals suddenly and hard. So let's talk first about the impact of COVID and then we can dive into kind of what hospitals were confronting already before COVID happened. So what's happened to hospitals in terms of the two volume shocks? First the influx of COVID patients, and then the elimination for a while and continuing slow recovery of elective surgeries. And then what the government's been doing to try to blunt that negative financial impact. Carsten, Jim, which you want to take this one first?

Carsten Beith (02:30):

This is Carsten. I will take this. So let's talk a little bit about the volume shock. What's actually interesting in terms of the volume of COVID patients, not withstanding sort of what's happening most recently in Florida, Texas, Arizona and so forth, is other than a few markets like New York, most of our hospital clients essentially emptied their hospitals in anticipation of the surge of COVID patients. That surge never came. So they took massive hits to their financial position because they were generating essentially no or very limited revenues. While at the same time, they were ramping up with high cost purchasing PPEs, ventilators, and so forth.

So the volume shock was first emptying the hospitals, then essentially seeing no COVID patients other than a few of markets. What we're seeing from most of our hospital clients today is that the volumes have not picked up nearly to the levels that they were pre-COVID. And so we're seeing a significant negative financial impact. So if a hospital is generating 10% or 15% or even 20% less volume than it was pre-COVID, that has a direct impact on their bottom line. So most of our hospital clients are either at break even, or many still in an operating loss position. So that's been a significant challenge.

Dave Johnson (03:53):

You know, you would think with the pent up demand that instead of volume coming back slowly, we'd actually be 125% or even 100%, 150% of pre-COVID volume, but it's more like 75%. Any sense as to why the patients haven't been coming back?

Carsten Beith (04:12):

My sense is it's a combination of things. So one is that those patients where it's truly elective, that's certainly an impact. The other piece, which may be the most significant is even those health systems that are seeing pickup in volumes on electives and so forth, their ERs remained at significantly lower volumes so that the traditional it's called front door to the hospital is seeing a substantial reduction in

patients coming into these ERs. I'd say most of our hospital clients have seen the outpatient ambulatory surgery centers and so forth volumes coming back often sort of more than they were pre-COVID, so 105%, 110% of volume. But at the end of the day, hospitals survive based on their ability to fill those inpatient beds.

James Moloney (05:02):

If you look at kind of the supply chain of the healthcare model, the first step usually is a visit to primary care physician and then a referral to a specialist, and then some procedure. And like ED, I think we're still seeing a very different utilization of the first step in that chain of primary care. The primary care offices are still doing a lot of visits virtually and so, the kind of things that would give rise to the identification of a medical condition or the movement of that medical condition through the higher acuity specialist chain is just not functioning at the same pace that it normally does.

As Carsten said, we're working with a couple orthopedic specialty hospitals and their volumes are at a north of 100% of budget right now because there are sort of unwinding backlog that had been previously diagnosed. The other thing that I think is relevant is our kind of stay at home strategy that was used throughout the country, resulted in a sharp drop in the transmission of flus and many other illnesses. The patients that have comorbidities didn't get as sick and so, it didn't lead to that cascading of other medical events.

Dave Johnson (06:21):

I'm wondering about the extent to which demand patterns among patients might be changing.

James Moloney (06:27):

We work really closely with group health, when they did their combination with Kaiser several years ago. And one of the things that was kind of interesting about that is that prior to surgery, group health provides a DVD that explains the risks and the rehab. And after looking at that video, something like 30% of patients determined that they don't want to get the surgery. Now, that is not a operating process that most orthopedic surgical groups employ. And I think the truth is that there are medical procedures that have a spectrum of benefits and costs. And I think that we could see a shifting in that trade-off, which could lead to fewer procedures being done for medical conditions that are sort of in the gray zone.

Carsten Beith (07:21):

When we speak to our large multi-specialty group practices that have moved significant amount of care to telemedicine and into their urgent care centers and so forth, they were motivated to do that, sort of pre-COVID. This really has just accelerated or created a capitalist and I think ultimately sort of proven out that more or less costly venues for care provide very good care to these patients. And I think hospitals are certainly seeing that as well. And those hospitals that were sort of on a value path, they've certainly seen that accelerate pretty significantly in their markets. All of that care is less costly care, which translates to lower revenue to somebody, most typically our hospital clients. So pretty quickly we get into the value based discussion and the trend that was well underway. And COVID certainly has some degree accelerated that.

Dave Johnson (08:19):

That's a really great transition to the next question. The metaphor we use to set this article up is The Gray Rhino, and that comes from the title of Michele Wucker's 2016 book. She contrasts gray rhinos with black swans, and I think most people are familiar with black swans. That high impact, low

probability events that really have a huge impact on the world at large, economic, social and so on. By contrast, a gray rhino is a high impact problem that we all see coming, but we choose to do little or nothing about it because it's complex or inconvenient or incentive structures favor the status quo. The problem with hospitals is definitely a gray rhino. I mean, you kind of look at these high cost centralized delivery mechanisms that aren't terribly convenient, that don't provide sufficient access that are unevenly distributed throughout the country.

And along with the development of all these alternative delivery models, we could see the industry in the midst of a fairly dramatic transition in terms of facilities and business models and so on. Now COVID comes, and I think accelerates that in a big way. And quite honestly, if it weren't for the funding the government is providing through the CARES Act, there'd be many hospitals that would be out of business today. Let's talk first about the hospital network as it currently exists and some of the fundamental challenges it's confronting, as society at large is trying to move to much more of a value-based consumer centric ways of interacting with the healthcare delivery.

James Moloney (10:12):

There's a couple of things I think that are pretty interesting about this period of time. I think we can look at the hospital sector and say the hospital sector was poorly positioned or struggled with dealing with COVID. I think you kind of have to elevate look at it sort of from the healthcare system. It wasn't a lack of dollars. The payers of healthcare experienced the flip side of what hospitals did, right? So hospitals had on average, a sharp drop in utilization and revenue. The payers of healthcare had a sharp drop in utilization and cost of healthcare. So they're benefiting by an amount that is comparable to what the hospitals are incurring cost of. What the US government did is poured a ton of money into the healthcare system to fund the hospital sector and the physician sector to a lesser degree. But what hasn't really been addressed is how to take the windfall profits from the payers and spread that around. And so one of my predictions that you'll hear later, Dave, is that's going to be a piece of the equation that is going to get rising intention later in the year.

Dave Johnson (11:19):

That United earnings call a week or so ago was breathtaking, wasn't it?

James Moloney (11:24):

Well, yeah, and it's true to varying degrees across the scale. So I think really what we experienced in this crisis is not a failure of hospitals. It was really a failure of public health, right? If we have the same national outcomes that Germany did, we would have about 800,000 people infected today and we would have had about 36,000 people that died. That's about flu season. I think it would have been for the families of the 36,000 people who incurred this condition, but it would have been not inconsistent with what happens in a normal year. And so, is part of the solution a more integrated model where the payment and the care delivery get integrated? That is possible, and I think the organizations like Kaiser, or like healthcare partners that collect premium dollars experienced far less disruption. How do you pivot to that is really difficult because it's a very different answer in San Francisco than it is in Chicago than it is in Des Moines than it is in Paducah, Kentucky.

Dave Johnson (12:32):

Right. Carsten, what's your take?

Carsten Beith (12:36):

It becomes pretty interesting at what Jim just said, when you look maybe three to five years down the road, and you do the analysis of kind of the total utilization or during this COVID period, right? Because as this we've talked about, there's been substantial reduction in utilization. Some of it reductions that shouldn't happen because these are necessary procedures, surgeries and so on. What will be interesting to see is how much of the reduced utilization just this sort of just lost in the sense that it never really comes back, and does that in some sense support the basic notion of a different form of healthcare payment and reimbursement, right? So if you look at sort of that total value driven model versus the fee-for-service model in a COVID world, we're sort of almost forced into a value model because we're literally forcing utilization down.

Dave Johnson (13:37):

Let's switch now because we've made the case that hospitals were already vulnerable before COVID, and they're probably more vulnerable now just given the financial impact. You two are in the M&A business and perhaps in massive government infusion to prop the sector up. I think we're going to see increasing industry consolidation. Carsten, was the hypothesis true? And if it is true, how is that going to unfold? And what are some of the impacts of that?

Carsten Beith (14:07):

I would argue that like everything else that we've talked about, COVID to some degree has accelerated what was already a consolidation trend. The main impact that we see from COVID is really the negative financial impact on hospitals. Obviously, having a strong balance sheet and cashflow is the lifeblood of supporting these high infrastructure costs. And when we think about it in the context of not-for-profit healthcare, there's really only three viable sources of cash for hospitals, investment generated cash, cash from operations, and tax exempt bonds. And those three are linked. So when boards are now starting to kind of look at both their financial position and what it takes to kind of work their way up, they face a pretty daunting challenge, right? Because from a not-for-profit perspective, you need to both make investments. Many of those investments basically are cash off of your balance sheet, so these non facilities based investments.

At the same time to remain strong and viable, you'd have to build up cash on the balance sheet. So in some sense, you'd have to almost double up the cash flow that's necessary to remain sustainable. And that's pretty daunting. We saw this really before COVID, some of these dynamics were at play, but we certainly see that that boards are now evaluating rather partnering up with stronger organization where they could get some scale benefits and stronger balance sheets. Anecdotally, we are getting more calls, I think, than we have in a number of years from organizations that at least want to explore what affiliations kind of look like and what the implications are. But net-net, I think we'll see a pretty significant uptick in the whole hospital M&A.

Dave Johnson (15:59):

Jim, is it a buyer's market?

James Moloney (16:02):

Well, a couple of things, Dave. Just to add to what Carsten said, one of the things that we have certainly seen in the last three to five years is an increasing presence of antitrust regulators' involvement in transactions. 10 years ago, there was definitely a revenue strategy around consolidation. I think what you're seeing now is consolidation that is motivated more around a balance sheet and a cost structure strategy. Like how do you get to a more sustainable cost structure? And how do you have access to a

balance sheet that allows you to assume some of the risk associated with transitioning into value oriented reimbursement models?

And so, I think it's likely that we'll have conflict between some of the rules and models that are used to measure whether deals are competitive or anti-competitive in contrast to what is actually going to happen when those combinations occur. I think there's going to be more challenges and more conflict with the regulatory infrastructure in these transactions.

Dave Johnson (17:04):

Who are the winners and losers?

James Moloney (17:06):

I think the winners are systems that are oriented toward delivering a different value equation in the market. And those winners are going to be facilitated by the adoption of those strategies by the payers. It's very hard to be a value-based healthcare system if the payer environment in your market doesn't embrace that approach. So it's not just the strategy of the health system, but it's how that strategy can be used with respect to the relationships with payers. So I think the payer market will matter a lot. And I think that argues that places where you've got very high market share by single payers are likely to be less innovative market, unless those payers are particularly aggressive about pushing and adopting those models. In markets where you've got a more competitive payer environment, I think it's more probable that you'll see greater innovation.

Dave Johnson (18:15):

And Carsten, picking up on that. Do you see more vertical integration? The payviders, for lack of... I hate that term. But the idea of that organizations will both receive money for insurance and then manage the cost of the care of the people under its umbrella.

Carsten Beith (18:35):

Yeah. I mean, certainly Dave, when you talk about sort of that model, rather a provider actually forms or builds the health plan or rather their value-based taking full risk. The dynamic essentially is the same, right? And that's going to be I mean very diverse. So you can see some markets where the CEO wants to lead on value-based and they will get there. And you have other markets where they will sort of go there kicking and screaming. So I think it's going to be highly variable, short of some meaningful policy change on a federal level to kind of push further the value chain. But I think there's sort of no ambiguity about rather value-based care is the right model. If you kind of take Kaiser as the poster child, if you will, for successful fully integrated value-based care, I think the lesson certainly is the further along the value journey that you are, the more likely you are structured to be successful in sort of this potentially variable world that we live in.

Dave Johnson (19:40):

It feels like musical chairs. Carsten, you mentioned you've got the volume of incoming calls are greater than you've seen in quite a while. It feels like if the market just plays out the way we're describing, that we'll see disproportionate numbers of hospital closures among weaker hospitals. Many of them located in rural areas and or inner cities. After we go through this next wave of consolidation, the market's going to push resources to where it generates the highest return that may not necessarily line up with what the healthcare needs of the country. How do you think about that?

James Moloney (20:21):

Well, I think you kind of raised a really critical point with that last statement, is you get what you pay for. And there's two places where that investment generates excess returns in the hospital sector and in the payer sector, that those returns can be used to make investments. And that's why we see those two pools of capital being the pools of capital that are doing most of the aggregation. So who are going to be the winners? I think the winners actually are going to be health systems that can do two things really well. One is form the right kind of reimbursement relationships with payers. And the second is managed their physician core effectively, whether they're employed by the health system or whether they're in contractual relationships with the health system and in different markets, different models will be deployed.

If you really want to boil it down to who's been most negatively impacted by COVID, I think it's mostly smaller physician offices. They experienced a pretty incredible demand shock, and they are struggling. And they're going to be looking for a different model of ownership and care delivery. And the well positioned hospitals will be able to step in and help solve those problems. Hospitals that haven't developed an infrastructure for working with physicians won't be able to, and I think there'll be a really big shift that takes place in the next year and a half or so, is you're going to see pretty dramatic alignment between hospitals and physicians. It's not going to be proportional, right? Some hospitals are going to get most of that and others won't.

So I think that'll have a huge impact on the sort of care delivery alignment. And then, the hospitals that are able to manage those relationships with physicians to deliver high quality care in an efficient manner will be successful. I think the real challenge is despite the fact that hospitals have been magnetic, one of the big accumulators of physicians as this physician aggregation phase has taken place, they've been good at aligning with doctors. They have not necessarily been very good at effectively managing their physician core. And that's going to be a critical, fundamental performance metric that successful health systems are going to have to be able to achieve.

Dave Johnson (22:47):

That feels like a good place to land drawing a distinction on the provider side between the facilities, the hospitals and the physicians. Of course, we've seen in the last couple of weeks, the announcement that the Walgreens is going to buy a big chunk of VillageMD and put major clinics in their stores. Also, that Oak Street is going for an initial public offering with a valuation well above a billion dollars. It will be interesting to see how the physician piece of this plays out as more and more of these front end primary care models kind of come into the marketplace. But before I let you two guys get away, I want a bold prediction for what's going to happen in healthcare over the next, say, one to two years. Something we can hold you accountable for when you come back on the show. So Carsten, what's your bold prediction?

Carsten Beith (23:44):

I'll make a prediction, but I think it will be more than two years. I think when you look at everything that COVID has brought to light in terms of the disparate care based on socioeconomic status, combined with what appears to be a meaningful shift in Washington, DC. I think within the next year to two, we will have very meaningful discussion around substantive changes in healthcare policy and healthcare reimbursement. And I think a significant reallocation of healthcare resources to underserved communities. I think to ultimately get sort of the next wave of healthcare reform, which is really what I'm talking about, that's probably a three-ish year process. But I think we are poised for meaningful to change to healthcare delivery, I think really highlighted and accentuated by COVID.

Dave Johnson (24:42):

Jim, what's your prediction?

James Moloney (24:46):

My prediction is we're going to see a pretty dramatic shift in the dialogue between are markets the right solution, or is the government the right solution? And I think that shift is going to be more toward looking to the government. One of the takeaways from this most recent experience is, is that everybody turned to Washington DC when they had trouble. And Washington DC threw tons of money out the door to try to solve the problem. I think that's indicative of the ability for the markets to solve the problem versus government intervention. And as a very sort of free market oriented sort of economic thinker, that's not necessarily the answer I think would be the optimal answer. But I think in practicality, that's what we're going to experience. Depending on what the outcome of the election is, that could happen in a more accelerated pace. But I think the truth is we're on a very kind of deliberate move toward a much bigger role for the government in our healthcare reimbursement models. I think that'll be one of the big takeaways from this experience.

Dave Johnson (26:00):

That's a really interesting perspective, Jim, and to some extent, shame on the industry if it can't develop enough value-based response. I mean, we've been at value-based care now for 10 years and the results have been pretty anemic up to this point. And I think consumers are losing confidence in the health system's ability to deliver on the promise of better, faster, cheaper care everywhere. If that happens, we will probably get more governmental healthcare and that could lead to things that the industry won't like, price controls, rationing, that type of thing, mandates. Well, it's not unexpected, and absolutely fascinating discussion. So here we are at the end of this talking about the post-COVID hospital environment and how the market will work its magic to rationalize excess facilities and reallocate resources to higher performing businesses.

And the probability that as that happens, we'll have massive gaps in the care delivery system, which will get us to the next part of this discussion is what are the public policy challenges, Jim, as you were relating to creating a vibrant healthcare delivery sector that truly meets the needs of the American people. So thank you, both. Take a look for the article, which will be coming out a little later this month. Then the next month's article on the second part on policy solutions. In the meantime, stay safe, stay healthy and keep doing what you're doing to make our healthcare system kinder, smarter, and more accessible and affordable for all.

Home Health Is Where the Growth Is: The Post-COVID Rise of Platform Solutions

The Home Health Care sector is poised for major growth and consolidation in the Post-COVID era. Matt Margulies, Managing Director at Cain Brothers, a Division of KeyBanc Capital Markets, talks with Dave Johnson about the forces changing this sector. Technology, consumer demand, payment reform, and new platform business models are increasing care quality, coordination and access.

Dave Johnson (00:01):

Welcome to house calls, where we talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets Inc. I'm your host, Dave Johnson, the CEO of 4sight Health, and the author of the customer revolution, and healthcare. Delivering kinder, smarter, affordable care for all.

I coauthor a monthly thought leadership article, with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of this dynamic healthcare industry. This month, our article is titled Home Health Is Where The Growth Is: The Post-COVID Rise Of Platform Solutions. That's a meaty topic.

And we'll be discussing this growing home healthcare sector, how the COVID pandemic is reshaping it, and the emergence of distinct strategies that are gaining market share, and fueling consolidation. Today, our guest is my co-author Matt Margulies.

Matt is a Managing Director at Cain Brothers, and a leader of the firm's home health, and hospice practices. Matt joined Cain Brothers in 2004, and leads the firm's coverage, not only of home health and hospice, but also pharmacy and distribution sectors, among others. He's a graduate of Dartmouth College, Go Green, and lives in Long Island. Matt, welcome to house calls, where the bankers are always in.

Matt Margulies (01:23):

Thank you, Dave, it's great to be here.

Dave Johnson (01:25):

Before we talk about home health, as interesting as that is, tell us a little bit about your career and life? Dartmouth College graduate, BA in Government and International Public Relations, how in the world did you end up in healthcare investment banking, and what sustains your interest in the sector?

Matt Margulies (01:41):

To be honest, going into college, I never heard of investing banking, I didn't know what investment bankers did, or what investment banks were. My education at Dartmouth, obviously exposed me to a plethora of opportunities across many different industries.

The more I learned about the options available to me, investment banking seemed incredibly exciting and challenging, and a great potential first career start, that could give me the background to extend into another profession, or another career. I didn't really know if I was going to be an investment banker for the long run, fast forward 20 years, and here I am still as an investment banker.

Dave Johnson (02:21):

So you got in, and never got out? That's great.

Matt Margulies (02:23):

Exactly. I also chose healthcare as an area of focus very early on as well. I started my career at Lehman Brothers in their healthcare group. The healthcare interest really stems from my childhood growing up. My father was a COO of a large not-for-profit hospital in New York City, and he took his work home with him quite a bit. And so healthcare sort of permeated our household as a child.

Dave Johnson (02:49):

Wow. Started in the family. And by the way, Lehman Brothers, I'm also an alum, may they rest in peace. Let's set the context of this discussion, of today's for our audience. As an aside, after the financial crisis

that crushed American banks in 08, 09, I got to hear, or attend a session with the Canadian ambassador of the us.

And he made the observation that people once thought Canadian banks were boring, and now they were sexy. You know, the same might be said for the home healthcare sector, it's historically been a backwater within healthcare, fragmented ownership, primarily mom and pop operators, staffed by low-skilled, low-paid workers, uneven payment. Why is that now changing, what are the dynamics that are driving its growth, and increasing importance?

Matt Margulies (03:40):

Sure, look, I think the last 15 years or so, has really demonstrated a significant shift in the paradigm amongst the home health sector, home-based care is really a broader term to encompass personal care services, home health, which is skilled in therapy, and hospice.

And I'd say that over the last 10 years, and maybe even closer to five, the sector has really been in a Renaissance, and is peaking, in terms of both its growth, its utilization, and also its perception, as a incredibly important tog in the care continuum.

The home health care sector has, and I think will continue to be the big winner, pre and also more importantly, post-COVID, as the substantial increase in utilization, the result of demographics, the baby boomer trends, patient and physician preference that we all know about as our loved ones are getting older.

And of course I'd say payment and delivery reforms, they're all driving the trends here in home healthcare. And as payment reform creates incentives for the referral sources, the hospitals, the payers, the physicians, to utilize home health more. You're going to see those trends continue to increase.

And then on top of that, obviously you have strong demand from the consumer, and the patient to age and home, and to try to remain outside of the facility for as long as possible. The last thing I'll say is I still think we're in the very early innings however, of demonstrating what home health is really capable of. There's obviously skilled home health and hospice, and there's sort of a cap right now, it's sort of the high level of acuity that these providers can provide care for.

But I think we're going to see a situation where those companies in the sector, are going to begin breaking through that cap, and being capable of providing care to an even higher acuity patient, hospital at home, and those sorts of programs are emerging today, and they're going to take a greater hold going forward.

Dave Johnson (05:41):

Yeah, so it's really this interesting combination, of consumers wanting to remain independent and stay at home, and technology making that easier to accomplish, in combination with payment models, that are increasingly putting risk on providers, who now need to find a lower cost, higher performing ways to provide health services. It all kind of comes together in the home, doesn't it?

Matt Margulies (06:15):

It certainly does. And now more than ever, you have a situation where you have technology that enables the provider, to both track real time, and coordinate between themselves, the physician, and the pharmacy.

You have a situation where companies, mostly the large and more sophisticated providers, have developed very specialized care programs, to care for an increasing acuity patient level, based upon

proven evidence-based protocols, using a cadre of highly trained nurses, therapists and supporting clinicians.

And these programs are really designed to treat patients with chronic, and highly complex conditions like COPD, cardiac care, joined rehab and diabetes. And then the technology that I mentioned earlier, there's an incredible job integrating the business, the patient, the nurse with the physician. Telemonitoring obviously also provides unprecedented ability to manage that population of patients, when the clinicians are not in the home.

And then the last thing I'll say is, based upon third party companies that have emerged, focused on the polychronic population, there is a situation now where providers, more than ever can manage patients drug adherence, and utilization, by working with third party home care focus pharmacies. And the technology exists that essentially directly links the pharmacy to the patient's EMR.

Dave Johnson (07:45):

Wow, really, really good answer Matt. For our audience that might not know the term polychronic, could you just explain what that is?

Matt Margulies (07:55):

Sure. So a polychronic patient, is essentially a patient that has several comorbidities, and requires complex care management. And I don't know the exact number of morbidities that's required to be turned polychronic, but it's at least two, and more likely five to six.

Dave Johnson (08:14):

Right. And that number of people, unfortunately, has been increasing with the aging of the population, and some of the lifestyle behaviors that people in America pursue. Let's talk a little bit about COVID, to say that the COVID pandemic has had an impact on healthcare, might be the understatement of the century.

We've seen non essential care flee the hospital, a tremendous volume has swung to telemedicine, and other virtual platforms. Home healthcare would seem to be another ideal setting, but it's a bit more complicated than that.

It does feel like we're at an inflection point in healthcare, and the pace of change is accelerating. So talk to us about how, and why the volume in home health care is shifting, and who's winning, and who's losing?

Matt Margulies (09:12):

I think the clear winner is the companies that provide a diversified service offering. Home health, personal care and hospice. Starting with hospice, because it's probably an easier trend to discuss. The hospice companies on average that we've spoken to, have seen either a flat census, or a growing census as a result of COVID.

And you'd expect that, the hospitals are obviously trying to push out patients, in order to free up the capacity for COVID patients. The more sophisticated companies, with good hospital relationships have seen a pretty nice surge of census on the hospice side. The home health is actually a bit more complicated, in that the shutdown of elective procedures obviously had an impact on home health volumes.

The home health companies treat patients that are recovering from elective procedures, orthopedic procedures, and such. And so that volume was down in the beginning, and towards the middle of the pandemic.

Now that the restrictions have been lifting around the country, the companies that we're speaking to are seeing an increase, or beginning of an increase of home health volumes of that, to where they were pre-COVID.

I think the trends that we're going to see as the pandemic continues to play out, and then after, is that the home health companies, particularly the ones that are partnered, or work closely with the hospitals, have done an exceptional job managing care for patients during the pandemic.

Clearly the very unfortunate situation that's occurred, within the skilled nursing facilities with respect to COVID, is a glaring, sort of indictment on the facility, and how hard it is to control infection, and disease within the facility setting, given that COVID may not be the last pandemic, or bug that we're going to be forced to deal with, home health is a natural to care for patients safely in the home.

There was some resistance initially about allowing caregivers into the home, patients obviously were concerned about strangers being in the house, and the family members as well. But as the news spread, and it quickly became apparent that being in a facility was much more dangerous, the consumer and patients have tact, and realized that getting care in the home is a safer endeavor, and more efficacious.

Dave Johnson (11:38):

And Matt, this is longer term and beyond COVID, but how are capitated payment arrangements, like Medicare Advantage, and some of the enhanced primary care models, where providers assume risk, how is that fueling the service mix offered, within the broader home health sector, and the growth of the need for services like this in the home?

Matt Margulies (12:03):

Well, like you know, the sector has traditionally been dominated by Medicare fee-for-service, and we can talk about reimbursement there, and some of the structural changes in a moment. But clearly the proliferation of Medicare advantage, particularly in home health, began about 10 years ago in Earnest.

And had a pretty punitive effect on the industry, initially. The payers were paying at a percentage of Medicare, typically on a per visit basis, there was no sort of value-based care models, no rewarding for quality of care, and good outcomes. And then obviously evolved over time, where today, there has been a significant shift of payment methodology to value-based care.

And basically, that's fueling proactive patient management that's rewarded, quality scores are now measured, and that's rewarded. And the providers that have demonstrated good outcomes, and cost savings to the payers, are able to negotiate somewhat better rates with the payers, that the larger companies have been successful in doing that.

The other thing I'd say is, being contracted with the payers is critical to just driving volume generally, the hospitals, which are the largest referral sources of home health and hospice patients, they don't want to have to refer patients to many different options. They want to be able to refer to a small catchment of providers that are contracted, with all of the large payers in that particular community.

Dave Johnson (13:30):

Yeah, really interesting. And you mentioned the larger companies are better positioned to provide this more comprehensive range of services, value-based payers, and presumably consumers themselves want, right? We all want better outcomes at lower costs, don't always get it, but that's what we want.

So how is this pressure to deliver a broader range of services, better influencing consolidation in the marketplace? It's historically been a highly fragmented sector, still is in many ways. But how are you looking at how the sector's reorganizing itself, both as it grows, and as the need for more diverse, and sophisticated services emerge.

Matt Margulies (14:19):

The sector has been consolidating for some time, and we've seen significant M&A activity over the last six, or seven years. The last two or three years, there's been very large transactions, that maybe even five years back, there's been some very large transactions.

The consolidation though that that I'm thinking about, is more about the mom and pops, the smaller providers that need to sell or want to sell, or just losing business, and that's accruing naturally to some of the larger providers, because of the sophistication that is now required, both on the care management side, the disease care model, and the specialized care programs that I mentioned earlier, the need to be contracted with a broad array of payers.

That is what's driving consolidation, in my view. In addition, there was a pretty transformative change to the Medicare reimbursement model, that was effectuated on January 1, of this year, which is called PDGM, Patient-Driven Grouping Models.

It essentially incentivizes providers away from the traditional therapy patient, and incentivizes them to focus on the chronic, highly complex patients discharged from the hospital. And they've changed the reimbursement methodology to essentially, focus providers, not to cherry pick the high therapy patients, but instead, focus on the complex cases, the complex patients, that are polychronic and such.

And the net impact of that is they've essentially reduced the episode, which used to be a 60 day episode, to now two 30 day payment periods, that providers have to essentially file, or make claims to Medicare twice. It'll have an impact on both the profitability, as well as on cashflow and working capital.

And so that is now another trend that's affecting consolidation. And of course the larger, more well capitalized businesses, will be able to weather that storm easier than, than the smaller mom and pops.

Dave Johnson (16:25):

Yeah, and follow the money. Boy, you can always count on catchy names, right? PDGM, rolls right off the tongue. But I got to say Matt, one of my core beliefs is we're not going to change [inaudible 00:16:39], until we change the way we pay for care. And here is a quintessential example of that happening in a beneficial way.

We change the way we pay for care, suddenly the industry begins to reorganize around that payment methodology, and deliver the good outcomes that fall from a more managed, less piecemeal approach to payment. So we profiled two prominent home health companies in our article, AccentCare, and Amedisys.

They have different strategic approaches to growth, let's talk about each of them, AccentCare first. We interviewed their CEO, Steve Rogers, what's their background approach, how are they succeeding? And I know you're a big fan of Steve, so give us some of your perspective on AccentCare.

Matt Margulies (17:28):

Sure. I mean, AccentCare is a privately held business, as most listeners probably know, it's owned by Advent International. It was founded about 20 years ago, and really was the first [inaudible 00:17:39] healthcare company to focus on personal care, and Medicaid beneficiaries.

The business slowly evolved over time, to really grow their home health and hospice business. And also was one of the few businesses that embrace the diversified home care based strategy, where they wanted to essentially provide all three services in communities, the three-legged stool approach, if you will.

And most of the other large providers followed suit over time, even the businesses that were diehard home health, Medicare focused businesses in the late 90s, and through the 2000s. The business has evolved tremendously over time.

Steve Rogers has a payer background, and has just a very innovative approach to the market, in terms of both building very complex care models using technology exceptionally well, but also in his approach to joint ventures.

And while the joint venture model with health systems is nothing new, I mean, LHC was one of the first to embrace it in a big way. Steve and AccentCare have taken it to another level. In terms of the size of the joint ventures, they're focused much more on meaningful joint ventures, than large MSA's, versus having many small joint ventures with rural, or worse suburban hospitals.

And they're deeply embedded in these communities. The fact that they're partnered with very innovative systems, like Baylor Scott & White, UCLA and San Diego, and then some others, they've developed very good data, and protocols along with their hospital partners, to essentially create a very strong product, and suite of programs, that really return great value, both to the hospital partner and to AccentCare, but most importantly, they've managed to create significant improvements and outcomes, for the patients and for the referral sources.

Dave Johnson (19:34):

Yeah, that's terrific, and really exemplifies this concept of platforming approach to healthcare, where usually health systems, but really could be any large company, accumulate the components needed to deliver a full range of health and wellness services, to consumers built around consumer needs.

And then in this case, with Baylor Scott & White, UCLA, San Diego, others, AccentCare is the part of the platform that focuses on diverse health services. And they are also able to share medical records, and ease care transitions, holistic, coordinated care is just better.

And the ways that companies are coming together to deliver that, is really one of the more fascinating aspects of healthcare dynamics right now. Now, Matt, one of the things I love about capitalism, and America's pluralistic approach to healthcare, is that it's not one size fits all approach to problem solving.

So there are multiple models, and they compete within the marketplace, and some emerge, some falter, but it's that sort of differing approaches that fills the innovation. So as we switching out to Amedisis, we interviewed their CEO, Paul Kusserow, who is a fascinating individual in and of himself.

But Paul and Amedisis have a very different approach than AccentCare, why don't you share some of your perspectives on Amedisis with us, and compare and contrast relative to AccentCare?

Matt Margulies (21:18):

Sure. I think the first thing to note, interestingly is Paul's background is also payer centric, and so I think that's a pretty telling sign of what it takes to be a successful post acute provider in today's market. It's not just about Medicare, it's about the payers, and that's a good dovetail Amedisys.

They do embrace hospital partnerships, and they do grow in the community like their peers, like AccentCare, but Amedisis has chosen a bit of a different path, and that their belief is, is that the long-term partner of choice, in post acute care should be the payer. And to quote Paul, they have the data, and they have the resources, and so they should be the partner of choice.

And so if Amedisis can create individual care plans, and maintain connections to chronically ill patients long-term, they believe they could be a net winner with the payers, and also with the patients, and the referral sources.

Amedisys and AccentCare have grown in parallel over the last couple of years, and have both done a tremendous job, both from a revenue, and from an earning standpoint. Both companies have been inquisitive, they've both diversified, and that they both provide all three of the core home-based care services.

It's just interesting that two businesses with really smart people, very sophisticated management teams and such, have taken a slightly different approach to the market. And the exciting thing about home care is that, there is so much growth and opportunity out there.

Like you said at the top of the question, there isn't one right answer to grow, and to take market share, and to deliver great quality of care in a value-based world. So I find Paul's approach very interesting in that respect.

Dave Johnson (23:11):

Yeah, plenty of room for both companies. Why don't you talk a little bit about the future of healthcare, particularly from how they're using technology, how they're using data, to just turbocharge their ability to deliver better care services more cost-effectively within the home?

Matt Margulies (23:30):

Data is everything. It enables companies obviously, to both monitor their patients, it allows them to adapt the care plan, it allows them to track outcomes, it allows them to demonstrate their value in the care continuum, to both the referral sources, to the payers. And obviously it allows for great outcomes for the patients themselves.

I'd say most of the large platforms have great access, to data through best in class technology. And each company has siloed IT, that provides them with access via EMR tablets, that are held in the hand by the clinicians. They have AI and predictive modeling technologies in the back office that identifies as complex patients.

It follows transitions, or allows for the transition of patients from one community of care to another. It identifies as an example, potential hospice, eligible patients within the home health census, and all of those uses of technology are critical today, but they're obviously going to become even more critical in the future, as the sector continues to be competitive, and businesses are looking for other ways to differentiate themselves.

AI will play a, a pretty meaningful role in our sector, for both identifying complex care patients, and preventing adverse events before they happen.

Dave Johnson (25:01):

Yeah. And that last point is one I just highlight, data is what data does, and the real power of these new analytic models, many of them cloud-based, is not only their ability to get the right answer, but to transmit that answer, or that prediction to frontline caregivers with the appropriate type of nudge, so that it actualizes into real behavior changes, both with frontline caregivers, and with consumers themselves.

So this opportunity for human machine collaboration, to really drive better outcomes, has enormous potential for healthcare, and maybe has more potential in the home health sector than any others, as we're increasingly looking to the home to become a primary place of care, maybe the primary place of car for American consumers.

Matt Margulies (25:59):

Very well said. I think the point to hammer home is that technology and data is great, but it must be used in concert with the human element. Clinical observation is still, and probably will always be the key frontline solution, that's used by the providers to use that in concert with data, and technology is obviously the best solution. But the human element is key.

Dave Johnson (26:24):

Matt, that's a good place to [inaudible 00:26:25], but we're not going to let you get away without doing what we ask all of our guests to do, which is to give us a bold prediction, regarding the future of healthcare over the next six months to one year. Pick your topic, home health care, or healthcare in general, but give us your big bold prediction for the industry?

Matt Margulies (26:48):

I think just staying on the topic here, I'm probably best equipped to comment on home health, and post acute. The sector obviously has performed well, pre and during COVID, I believe that the importance of the sector, and the recognition of what the sector can do, and has the ability to do going forward, is in the process of being recognized by the most important constituents within healthcare.

The hospitals, in my view, have observed some pretty incredible things that the post-acute providers have done, both with the patients and then for them, the hospital itself, in terms of freeing up capacity, providing staffing where there are shortfalls and so forth.

The government has recognized how well the post-acute providers have performed, particularly in light of how poorly the outcomes have been within the skilled nursing facility sector. So I'd like to believe that home health and hospice, are going to play an increasing role in the continuum going forward.

I would like to think that the government will continue to support the sector, through a slowing down of regulation and reimbursement cuts and so forth. That may be wishful thinking, but at the end of the day, everyone recognizes that the sector is the lowest cost setting for care, what I think the larger community needs to also understand that it's the safest, and it has the potential to be the most efficacious as well.

As technology continues to evolve, you'll be able to see providers caring for even sicker and more complex patients. That's obviously way past the six month horizon that you referenced in the question to Dave, but there is a lot of exciting things to come in the sector.

Dave Johnson (28:28):

But I love it that it's a glass half full answer, and I'm optimistic like you are too, that as we unlist the American innovation engine on all problems in healthcare, but maybe more importantly than any other, the opportunities in home health, that we will see real results.

Better outcomes, better customer service, lower costs, and a healthier population, which is wonderful. So, thank you so much, Matt, it was a pleasure working with you on our article. Home healthcare is where the growth is, the post COVID rise, the platform solutions.

Matt Margulies (29:04):

Thank you, Dave, and thanks to your team as well.

Dave Johnson (29:05):

And I think our audience now understands why we're both so excited about the sector's potential. Also, thank you to Cain Brothers and KeyBanc, we'll have another great thought leadership article next month, covering an interesting topic, but then an interesting industry that is never, ever boring or static.

In the meantime, stay safe, stay healthy, and keep doing what you do, to make our healthcare system kinder, smarter, and more accessible, and affordable for all.

COVID-19: Healthcare Private Equity Executives on Life with COVID

Join Wyatt Ritchie, Managing Director at Cain Brothers, as he interviews the following healthcare private equity executives to discuss life with COVID-19 and investment strategies moving forward: Benjamin Edmands, Managing Partner & Co-Founder, Consonance Capital Partners Marty Felsenthal, Partner, Health Velocity Capital Gregory Moerschal, Managing Partner, Beecken Petty O'Keefe & Company

Rob Fraiman (00:03):

I'm Rob Fraiman, President of Cain Brothers. During this unprecedented and disorienting time, the team at Cain Brothers is conducting weekly interviews with leaders from throughout the healthcare industry for this special edition Industry Insights series. Our goal is to provide you and your organization with a wide array of views on the multifaceted dimensions, challenges and responses to COVID-19. Transcripts are available on the Cain Brothers website. Please share your feedback with me, or any of your Cain Brothers contacts, and thanks for listening.

Wyatt Ritchie (00:39):

Thank you for joining us. This is Wyatt Ritchie a managing director with Cain Brothers. We're now six to eight weeks into the COVID pandemic, and how this is all unfolding. We thought it would be really enlightening and helpful to reconvene some of our friends in the private equity community to give us an assessment of how things are on the ground since the unleashing of the COVID virus in the United States. With me today is Greg Moerschal. Greg is a managing partner at Beecken Petty O'Keefe & Company. Ben Edmands, who's a managing and co-founder at Consonance Capital Partners. And Marty Felsenthal, partner and co-founder of Health Velocity.

First question I'd like to, actually, have all of you address is just what we've learned over the last six weeks, and how that compares to some of your initial thoughts, as we went into the COVID virus? For example, how the virus has manifested itself, how your businesses have reacted, LPs, et cetera. So, with that, Marty, like I said, how has this changed relative to what you originally thought it would be?

Marty Felsenthal (01:56):

It's obviously been a very interesting eight weeks. I would say that relative to our existing expectations, we haven't unfortunately been surprised with how the situation has evolved. I was on a call with a very senior Kaiser executive about a week and a half before San Francisco implemented its shelter in place regulations. Kaiser was on the front lines dealing with the crises up in Seattle. And what I was hearing from this executive was extraordinarily scary in terms of both, the health impact and the impact on the healthcare community in Seattle.

We actually shut our office down about a week before San Francisco did, and very quickly started to prepare our portfolio, put the storm shutters on our windows of our portfolio companies, and are glad we got on it early. I would say that, in general, in terms of impact of the lockdown on portfolio companies, and we probably got a slightly different portfolio than Ben and Greg, more growth oriented, less direct provision of care oriented. Everything we're doing is geared towards a more affordable sustainable consumer friendly healthcare system.

And so, the biggest impacts we've seen on the companies that we partner with has to do with morale. I think it's a really depressing time to be a part of these companies. They are implementing hiring freezes. They're doing job layoffs. Sales, last year, our average portfolio company grew 77%. At some of our portfolio companies, sales have ground to a halt over the course of the past six weeks. All of the work involved with scenario planning, understanding the SBA loans. What I've noticed the most is just a very high level of frustration and angst in the companies that we partner with. However, no real surprises when it comes to operating performance.

Wyatt Ritchie (03:56):

Greg, how about you, relative to original planning versus how things have unfolded? Were you spot-on on the planning, or has it been better or worse than what you thought?

Gregory Moerschal (04:09):

Sure. Maybe my first comment will be related to the public health response, which has been both, surprising and frankly a little disappointing, because it feels like we still don't have the handle on the mortality rate of this disease. And that's a function of not enough testing and probably some really bad data coming from the rest of the world that has caused the public health response to be so severe and, in some cases, arbitrary. I think when history is written about this period, you'll wonder if we could have addressed the economic consequences a little differently. Namely, could we have shut our borders, quarantined the elderly and those in nursing homes, and focused just on the hot spots geographically?

Instead, we've got a situation, again, where there's been... We shut a $21 trillion economy down. And the longterm effects of that, I think, are going to be painful, not only for those who were affected by the disease, but also the families, and children, and college kids who are missing experiences and have seen their wealth destroyed. If I have a concern and a surprise it's the uncertainty related to the return to demand on the part of the consumer. And have we set a precedent for future breakouts of disease that maybe difficult to break. This did not happen in H1N1 when there were 60 million people infected. It was a much less contagious deadly disease. But the government has really enabled this shutdown to occur by virtual of flooding the economy with capital.

Inevitably, it will be politicized, but, as we talked to our companies, I echo Marty's comments. There's a heck of a lot of frustration, because the geographic response, at a high level, has been the same, but there's all kinds of little differences that the executive orders are being implemented, and that just portends uncertainty for the ultimate recovery. A rancher in Nebraska is different than somebody living in New York City, for example, yet many of the rules are the same. We have to figure this out, because the longterm effects could be much worse than, frankly, what we're going through today, in my opinion.

Wyatt Ritchie (06:26):

Ben, how about you? Any thoughts on what we've learned that was different than we had originally thought?

Benjamin Edmands (06:33):

Well, I think it's tough for me to answer that in terms of what we initially thought, because at the beginning of this we also were close being in New York City. I think I'm one of the only three panel members in New York. We saw, particularly since one of our portfolio companies, City MD, was right on the front lines. We saw this coming, but we decided we had no idea what to expect. Our answer to people calling and asking us questions was we just don't know. We're reading the same things you are. We're talking to experts, but we don't really know.

I think having looked back though, the last eight weeks, versus what my expectations were. What's amazed me more than anything is just how amazingly resilient people have been, particularly, the healthcare provider world. And just the humans' ability to completely reset expectations and adapt to new situations is amazing. I mean, I think if you told people eight weeks ago, "We're going to shut the economy down for eight weeks. You're going to be in your home with your family for a bunch of time. You're not sure what you're going to get, and oil is going to go to negative 37." People have stayed pretty calm. I mean, there's been a media frenzy. We've completely changed the way we live our lives. We've completely changed the way we work, those of us that are still working.

But, yet, there still seems to be an amount of calm in the country amongst the people, which to me has been surprising. I would have thought there would have been a lot more unrest and more outbreaks of civil unrest. But we're still early in it, who knows what's going to happen. But I think what I also would have thought eight weeks ago is that, by now, we would have had a much more clear national response. And I've been underwhelmed by national testing movements, and tracing, and it's all been... Having said that, I've been pretty impressed, a lot of the action has happened at that local level, the local structural level. I think there's been some real cause for accolades for some heroes that have stepped up, but still I think we're largely grappling with how to get out of this. And it feels like we're just missing some real true national leadership on that front.

Wyatt Ritchie (08:42):

Well, speaking of heroes and creativity, we've also been impressed with our conversations relative to how companies have been able to adapt and make changes to their business models in light of COVID. And I'm curious what you guys have seen within your portfolio companies. Are there changes that have been implemented as a result of necessity that you now think are going to be more long lasting than what is just a COVID related activity? Marty, I don't know, within your portfolio you've seen some of that innovation? And, more importantly, do you see that long lasting? Telemedicine, for example? Any of those kinds of things? I'm just curious what you've seen on the ground with your companies.

Marty Felsenthal (09:32):

We've seen a tremendous amount of creativity, particularly from a product development standpoint within our portfolio, as well as an unusual amount of speed with which those companies are innovating on the product side. I think our current portfolio is comprised of 11 companies. As I was preparing for this call, five of them very quickly implemented product development plans that were impactful. MD Live, one of the nation's three largest telehealth platforms, had saw volumes, basically, double in the span of a week. That creates a tremendous need for additional providers. You have to credential those providers. We credentialed hundreds of additional providers faster, more reliably, and better than we ever have in our history.

We work with a company called, Well Health, that's got a communications platform that allows a provider to convert any communication, clinical or administrative, into a unified bidirectional text chain. The thesis being the telephone and healthcare creates a friction. Patients say that staff is frustrated, expensive, the turnover, lost patient volume, so lots of more clinical outcomes. Within the span of a week, they implemented a new product that could be deployed within 48 hours. And implemented, almost on a premium basis, to help health systems convert in-person visits to virtual visits without all of the telephonic back and forth. One of our clients used it for a virtual waiting room. Where they would basically have patients come to the parking lot, wait in their car, and they'd get a text when it was safe to come into the office.

Canceling visits, rescheduling visits, collecting faster, community messaging, individual messaging. Ginger Health, which is a tele-behavioral health company, implemented, I think, a really wonderful service, where they started providing their services, tele-behavioral health services, really interestingly, Wyatt. We work with a company called, Contessa Health, which is a hospital at home company, partner with Mount Sinai in New York. Ben, obviously, right at ground Spero in terms of the pandemic in the United States. Within a week of the crisis in New York, they work with Mount Sinai to start providing hospital at home services, initially, to all of Mount Sinai's patients, all of Mount Sinai's non-COVID related patients. And now they're actually taking care of some COVID patients, as well, in their homes where it's safer for everyone.

Spero Health Company that provides medicine assisted therapy to individuals with substance abuse disorder. I think in the span of a week they converted 50% of their visits to telehealth. We've seen faster, better, stronger product development initiatives over the course of the past eight week than I'd say we've seen at any point over the course of the years. I think on a more holistic level, we're going to see that continuing going forward. This has been a real wake up call for the entire healthcare system, in my opinion. The pace at which we then working towards a more affordable, sustainable, consumer friendly healthcare system has not been fast enough, and this pandemic has exposed real flaws in our system.

Wyatt Ritchie (12:57):

Greg, how about you? What have you seen in terms of changes? Do you think those changes are going to be more permanent? Going to be part of the operational delivery system that they weren't before, that COVID has been a facilitator of that?

Gregory Moerschal (13:11):

Sure. Just brief, I would echo a number of Marty's comments, particularly, the notion of virtual visits. A number of our provider facing businesses have implemented quickly that capability, and it's been well received by patients. The other comment I would make is just work at home. I've been very impressed with both, our firm and, frankly, the interaction with all the companies and between companies, at how

flexible and resilient, to use Ben's word, folks have been to work at home. And I think the implication for the business going forward is it's an opportunity to revisit your real estate footprint. And can you eliminate some unnecessary offices and provide more worker flexibility to induce them back into the workplace quickly by enabling work at home as a more permanent solution. I think there's a real economic opportunity there that we'll see sustained over time.

Marty Felsenthal (14:13):

Listen, I think the telemedicine question is going to be one that we're all going to be thinking about, because it's something that we've talked about conceptually for a while, but there was a lot of resistance to it from the patient, and also from the provider base that, I think, in some ways felt threatened. One thing I think, going back to resilience and flexibility, the speed at which CMS is dealt with and a lot of the local state agencies have dealt with credentialing and authorizing telemedicine for various different things has been great. We were woefully under prepared for this pandemic nationally, but through duct tape, and speed, and flexibility I think we managed to clear a lot of the underbrush and hopefully we're at the beginning of getting through it.

But the telemedicine question, we've gone from... One of our companies was Spero telemedicine, we went to 100%. Another was 2%, we went to 70% our visits telemedicine. And I'm not saying we're going to stay at that level, but clearly a patient who experiences that, and a doctor who has that type of interaction, and realizes that they can have a pretty fulsome visit, and not have to have someone sitting in a waiting room, and a patient not having to go find parking, and all that stuff. I think the move towards telemedicine is going to be, at least, a significant chunk going into that. So the question we're asking is, what does that do to the infrastructure, the existing infrastructure? What does that do to real estate? What do MOBs look like outside of hospitals and those types of things? What opportunities do you have to repurpose some of that space for other things? Where people might be wanting to get out of the hospital quicker, for example, but they're not ready to go home. Do you repurpose some of that real estate?

The question that we're asking is which one of these changes are lasting, and what are the implications for the healthcare system overall?

Wyatt Ritchie (15:59):

Ben, in addition to telemedicine, I think the boss would agree, it definitely is a positive. You see any other sectors or applications that have actually been positively influenced as a result of COVID?

Benjamin Edmands (16:14):

Yeah, obviously, urgent care. We have one of the larger urgent care players in the New York metropolitan market in City MD and partnered with Summit Medical Group, which is one of the largest outpatient physician groups. We had volumes go up dramatically at the beginning. We, unfortunately, had volumes slightly go down, because we just couldn't staff the sites. We had to shutdown 20 sites, because we couldn't maintain staff because we had people that were getting sick, and had childcare issues. But now we've been able to largely fix that, and we've been able to offer... We're now launching a more full scale PCR COVID test. And then, last week, we launched the ability to do immunology test, so the volumes have gone up.

I don't know how sustained that's going to be, but the volumes there have obviously largely been up. We have a behavior health asset service the geriatric population in the rural communities. That's particularly partnering with critical access hospitals and, obviously, hospitals do not want elderly people showing up, and people do not want to go there. We just shifted to telemedicine, and I think

we've now largely shifted completely over to telemedicine for behavior health group therapy. And we think that the demand for those services will increase, as well.

One of our other portfolio companies is a diagnostic lab. And, obviously, with telemedicine, there's going to be less ability. You're not going to be able to take samples, whether it be to skin, or nail, or blood, or whatever, but we had a PCR technology there. Two and a half months ago, we totally focused the R&D team on launching a PCR test for COVID, and we launched that two weeks ago. We'll see, hopefully, some more optic there. There's a lot of puts and takes within our portfolio. But, overall, the impact on healthcare demand has been significant. It's been largely that. I mean, we see practices like Durham and others down 70, 80%. So it's a question of when people are going to start funneling back into this therapeutic care.

Wyatt Ritchie (18:18):

Well, obviously, we've started slowly to reopen things. I'm not sure Durham or dentistry necessarily, but the economies are starting to reopen, and obviously there's geographic disparity around that. But I'm just curious, within your portfolio companies, Greg, are you starting to see green shoots of activity are returning, or are we still too early to really see that?

Gregory Moerschal (18:46):

No, we are seeing it. And I think our leading indicators in a number of companies that... For instance, we have a staffing related business and we're aware that elective procedures in some hospitals around the country are being scheduled eminently, and certainly into the June period. Again, by virtue of some of the virtual visits we're conducting on a diagnostic basis, one of our businesses is now scheduling procedures eminently. We generally put the brakes on new site expansion in our provider businesses. But now, I think, again there's enough visibility on opening dates by state, and we can start revisiting those. It's very much state specific and, even beyond that, it's very localized as to what can open.

I think, potentially, the bigger challenge is do you have workers? Do you have particularly lower wage workers willing to come back to the workforce when it's not completely safe, potentially? Again, there's unemployment benefits, which are affecting that decision, as well, potentially in the short term. Labor is a big component, a big contributor, to whether you can open a provider based business in the near term, I think.

Wyatt Ritchie (19:58):

How about you, Marty? Are you starting to see any green shoots within your portfolio companies?

Marty Felsenthal (20:05):

It's really interesting. We've got... I was talking to Rob about this last week. We've got 11 companies in our current portfolio. Ben, I think, said it well. There are puts and takes in every company, but four of our 11 companies are either, directly or indirectly, related to telehealth. And I'd say that, unfortunately, they've been net beneficiaries of this environment. You wish it didn't take a pandemic for an area, like telehealth, to reach an inflection point, but they've generally been doing fine. We have three provider based services businesses, IVX Health, which operates ambulatory infusion centers for patients on high cost drugs. Their volume really hasn't been impacted. These are persons with MS, and rheumatoid arthritis, and sever asthma, and Crohn's, and colitis, and use these drugs to be well.

And, in some cases, hospitals have been emptying out the hospital infusion suite for safety reasons, and sending their patients to us. You got a hospice provider, you unfortunately can't slow down death. They really haven't been impacted. The business I eluded to earlier, Spero Health, that provides

medication assisted therapy to individuals with substance abuse disorder, they've probably seen a 20, 25% impact, that rebound. And then we've got four SaaS businesses that one sells to payers, three sell to providers. The payer business actually sold a large new contract last week. The provider businesses, their sales cycles have largely ground to a halt. And we have not seen a rebound there yet. I think the provider community is still, generally, heads down dealing with the pandemic trying to understand what their budget is going to look like for the rest of the year.

We've been fortunate in that we haven't seen any meaningful turn across any of those SaaS software businesses, but we really haven't seen the wheels fall off anywhere. We've been really lucky so far. Haven't had that much to rebound from, yet, and I say that recognizing I'm going to get struck by lightning somewhere.

Wyatt Ritchie (22:10):

Ben, I'm curious, how about just taking a counter? Are there any sectors, in particular, you're particularly concerned about, or is it just more weather the storm?

Benjamin Edmands (22:24):

Well, listen, I'll be the master of the obvious here. But, obviously, sectors that are more consumer oriented, that are more elective in nature, are going to take longer to come back. And these people are going to do the calculus of do I really need to go see my dentist, right now, for example, and risk contracting COVID, or can I wait nine months for my teeth cleaning? It think there's that calculus. And then, I think the other thing that we're trying to figure out is, what's the second derivative impact here? When you have this much of a shift, for every 1% point of an unemployment, it's over three million people that are shifting out of employee sponsored health insurance. And the rough math is, we think, about half of those go into Medicaid, and pays, what, 50% of what commercial typically pays.

And other people are going to exchanges, and they pay 25, 30% less than traditional insurance. And then, self-insured, obviously, you're looking to collect 15 or 20 cents on the dollar there. I think sectors that are more elective, non-essential, will take longer for people just to do the calculus. And then, when they shift into Medicaid, that's one thing. And then, I also think there's probably the potential for pretty significant benefit design change. Again, we saw, after the financial crisis, an acceleration of the push towards high deductible health plans, and started to flatten out. But I think once you have a soft labor market, and most employers are going to be under pressure for the foreseeable future, we think there's going to be more benefit buy downs. And that battle impacts consumer behavior even more.

Marty Felsenthal (24:05):

I think it'll be really interesting to see, to that point, if there's finally a move now towards more narrow networks, the next phase of high deductible plans, reference based pricing.

Benjamin Edmands (24:18):

Exactly.

Wyatt Ritchie (24:18):

Well, speaking of derivative effects. I love all you guys in a way, and the federal government is a huge influence over healthcare, over the payer, and in other ways. They've obviously been doing a lot in terms of liquidity into the market. That's going to have implications. They've obviously put money into

healthcare providers through prepayment services, through CMS. What are you guys thinking about vis-a-vis short-term and longterm implications of all the action that the federal government has been taking in light of COVID? Greg, how about you taking that one first?

Gregory Moerschal (25:00):

Yeah. I think there's potentially a historic opportunity here, to be honest. Obamacare was spawned partially out of the financial crisis, and what it cost the federal government to implement ACA was 900 billion over 10 years. On a relative basis of today, and what's being financed elsewhere, it's nothing. I think that there's an opportunity to expand coverage in 2021, regardless of political party persuasion and leadership, and that benefits all of us. It benefits, most importantly, the consumer and those who are uncovered. But you could revisit Medicaid expansion, even though there are barriers to that with the Supreme Court ruling several years ago. You could revisit Medicare eligibility.

I think Medicare Advantage will be a boon, so there's an opportunity really to finally close the donut hole on coverage. And I think, again, on a relative basis, the dollars are going to be insignificant if we look in the recent rear view mirror. I'm net positive on the coming out of this from that standpoint. It doesn't address the cost equation and, naturally, the country is always been reluctant to go there, but there's going to be a near term opportunity in coverage, and the number of paying customers to all of our provider base businesses.

Wyatt Ritchie (26:30):

What's your take on the outlook from a federal government point?

Gregory Moerschal (26:36):

Yeah. One comment I neglected to make on surprises. I mean, just the fact that we all maintained liquidity in the system for the last eight weeks. I think we all would have said there was, at least, a 20% chance there's going to be some sort of liquidity problem, and the fact that there wasn't, I think it's impossible to say how important that was. Maintaining liquidity is definitely fantastic. And there is a liquidity problem and, obviously, completely changes the outlook for any recovery on the overall economy. In terms of CMS making changes and potential impact there obviously, the federal government is under massive budgetary pressures. I think we're already dealing with the massive deficit issue.

I think what CMS realizes is that making big impacts in the sectors is a critical... It's just short-term dollars. They end up having to put more money into the system. You continue to look at ways to get people to low cost setting. I think it was Greg's point on Medicare Advantage. I think Medicare Advantage is going to be increasingly a great solution to control cost. And then, enabling telemedicine, making some of these changes that, maybe, might have been temporary, more permanent, I think, is going to be a big push, for sure. I think people in the home, we think is going to be another... Service in the home, I think, is going to be another key initiative, as well.

Wyatt Ritchie (28:00):

Marty, has this caused you, at all, to rethink strategies from an investment point of view, or still sticking to your general thesis?

Marty Felsenthal (28:08):

Our broad thesis hasn't changed, at all, as a result of the crisis. Some of the more specific areas that we're interested in have been reprioritized, as we've thought about areas to target as a result of the pandemic. Some of the areas that we're focused on are telehealth, telehealth and telehealth. Anything that can help some of them payers deal with COVID-19 over the next 18 to 24 months. Businesses that can help providers capture meaningful and fast ROI. I'm not sure the country realizes the economic pain that's been inflicted on our provider community as a result of shutting down elective procedures. We were on a call with a number of health systems last week. One of them lost $80 million in March. One lost $100 million in March. One is expecting to lose $800 million this year.

We're going to have to find ROI savings. We think that communications and, for lack of a better word, the digital front door become that much more important in healthcare. Communications in an environment, like this, communications has never been more important. There's community messaging, individual messaging about COVID, about canceling procedures, rescheduling procedures. The more you're able to communicate in healthcare or snail mail. We're interested in businesses that can help seniors age at home. I think a quarter of all of the major deaths, as a result of COVID-19, has taken place in senior care facilities. Consumers are going to want alternative solutions to assisted living. And because of the economic prices, a lot of people aren't going to be able to afford it.

Remote patient monitoring, I think Ben mentioned this earlier, getting as much as possible out of the hospital. That trend seems to be accelerated both, for cost and safety reasons. We've seen a lot of interest from both, payers and providers, around analytics, so predicting who's at risk for COVID-19 and localize or reduce their... And what their staffing and labor needs are both, for the surge, as well as for the eventual comeback of elective procedures. My belief coming out of this crisis is going to be that innovation in healthcare will never be more important. I also believe that because of the crisis, payers and providers are really centralizing and speeding up decision making at a pace that we've never really seen over the course of our careers. However, I am concerned that, not withstanding the fact, that innovation has never been more important for healthcare, for innovation, particularly on the providers side, is going to get gutted, which is arguably the last thing we can afford, right now.

Wyatt Ritchie (30:49):

I want to conclude with just transactions and deal making, a little bit on that front. Ben, you'd mentioned about liquidity in the market and the strength of liquidity. I would certainly concur with our conversation. We've also had a lot of conversations with private equity firms, who have talked about broadening their investment criterion to look at types and minority investments, and structured equity, and filling stop gap measures for companies. I'm just curious, what's your take on that? Do you think that, that's going to be an active area? There's obviously a lot of complexity with that. I'm just curious, what's your sense of are there going to be a lot of those types of transactions, or do you think we'll go back more to traditional change of control type transactions as we get through this?

Benjamin Edmands (31:44):

It's a great question. We talk about this a couple times over the last couple weeks. Going back to your first question, or the previous question, about reevaluating our investment strategy. I think the sectors that we like are largely intact. Are there some new ideas that we have that we think could be interesting in this market? Sure. We're trying to get ourselves to come up with crazy ideas and this change. I agree with Marty that we think innovation will be a bit accelerated, hopefully, again. We spent a lot of time... But our investment piece is largely intact, for now. We are thinking of how do we execute that same strategy in different transaction types? Obviously, types and preferred equity investments, and good

companies that have temporary liquidity or leverage issues because of the crisis, obviously become a lot more action.

I think, to answer your question though, my answer is I don't know, and it's largely the function of how long this lasts. I think if it's we're back to normal in the fall, and it looks like we're going to pull out of this. I think existing GPs would say, "I'm going to bite the bullet. I'll continue this for a few." I think if it lasts longer, the abilities for these companies will come under pressure, and they'll need fresh capital. I think it's a function of how long the cycle, and how deep it is. Because if it's a good company that's got an upside down balance sheet, most people are going to finally support that, if it's only a temporary blip and there's just going to be a pretty large gap in the bid ask, when someone coming in thinks the company's worth versus an existing investor.

I hate to be...

Wyatt Ritchie (33:24):

I agree. I think there's a reality of what we're all dealing with. Greg, really quickly, just other capital partners, the lenders. How have they been? Our sense is they've been supportive. Do you expect that to continue? My guess is you'll give more answer than it depends. But I'm just curious, what's the state of play with lenders, as they look at your portfolio companies with you.

Gregory Moerschal (33:48):

Sure, sure. Again, we've had distribution of days that are accelerating and drawing fine through this. Another subset that is treading water and getting through it, and a couple that are struggling that are more consumer facing. Our lenders aren't banks for the most part. They're largely unregulated finance companies, and they have been constructive. They're longterm relationships. I think, however, Q2 will be the real test when covenants are breached in some cases, or there's liquidity needs in the industry around... It'll happen in Q2, in my opinion. I also am a little concerned as to the capital of our capital, our lenders. It's going to go up, if their portfolios become troubled. That's not like a bank. These finance companies rely on banks. And to the extent their ratios are impaired, or their cost to capital goes up, it could effect their behavior in amendments, and the quantum and cost of debt that they're offering to all of us going forward, at least, temporarily.

We're watching it. We've implemented a pretty rigid communication strategy, which the lenders have asked for and are appreciative of. We're over communicating and hopefully getting ahead of any difficult discussions we may have to have in the second quarter, in the summer time period. But you're correct in saying, for the most part, so far, so good, but I do foresee a little bit more resistance and, again, there's going to be gradients of pushback or acceptance to changes going forward. But that would be my comments.

Wyatt Ritchie (35:33):

And then, finally, curious, as you guys think about just transaction activity going forward, near term, longterm, and more importantly, just what do you think it's going to take to get back to "normal" levels? And even in a normal environment, I'm also curious, what does that do to valuation? Do you think we're going to get a re-basing of just what I call normal valuations in light of all of this, or do we go back to pre-COVID environments? Just generally speaking, and overall assessment across all of those things. Marty, why don't you kick us off there?

Marty Felsenthal (36:08):

I don't know how we can get back to normal pacing of investments without being able to travel freely. We're all ultimately in the business of partnering very closely with management teams. We would all characterize partnerships as like marriages. The prospect of investing in a company without meeting them in person is a little bit like a mail order bride, which, Wyatt, I'm assuming you got married.

Wyatt Ritchie (36:34):

Exactly, exactly. Virtually.

Marty Felsenthal (36:41):

As we're looking, I think it's hard to get back to the normal pace of investments. The ability to travel freely. The companies that we're looking at now, and have been looking at over the course of the past eight weeks, are by-and-large either businesses that we've looked at in the past that need additional growth capital, or management teams that we've known for 15, 20 years. We haven't figured out yet, as an organization, how we feel about traveling, even if some of the restrictions come off. Until there is a vaccine, or herd immunity, we're putting ourselves at risk and we're putting our communities at risk.

And so, we're having a lot of really interesting moral and ethical debate inside of the partnership about what our return to normal is going to look like. I'd say on the flip side of that, Wyatt, relative to your question about valuations, and growth factor, or growth equity. We haven't really seen a valuation reset yet. We have seen a handful of interesting companies over the course of the past eight weeks that either, needed capital or optionally would like to strengthen their balance sheet. However, they're raising off of their last rounds expectations, and their syndicates are sufficiently deep enough that the insiders are willing to do entire rounds rather than take a haircut. And that's really prevented us from digging in hard into much over the course of the past eight weeks, which isn't to say we haven't seen businesses we like. We just had a challenge of underwriting.

Wyatt Ritchie (38:11):

And how about you? What are your expectations?

Benjamin Edmands (38:16):

I don't really know. I hate to keep repeating that phrase, but I think it's going to be slow for the next quarter. We bought a company last week and we sold a company last week, and the only reason that happened is because we were working on these things long before the crisis hit. I think it's going to be... I think the third quarter is going to be pretty slow. And I think, when the market comes back, and I think it was Marty talking about it, we haven't seen a real reset on the piece. It's tends to be a bit of philosophy. My guess is that when the market comes back, we're going to see a bifurcation. We're going to see a big bifurcation. We're going to see some things there. And the MA plan, Medicare Advantage plan, that's largely in the way of something like this, a factor to growth at the top, it's obvious, and then they're going to go for a premium.

The ones where it's a little bit less clear and you're making a bet when things come back, those will probably be cheaper. And my guess is, when we look back four years from now, or five years from now, and look at where the outside returns were, there's going to be people who've made bets in '08, '09. Ones that weren't really that obvious at the time, but they worked out. And those were the outside returns. People picked those factors that's not exactly obvious. They go in, and they're not paying a big price. They don't have to leverage and they have the patience to make their way through.

Wyatt Ritchie (39:30):

Greg, how about you?

Gregory Moerschal (39:32):

Sure. A couple points. The businesses we buy are founder owned, so we're the first capital in. And there will be, or we're anticipating a bid ask, as folks try to look through this current environment, not only from a performance standpoint, but from a just a market multiple. They're going to look backwards. We're going to look forwards. And once that's resolved, I think there will be good activity. It's going to be proactive in nature more than anything. And that's where you have to get creative on structuring and, perhaps, Ben, to your point about bifurcation, paying for an asset for what you could look around the corner in the industry, or getting comfortable with the high valuation on a company that's performing.

I completely agree with the bifurcation comment, by the way. I think the premium assets will continue to get premium multiples, notwithstanding the environment today. There's still a ton of capital out there, and I think the willingness to look through and over [equitize 00:40:35] in this environment is still going to be the instinct of most buyers. And there's probably going to be less leverage available, answer I gave previously, and also because of the lenders less apt to accept add-backs. I mean, that was a bubble that was waiting to burst, and now it has. So, potentially, it's a return issue for all us entering at those multiples. Again, the bifurcation point is, I think, right on, and I think we're going to continue to see it. Certainly, activity is extremely slow now, and it's probably, at least, three months away from picking up measurably, so Q4, I would say.

Wyatt Ritchie (41:11):

Right. Well, you guys have all been very generous with your time and insights, so thank you. I do very much appreciate it, and there will be more to learn as the next few weeks unfold.

COVID-19: CareMont Medical CEO & CFO talk with Rob Fraiman, Cain Brothers

Join Rob Fraiman, President of Cain Brothers, as he interviews Scott Hayworth, M.D., CEO of CareMount Medical, and Kevin Conroy, CFO and Chief Population Health Officer of CareMount in a discussion of the COVID-19 pandemic, its impact on the healthcare sector and how CareMount Medical is responding.

Rob Fraiman (00:03):

I'm Rob Fraiman, president of Cain Brothers. During this unprecedented and disorienting time, the team at Cain Brothers is conducting weekly interviews with leaders from throughout the healthcare industry for this special edition industry insights series. Our goal is to provide you and your organization with a wide array of views on the multifaceted dimensions, challenges and responses to COVID-19. Transcripts are available on the Cain Brothers website. Please share your feedback with me or any of your Cain Brothers contacts, and thanks for listening.

Hi, my name is Rob Fraiman. I'm the president of Cain Brothers, and I'm delighted today to be interviewing Dr. Scott Hayworth, the president and CEO of CareMount Medical, and Kevin Conroy, the chief financial officer and chief population health officer of CareMount. CareMount is based in Westchester County, New York, just north of New York City, and is one of the largest primary care

oriented multi-specialty physician groups in the United States, with over 600 providers in 50 locations and specializing in over 50 different areas. The business is one that is, today, one of the largest independent physician groups in the United States. So we're going to jump right in. And Scott, I'll start with you. Let's start with the big picture. Would you describe the impact, both positive and negative, of the steps that CareMount has taken to treating patients, protecting your clinicians and your staff, and securing the necessary supplies?

Scott Hayworth (01:37):

Sure. Thank you, Rob. Well, let's first look at CareMount before the crisis. We were 600 plus providers providing care in six counties in New York, everywhere from Manhattan, 120 miles up to Kingston. We're the only Next Gen ACO in New York and we're one of 40 Next Gen ACOs in the country in eight urgent care centers. And of course, safety of our patients and our providers is our number one priority. Once we ensured the safety as our volumes dropped, we did a few things. First of all, we went to well visits in the morning and sick visits in the afternoon. And we did interview patients ahead of time to make sure that they were in the right classification.

As our volumes went down, unfortunately it was necessary to furlough our employees. We had an A and B team. They would work one week and be furloughed the other week. We also leveraged our Teladoc platform. We had decided, a couple of years ago, to start getting into telemedicine. So the team did an incredible job of bringing it up to speed quickly. Unlike other areas in the country, we have every provider on telemedicine. So they've done an awesome with doing that, and we are presently doing 1400 visits a day.

I think the positives is we had planned for this a few years ago and we had PPE in stock. So some organizations had to cut down their visits because they didn't have the PPE. We were blessed that the management team had thought of this and had PPE in place. We also obviously bought the telemedicine platform ahead of time, and our providers really stepped up. With having to maybe work in a different building and with different staff each week, they really show leadership and I'm very, very proud of our providers. They really cooperated with the teams and did everything they could, and they're also doing more themselves as well. So I'd like to give a shout out to our providers. Also, the only real negative is the drop in volume, and Kevin can go into that later because obviously, that affects revenue. And also, the substantial cost to PPE because we did have to go to the market and buy more PPE to replace the PPE we're using because we do put a mask on every patient who comes through the door, as well as full PPE for the providers and staff.

Rob Fraiman (04:15):

Kevin, how would you describe the financial impact? And in particular, which of the various CARES Act programs have you participated in so far, and how have your commercial insurance partners responded in the New York market?

Kevin Conroy (04:31):

Thank you, Rob. Yes, I can only describe the financial impact as dramatic as you might imagine. We're looking at a loss in revenues of upwards of 20%. Probably, it's very difficult to tell at this point given the trajectory of the crisis and the virus, but time will tell. But at the very least, we're thinking that we're going to be down roughly 20%. From a federal aid perspective, we fall into an interesting category. The CARES Act is providing some relief for physician groups, but as you know down in Washington as the aid packages evolve, a lot of it is going to be destined toward the hospitals. And while the hospitals are absolutely on the front lines, and I completely admire what's going on there, they're suffering to a

similar extent. We, physician groups, are also as an alternative to the hospitals and trying to treat our patients as Dr. Hayworth spoke to. We are also being devastated as well.

So the CARES Act is giving some relief through the Medicare program as you know. HHS has a program. And depending upon your proportion of Medicare activity, you're getting a check for that. On the small business administration payroll protection act, which of course has gotten a lot of press and airplay, we're simply too large to qualify for that particular program. So in terms of recovering loss revenues, the programs simply aren't going to be near matching what we're enduring. On the commercial side, Dr. Hayworth and I reached out very quickly from a telehealth perspective to make sure telehealth [inaudible 00:06:07] from a reimbursement perspective was in place. And I'm pleased to report they worked with us in that regard, Rob, and we're getting paid as if it were a typical E&M visit. So we're okay there.

But also, some of the plans have stepped up in terms of trying to accelerate claims processing and relieving some of the other barriers to getting paid quickly. I see some of that, but not nearly enough, but they're trying to be there. But it's simply probably not to a degree we're going to need. So all in all, we're taking other measures to try and mitigate the losses, as Dr. Hayworth pointed out, from a furlough program. We're also looking at all of our vendors in terms of timing and payment. Of those, we're looking at other supply chain opportunities and seeing where we could make a difference there. So we're having to take steps.

And by the way, I would also compliment our physicians and our frontline teams that were also enduring, as you might imagine, an income hit from this particular program given the fact that we're a shareholder owned entity.

Scott Hayworth (07:13):

And I'd just like to add to what Kevin said is that if you think about it, we're not doing elective procedures and elective visits. So that's a real reduction in revenue for the group, as well as not providing the ancillary services in the same level as we were before.

Rob Fraiman (07:31):

Let's dig in a little more on telehealth. Scott, you talked about it before. It's obviously a critical element of the adoption of teleheatlh to this crisis. Give us a little bit of detail, if you can, about how many telehealth visits per week or however you're measuring it, you're doing now, versus, for instance, six months ago. So why don't we start there and then ask them where we think it's going in the future? Kevin, you want to take a shot at that? [crosstalk 00:07:57]

Scott Hayworth (07:58):

Sure. Yeah, sure. So we're doing roughly 1400 televisits a day. Six months ago, we were probably doing maybe five to 10 a day. Also, the big difference is we were using telemedicine for some postoperative visits six months ago, and to sick patients coming in and we were using it for after hours, urgent care in the middle of the night. Now, we have every specialty up on urgent telemedicine, and that's how we really leveraged her Teledoc relationship because it really wasn't set up for that. So the team did a phenomenal job of taking somebody who should've been a three to six months [inaudible 00:08:41] ... and they got it done in two weeks.

Rob Fraiman (08:43):

Scott, as somebody who's a physician and a leader in the industry for decades now, how do you think this plays out in the future, in specifically teleheatlh? Is this going to be the beginning of a permanent in terms of the proportion of teleheatlh versus in-person visits?

Scott Hayworth (09:01):

Without a doubt. I think the public's gotten used to it. The public likes it a lot and the providers like it. They can do televisits at night after they're home, after dinner, after maybe they put their children to bed, and they can do it on the weekends. It's a lot easier. They don't have to come to work to do it. I think we have to look at our facilities and how we're set up in the future and we're already studying ways to come out of this, but I think telemedicine's here to stay. I think employers are going to like it. People don't have to leave their desk to go to the doctor's office for many things. So it's going to be a combination of telemedicine with in-person visits. I think it all depends on what's going on.

I think also, the technology gets better and better. Eventually, doctors are going to be able to listen to a heart, listen to lungs, maybe even do other types of exams through telemedicine. So I think it's here to stay. I think this has been a revolution in industry.

Kevin Conroy (09:59):

And I would add to that, Rob, very quickly that while we're seeing 40% to 50% of our current visits utilizing the teleheatlh platform, it probably is going to settle down post-COVID to somewhere in the neighborhood of 10%. It is here to say, as Dr. Hayworth pointed out. One of the things that we recognized being a value player and a value based care program believer so to speak is that we recognize that teleheatlh is going to play an important role in providing care when we can't. We're actually in contact with our multiple comorbid patients. More often, we're re-stratifying to understand that. So that's a key piece.

And then one other I would add to is that we're also using teleheatlh to communicate in the inpatient side from a discharge planning perspective, as well as in our post-acute [inaudible 00:10:46] settings as well. So it's an added value there in terms of integrating and coordinating care for our patients outside of our four walls.

Scott Hayworth (10:54):

Especially with the next gen ACO and being at risk. Our next gen ACO has been very, very successful, so much so that we now have hospital clients for the MSL, which is [inaudible 00:11:05] ... to help them choose both MSSP as well as next gen.

Rob Fraiman (11:12):

Let's continue going down that path. Let's talk about value based payment models. CareMount has been a leader in the New York market and nationally for physician groups in adopting value-based models, particularly in the MA world. How do you see this crisis impacting your ability at CareMount to grow that portion of your business, your value based business?

Kevin Conroy (11:36):

Thank you, Rob. Yeah, you're absolutely right. Dr. Hayworth recognized the need for value-based care and going down that road years ago, and we've been committed to that and taking on a greater responsibility for the total cost of care. As Dr. Hayworth suggested, we have 30000 lives in our ACO. We have over 10000 lives in our Medicare advantage programs, and this has translated into value based and

proactive care. We've made significant investments in data analytics, care coordination, and we've deployed robust physician led medical management programs. These investments have been vital for our patients, particularly our most vulnerable patients who potentially are deferring care during this crisis. So through risk stratification and utilizing our care coordinators, we are reaching out to them at this particular point to keep them healthy and avoid potentially complicated and costly episodes down the road.

Perhaps, most innovatively, as we've alluded to already, we're working with our provider partners throughout our geography and outside of our four walls to coordinate care, discharge planning, post-acute patient management programs, all with the eye on improving care and improving outcomes and total cost of care. We think that we're going to go down this path even greater. I'm not going to suggest that COVID is going to accelerate our road to value, but we're looking to double the number of Medicare advantage lives we have over the next two to three years. This, perhaps, puts a bit of an exclamation point on it because as you know, at some point in time, full capitation of full global programs is something that we are absolutely keenly focused on in the future. We're going to do this anyway.

I think the key for us and for current providers that take on risks is that, what does it mean to not be able to access these patients? We're doing the best we can over telephone. We're using our platforms to reach out through our coordinated care platforms, but at the end of the day, we're deferring care. And what is that going to mean for fully a fully global providers is a question mark, but we're ready to take that on. We're going to move in that direction regardless.

Scott Hayworth (13:48):

So Kevin's a very modest individual, but Kevin's built an awesome team of people. His carrier background, Kevin used to run a health plan in New York, and when he came on board six years ago, I asked him to help with setting up. We were an MSSP plan. We were in the first wave of MSSP in the country, and Kevin has taken it to a whole new level, so much so, as I mentioned earlier, we have hospital clients now, and we want to continue to expand our value of consulting and our value technology, both in New York, as well as across the country. We have built a team of data scientists and consultants. It just really is beyond what anyone could have expected.

Rob Fraiman (14:34):

Scott, as we sit here on Friday, April 24th, people are talking about a return to normalcy over some period of time in the coming months. Talk about how CareMount is thinking about growth opportunities. You've talked a little bit already about value based, but how do you see the environment for CareMount to continue it's decades long growth plan as we do return to normal in the coming months and the rest of the year?

Scott Hayworth (15:07):

Well, we've been getting phone calls from providers. So it's actually easier than it was. People are looking for a safe landing. I think they look at CareMount providing that safe landing, and I think they like the fact that we're an alternative to the hospitals, that it's a physician led organization and we will continue to grow. We obviously want to cherry pick the best providers, and we're very careful about who we bring on board. We want providers who believe philosophically the way the rest of the organization, that the patient's at the center of everything we do. However, I think if anything, we're in a better position to grow. We're going to come out of the COVID crisis stronger. We're going to re-look at

how we do things. We are going to do things even more efficiently than before, and I think we're perfectly positioned to grow.

Rob Fraiman (16:07):

To wrap up, at this stage of the crisis, Scott and Kevin, share some lessons learned and specifically, changes that should be implemented at physician practices like CareMount and other organizations that you're familiar with and around the country to improve the nation's responsiveness to future health care crises, which probably includes a second wave later this year.

Scott Hayworth (16:34):

Why don't I start, and Kevin can finish? So I'm blessed to have built an incredible matching team over my 23 years as CEO. Actually, two of my senior people, Chris Sclafani, my chief operating officer and Dr. Rich Morel, who's my chief physician executive, were Eagle Scouts. I didn't get that far in the Boy Scouts, but obviously, we try to be prepared. I think that shows in how we do things. We're actively working on post-COVID and I'm very proud of the team on that. I think one thing we learned was we over communicated to physicians, patients, and staff, both with group-wide calls, videos, emails. We have kept in touch with everyone. I think that's key. I can't stress communicating enough.

We are ready for the second wave. We have a robotic lab that does 2 million specimens a year. So they're very ready. So if there is a return in the fall, we're going to make sure we have enough PPE, as well as testing so that we can tell whether it's flu, whether it's COVID. So we'll be prepared. Hopefully, for everyone, obviously we hope we won't be there. So now, I'll turn it over to Kevin.

Kevin Conroy (18:03):

Sure, doctor. I think you hit most of the points. Clearly, we understand the safety aspect and component. Clearly, we understand sort of how we need to consolidate. The thing I'm most impressed and proud of too is perhaps, our nimbleness as a management team, as Dr. Hayworth alluded, [inaudible 00:18:21] ... core the idea that we've worked together collaboratively across all lines of the organization and quickly responded, and that everybody worked together from the physicians on down to the couriers all throughout the organization. And I think that's the number one piece. If a second COVID, inevitably there probably will be, we're going to be ready.

Scott Hayworth (18:44):

I think that's a good place to wrap it up. Dr. Scott Hayworth, president and CEO of CareMount medical, Kevin Conroy, chief financial officer and chief population health officer of CareMount, thank you for your time today. And in particular, thank you to your entire team providing care to us in the New York area at the epicenter of this crisis during this incredible time. Thanks very much.

COVID-19: Terry Akin, CEO of Cone Health, talks with Carsten Beith, Cain Brothers

Join Terry Akin, CEO of Cone Health and Carsten Beith, Managing Director at Cain Brothers, in a discussion of the COVID-19 pandemic, its impact on the healthcare sector and how Cone Health is responding.

Rob Fraiman (00:03):

I'm Rob Fraiman president of Cain brothers during this unprecedented and disorienting time, the team at Cain brothers is conducting weekly interviews with leaders from throughout the healthcare industry for this special edition industry insights series. Our goal is to provide you and your organization with a wide array of views on the multifaceted dimensions, challenges and responses to COVID-19. Transcripts are available on the Cain brothers website. Please share your feedback with me or any of your Cain brothers contacts. And thanks for listening.

Carsten Beith (00:39):

Hello. I am Carsten Beith, a managing director and co-head of health system M&A at Cain brothers today. I'm speaking with Terry Akin, president and CEO of Cone Health, a $2 billion health system based in Greensboro, North Carolina, and one of the nation's leading-edge value-based healthcare systems. Terry, thank you for taking the time today to speak with us regarding COVID-19 and your perspectives as CEO of Cone Health.

Terry Akin (01:06):

My pleasure. I appreciate the opportunity, Carsten.

Carsten Beith (01:09):

So to start that I'd like to get just your overall perspectives on where Cone stands today in the healthcare crisis and your response to COVID-19 in general.

Terry Akin (01:19):

Yeah, so needless to say for the last few weeks, the level of intensity around our organization has been very high. We are working on trying to be a resource to our elected officials at the federal state and local levels to try and help them remain as fact-based and science-based as possible in the decisions that they're making many of which have a direct bearing on the spread of this virus and containment of this virus. The flattening of the curve, as most would say, and then simultaneously all kinds of operational needs and challenges and imperatives. As we care for infected COVID 19 patients and prepare for what we expect to be a surge or a peak that's likely to come later for our state and for our region. So everything from all the basic issues you've been hearing about, masks and PPE, testing supplies, testing turnaround time, how to deal with concerns from the community and how to continue to message to the community, how they can help us, what they can do to help us.

It's been a major undertaking, I will say. I think we've got a great culture within Cone Health. Sometime ago really been intentional about creating leadership as a team sport while we work carefully to coordinate and communicate. We don't have a lot of leaders who walk around asking for a lot of permission, we empower people to act, and I think that really has served us well because there's so many issues and factors that need to be dealt with right now, having that sort of team-based leadership serves as well.

Carsten Beith (03:27):

Terry as you mentioned, North Carolina in Greensboro, more particularly has not yet been hit hard as other parts of the country. And it sounds like you're expecting that surge. Can you just describe some of the operational challenges that have arisen for you even now in the absence of kind of a broader surge.

Terry Akin (03:46):

Sure. So we're trying to be very careful with respect to use of PPE and supplies, which are limited. We're accessing every possible resource we can find. In fact, I've frankly, as CEO of the health system become much more of a creative supply chain sourcing expert than I ever intended to be. And that's been an adventure unto itself, but really trying to balance the short-term needs, practical needs, science-based needs to protect our people and also attend to their psychological and emotional sense of safety. Mindful of the fact that people really feel secure and want a universal masking protocol. And we've been able to move to that, but also conscious of the fact that every mask we use today or every supply we use today is a supply we won't have if and when the surge hits. And I think that really describes probably the biggest operational dilemma that most health systems around the country are facing right now.

Carsten Beith (04:59):

How have payers, other providers in both the state and local government reacted in, in North Carolina?

Terry Akin (05:07):

I think there's been a strong desire to help. I think there's been a fair amount of forbearance from payers, frankly I just think a lot of us were not as prepared proactively as in retrospect I wish we could have been, should have been. But I think that there's a widespread ethos across all the entities that you named that we really need to put our communities first. We really need to put our patients first. And in many ways we'll kind of sort out the payer and the financially related issues later and as we go.

Carsten Beith (05:53):

I know you've been very passionate about this steps the state needs to take, to reduce the impact of COVID-19. Can you describe those efforts and what you've accomplished so far in North Carolina?

Terry Akin (06:05):

Sure. I've been very vocal about the need to pay attention to the scientists and the clinicians and heed their advice, which is born of a lot of experience, observation, nationally and internationally. And I mean, let's face it, the infectious disease physicians and epidemiologists, these are people who study pandemics for a living and early on when they were advising us that we really had a chance or that our best chance to stem the spread of infection to limit fatalities and to prevent overwhelm for our hospitals and health systems was to implement these shelter in place or stay at home orders. That's a cause that I took up and it has not been without its challenges, and I certainly understand those challenges. It has a tremendous impact economically. I feel for businesses and particularly smaller businesses that are struggling at a time like this.

And so I do think it's got to be a both and kind of conversation that said it, I believe strongly and passionately that we really have to take the advice of the scientists from the federal level on down who were saying that, staying at home, limiting social interaction to reduce what has become clear is an exponential level of potential spread of this virus. That those are mission critical steps, and while we're enduring the pain, both economically and from a business standpoint, it's hard to keep your eye on the ball.

When you start to have an impact, when you start to flatten and shift the curve, people start to believe, well we really didn't need to do that in the first place, or see, I told you. It says if pointing to the flattened curve as evidence that we shouldn't have gone through all the trouble to then flattened that in the first place is one of the conversations that we're having to deal with. But I think we do have to deal with a very real issue of economic impact, and how do we balance that against what the scientists are telling us about the need to contain and stem the spread of this highly contagious virus.

Carsten Beith (08:38):

How many COVID-19 patients have you had, and has there been a significant impact on your employees and have your employees tested positive and what sort of the [inaudible 00:08:52]There?

Terry Akin (08:54):

Yeah, so that's all obviously clinically and operationally things that we concern ourselves with. We have, I don't know what the total number of in-hospital patients we've had over the course of the pandemic, but currently today, I believe we have upwards of 30 patients in our hospitals that are COVID-19 confirmed. Probably a little over half of those are actually in our ICU, and then the majority who are in our ICU are on ventilators. So we've got some sick people and we've actually within Guilford county where we're located, we've had 11 deaths so far that are COVID-19 related, and a lot of those well, virtually all of those have been older folks over the age of 70, who were vulnerable and had multiple comorbidities to begin with. So again we're managing a fair number of patients, and we're trying to equip ourselves what we expect to be an even greater surge of patients.

Our project best projections are probably in the May to June timeframe. With respect to our employees. We're being very careful to screen our employees. Each and every day we have had some employees confirmed. Others have, because of limitations on testing, not even been tested, but sent home to quarantine and treat symptoms. I'm only aware of one employee who unfortunately has become critically ill related to COVID-19. And as among those we're caring for in our hospital today, but something we all have to be very, very mindful of and continue to focus on.

Carsten Beith (10:47):

Yeah, well, best wishes to that employee, and obviously all the patients.

Terry Akin (10:54):

Thank you.

Carsten Beith (10:54):

A little bit about the demand for COVID-19 testing that you're seeing and your ability to fulfill that demand.

Terry Akin (11:02):

Yeah. That's a major issue. One of the concerns that I've had quite frankly, is I believe that at the state and national level, we're overly focused on quote unquote confirmed cases. I think the number of confirmed cases dramatically understates the prevalence and the existence of the virus in our communities. And that is because we have been very limited in our testing capabilities and in the turnaround time for tests. Now, there, there are some exceptions, there are some larger health systems or academic centers or others that sort of by the luck of the draw had some of the right testing platforms and supplies and equipment already on hand. Others like us, weren't, so lucky. We've really had to wait for manufacturers to kind of catch up. But what that's resulted in is a high degree of variability in testing prevalence across the state and organizations like Cone.

And I believe this is in keeping with some CDC guidelines because of limitations on testing as a practical matter, up to now, we've largely only tested people who were deemed to need hospitalization. Others who were symptomatic and who were identified either through their physician or E-visit or through other types of screening generally are not tested, but are sent home told to quarantine and

treat their symptoms. So as a result, the confirmed tested cases we believe are dramatically understated, and that creates some confusion in the public. For example, in the triangle we have some academic centers, one in particular, that's been able to test at a much higher rate, and so as expected, they have a much higher number of confirmed cases.

But what I'm trying to emphasize to people is that that really shouldn't be the comparative denominator because of the variability in testing the real comparative data We believe our numbers of deaths, numbers of patients actually hospitalized and numbers of patients on ventilators. And if you look at that on a per capita basis, Guilford county is unfortunately leading the state. And so we're trying to be mindful of that, we're trying to deconfuse the public and deconfuse public officials as to how to look at that. So that's one challenge of limitations of testing. We are increasing our capabilities, so we do have more and more rapid turnaround testing coming online. And we're actually consulting with and collaborating with the state and the county as we speak, on how we can actually broaden our testing and go out into the communities and try to be more proactive and identifying the virus in less acute forms so that we can have some targeted containment and hopefully stem the spread that way.

Carsten Beith (14:08):

That's an interesting perspective. In addition to let's call it testing capacity. What additional resources are you trying to secure to address the expected surge in patients in the coming weeks?

Terry Akin (14:24):

Well, it's a lot of the basics that you've been hearing about. Personal protective equipment, namely masks and in particular, the N 95 masks, which are like gold and very hard to come by, in short supply. There's a lot of really challenging dynamic out there. Everybody seems to know somebody whose brother knows who's got access to a supply of masks, and we've learned the hard way several times, especially if those are masks coming from China, to be very, very careful with our money and with our expectations. Because there are a lot of scams, just to be blunt about it, and even state side there's a lot of sellers and resellers and agents and examples that we've had where we had a confirmed order for a large number of N 95 mass that then were sold out from under us to a higher bidder. Apparently.

I mean, it's just really kind of crazy and really very frustrating to be honest. So I would say that's just a very important and critical core challenge. Those masks, they're low lower-level masks to continue to enable universal masking among our staff ,gowns, face shields. Those are all just mission critical things that are in, in short supply. And we're sourcing those through every creative means that we can find including through some local manufacturers. Our communities in this region have really stepped up. We've had a fair amount of manufacturing, and some of those folks have retooled to really help us with, with masks and face shields and even ventilators. I mean, that's another area where depending upon the surge and the degree of the surge, we could, we could outstrip our ventilator capacity.

So actually working with local manufacturers to come up with more ventilators, to come up with acceptable ways to perhaps treat multiple patients on a single ventilator. These are all things that we've been working on and focused on.

The testing, as I mentioned, and accessing testing supplies. As basic as the sampling swabs and the transport media that are used to actually transport the samples, those have been in short supply and challenging to source. And then as I alluded to before accessing means through which we can get rapid turnaround for a while, the fastest turnaround we were getting on our tests through outside referral laboratories was five, seven even nine days. And the problem with that is, as those patients are in the hospital, awaiting results, we're burning through masks and PPE caring for them not knowing if they're infected or not. So it just kind of compounds the problem, we are starting to make some

headway in terms of testing, rapid turnaround availability, and as I mentioned before, we've gotten some good support here in the last day or two from the state toward end. But, but those, those are the things that I would say are sort of most acute around the operational supply related that we're dealing with.

Carsten Beith (17:51):

Thank you. Can you elaborate a little bit on what the state is doing?

Terry Akin (17:56):

So the state is doing everything they can to be supportive. They have in collaboration with the federal government, a certain level of stockpiling of supplies that we're able to access, although it is very limited. This mythical sort of stockpile, as I think you probably have heard in the media really does not exist to any large degree, but they are helping us with supplies. They're helping us with some coordinated data collection to understand across the state where really are the hot spots and where do we need to prioritize help and support. The state is obviously working with our counties from an epidemiological standpoint to try and especially now that we've got better testing capability coming online, trying to support us and taking a more epidemiological approach to understanding the degree of the spread of the virus and contain it.

Carsten Beith (18:58):

Thank you, Terry. We've got just a few minutes left, just a couple of other questions. Obviously in addition to taking care of patients and all of the clinical dimensions that that implies, how are things going just financially and operationally, what's happened to your volumes? How are you managing through this crisis on that front?

Terry Akin (19:21):

Carson. It's a huge unprecedented impact for us as and I think that anybody who does what I do for a living that you could talk to around the country would say exactly the same thing. When you take an organization, even an organization like ours, which as you know, is pretty far out on the curve, when it comes to value based healthcare and value based agreements, we still have a preponderance of our contracts, volume-based. When you take a step that has you basically canceling all elective surgeries and procedures you're basically taking away the revenue stream that under the current healthcare model keeps the boat floating. So it's a dramatic financial impact. I don't know, I can't exactly quantify it, but it's an order of magnitude that we've never had to encounter or deal with before.

The federal government through a stimulus package has provided some help and support. We're certainly carefully tracking everything that we can related to revenue, deficits, and expense increases in the hopes that over time we will get additional support. We're obviously having to be rigorous internally around counter measures that we can take to reduce expenses and to match resources to volume. But the degree is just unprecedented. I mean, we've got a very rigorous productivity system, for example, that that has allowed us over time to match our staffing and other resource to volume and acuity. But when you take literally a 30 to 40% volume drop almost overnight by virtue of canceling, a lot of elective discretionary cases, that's hard to recalibrate to. So we're, we're in progress on that.

We're trying to identify every possible reasonable financial countermeasure we can while also knowing that we need our people and we're calling upon them to those who are in the trenches to work as intensively as they ever have. And we've also got to keep an eye on the need to ensure that we've got adequate staff, including on the bench and in the pipeline, if, and when more of our staff become

infected and become quarantined. So it's a Herculean undertaking when it comes to trying to manage and moderate the financial impact. But I can tell you it is big, and it's set at an order of magnitude on a monthly basis that we've never even gotten close to before.

Carsten Beith (22:07):

Yeah. I can imagine the challenges, that's something you've ever seen before. Terry, final question. Do you have a view of how this crisis will impact the hospital industry generally? Will it result in more changes and significant changes? And if so, how do you see it?

Terry Akin (22:27):

You know` that's an interesting question, and one that actually, I've, I've been at several conversations with colleagues and other advisors and people who are looking at that. You know, we are largely across this country a fee for service based healthcare system. And so the kind of pain and challenge that I'm describing repeats itself all over the nation. And I might even argue for this, those that are less sort of value-based then Cone health, the pain is probably even greater than the impact is probably even harder to deal with. I would speculate if there's sort of a silver lining inside this pretty dark cloud that we're all dealing with right now that this may force us even more toward value-based approaches to care, to really at all costs reduce costs, reduce waste, focused on people, keeping people healthy and well, And out of the hospital.

I think we've learned a lot of new things about what's possible virtually we've become unconstrained for the most part in terms of providing virtual care, E-Visits, assessments, which everyone knows is more cost-effective and more efficient than, than creating infrastructure of offices and physical facilities that people have to visit. So I think we'll move more in that direction. And I think the cost pressures are going to be so high on everyone just exacerbating out of this crisis, that those who have not gotten serious about moving toward a more value based model, which is less reliant upon fee for service and more built around incentivizing keeping people healthy and well, and reducing utilization. I think it's going to become even a greater imperative.

Carsten Beith (24:23):

I think well said Terry and great insights. So with that, I'd like to thank you for taking valuable time from the battle, if you will, and we greatly appreciate your insights, and we wish you the best of luck as you continue on and address what hopefully will be a relatively flat curve that allows your community to weather the storm, so to speak. So with that, Terry, thanks so much again we are very appreciative of your time.

Terry Akin (24:58):

Thank you very much, Carsten. I appreciate.

COVID-19: Steve Rodgers, AccentCare, speaks with Matthew Margulies, Cain Brothers

Join Steve Rodgers, CEO of AccentCare, and Matthew Margulies, Managing Director at Cain Brothers, in a discussion of the COVID-19 pandemic, its impact on the healthcare sector and how AccentCare is responding.

Rob Fraiman (00:03):

I'm Rob Fraiman President of Cain Brothers. During this unprecedented and disorienting time. The team at Cain Brothers is conducting weekly interviews with leaders from throughout the healthcare industry for this special edition Industry Insights Series. Our goal is to provide you and your organization with a wide array of views on the multifaceted dimensions, challenges, and responses to COVID-19. Transcripts are available on the Cain Brothers website. Please share your feedback with me or any of your Cain Brothers contacts and thanks for listening.

Matthew Margulies (00:40):

Hi, I'm Matt Margullies Managing Director at Cain Brothers and head of our firm's post-acute care and Home Care & Hospice advisory practice. Our guest today for Cain Brothers interview series is the CEO of one of the largest home health care providers in the country. Since 2012, Steve Rodgers has transformed AccentCare into one of the most innovative and diversified providers at home health, personal care, and hospice services across more than 175 locations in 15 states. AccentCare was one of the first companies to recognize the strategic and clinical importance of providing all three home care services. And under Steve's tenure was a first mover in developing a winning home health strategy with managed care organizations. In addition, AccentCare is partnered in two of the largest post acute joint ventures in the country with Baylor Scott & White Health in Dallas and UCLA Health System in Southern California.

Steve and his company are not only on the front lines of the COVID-19 crisis, but also at the intersection of our nation's health care delivery system, interacting with every constituency on the health care continuum during this pandemic. Hospitals, SNFs physicians, patients, their families, and of course AccentCare his own clinical workforce or going into patient's homes on a daily basis. I can not think of an executive who has a more comprehensive perspective on our healthcare system during the COVID-19 crisis than Steve Rodgers. Steve, thank you for joining us, and I'm very excited to speak with you today.

Steve Rodgers (02:11):

Thanks, Matt. Happy to be here with you.

Matthew Margulies (02:14):

Starting from the top. Has there been any material disruption in your branch and clinical staff's ability to provide care in the home and the other settings that you provide TRN, SNF, and the assisted living facility?

Steve Rodgers (02:29):

I mean, I think the entire healthcare system has gone through a significant disruption, right? With the COVID crisis over the course of the last six weeks. And I think we're part of that system and we have these partnerships with the hospitals and the others, and I think, rightfully so as we've seen some of the changes in the systems towards the social distancing, as well as the preparation for the surge activities.

There's been a very flow of patients, in the way patients are moving into the system and interacting with this system right now. If I just ticked off in our acute care setting, we saw actually coming into the middle of March, increased activity out of acute care as they started discharging patients out of the acute setting into the home to actually create capacity. And what's that resulted in right now, as far as right now you have hospital systems that are essentially operating at about a 50%

capacity level or so out there in the marketplace, but were also seeing the throughput of patients with this, especially the elective surgeries being canceled.

You've seen the throughput of patients both through the system on the inpatient side, as well as by generally the patients that might have been brought in typically through the ED significantly drop-off. So, the combination on the acute care side is as much as a 30% drop have been in the business that you end up seeing coming out of acute during this time period. Over on the assisted living side of the business and the skilled nursing, there's been a lot tighter lockdown. Once again, those facilities that the assistant livings are the ones that they pretty much put a framework in place where it's only essential personnel going in and we've managed to maintain a lot of access on the hospice side that, because there's... Especially with patients that are inactive dying process is you've got to be able to be in the system there and assisting them.

But they're really more of what I call the therapy and some of what I call less needed or less mandatory home health services and the AL should have been taper down significantly across the board. And then in the SNF setting this have done... It's a variation of activities, right? So on the SNF settings, you've seen the general, you've seen some discharging coming out of this steps, generally speaking. And then we've continued to have some access with the hospice. And then from our primary care standard, our physician standpoint, the biggest thing about the physicians out there at the marketplace is essentially finding them because as they've had throughput in their own offices, many of them are only working half days themselves or working virtually out of their different places.

And so their interactions with their patients have been very different too. So there's been some modest drop off in the interactions on some of the physician services too, although it does differ by the specialties. Obviously, with the orthopedics, they've fallen off a cliff, but more than needed practices like oncology, there's been a consistent flow of patients moving through the system there.

Matthew Margulies (06:03):

And In terms of your workforce, would you say on average, they've been able to both stay healthy and have been willing to come to work, put themselves at risk. Obviously they're going across the threshold into patients homes and into these facilities. What has been the feedback from your clinical workforce in that regard?

Steve Rodgers (06:26):

The workforce issues are huge and incredibly significant environment like this, because these people aren't just clinicians. They're people that are going through all the same shocks that I think the country is generally going through. And what I would say is what's been interesting is just to watch the stages as this has moved on. And part of this is the way we managed through it too. And there has been some geographic variation. And the way that I've seen the workforce has react to some of these situations but on the whole, I'd have to say that the clinicians have stepped up incredibly well to this. I mean, we, as an organization have essentially put our communications on steroids. So we did a number of things across the board. There are daily messages of going out six days a week to basically our workforce. We have an online... We have an application and it goes both on iPhones and Android operating systems that essentially pushes messages out to our workforce, including I do a weekly video message.

And one of the things that's been incredibly important is this, what we've talked about a lot is called the purpose of why we're in this business and what we need to do. And a lot of that underneath that, to put your people on the front lines, they've got to have a combination of trust that they have the equipment they need, trust that they have the training that they need and trust that they got leaderships that isn't going to put them into harm's way. And so when you address those through your

communication programs out there with, you can tend to get them aligned around the mission. And I would say that we have put in place, we actually have dedicated COVID teams of clinicians. I taken care of COVID patients out there today, and we have put in place a monetary and other incentive and protection mechanisms for them.

But I would say what has really made the nurses and therapists and the other clinicians step into this has really been the call, the purpose of recognizing that this is what they're in the business for. And so with that, we have gone through and in our workforce we've had patients or not patients, nurses and clinicians positively diagnosed with COVID. None seriously, none hospitalized so far. And we put in... We've had some over on the attendance side of the business, too. These are all tracks. We track. We've been tracking both, and we actually have a whole clinical process built around tracking quarantined patients where they're presumed or active quarantined for COVID so that we can monitor the return to work and the status of our employees at any given time.

Matthew Margulies (09:32):

In terms of the patients and their families, have you seen any pushback from either, from in terms of allowing your clinical staff to enter the home, any fear around spreading the virus to the family member or to the patient in their home?

Steve Rodgers (09:53):

Yeah. No, we've seen it on both the personal attendance side of the business, as well as the home health care side of the business. I would say early into the crisis on the home health care side of the business, there was a spike in miss visits. I think the spike and miss visits on the early stages of this. And there was also a spike in what I call where we had valid referrals coming in, where the patients were not accepting of the service, or did not want the service. I'd say we, once again, developed communication protocols and campaigns to make sure that we could educate our patient and client workforce around essentially the sterilization procedures that we have to once again, take down the fear factor.

I think some of those miss visits we're also our own system adapting to basically how to deal with some modest pushback I think coming from the patients over time. And so the miss visits spiked out probably about two to three weeks ago. And over the course of the last several weeks, we've seen a precipitous drop. I think the other thing has happened is we've been very persistent on patients that initially said that they didn't want service or were prohibiting us from coming into the home. We call them. We call them multiple times a week to make sure they're okay, to check in on them. We also have, like I said refined both the sterile, how our sterilization procedures are and the protective procedures that we put in place.

But I think another piece that we've done is we talked to them about our Telehealth program, because we are basically, especially with COVID patients, but non COVID patients we've significantly increased our Telehealth services and our ability to interact with them virtually both through a synchronous communication applications that are HIPAA compliant, as well as more complex Medtronics types devices that we have out there. And I think that's helped break down some of the barriers too.

Matthew Margulies (12:05):

And then what about your workforce? The call center and the back office. What programs have you put in place to move to a virtual office working from home, those types of measures?

Steve Rodgers (12:20):

Yeah, it was interesting. I think we've always had a disaster recovery plan and part of the disaster recovery plan was built around moving to a virtual workplace and having staff being able to work out of the house, right.

Whether it was a tornado hit a service center or hurricane or something like that. And I always doubted whether it would work to tell you the truth. And I have been incredibly pleasantly surprised over the course of basically a week after we decided to go ahead and do it. Our IT organizations systematically worked through to make sure that all of our employees that were in their back office operations basically had technology appropriately installed on their computers, had the soft phones appropriately installed on their computers, had headsets, had appropriate internet connections at home. If they didn't we got MiFi cards to take home with them. And essentially over the course of four days we moved 700 people home and got them all home, got them working virtually. And during that time period, we have seen zero drop in productivity whatsoever. And I will tell you, the thing that happened too is there was a lot of noise of fear factor.

Once again, while they were still sitting in the offices. And as soon as we moved them home, all that fear just dropped off. And so we actually do have a call every day, checking on where our workforce status and what's going on and making sure that we had the right workforce in place to both continue to process our bills and get our bills out the door and get paid as well as all the centralized back office operations we have out of McKinney, Texas. I mean, one of the things that's different about us with AccentCare is we have a 100% of our intake centralized across our home health care platform. So if that goes down, that means we have no business coming in. Right? So it was even that much more nerve wracking during the time period like this, but we've seen absolutely no drop-off.

And in fact, I will tell you by having more of a centralized back office function in something like this. We have a greater pulse on what's going on. I get updates three times a day about how many referrals are coming in, what the admits are developing up like. That basically gives me essentially a sense of what's going on inside the business.

Matthew Margulies (14:41):

It's a really interesting comment you just made. I know there's different views on the right way to structure intake. Some of that obviously is a function of how the organization was built and it's also a function of viewpoint on what the right, the best way to structure intake. Do you think there'll be a greater move towards centralizing intake at other key functions post this pandemic as companies think about better ways to protect themselves in the future?

Steve Rodgers (15:18):

Yeah. I can't talk for with some of my for-profit publicly traded competitors are going to do, but this has been an incredibly, I think, helpful capability for us, because it really does give you a really great handle on the business side going through times like this but there's risk. Right? But I mean, I think what we shown is we can mitigate that risk coming through it, but we have a 100% of our insurance authorization and verification. So we know what's going on on that and how the activities are coming in. It's been incredibly... I mean, think about Texas going through. In Texas, Texas went live on RCD on March 1st or April 30th or not March or, I mean, February 29th, one of the two. And you sit there and we had to manage through RCD at the same time period, which is all the pre-claim that CMS put in place at the same time period, as we were putting in this operation.

And it gives you a better sense on pulse, on what's going on inside your business, then trying to collect it out of 200 call points out there and understanding how the business is coming in and what's it looking like, where things are falling off on and everything else. And so I think it's just given us incredible

visibility, I think, into our ongoing operations and stability too, because we've seen where there are pressure points that we might want to push on a little bit more differently. We monitor all our portals are a 100% centralized too. So the portals for the referrals coming in are through there. So we can pretty much see what are the activities coming in, where there might be problems. It would help us to immediately set up the COVID profiles out on all the portals for whether it's naviHealth or Allscripts, so that people knew that we could accept the COVID patients instead of relying on each of our individual sites to set up those profiles like that.

So it just gives you, I think, a different level of visibility and capability to react to a situation like this.

Matthew Margulies (17:19):

And have the managed care plans. And the Medicare intermediaries been processing claims at the same pace as they have, or they were pre COVID-19 or has there been a noticeable slowdown in their productivity?

Steve Rodgers (17:38):

We have had no drop-off on once again, cash and cash coming in the door and the claims getting processed. We did have one small health plan up in the Northeast that was problematic and their prior authorizations and were completely backlog and their prior authorizations through the process. And we sent them a pretty strong letter and to their credit they adjusted through their processes. So the big players, the Aetnas, the United, the Cigna. we haven't seen any drop-off whatsoever.

And the intermediaries too, the Fiscal Intermediaries, the Palmetto's and the others have done a good job, I think in maintaining their operations through this and the claims flows and the payment cash is still coming in the door.

Matthew Margulies (18:22):

Switching gears there, obviously is a vastly different response to COVID-19 state to state. You're spread across 15 states in the country, three of the biggest in New York, Texas, and California. Can you speak to the differences in how some of these states, particularly in New York, Texas in California have reacted from a healthcare and policy perspective specific to your business and to healthcare generally?

Steve Rodgers (18:54):

Yeah. Well, I think in some ways we're lucky in being out in California to start in a large presence in California, because it made us have to... They were the first on the line right outside of Washington and they got hit in this.

And so it basically allowed us to quickly establish procedures. So I mean, there are these things that's just set off your workforce, right? When they started putting in the shelter in place orders out there, and the counties were flying by on the shelter in place orders that were taking place there. It was sending shockwaves through your employee base there. And so you had to be able to, to react to some of that. And that allowed us because we got it early on quickly established the procedures that we've cascaded across the country so that we were ahead by the time that it got to New York and Texas and actually Mississippi is another big, very big state of ours. What I see and some of the differences, I'd say there are some cultural differences, I think in the way that I think workforces and populations managed through some of this and then even the systems and the way I've seen some of the systems managed through some of this.

And so I'll use an example like UCLA and UCLA Health, as well as UC San Diego through her joint venture partners are used to be dealing in a situation where they actually don't have enough capacity, because California is a state where it's too expensive to build and they have no ability to actually build more beds, right? So they're constantly in a state of essentially over capacity and I couldn't run it, I think over a 100%. And so because of that, they've got more refined procedures on how to manage overflow. And so it was for them putting those procedures on steroids, on how they use dorms, how they use hotels, how they do things, and even to the extent of how they manage it from... They readily already know how to use personal attendance in those spaces, how to contract for additional labor in those spaces.

And some things like that. So I think California, because of that and some of the systems because of that had a little bit, whereas some of our Texas systems who've actually got overcapacity, they basically... They haven't had to use these alternative settings to be able to manage overflows of patients or get ready for a surge. Right? And so I think that was some of the differences that we saw. I'd say there's differences in workforces. A California workforce tends to be... The labor market in California, especially around the clinicians is much more mobile. And I would say that... I don't want to call them they are very committed clinicians, but I'd say they're almost like independent contractors in the way that they move around it.

Whereas you get in some of your Texas and your Mississippi type marketplaces. These are people that are embedded in the organization that have been in the organization. So the way you manage those workforces, I think is slightly different and how you interact with them and work with them and incentivize them to essentially be able to manage through these difficult situations like this. I think New York is... You just look at the whole New York and the whole Northeast. I mean, we're both up in New York and Massachusetts through this. I will tell you, I'm very proud of the teams that we have in place there. They're incredibly resilient people that have actually stepped in and faced into this through some... Between the combinations of patients that have died on a some service out in the New York marketplace, just oftentimes even up in Massachusetts, we'll have patients that are referred into us and they'll die before we even get them into the home.

And back into the home on this. The amount of workforce that they've had to manage through on who have been out at any given day, all the moving variables of managing through an incredibly difficult situation. I'm very proud of the way that they've continued to not only the back office staff, but the personal attendant taking care of these people. I would say that if you look at in the horrific situation and New York, we've only dropped off about 10% of our hours there. People are still showing up. People are still getting out to these patients. People are taking care of them and we're giving them the PPE they need to get out and basically manage these patients at the home. And incredibly resilient. I'd call it, they're incredibly resilient up in Massachusetts too.

I've been very proud of the way they faced into it. And they face into it a different way. You get down in Mississippi and some of the Texas marketplaces, there's a much more metaphysical religious undertaking in the way that they face into these, and I'd say, the New York's and the Massachusetts cultural differences is they're just tough, right? And so it's just a very different in the way that the populations are managing through this and the way you got to work with your workforce to basically motivate them.

Matthew Margulies (24:15):

You mentioned at the beginning of your comments on this question, the way that the California hospitals are working, dealing with a lot of capacity. As a joint venture partner in Southern California, have you had a higher level of interaction with your hospital partner and helping them think through

post-acute discharge strategies and freeing up capacity, or has it been business as usual in that regard with the hospitals?

Steve Rodgers (24:45):

No, we're very engaged. So we've basically... So it gets into a combination of our model and then these partnerships in and of themselves. So if you look actually in all our joint venture and heavy partnerships, and there's slight differences in each one of them, but we're closely linked with them on managing their capacity. And so they've been very transparent with us on when they expect the surge to happen. We literally have daily calls. We have daily calls with UCLA Health, UC San Diego, Asante, Stewart. Each of these have their daily calls where they're going through. Basically what they're expecting, what they're looking at, how much they plan on, what they see is their discharge is coming up, what they need from us from a capacity standpoint. And then, different ones are working with us on different programs.

I mean, out in UCLA Health, we brought in our private pay personal attendant business because once again, as they move these into alternative settings, they have a need for more 24 hour attendant type services in there. We're one of the only ones in California that could bring up a service like that because of our heavy clinical background at our home health and our access to PPE for a private pay attendant population. Right? And so we were able to quickly train our attendants on appropriate sterilization and protective procedures around this, get them the equipment that they need and we're ready to play on that. I would Baylor Scott & White, we've actually instituted a emergency department, basically a hospital at home program that we've been able to... So that certain conditions, once again, instead of these patients ended up back on their floors, we've been able to work with them.

So we're bringing them up both in their Downtown Baylor University Medical Center Hospital. We're bringing up this diversion program as well as down in their Austin marketplace. We're bringing up a diversion program. So we're very linked at the hip with all of our joint venture partners across the board in different programs in each one of these different places. And I think that does give us... And the other thing we're seeing on this quite frankly too is this is becoming I think, a distinguishing opportunity for what I'd call more tier one home health care companies. Because once again, we have set up very rigorous procedures and protocols and how to be able to appropriately take these patients out of the systems, get them stabilized and home, and be able to give them a level and type of service that I think gives the systems competent that we can maintain these.

And there's only a few of us that can do this. Then a lot of the mom-and-pop and even smaller regional home health care companies, either don't have access to the PPE, don't have the training programs or the oversight and the clinical supervision that they need to be able to take on these patients. And so, we're getting brought back in the hospital systems and marketplaces now that basically we've had trouble being in before, because they need a partner at the table to be able to work with them as the surge comes through their system to stabilize these populations. And so it's been a, I think an advantage and for more of us tier one, the home health care clinical organizations. And I think some of the more regional and mom-and-pop providers out there.

Matthew Margulies (28:16):

As the health systems prepare for a new normal. We've been told by the government that's these types of pandemics may continue in greater frequency. The COVID-19, may slow down and then speed up again. Do you think the hospitals that aren't partnered with home health companies are going to be increasingly thinking or rethinking their post-acute strategy, given the successes that you and some of your peers are having with your joint ventures? And do you expect to see a greater volume of potential

joint venture interest in activity in the short term with hospitals like Baylor Scott & White, UCLA, San Diego, et cetera?

Steve Rodgers (29:02):

I think with the systems of seeing as they complete one of the things that's been a consistency, and you just have to look at the New York Times this weekend, as well as the Wall Street Journal to see complete failure of the skilled nursing system, facility system. I mean, the system has been unable to staff appropriately. They've ended up not having appropriate protective procedures and how they kind of manage their patients across support on it.

And so obviously this has generated an incredible amount of high fatality rates inside of the skilled nursing facilities during this crisis. And I think because of a combination of that, and then over on the other side, because I think some of us in the industry have been able to actually be an incredibly consistent partner for these people. I think these systems are going to step back and recognize more than ever the value of actually being able to better manage throughput within their systems of having a reliable partner out there. And whether that ends up into joint ventures or tighter preferred partner relationships, I think they will step back at the end of this and say that this has got to be addressed. And I think when it comes around, I think is, Matt, that typically the hospitals have had are very difficult times themselves being able to run these businesses because they're very different than managing a facility. So I think there is an opportunity to push them towards greater joint venture partnerships over time.

Matthew Margulies (30:42):

And then, in terms of how the crisis has impacted your strategic growth initiatives, are you still evaluating and executing on M&A Partnerships and the noble opportunities even through all of this crisis?

Steve Rodgers (30:58):

Well, we have one active one that we continue to work through that we're excited to get done. It slowed it down a little bit as you've had to have managed through that, but we are still working that I think, we haven't talked about it too much, but hospice has been incredibly resilient through this. In fact, our hospice has grown through this entire crisis. And so, we're continuing to move ahead on some regional hospice place that are out there and are excited about some other potential larger hospice place that are coming out to the marketplace, around that.

And then, we've continued to work through some other joint venture opportunities that we've had there. So I think it's slowed it down some, but here's what I think is going on. I think, we're all moving into the new normal now, and as we're moving into this new normal that is going to go on for a better. I will tell you just over the course of the last 10 days within our own organization, we're just like, "Guys, it's time to get back to work." I mean, everybody we're in the setting, but we've still got to execute on these businesses. And we actually in our own business plan expect to show year over year growth, both top line and bottom line growth inside this business. It won't be quite to the plan that we had set out before, but we still think we can produce that kind of growth.

So, I think all the strategic stuff has been slowed down a little bit, but I think you'll start to see it, I think pick up as we get into this new normal in the summer months and people... I think, I actually expect the summer months to be fairly busy because everybody's going to be ready to get back to work. And I don't know if we're all going to be back in the office or not but I think, we all got to make, we're all going to move these businesses ahead. You guys, as bankers, you got to move your deals ahead. Things

got to keep going on some level. And I think you'll start to see some of the bigger players potentially pop back up out there. So we're hopeful because we're at the early end of our relationship with Advent and we have strong desires to significantly grow the top line and the bottom line of the business to go through M&A joint ventures and the organic growth engines we got the company.

Matthew Margulies (33:12):

And then last question, Steve. Do you think that the government becomes more home health and hospice friendly from a regulatory and reimbursement standpoint, given how well your business and businesses like yours have fared over the last several weeks, particularly in light of how much a failure the SNF industry has been like you mentioned earlier and the relief valve that you've been providing even to the health systems. So obviously you don't have a crystal ball, but do you think that the government, the regulators, and the legislators see that eventually, and become more friendly to your industry or no?

Steve Rodgers (33:59):

I would hope so. I think they're probably... We're unfortunately is an industry, we're sometimes get buried in all these, right? And the general kind of a... It's typically when things aren't going well, you get it. I think actually what we've managed to do. And I think once again, I think the lobbying and the partnership, both the partnership as well as NAC have done a much better job in recent years and continuing to push our agenda out there. Have they managed to get some wins in this? I think having a nurse practitioners be able to actually now actively manage and sign off on home health care cases was a big win for the industry. And I think we'll actually open up the business some. I think this whole thing around Telehealth is common. And I think that without getting into a lot of details, we've been very big advocates and pushers that once CMS was in moving down with getting some of the insurance companies, we're fairly confident that one of the largest insurers is going to actually pay for telehealth services and home health care.

And I think with that, that will put some pressure back on CMS that would say that's pretty legitimate because I think once this one does it, I think we'll have probably two or three others do it. And I think we can show the efficacy of Telehealth and actually drive in an efficient, effective home health episode. I think that would be a big one for us. I think the government, out of this will have to see the rate pressure thing. We have an obligation as an industry to be good stewards of the money that we ended up getting. And I think there's opportunities for it continuing to actually do a better job with the money we're getting and be more efficient and effective with it.

And so I think there's some opportunities for us. I'll be happy if CMS just continues to give us cost of living increases, the normal for the nurses salaries in there that we can push long while we drive so efficiency, et cetera. So I wouldn't expect any other windfall coming out of them.

Matthew Margulies (36:03):

Great, Steve, I really appreciate the time. This was a fantastic and really insightful, and I know you're running around in a thousand different directions, but thank you very much for making the time for us.

Steve Rodgers (36:18):

Yeah. Happy to do it, Matt.

COVID-19: Healthcare PE Executives on Impact & Influence on Investing

John Soden, Managing Director at Cain Brothers, a division of KeyBanc Capital Markets, discusses the challenges of and investment strategies in the COVID-19 crisis with healthcare private equity executives.

Rob Fraiman (00:03):

I'm Rob Fraiman president of Cain Brothers. During this unprecedented and disorienting time, the team at Cain Brothers is conducting weekly interviews with leaders from throughout the healthcare industry for this special edition industry insights series. Our goal is to provide you and your organization with a wide array of views on the multifaceted dimensions, challenges and responses to COVID-19. Transcripts are available on the Cain Brothers website. Please share your feedback with me or any of your Cain Brothers contacts. And thanks for listening.

John Soden (00:40):

This is John Soden, managing director at Cain Brothers. I'm pleased to be here today with a panel of very well known healthcare private equity investors, Ben Magnano, who's managing partner at Fraser Health Care Partners. Dan Roskin managing director and management committee member at JLL Partners and Tony Davis president and managing partner at Linden Capital Partners. Gentlemen, thank you. First of all, we were all blindsided by this crisis like everyone else. I'm wondering if there's any early learnings that have come out of the initial stages, including what preparations you've made intentionally or otherwise that have paid off.

Ben Magnano (01:18):

John it's been, I'll go ahead and start, I won't claim anything intentional, as you said appropriately, we're all blindsided here. That being said Seattle was on the early side in the United States. So I think for better, for worse, we had a two to three week headstart on the most, the rest of the country.

We pretty immediately flipped, just tactically our entire office to remote work from home in the first week of March. We were simultaneously having our kids' schools closed and seeing the city shut down pretty quickly. And so that was a pretty easy tactical decision that we made. Our new reality immediately became, just starting out with daily calls with our entire investment team and all of our operating resources around the country. What we did first as we were feeling our way through this, was basically take our entire portfolio through an exhaustive stress test. It took us a week and a half, two weeks to execute on this in partnership with the management teams. Part and parcel with that, it was jarring down all available liquidity across the portfolio, going through the line by line expense management work with our CFOs, working capital optimization and the like. And then the other piece we, of course done, with our operating resources was standing up a vertical leader of functional area so we can help the companies.

And those were things like supply chain, human capital, navigating potential furloughs and risks and things that were to come. Somebody to sit over debt capital markets and assist our CFOs. And then we had a vertical on medical and healthcare care, staying abreast of the disease spread. One of my partners is a medical doctor, an academic researcher by training. So he was on point for that. After we got through sort of that hurried, first couple of weeks, we slowed down our cadence to Monday, Wednesday, Friday calls. And then we switched everything over to video, is probably mainly you have,

just to keep as much of a human element as we could to our job. Especially for the junior team and those that don't have families and kids pressing all over them all day. Being able to look at people and interact both with the portfolio companies and with our investment team, was important for us. So that's a quick rundown of our activities.

Dan Roskin (03:54):

Yeah, this is Dan. Maybe the only thing to add and it's a little bit of a copycat of what Ben said. But certainly, when I think about the constituents who are in our ecosystem, it's certainly all the employees of JLL and similar to Ben, we shut down the office pretty early on. In fact, some of the younger guys, we have to kick out of the office and told them not to come in at the prohibition rather than a recommendation. And so we turned it into a virtual model as well. It was relatively straightforward. I wish I could say that we had some advanced pre-work of how we're going to work remotely. We didn't. Fortunately with all the IT improvements and inventions that have gone on last few years, it's became pretty seamless. And I think everybody is well organized and we're similarly doing zoom calls across the whole farm once a week.

We're including everybody, not just the investment professionals. And then twice a week, we have just a lot of professionals on. And I think the office is operating a pretty good pace and everybody's getting done what they need to get done. We then kind of focused on the LPs and had pretty good communication around that and make sure we're transparent around everything that we see happening real time. And that obviously moves quickly. And I know we will talk about the LT communication piece. And then lastly, on the portfolio side, similar to Ben, but the goal was to troubleshoot and get through crisis management and situations that are really severely impacted and ensure that there is ample flexibility and runway from a liquidity standpoint.

And then other businesses you have to scenario plan if things got worse, but the current run rate and the things that we're seeing, they're not really impacted as of today. But doing that pre-work ahead of time, was really important, then we're continuing to stay on top of those things. So maybe I'll pause there, but that was kind of our initial reaction.

John Soden (06:04):

Yeah. So leading off from there, as you looked at scenario planning in liquidity concerns, how did you guys go about addressing these with the portfolio companies? Maybe Tony, I'll turn that over to you.

Tony Davis (06:17):

Sure. So early on what we did was, we're at the very front end of drawing down essentially oral balers across the entire portfolio. So, that was right at the front end when people were starting to do that. And then like others have talked about these scenario-based planning. We also began that right at the front end and talked about ways to create a liquidity running 1326 week and end of your cash flows. And in every way imaginable from cutting salaries or deferring salaries of senior management, laying or furloughing people, if appropriate, depending on the severity of the company, is all very much based on a specific company, looking at any expense within the company that we could cut, the Lang payables, trying to accelerate receivables or offering a slight discounts for people to pay the receivables early, which actually worked. So we've done all of those kinds of things, both on the creating cash from a revolver perspective, but then on cost-cutting to make sure all of our companies, regardless of how long this goes, are in a liquidity position to come out the other side of it.

Ben Magnano (07:36):

John, it's been very similar approach taken to Tony and what his colleagues did, the backend of our liquidity analysis. That very much mirrors what Tony talked through. It was really doing a double and triple check on the reserves that we have against each one of our portfolio companies. And as we looked at 1326 week and the year cases. Did we need to revise up or reserve more capital in individual circumstances after going through all of the exercises that we've all talked about it? In some cases, we've got LP or other GP co-investors and just making sure that we're all joining hands and synced up on the approach that we were going to take depending on which scenario we were signing off on. Well, a derivative question is, how have the lenders reacted? Have they been constructive? How have those initial discussions gone?

Tony Davis (08:40):

It varies by the lender. Some lenders are healthier than others. And some of the relationship lenders have remained a relationship lenders, others, I think get more difficult portfolios and have become somewhat less relationship oriented, that I would have expected. I think generally, if they believe the company has been managed well from the private equity side. So the private equity firm has worked very quickly to cut costs where it can and think through various scenarios and liquidity ramps and is willing to support the company from the fund itself. I think Ben, lenders are generally being fairly amenable. I think if they don't see that, some of the lenders are getting more aggressive than I would have anticipated.

Dan Roskin (09:25):

And I think it's actually early because the big date that came and went was March 31st when the interest payments for the first quarter was due. I think even the businesses who are most severely impacted as a result of the crisis, made those payments for the most part. And so the next big date that I think everybody is looking towards and the decisions will have to be made, and they're not going to be easy, whether or not those payments are made in businesses that are effectively shut down. And I think that's when you will see how the interaction between the private equity firm and the lenders are going to come to be. My sense is that, the lenders will be a little bit more flexible and understanding because this is not a typical kind of workout situations for the challenge businesses. But that being said, they all have, their own constraints and imperatives, and they also potentially have back leverage that they have to deal with.

And so ultimately, I'm sure the lenders will operate in their best interests. Although maybe there's going to be a little bit more flexibility, but I do think that there's going to be some tough situations to come if the crisis continues for the duration of more than a month or two.

Ben Magnano (10:40):

Yeah. Tony and Dan's comments, I'm sure they experienced similar, but we had plenty of top of the house to top of the house conversations with folks where it started right out of the gate with open for business, let's engage, let's figure out ways to work through this together. And in some instances, tenors change rather quickly, like within a week. I think they were starting to get a better understanding of what was going on in their own portfolios. So to Dan's point, 331 was key. And I think if there was a constructive approach there, then they were willing to say like, "Let's all figure out where we are," and the 2Q and a 3Q.

John Soden (11:20):

That stuff I realized, they are one step removed from the actual performance of the companies. You guys are just getting your arms around how these companies are performing, going into this crisis. What sectors within your portfolio had been more or less impacted at least to date that you can see? And, I guess the natural full-on question is, what types of portfolio companies are going to emerge stronger and why?

Dan Roskin (11:58):

Well, the irony of this crisis is that in some ways, businesses that falls on the road as most defensive, are the ones that are may be on the front lines of being hit. So, some examples are obviously anything related to retail, healthcare and physician centric businesses are effectively shut down, businesses around dental procedures, physical therapy, dermatology, and other physician partner businesses. They're probably the hardest and the fastest set. And you can also argue maybe will be the slowest one to come back because even when kind of life goes back to normal, dental procedures by way of example, are not going to ramp back 100% overnight.

And there was going to be a long lead time for those businesses to come back to normal levels. And the challenge will be in some ways, and this is what makes the cash forecasting really difficult, is you can forecast to when the business reopens but then operating at suboptimal capacity utilization, called 80%, 70%. None of these businesses are really equipped to make money at those levels. And so getting through that ramp-up period will be pretty challenging for some of these businesses. The other area we've seen hit, maybe it's in Genteelly related to this as anything around elective procedures. And those are obviously delayed either because the hospitals don't have the capacity or because of the directive from the regulators, or the patients or the doctors unwilling to perform them. So I think that's the other big area that has gotten hit. And from what we've seen.

Ben Magnano (13:44):

And just adding on to Dan's comments, similar sentiment to provider businesses are most heavily impacted. In some instances volume's down 70% plus in certain geographies. As we go through our modeling, the interesting part is, the flip side of that is from a liquidity standpoint, some of those businesses for us are in the best position because the comp programs and the way they're structured, they're productivity based and your largest variable expense is provider compensation. So no one jumping up and down excited that we're lowering expenses, because we're not paying for production, but it is a nice yin and yang in terms of stress testing new businesses and thinking about how long they can last with the decreased volumes. One sort of bright spot to just bring up for this question John, is we've got a business called Matrix Medical, which is a network of nurse practitioners that normally services MA plan and helping them conduct health assessments and then risk adjustment populations.

They've had a couple of opportunities flow to them by virtue of this, which we certainly didn't see coming. One of which was participated in vice president Pence's task force around how to prepare for a testing more broadly in the country. And so that was one. And then the second one was a way for some fortune 50 companies to provide clinical services onsite at their operations. And so that's become a keeping businesses up and running risk mitigation. And frankly employee-based PR move for a couple of fortune fifties that have signed agreements with Matrix here just in the last week or two, which, we probably wouldn't have been talking about if not for the pandemic.

John Soden (15:46):

Are there other fringe benefits associated with unique efforts that are being exerted within the companies and at the management level? Are these companies going to come out stronger or is it just purely an effort to get back to the normal level of operations?

Dan Roskin (16:09):

I guess an optimist like me would say, yes. Stress stuff in the businesses will ultimately make them efficient and drive better delivery of their services. I'm not sure I'm a cup half full kind of guy. I respect maybe on the margins, but I'm not sure I would've wished this for our companies to go through it. Because I think the stress that they're incurring both for the people on the ground on the management teams, is pretty dramatic and it will weigh, I think, on the overall strength of the businesses. I think for a while, even after the crisis subsides from the level that it is today. But I don't know if others... I'm more optimistic on that front.

Tony Davis (16:56):

I think I generally agree with that. And as a general matter, that's absolutely true. I think there's going to be long lasting impacts. We do have a few businesses where, to the extent that there was a silver lining, I'm not sure I'd go to the glass half full, but at least a silver lining is, some of the businesses are dramatically increasing or ramping their digital delivery of various kinds of healthcare services. So I think that's a positive, but certainly agree that I'd rather the dot had to go through this and been a slower ramp on their digital delivery of services.

John Soden (17:37):

Great, given that, the risk profile of the portfolio is not what it's expected to be, as Dan was saying, given the unusual nature of this crisis and given the speed at which we've been hit by this crisis, how do you go about communicating with your LPs?

Tony Davis (17:59):

So we've taken a pretty forthright and aggressive approach with our LPs very early relative to how this unfolded. We had a call with our joint advisory boards across all three active suns and laid out a pretty bearish view of the world on how we thought it would impact the US economy. And then specifically going through the funds. And we got feedback that that was probably the most negative call that they had had at that point, is at the very front end, I think within a week or two, I think they felt that we actually were spot on and so they appreciated how forthright we had been. We followed up with another advisory board call, and then for the first time in our history, we did an all investor call for literally every single investor in the fund and addressed fund by fund where we thought things were headed and then went and discusses a lot of people have, kind of where the companies were by tier. So red, yellow, or green is many people have done both from a revenue and liquidity perspective.

So we've tried to be quite open with them, which they've appreciated. We've also let them know for a fund four it's nearly 60% uninvested. And as a result, we've got a lot of dry powder there and there should be some great opportunities going forward. So while their funds two and three will be negatively impacted from this, realities are fund four, will probably end up being a better fund because of the buying opportunities. We've tried to also then let them know about capital calls. We're trying very hard not to issue capital calls right now, understanding that people are not in a particularly liquid position. And then talked with our advisory boards about what they want us to do. So we've also spent a lot of time talking about how we're defending those companies that are in the red zone and the yellow zone is, they're fine for now as others to discuss. But if this goes on a long time, it could be different. So

talk about how we're addressing those, but that's been the generally communication we've clearly opted for more frequent and more open communication.

Dan Roskin (20:17):

Yeah, for us, it was very similar. Our approach were just, am sure similar to Tony's and Ben's. Let's just be really transparent with LPs and share the good and the bad and over communicate. And that's exactly what we've done. We also put out a detailed memo describing what we're seeing on the ground pretty early on in a fair amount of detail for each company. And that obviously changes rather rapidly on the ground. And so we're continuing to stay abreast of communicating with them and giving them real time updates. I do agree that the silver lining here is for uninvested capital. There should be great investment opportunities. And I think the investors are excited about that maybe, but even more concerned about what's what's on the ground already. But I think over-communicating certainly, I think is the best approach.

John Soden (21:11):

Yeah. So how do you turn lemons into lemonade in this environment? Are there LPs that are willing to be supportive of doubling down, given how attractive the valuations are right now?

Tony Davis (21:23):

We haven't seen that yet from our own investors. I think they are trying to understand what the liquidity needs are of their underlying GPs. So we haven't any yet come to us. We're raising money for a different vehicle right now. And there are people who are so interested in put putting money in that vehicle. So LPs are not all shut down, but we haven't had any coming at us with kind of aggressive requests around doing a special situation fund.

Ben Magnano (21:52):

John I'd say the same thing as Tony in talking to our peer group in our LPs, who we've been in the frequent dialogue with. It feels like we're four to eight weeks out to venture a gas before, people are really wanting to sharpen a pencil on and think about those things. What I read through from the conversations with the LPs is, they really want to understand what marks may look like for 331 and then for 630, to the extent we're willing to hazard a guess, and then they're looking to pull all their dials and figure out where that's been from an allocation standpoint first, before they then start to be forward-looking or opportunistic around new investment opportunities.

John Soden (22:38):

And in terms of what you guys are doing with your existing swans, are you looking for new platform deals right now, or are you mostly focusing on add-ons?

Tony Davis (22:46):

We are not yet looking for new platforms. I think that we've been attending to the portfolio for the last 30 days or so, principally focused there. There are some add-ons that are coming up, but I think it's going to take some time for sellers to adjust their price expectations for new platforms and or they're going to have to be in a distress situation where they don't have too much of a choice. So we're not seeing a lot of traditional new deal activity right now.

Dan Roskin (23:13):

And for us, we're trying, obviously you have to show off the portfolio and defend the companies that you own, and make sure that that's progressing in the right direction. On the new deal front, we will try to be a part of this stick in the distrust land during the 08 09 crisis. We certainly made a number of investments that will prove to be quite successful. And so we're going to look at things as simple as just buying that on the secondary market, to the extent that the yield approach equity like returns. We haven't seen a lot of companies at those levels yet, the companies that are trading north of 20% yield towards those that had issues going into the downturn, and this will probably tip them over. And so there you're really taking principal risk, but businesses that have had issues as they're out of the crisis have not come down in price yet.

But that's certainly going to be something that we're going to look at pretty hard. And then along the same vein, if we can be an investor who can provide a pie for some kind of structured equity to a public company, to either deliver or give them capital to be aggressive or other liquidity solutions. Again, as long as it's price equity like returns, those kinds of structured type of investments are ones that we're going to look at hard. And I think it's going to be determined whether or not that's actionable really, by how long the downturn continuous for and how long the economy stays shut down.

John Soden (24:47):

Right. And I know on the debt side for your existing portfolio companies, some of the debt may be available at very attractive yield. Is that something you guys actively look at?

Dan Roskin (24:59):

We do. We have the ability to acquire that in our own companies. I would say the yields are not really where it would make any sense for us to act on it yet, but certainly if there's a way to capture equity value, we would think about it.

John Soden (25:18):

And how do you get around the LP complex? Can you do that at the... Or where do you actually do that investment? Do you back lever that at the GP level or is it go into the same vehicle that's already in the equity?

Dan Roskin (25:31):

No, you'd have to do it in the same fund. I think doing it from different funds there, you run into real serious conflicts. And the way we'd approach it, we would talk to the advisory committee and make sure everybody's on board. And as long as there's comfort around, buying the data in our companies, that just could be a very attractive way to enhance equity returns. But you have to do it in conjunction with the conversation with the advisory board in my mind.

John Soden (26:00):

Interesting. Now as you look at the waterfront of opportunities and what we assume will exists a month from now, three months from now, four months from now, what do you see as being the most desirable sub-sectors to invest in? What's going to recover the fastest? What is likely to be somewhat predictable in the interim period? Have you guys started to do that landscaping effort?

Ben Magnano (26:30):

We've started to dig in a bit there, John. I think maybe the most obvious answer is those either facility-based or provider-based that are largely electives where, you've had long waiting list and plenty of demand, probably takes the bravest souls to lean in on something like that. Not knowing how long this is going to persist, but some of those areas are places where we're spending some time. And then somebody mentioned on the call earlier, I think that the advent of the new day for technology being pervasive in a lot of the different practice state businesses that we all look at, I think that is right. It is here to stay.

So for us looking broadly at healthcare IT, specifically for us, in and around tools and services provided to payers, and then also broadly the healthcare payment space. Those seem like they could be opportunistic as we venture forward.

John Soden (27:37):

I know this is probably the most interesting topic for people listening to this interview. Given that you guys have a pretty unique purview with the healthcare space and all the sub segments, which ones to you are likely to be the most exciting to investment?

Dan Roskin (27:54):

Well, I think it's what Ben said a little bit. I put it in a couple of different buckets. One, the sectors have been most impacted by the downturn. And is there a way to get in at maybe somebody's distress levels or interesting entry point as the way to play the other side of the crisis? Which invariably, most of these businesses are healthy, good business model and they should come back in time. So one area of focus is those that are most impacted. I would say two, is thinking about areas that maybe have been benefited by the crisis. We've talked a little bit about telehealth and digital delivery of care diagnostics. Some of the personal protective equipment areas that really have gotten the upside of the crisis, if there's such a thing.

And then the last thing is just healthy businesses like healthcare IT, like payment type businesses, that are really good areas to invest in. That's historically I've traded at a sky high multiples and obvious evaluations that have come in. If you look across, the different sub sectors of healthcare, the enterprise value to EBITDA is probably down four to five turns, and I'm not sitting here pretending like the seller's expectations all of a sudden I've gotten to those levels. But certainly there should be better buying valuations for really attractive businesses that trade at the sky high multiples, just a month ago. And take advantage of maybe people pulling in risk and valuations coming down.

John Soden (29:43):

As you look in your crystal ball, I know it's early. What are your investment committees assuming in terms of how long... What's your base case for return to a normal environment?

Tony Davis (29:54):

I think it really depends on which business we're talking about. There's been a lot of discussion around the multi-site healthcare businesses and how long they're going to take to return to normal. And we agree with that. We were very early in calling for an extended period of a downturn, and we continue to believe that. So I think that true return to normal will occur not when any government policy changes, but when effectively you're comfortable taking your 80 year old parents to a crowded restaurant, and that's going to take a long time. You need either a vaccine, which is a very long way off, an effective therapeutic that can actually be manufactured at scale, which will take a long time, particularly the

manufacturing at scale, and a combination of truly accurate fast testing. And a lot of that fast testing we've seen recently is not particularly accurate.

We have got a diagnostics expert, one of the country's experts as one of our operating partners. And the public news you read about the diagnostic test is somewhat misleading given their actual accuracy and true throughput. So we do think this really does last quite a long time. True normal is probably a year out. There are some businesses that'll start to get back to normal in three to four months, but many of the ones that are hard head it's going to be, we think a longer haul than people are assuming right now. And I'm hoping I'm wrong on all of this.

Ben Magnano (31:31):

May be a dad to the glass, half empty, I almost entirely agree with what you've said. One of the things we've been doing with our LPs, John, is having a call every three weeks with our partners from the venture side of Frazier Healthcare's business. Tachi Yamada, who was the head of healthcare for the Gates Foundation, and one of our partners on the venture side, who's the MD-PhD in Public Research, would echo a lot of what Tony has just walked through in terms of likely timing. And when we get back to normal, I think everyone believes that at least on our side, that there are going to be waves of this. Hopefully not as deep and severe as what we're all going through now, but our stress test modeling contemplated college five to six months of quote non-normal. But I think I would echo exactly what Tony said.

If you ask me, "When are we going to get back to what we all knew to be normal in January, February of this year?" I think you're talking the back half of 2021 at the earliest.

Dan Roskin (32:38):

I want to be the optimist on the call, but I almost can't disagree with anything you guys said. I think I'll return to normal as 2021 and probably until the latter part of the year. Because the other thing you're dealing with, it's just, and I think Tony you said it, well, it's the general psychology across the population. There's a lot of fear. Some of it is fact-based, others is not, but to have the psyche and the approach to life change overnight, it's just not going to happen. So beyond just all the numbers and all the stuff that you're seeing on a number of cases and the like, it's a lot more to do with just people's psychology and willingness, and the ability to get back to normal life and that's just going to take a pretty long time. Again, I hope I'm wrong as well.

John Soden (33:30):

So related to this, Cain Brothers was working on probably around 20 sell sides going into this crisis and all different stages. And the question that every client has for us is, what do buyers need to see in order to pay a fair price? Is it one quarter of normal operation? Is it just visibility on when that normal level is likely to occur? Even if it's sort of 12 months out, just having some competency to get back to that level. How do you guys think about that as far as?

Tony Davis (34:02):

Well. I think I'd like you to tell me, so I know when we can sell our businesses. But I think you've got to be at the point where there's a return to normalcy and you've got to see a couple of quarters, that at a minimum. So we're thinking, because we had a couple of sell sides, that we pulled and our view is, you're going to have to see a couple of quarters of a return to pre COVID levels to be able to get the kind of valuations. And at that point, who knows what the multiples are. We're obviously at the tail end of a

10 year boom, with a very, very high multiples and at least looking back to the 08 09 time period, it took a few years for multiples to come back.

Ben Magnano (34:44):

Just one thing to add on. I completely agree with those comments. And as you think about getting a couple of quarters that look more normal, we're all going to have this second quarter, whatever it looks like, in our trail. And so John, as you guys advise folks like us on taking businesses out, it's going to be selling through to a buyer group that you got to ignore that the rat moving its way to the python, if you had by the metaphor to get this terrible quarter, that we're all about to experience, out of the trailing numbers.

Dan Roskin (35:21):

No, I agree wholeheartedly. It'll just take time. And I think Q2 is going to be very bad. I think worse than kind of the general perception is out there. And as we talk Q3, it's hopefully going to be on that swing, but you don't just return overnight to kind of pre COVID levels. It's just very hard for that to happen. And so you're probably talking about not just one quarter of very bad results, but at least several. And that will just take some time to work its way through the system. So I'm completely aligned with what the other guy said on the call.

John Soden (36:01):

And so, along those lines, how do you think the healthcare private equity environment is going to change longer term? Is there a new normal that will follow from this crisis?

Ben Magnano (36:14):

Yeah, John, for us, the thing that we're really focused on with our businesses right now, a little bit like Tony and Dan talked about is, preparing testing capabilities so that we can safely reopen and certify to the public, our patients, our customers, that they're entering a safe environment. I think that story or analogy around taking your parents to a restaurant is apt. Whatever that new normal is, everyone's going to have that thought in the back of their minds.

We're probably never going to see a clinical site again, where there's busy waiting rooms and any one of us are going to be walked through a clinical operation. It's busy and we're passing by other patients in closed quarters. So how you have settled that into your model is the question. And then the other new normal question that I don't have answers to, but we're trying to think through and doing some analysis around is the payer community, both public and private. Given the macro economic stress that the country is experiencing, that probably spells darker days for Medicaid funding and by virtue of that, the reimbursement regime within that. And then, how the commercial payers are going to behave here is an interesting one with lots of different variables where they're not seeing a lot of volume from things like car crashes and electric procedures today.

But the open enrollment period later this year is probably going to be informative and different. And then what that means for how they choose to pay rates and the like in 2021 and beyond. These are all the things that we're trying to get our arms around and informing how we do our underwriting.

Dan Roskin (38:05):

And I do think maybe to just put a positive note into the conversation, which there hasn't been a lot of is, fundamentally the reason we're all in the healthcare industry business is it's a great, and market and

all the macro trends that existed before the COVID hit, will still persist in the post COVID world and those mega trends are going to continue to meet the multi-decade long trends, demographics, technical innovation, pharmaceutical innovation, it's all the trends that everybody knows quite well. And the efficiency in the delivery of care will only improve. And so to me, the mega trends will continue. There's still a ton of dollars on the sidelines wanting to invest in healthcare businesses. So I think the fundamentals will still be there. It's just to me, how long does it take to get back to an environment that is somewhat normal? And that will take a bit of time.

Tony Davis (39:03):

I agree with that. I think on an overall basis, the trends are there as was just stated. I do wonder on how it's going to affect the physician practice management or doctor deals and whether or not those will... How quickly multiples will come back in those businesses. Because I think there's already a little bit of understanding that they're difficult businesses to manage. They can go very well, but they require a lot of work. And this only reinforces that,

John Soden (39:34):

Well, look, I realize this is not the perfect time to ask people to do a panel. So thank you very much for participating. You've been tremendously transparent. It's been incredibly insightful for us and for me as a banker. So thank you.

Ben Magnano (39:34):

Thanks John.

Tony Davis (39:52):

Thank you.

Dan Roskin (39:55):

Happy to it. Thanks for having me.

COVID-19: James Hereford, Fairview Health Services, speaks with Dave Morlock, Cain Brothers

Join James Hereford, President & CEO of Fairview Health Services and Dave Morlock, Managing Director at Cain Brothers, in a discussion of the COVID-19 pandemic, its impact on the healthcare sector and how Fairview Health Services is responding.

Rob Fraiman (00:03):

I'm Rob Fraiman, President of Cain Brothers. During this unprecedented and disorienting time, the team at Cain Brothers is conducting weekly interviews with leaders from throughout the healthcare industry for this special edition Industry Insights series. Our goal is to provide you and your organization with a wide array of views on the multifaceted dimensions, challenges and responses to COVID-19. Transcripts are available on the Cain Brothers website. Please share your feedback with me or any of your Cain Brothers contacts, and thanks for listening.

Dave Morlock (00:40):

Hello, I'm Dave Morlock, Managing Director and Cain Brothers Health System Advisory Practice. Joining me today for our interview series is James Hereford, President and CEO of Fairview Health Services. James, thank you for joining us today.

James Hereford (00:57):

It's my pleasure, Dave.

Dave Morlock (01:00):

James, what level of demand for COVID-19 testing and then care are you seeing at Fairview and what's been your ability to meet that demand?

James Hereford (01:10):

Well, I think for testing, it's been difficult to meet the demand. Ideally we would have been as a country, as a state, as a healthcare system, doing much more broad-based testing so that we actually understand the prevalence of the disease. It would have changed the way that we could have done contact tracing and follow up to limit the spread of the disease. We have struggled in large part because of supply side issues in terms of reagents, but also testing medium and even swabs to be able to do that.

It's limited our ability to only the most acute needs, to be able to do the kind of testing that we need to do, but nowhere close to what we'd like to do. Hopefully that situation will continue to improve over time. But at this point, some of the early surveillance kind of testing approaches or largely that opportunity has passed us. It also impacts us in terms of being able to keep our healthcare workers working, which is going to be a big part of this, and understanding, and being able to test quickly, with both the PCR kind of tests, and also to have a serum level test will be critical for our ability to maintain the workforce we're going to need, as we still see the surge in front of us.

Dave Morlock (02:47):

Are you seeing a material increase in the medical staff and other care providers contracting the virus?

James Hereford (02:54):

Well, I guess I would answer that in saying that everything is material, but we haven't seen a huge percentage of it. We've gone to universal masking, as many have. We have taken as many steps as we can to protect our staff, especially at this point in time when we're still on the flat side of the epidemiological curve to try to maintain their health because that's going to be crucial. So thankfully, not yet.

Dave Morlock (03:29):

How about the actual delivery of care for COVID-19? You mentioned being on the flat side of the epidemiological curve.

James Hereford (03:38):

Well, it's been a gift to have the prep time. I couldn't be prouder of my team. Laura Reed, our Chief Nursing Executive and Chief Operating Officer, Mark Weldon, our Chief Medical Officer, Greg Beilman, who runs all of our acute side settings. They have done a wonderful job of doing the work to prepare, to create more surge capacity.

We converted an LTAC into a COVID hospital in about seven days. What's been gratifying to watch is the entire system coming together and really doing things that I don't think we would have thought possible prior to the presence of a pandemic. Yet they've come together and really done amazing thing. At this point we're still working diligently, but a lot of the big lift is starting to become a little bit more behind us. Now it's in that kind of strange waiting period as we see the ramp up of cases.

Dave Morlock (04:55):

What are the pressure points in the supply chain and with staffing that you're seeing through all of this?

James Hereford (05:02):

Well, there's several, obviously vents is the one that's the most topical. In terms of having access to vents, they just are difficult to get right now. As we continue to expand our surge capacity, vents are quite likely to be one of our rate limiters, all kinds of PPE, whether it's face shields or it's N95 masks or it's regular surgical mask or it's protective, just surgical gowns. All are in a shorter supply than would make anybody comfortable. Part of that is that one of the disadvantages of being a little later to the game in terms of how this impacts Minnesota and the twin cities is a lot of that stock is going to the places that are truly the hotspots right now, which are Seattle, California, and New York.

My hope is a lot of that's going to catch up to us as we start to get into the peak of this. We're also continuing to develop non traditional suppliers for a lot of this. It's always difficult in the heat of this to separate what's real versus what's a misrepresentation. We're advantaged here because of our Medical Alley Consortium of really being able to have a capability to vet overseas suppliers, whether they're in China or elsewhere, to make sure that what we're getting is going to meet the quality needs of the organization.

Dave Morlock (06:52):

How about capacity in the ICU? How are you planning for those issues over time?

James Hereford (06:59):

Well, we're trying to create as much surge capacities we can. Part of that was why, as an entire state, we shut down elective cases about a week and a half, two weeks ago. Now that obviously has a downside in terms of financial impact. But what it's allowed us to do is free up a lot existing ICU capacity. We've not consumed a lot of the PPE at the same rate that we would have. The bigger piece is not going to be the existing. It's going to be the surge capacity. So as I mentioned, the creation of a COVID hospital and converting an LTAC into that, allowed us to create another 35 ICU beds.

Our surge planning, let's just take the academic center at the university of Minnesota. We believe we're going to be able to leverage a lot of our existing space. Some of it's going to be, surgical suites, some of it's going to be recovery suites, some of it's going to be where we have negative pressure and kind of inventive views. But we believe we're going to be able to expand pretty significantly that ICU capacity. The challenge is when we look at the models, that's good. Still not sufficient. Even as we collectively across the Metro area, all the systems are doing this, it still won't be enough to meet the level of surge that we see predicted by the models.

Dave Morlock (08:30):

You talked about the financial hit from reducing elective cases. You talked about the difficulty in tracking down supplies and things like that. What are the additional resources that you're trying to secure?

Whether they're financial, supply related, personnel related, in order to address that expected surge that will be coming in the next few weeks?

James Hereford (08:52):

Well, we've been working really closely with the state. I think our government has done a good job of implementing their incident command structure and looking to source supplies and really being a significant assistance for us in that we're still, I think as everybody is in healthcare, looking to see how the stimulus is going to get enacted administratively, but we're very active in that our state has taken some steps to create some support for the kind of the financial side for the preparation. So they've appropriated money from the state legislature.

There are a number of things underway. The challenge is at the end of the day, none of that, from a revenue perspective, is sufficient necessarily to cover the lost opportunity, in terms of higher end surgical cases, that we're not doing. But that's a problem everybody has and it's going to inevitably create a bit of a shakeup, I think, in our industry as we get to the other side of this.

Dave Morlock (10:09):

I think you're right. So with things like social distancing and stay at home orders, there's definitely a unique dynamic in place now in terms of communicating. How are you approaching your communications and leadership, your staff and team during this time?

James Hereford (10:35):

We're somewhat advantaged because we had some mechanisms in place. In that overly tortured bio that you read and the work that we've done around lean management. So the fact that we have the kind of tiered management approach that we have daily huddles, that when we enacted our incident command structure, it fit naturally into that. That's helped significantly in terms of the overall ability of the organization to communicate. Now, what is also kind of elucidated for us though, is some of our shortcomings that in normal times, you wouldn't necessarily notice.

The fact that email really is a poor communication mechanism to staff. Me writing a message and emailing it out when things are changing, ever evolving, we continue to learn through this, it just doesn't keep pace. We're working to implement some new text-based and other, a little more facile, a little more dynamic kind of communication mechanisms. So that we can make sure that our staff, we have 35,000 people, that 35,000 people are coming with us, really aware of what's going on. There's so much that's not known and so much misinformation out there. It's critical that we have a much tighter loop of communication and feedback with our staff. And that's really been highlighted as a gap and credit to our IT teams who probably have done two years worth of work in the last month and a half, but are really starting to stand up some capabilities that heretofore, we just didn't have.

Dave Morlock (12:30):

That's fantastic. Across all of these dimensions, what would you describe as, as your early learnings in this crisis, given that we're now three to four weeks into it?

James Hereford (12:46):

Well, one is, we kind of knew this already, but healthcare loves a crisis, right? We probably are at our best when things are really at a critical point. It's not unusual, you go into an organization, you start talking to them about their organization and you ask them to talk about a time they were extremely

proud. Inevitably it comes down to some emergency situation. A strike or when I was at Stanford is when the airline went down at San Francisco airport and we had a mass casualty event. It's often those things or healthcare organizations site is when they were at their best. We get a lot more focused around, what do we need to do to care for our patients? I think that's the thing that is most salient in terms of reinforcing that learning.

I think it's also highlighted in some ways, just how person dependent we are in so many ways that we don't necessarily have the level of infrastructure or we've resisted the level of infrastructure to do the kind of teleconferencing that now is the norm. We're on it all day long and we find it completely works effectively as opposed to, let's schedule the normal meeting and not get much done. I think in many ways, it's really going to change our work patterns. It's certainly changing our practice patterns. When I was in Seattle a long time ago in a prepaid system, when I left I was leading the care delivery system. Over half of our primary care visits were virtual, but that was the product of a lot of work. In the last month, 80% of our primary care visits have become virtual.

Our physicians and our teams are really rising to the occasion, meeting our patient's needs in unique ways. I think we're learning that those changes aren't so scary, we can adapt to them quite capably and they're effective. I think there's a number of things that are going to be fundamental changes to how we think about our healthcare system as we go forward.

Dave Morlock (15:19):

It will be interesting to see if the state and the federal regulators on the other side of this crisis are as adaptable to those changes as, I think our people have proven that they can be.

James Hereford (15:31):

I think that's a really good point because I think a lot of people have been saying the care delivery system resist, the changes that payers or the risk takers want. Well, one of the things that this has precipitated is the care delivery systems have really embraced and initiated those changes. Now I think it'll be an interesting conversation, as you say, on the other side of this, about how do we start to think about reimbursement differently as we're informed about our experience here,

Dave Morlock (16:12):

How do you tackle the broad conundrum, from a public health and an economic and leadership perspective, of balancing the desire to reopen the economy with the desire to get control over the spread of the virus? Wrestle with that conundrum.

James Hereford (16:29):

Well, I think one, the science and the math should guide us. Now, clearly you're talking to a guy who spent too much time in math classes. I do think that is crucial because there is a temptation, and I understand that fully, this is a huge economic blow, and it's a disproportionate blow to people who don't make as much money.

The challenge is that if we try to open things up more quickly, what we're going to end up doing is to have a negative effect in terms of the spread of the disease and the reoccurrence of the disease.

That actually my belief will be, it's going to have an even bigger impact economically over the longterm. I think there's been a lot of analogies drawn to World War II, where you just going to have to suck it up. You're going to have to do what it takes and take the economic hit. Make this as short as humanly possible in terms of its impact. Trust the science, and I believe that we're going to see, we're

early on in this, we're going to see significant improvements in the treatment. I believe we're going to see significant breakthroughs on the prevention side, but we're just going to have to take our licks here for the next month or two, hunker down, get through this. Get that R0 below one, so this disease dies off for at least this period of time. Trust the science to continue to progress so that we are in a better position when there's a reoccurrence.

Dave Morlock (18:22):

I agree. That's fantastic.

James, thank you for your time and your insights today. I know that we here at Cain Brothers as well as our listeners appreciate it very much.

James Hereford (18:34):

Well, thank you. I appreciate being asked.

Dave Morlock (18:37):

All righty. Have a good day.

James Hereford (18:39):

Thank you, you too.

COVID-19: Paul Markovich, Blue Shield of CA speaks with Court Houseworth, Cain Brothers

Join Paul Markovich, President & CEO at Blue Shield of California and Court Houseworth, Managing Director at Cain Brothers, in a discussion of the COVID-19 pandemic, its impact on the healthcare sector and how Blue Shield of California is responding.

Rob Fraiman (00:03):

I'm Rob Fraiman, President of Cain Brothers. During this unprecedented and disorienting time, the team at Cain Brothers is conducting weekly interviews with leaders from throughout the healthcare industry for this special edition industry insights series. Our goal is to provide you and your organization with a wide array of views on the multifaceted dimensions, challenges, and responses to COVID-19. Transcripts are available on the Cain Brothers' website. Please share your feedback with me or any of your Cain Brothers contacts and thanks for listening.

Court Houseworth (00:40):

Hello, I'm Court Houseworth, the Managing Director at Cain Brothers, and I'm co-leader of our managed care practice. Today I'm pleased to be joined by Paul Markovich, President and CEO of Blue Shield of California. Paul is a 20 year Blue Shield veteran and was the board chair of the Blue Cross Blue Shield Association in 2018 and 2019. Paul has been leading Blue Shield's efforts to transform healthcare and drive innovation.

Court Houseworth (01:06):

Paul, thank you for taking the time today to speak with us regarding COVID-19 in your perspective, as CEO of Blue Shield of California.

Paul Markovich (01:17):

My pleasure, looking forward to it.

Court Houseworth (01:20):

Great. So to start things off Paul, I'd like to get your perspectives on how California has responded to the COVID-19 outbreak thus far, and how Californians are managing today.

Paul Markovich (01:32):

I feel like California has been a real leader in this area, and I give a lot of credit to Governor Gavin Newsome and his team for being the first state to announce a shelter in place effort. And of course it's not just him and the state, the bay area was really one of the first geographic areas to do a shelter in place order. And based on what we're seeing right now, that seems to be paying dividends in terms of reducing the spread of the virus. We still don't have all the data that we need to really understand it. Even the data we do have seems to be pointing towards a reduced level of increased cases, relative to what it used to be at least in Northern California.

Paul Markovich (02:19):

And so while we are not out of the woods yet, no one is celebrating a final success by any means. I think that the steps that we've taken and the adherence that we've seen from Californians to that shelter in place order has been impressive. And I think it's paying dividends. And I'd say even beyond that, granted I'm sheltering in place and working from home, I've been incredibly impressed in all of my conversations across the spectrum, public sector, private sector, hospitals, pharmacy, labs, et cetera, medical suppliers, how much people are leaning in and just trying to do the right thing. So it's bringing out a lot of good in people.

Court Houseworth (03:07):

That's great to hear. How have you prepared the company and your members as well as your providers to deal with the expected surge in California?

Paul Markovich (03:18):

Well, we're certainly doing our best to do that, Court, and we are granted, aren't really sure exactly how to best help in all situations. So one of the things we're doing is just asking. We're spending a lot of time reaching out, not trying to overwhelm these various constituents, including providers, especially, but trying to understand where are you? How are you doing? How are you doing for supplies? How are you doing for staffing? What is your bed capacity look like? How can we help? So again, we're trying not to be annoying because these folks have a lot of work on their hands in terms of the preparation, but we're certainly reaching out and trying our best, but there's a number of policies that we've already announced waiving any cost sharing for testing and associated costs for members. On the provider side, we've been having a number of different conversations about how to ensure that they get adequate supplies.

Paul Markovich (04:26):

In fact, we went ahead and bought protective equipment when we found it available, like several million dollars worth of it, to help with the crisis and then distribute it. We have been doing a lot of work with the state, as well as with the labs and medical suppliers around trying to secure and distribute important supplies that would help advance the testing, simple things like getting swabs and contributing $500,000 to the Oakland Fund in large part to set up drive by testing site, so people could get tested for the virus. So I won't give you the entire laundry list of what we've done, but we really have tried to lean in and do the best we can, but I think we're all dealing with something unprecedented. And so it wasn't like we had a playbook walking into this and we're learning as we go.

Court Houseworth (05:21):

Well, that's terrific. What specific changes has Blue Shield made in the way it interacts with its members? I mean, for example, how have you addressed what I imagine is a large increase in member call volume regarding benefits or other questions and concerns?

Paul Markovich (05:39):

Well, fortunately thus far, touch wood, our customer service levels have not really... We've been hitting our customer service goals. We've been on average answering the phone within 30 seconds, getting a pretty high level of satisfaction from the people who do call in. We did advance communicate, almost a month ago, and encourage people to get larger pharmacy supplies via their mail order benefit. And that seemed to have helped quite a bit. We've also had extensive use of our telehealth services. That's really gone up substantially, which we also encouraged, so people could talk to a physician if they felt they had symptoms or needed to, without creating the risk for themselves and for others going outside the house.

Paul Markovich (06:30):

And so those things have, I think, helped quite a bit. That said we haven't hit the peak yet, I don't think, in California. And so my guess is we aren't all the way into it. And so those I'm sure those things will get a little more stressed in the coming weeks, but for now just the steps that we've taken to try and anticipate people's needs, the need to shelter in place, the need to access medicine, they seem to have been working to this point.

Court Houseworth (07:03):

That's great. I know you guys were one of the early proponents of using telemedicine and virtual care. What kinks have you found in the delivery model?

Paul Markovich (07:16):

Well, I think the part that is most important to do is then connect back to your primary care physician. And because we have the capability to create comprehensive real-time digital records and provide that closed loop between, "Oh, I had an appointment and some advice from an online physician and now I would like my primary care physician to know that," and to get that incorporated back into their traditional path of care, that's the place where we really need to get the digital infrastructure nailed down and close that loop because it's important. You can't get all of your care depending on your situation, but you can't get all of your care virtually. It's very difficult to have a hip replacement via telemedicine.

Paul Markovich (08:18):

And so at some point you have to come back to the actual system and you want that care to be as seamless as possible and that information to be transferred and that's probably the place we've had the biggest challenge up until this point. We do have a solution for it. It's just that we don't have all the providers participating and sharing their information in a way that would facilitate it working.

Court Houseworth (08:43):

How do you think the accelerated adoption of telemedicine will change the way healthcare is delivered post the pandemic?

Paul Markovich (08:59):

I think this is going to have accelerated the adoption of it. I think people are going to, because there's going to be so much more use of it. I think it's going to be much more commonplace. It's going to be more accepted. I think folks will be more comfortable. I think it's one of those things where, you know how there's a typically an adoption curve and you have the pioneers start and then eventually others follow. And then it becomes the common norm. I think by virtue of almost forcing more people to use it sooner than they otherwise would have on the natural, it will become a much more widespread and more common after this than it was beforehand. And I think that's a good thing.

Paul Markovich (09:38):

I mean, honestly, why wouldn't you want to, if you could, access important medical advice in a manner that doesn't require you to leave your home? I think, especially for things like behavioral health issues, but also for something that's an infectious disease, it's very, very helpful to everybody for you to do it virtually. So I think it will accelerate the adoption of this important new technology.

Court Houseworth (10:11):

I would agree with that. And speaking of, kind of mental health, I should say, how is Blue Shield providing additional support to members experiencing challenges with anxiety, depression, stress, substance dependency?

Paul Markovich (10:29):

Well, I do think that telehealth can be helpful that way. And so I hope that it's helping people in those circumstances. We are doing our best to encourage people. I think too, we're trying to communicate that as acute as this crisis is, as long as you're smart and following the guidance that you've been getting from the Centers of Disease Control and the state, then you're going to reduce your risk quite a bit and we will get through this. And so I think trying to help people understand that it's an acute crisis, but it's not an existential crisis. And if you can reduce your risk to yourself and your family, we all won't be sheltered in place forever. It's going to be something that lasts weeks, not months or years, and we'll get through it. And we will figure out how to manage with this virus because we manage with viruses today, we do every day.

Paul Markovich (11:26):

And our immune systems and our medical systems, they are built to deal with this eventually, even if we weren't completely prepared to do so right now. So I think we are trying to give people options and alternatives if they're feeling a level of stress and to the extent that we can be fact-based and calm and

share a sense of, as challenging as this is, there's a path forward. I think that's what we're trying to do to help people remain calm and avoid getting over-amped in a situation like this.

Court Houseworth (12:04):

That's terrific. Over the weekend Covered California published a report that premiums in the individual and employers market could increase by 40% or more solely because of unexpected COVID-19 costs. How will we get to solutions to address these unplanned costs? And ultimately is the federal and or state governments going to have to be part of this solution set?

Paul Markovich (12:31):

Potentially I think, Court, one of the things we found in these situations is that healthcare costs can only go up so much because the supply of healthcare, like just hospital beds, for example, is not that fungible; it's reasonably fixed. I mean, it's almost no matter how sick the population gets, it's almost impossible for a health plan to have their inpatient bed days per thousand go up by twice the amount that they are today. There's just not enough. You can't put enough hospital beds up quickly enough to do that. And you're seeing that now that when the population gets sick all at the same time, there's just not enough capacity in the system. And so it's, I think unlikely that you could get to a jump that large and sustain it over time. And so I think that really the way to deal with it ideally is that if the federal government could put in place kind of broad thresholds at which they kind of almost provide stop-loss coverage for health plans, I think that would be the ideal way to deal with this.

Paul Markovich (13:57):

So that going in as a health plan, you don't feel like you've got a price for the worst case scenario. You can price for a level that says, "Okay, it should be reasonable to expect this virus will not repeat in a way like it did this time. I can project my premiums and my cost based on something closer to a norm. But if I'm wrong, if I'm wrong by a really large margin, I'll have a backstop. I'll still generate losses, but they won't be the kind of losses that create an existential risk to the company or financial risk that could topple the company." I think that's the kind of thing that can really help. The sort of thing that they did or we tried to do at least at the beginning of the Affordable Care Act and then didn't fund later.

Paul Markovich (14:43):

But that kind of sort of stop loss backstop for health plans, I think could do a lot to stabilize premiums. And in all likelihood we wouldn't tap into it because I honestly believe we will work our way through this crisis. We will figure out treatments. We will figure out a vaccine. We will develop natural immunities over time that will really make any next future wave much more manageable, and I think a little more like other viruses that we deal with over time, like the flu. So I think that is probably the best way to deal with it.

Court Houseworth (15:24):

That sounds like a good strategy. So as we wrap up here, Paul, at this stage in the crisis, can you share with us any lessons learned and changes that you hope to see implemented to improve our overall responsiveness to the current healthcare crisis and to future health care crises?

Paul Markovich (15:46):

Well, I'm certainly happy to share my perspective. I am not a public health expert at all, but I have been delving into a lot of those questions just to try and help. And I'd say that we just need to get better

coordinated and plan ahead better and put better infrastructure in place at the federal level, at the state level, and at the local level to deal with a pandemic like this and be ready, prepared to do so.

Paul Markovich (16:18):

You know, just having, for example, an appropriate supply of protective equipment, so that you're ready for this. And you have a means of gathering data around the testing and where it's coming, deploy it, gather the data, trace the individuals that have the disease, selectively isolate and quarantine those individuals. That's basic public health and the ability to track and understand that at the federal level, have a way to also coordinate at the state level, have those state resources coordinate with local public health officials and have that entire infrastructure go all the way up from the local level, all the way back up to the federal level, with the right reporting, the right data coming through real-time and just allowing us to understand what's happening on the ground and then respond to it quickly as a country, as a state, as a locality. That's what has really been lacking in this response.

Paul Markovich (17:26):

And so when you're trying to play catch up, when you're trying to create those things on the fly while a virus is just rampaging really through the population, it's so highly infectious, you really can't keep up with it. So you have to plan these things out and have these things set up well in advance. And then the same way that you kind of had a fire when you were in school or at work and said, "We all known what the fire drill is. And when the fire alarm goes off, this is what you do." You know, if there's a fire in the building, you don't want to be planning for how to line up and how to get down the stairs and not to use the elevators, et cetera. You want to have a plan. And I think that's the same thing for pandemics like this one. You really want to have plans and drills and have everything you need in place before it starts, and then just put it into motion once it does.

Court Houseworth (18:20):

Is your sense that the industry will start to think that way, or will everybody just go back to the way it was and forget about March, April, and May of 2020?

Paul Markovich (18:31):

Well, I certainly hope it's the former, not the latter. I think this has been intense enough and long enough that we will, if we can make these changes and put them in place right away. I think our memories won't fade that quickly. And I don't think it's the industry as honestly as much as it is the government, but there may be some changes required to private industry.

Paul Markovich (18:55):

For example, it's clear that a lot of the manufacturers of tests for testing for various things, including infectious diseases have put out their own proprietary machines that can be used to process the test by the labs, but they only really allow their tests to be run through on their machines. And so you don't have a lot of interchangeable parts in the lab operations. And as a result, if some other... I was talking to a south Korean firm that was generating huge volumes of test kits, but we couldn't bring all those test kits in and dramatically increase the test kit supply because there wasn't the equipment and the reagents in place here in the labs to run and use their test kits.

Paul Markovich (19:51):

And so I do think there's going to probably have to be some changes, but my guess is they'll have to be prompted by government in the industry to get in place something where there's more interchangeable parts in the labs supply chain, so that when we need to ramp up our testing, we can do it really quickly. And we're not stuck for example, because Roche doesn't have a test kit yet. And there's all these Roche machines just sitting idle because there's no tests that can run through on their equipment. So that's the sort of thing that I think will impact the industry, but I think needs to come from government.

Court Houseworth (20:31):

That makes total sense. Well, Paul, on behalf of all the Cain Brothers and our clients, thank you for taking the time to speak with me today. I wish you, your family, and the entire Blue Shield team, all the best in these tumultuous times.

Court Houseworth (20:44):

Thank you.

Paul Markovich (20:44):

Thank you, Court. Be safe and be well.

Court Houseworth (20:47):

Great. Thanks, Paul.

COVID-19: Dr. Steve Udvarhelyi, BCBS of Louisiana speaks with Mike Elizondo, Cain Brothers

Join Dr. Steve Udvarhelyi, CEO & President of Blue Cross and Blue Shield of Louisiana and Mike Elizondo, Director at Cain Brothers in a discussion of the COVID-19 pandemic, its impact on the healthcare sector and how Blue Cross and Blue Shield of Louisiana is responding.

Rob Fraiman (00:03):

I'm Rob Fraiman, president of Cain Brothers. During this unprecedented and disorienting time, the team of Cain Brothers is conducting weekly interviews with leaders from throughout the healthcare industry for this special edition Industry Insights series. Our goal is to provide you and your organization with a wide array of views on the multifaceted dimensions, challenges, and responses to COVID-19. Transcripts are available on the Cain Brothers website. Please share your feedback with me or any of your Cain Brothers contacts, and thanks for listening.

Mike Elizondo (00:40):

I am Mike Elizondo, a director at Cain Brothers in our managed care practice. Today, I am speaking with Dr. Steve Udvarhelyi, president and CEO of Blue Cross and Blue Shield of Louisiana. Dr. Udvarhelyi is a board certified internist with more than 25 years of experience in the health insurance industry. Prior to joining Blue Cross and Blue Shield of Louisiana, Dr. Udvarhelyi was executive vice president of health

services and chief strategy officer of Independence Blue Cross in Pennsylvania, and has held various roles with Prudential Healthcare as well.

Dr. Steve, thank you for taking the time today to speak with us regarding COVID-19 and your perspectives as CEO of Blue Cross and Blue Shield of Louisiana, and as an internist, although obviously not a practicing physician these days. We're confident that your experience and insights will be valuable to the broader Cain Brothers client universe throughout the healthcare economy in the United States.

Dr. Steve Udvarhelyi (01:41):

Thanks Mike, happy to join this morning.

Mike Elizondo (01:45):

Thanks. To start, both as a physician and as a Blue health plan CEO, I'd like to get your perspectives on where we are today — Friday, March 27th — in the health care crisis and the response to COVID 19 generally.

Dr. Steve Udvarhelyi (02:03):

Sure, Mike. Well, I think in different areas of the country or in different places, but overall, I think we continue to see the spread of the COVID-19 infection on a national basis. United States now has the largest total number of cases in the world, we'd surpassed China greatly. We don't have the highest number of deaths yet, but we are seeing in the country, continued spread of the virus in highly localized areas. Obviously for us Louisiana, New Orleans is an area that has a very high per capita rate of the infection; unfortunately, one of the highest per capita death rates, but also New York City. We're hearing this morning that Chicago and Detroit are increasing and what's challenging about this is that it really accelerates at a very fast rate and it's probably accelerating beyond our capacity with test.

I think what I would say to everybody is we are still in the process of this virus and this infection spreading, which is why the social distancing and the measures to limit contact that can lead to spread of the virus are so important. If you live in an area that does not yet have a high number of cases, the best time to do the social distancing is before you have really high rates in your community.

I think what I would say is we're still on the rise. I think as many elected officials have said, certainly our governor, the mayors of our cities here in Louisiana, while it's troubling today, we're going to continue to see it get worse. I think that the real critical issue for all of us is when does the number of cases start to overwhelm our health care delivery system? We're beginning to see that in selected areas.

Mike Elizondo (04:33):

Dr. Steve, you've mentioned social distancing and the optimal time to do that before it starts to become a crisis. As a physician yourself, is it a strategy to continue to practice social distancing after it's become a crisis? Does that make it even more acute to continue that strategy?

Dr. Steve Udvarhelyi (04:55):

I think it does. I mean social distancing, just to put it into sort of plain context, it means avoiding contact from people unless you need to be out and about. And if you are out and about, maintain a distance of at least six feet, maybe preferably more than that. Limiting the number of times you go out of your home. You can certainly go out in your backyard, but limiting the time to come in contact with other people, including going to the grocery store, the drug store, et cetera. Handwashing is more effective than alcohol sanitizers, so wash your hands if you don't have access to alcohol sanitizer. If you have

access to some simple gloves, sometimes using that, if you need to go to an area where you think the virus may be on surfaces. If you're in an area where the virus is highly prevalent, that's even more important than before it becomes widespread, because the likelihood that you're going to come in contact with it just goes up.

The question everybody wants to know is when can that go away? I would say, we're not there yet. I know that folks are getting concerned about the economy, the effect that social distancing and business shutdowns are having on our economy. But if we don't take care now to practice that and we go back to sort of our normal daily routine too quickly, we're just going to see a further acceleration in the number of people that get impacted. Whether we're able to change the total number of people, ultimately, would get this virus ... and many countries around the world have said, I think appropriately, that 70, 80% of their population's going to get it. The reason that number is out there is that as the number of people that once they're infected will get something called herd immunity and sort of the virus begins to [inaudible 00:07:07] out. So even though we may not able to change that ultimate rate, what we're trying to do is slow it down and really slow it down so that the healthcare delivery system does not get overwhelmed. The one thing that every person can do is maintain your social distance. That's why that message is so important to the entire American people.

Mike Elizondo (07:30):

Given that Louisiana has been particularly affected, what operational challenges have arisen as you in the Blue Cross would feel the Louisiana team look to address the needs of your constituents, including your members, your employers, and as well as your own employees?

Dr. Steve Udvarhelyi (07:48):

That's a great question. For us at Blue Cross Blue Shield of Louisiana, we were responding to the pandemic really from three lenses. First, we're responding as an employer. Like many new companies, how do we manage our own employees through this? Second, as a health insurer and making sure we're there to meet the needs of our members, work with our network of providers. Then lastly, we have one market and Louisiana and the Monroe market, we actually have as part of our family of companies, a medical group and a small 10-bed hospital, so we're looking at it as a provider as well.

Just start with us as an employer, our initial objective was to try to move as many of our employees to work remotely as possible. The reason that's important is in a headquarter building where we had almost 2200 people coming in and out every day, if we have someone who's diagnosed with the COVID-19 infection walking around the workplace, they will likely have exposed a great number of people and not only need to be quarantined, but we want to make sure they don't come down with the infection. We're delighted to say that in the course of one week, we moved almost 2000 people out of the building to work remotely, a remarkable achievement by our IT team, and we're able to do that ahead of the stay at home mandate that the governor announced. Fortunately, today, while we've had a few of our employees been exposed to people with COVID-19, none of our workforce has been infected.

That's the other challenges in employers. You worry that if the virus spreads through a workplace ... and what we know about the virus, I'll just say, is that it tends to spread most rapidly in confined settings. That's why nursing homes are such a challenge. It also seems to cluster in families, in their own homes, and the same thing can happen in a workspace. We've seen that in hospitals, actually. So getting your employees home and away from each other, again, the social distancing was important.

As a health insurer, what we've done is really tried to help both members and our providers still on the member side. We've announced, like others have, that we're going to waive cost sharing for COVID-19 testing. We've greatly expanded access to telehealth and to the extent possible, we're trying

to do that again with no cost sharing. We've worked with our physicians and hospitals to actually expand their capacity to provide services on a telehealth basis. It's not just physicians. We've worked with therapists and behavioral health providers to do that and have ramped that up significantly so that people can get the care they need without having to necessarily travel and be exposed to people that are coming in for acute care.

Then lastly, on the provider side, while we only have a small footprint there, we like others are seeing the biggest challenge in shortages of personal protective equipment and in some of our own workforce becoming ill as they treat patients. I think we've done a good job at managing all of those, but this is an evolving, very fluid situation. I think, like others, what we're doing is managing this as a crisis with very formal crisis management process. One of the benefits of living in Louisiana, since we have a lot of hurricanes here, is we do have a good crisis management process that we're able to tap into that allows us to address things rapidly and respond. We're staying very focused on that.

Mike Elizondo (12:10):

Thank you. With regard to your hospital and physician provider network, which are undoubtedly experiencing strain as other parts of the country, what is Blue Cross and Blue Shield Louisiana doing to provide support? Or in other words, what are your provider's key needs to support your membership and how can Blue Cross and Blue Shield Louisiana address those needs?

Dr. Steve Udvarhelyi (12:37):

I think the hospital and physician network, the needs vary substantially by whether it is a hospital or a physician group. It also depends on whether it's an urban area or a rural area. The first thing we're doing is we're listening and trying to meet their needs, which do vary. Going back to the comment we just made, they all need help with expanding their ability to provide services to their patients remotely through telehealth, et cetera. We've relaxed some of the criteria and the federal government has responded that way too, so that some non-HIPAA compliant devices are now being allowed to be used for telehealth services. We're allowing providers to get paid for that expanded footprint of services, including in some cases, just telephone calls if they don't have a video of capacity available. That's important for them so that they continue to get paid while providing services in a different way during this pandemic.

We've relaxed some of the normal protocols that we have such as prior authorization, expanded access to medications for our members, and relaxed, again, prior authorization requirements there. Really, from an administrative standpoint to try to make it easier for hospitals and physicians that are becoming increasingly burdened with caring for COVID-19 patients.

I think the financial support that is hopefully going to get passed today by the federal government is important to the provider community. I think the providers are worried about cash flow and so we're trying to address that. That again is not a one size fits all, but we're also worried as an insurer about making sure that our financial strength is used what it was set up there for, to take care of the healthcare needs of our members when those needs explode in a time of crisis like this.

Again, we're watching that carefully and trying to balancing the needs of a lot of folks. We hope the stimulus money also comes down to businesses to allow them to have their employees stay employed, maintain their health coverage so that we can then in turn, pass that money along to the providers who have taken care of those people.

Mike Elizondo (15:47):

That's a great segue to the next topic. We discussed a little bit about, or you just discussed a little bit about the impact of the stimulus package passed by the Senate to the provider community and to business, but are there other areas that you feel the stimulus package will help particularly? Then secondly, are there areas at this time you feel may require additional support by either federal and/or state governments?

Dr. Steve Udvarhelyi (16:18):

I think the stimulus package is important. I think we don't yet know how quickly those funds can be made available to the states and the provider community that's going to need them as well as the business community. I think that will be important to find out. There may need to be some things that all of us try to do to bridge to that point. I think federal support for the provider community in terms of protective equipment, supplies, ventilators, and just assistance in setting up temporary hospitals, at least in select markets, is going to be critically important. We're seeing that in New York, we're seeing that now in new Orleans, I think we can see that in other major cities. Governor Cuomo, when he said this is where we are now, but this is where the rest of the country is going to be later, I think set a pretty clear warning signal to all of us that we need to be prepared for things to get strained in other parts of the country.

Our former secretary of department of health actually was interviewed this morning on the Today show and correctly said that what's very different about this crisis, compared to other things that we deal with like hurricanes, is the whole country is being impacted simultaneously. So unlike other events, weather events where people from a non-impacted part of the country can come to the aid of an area that's impacted, we don't have that flexibility in this crisis, which make it very different.

I do think in the supplies of protective equipment and particularly for healthcare workers, if our healthcare workforce is substantially diminished because they become ill with COVID-19, that's just going to exacerbate the situation that much further.

Mike Elizondo (18:27):

We spoke a little earlier around Blue Cross and Blue Shield of Louisiana's role, particularly around telehealth and engaging with members. Are there other things that the company is doing to engage and interact with members in this time? How do you view Blue Cross Blue Shield of Louisiana's role in engaging with the broader Louisiana population outside of your own membership?

Dr. Steve Udvarhelyi (18:58):

I think that first and foremost, we want to make sure that we're communicating frequently and accurately with our members, with our providers about what is going on and how they can continue to depend on us as they have to help support their health care needs. I think there's a lot of misinformation potentially out there. Whether it's CDC recommendations or other recommendations from healthcare professionals, we're kind of point people to accurate and correct information, trying to get them guided to where the best care delivery could be for their issues, and just remind us all that while obviously COVID-19 care is front and center, there are a lot of people with ongoing illnesses that they need care, there are people that still are having urgent kind of issues that need to be attended to. We're trying to make sure that we provide that guidance where we can, we're not looking to be necessarily the preferred source of information on all things, but we are working cooperatively with others.

The one area where I would say that we've lent a hand to the state is we have a very advanced analytics department in our company. We've been able to use that to help the Louisiana Department of

Health understand where people are going into hospitals, what are the diagnoses that they're going in for, and that really helps them from a planning perspective and understanding and maybe anticipating where the viruses can be going and what kind of support is needed in different areas around the state. We're happy to sort of lend them that capacity during this crisis.

Mike Elizondo (21:09):

That's a great segue into the next topic I wanted to discuss, which is how is Blue Cross and Blue Shield Louisiana working with state and local governments and regulators, and how can government in regular support Blue Cross and Blue Shield Louisiana? You've clearly discussed how you are supporting state governments and regulators with your analytics platform, but are there other ways that Blue Cross and Blue Shield of Louisiana can continue to support local governments?

Dr. Steve Udvarhelyi (21:43):

I think, again, I think it varies depending on the state, the issues will vary a little bit state to state. I think, first of all, we have a very good relationship with our state government. We have a good relationship with the governor's office, with the Department of Health and with our Department of Insurance. What we're doing really is making sure we're staying in touch with all of those state government departments and understanding what we can do to be helpful, provide information, and also, in some cases, provide some guidance that may be some things that may seem to be beneficial, may have some unintended consequences that are actually not helpful in the long run. You try to provide some guidance there as well.

I think our biggest concern as an industry is that we're not put into a financial squeeze by, again, well-intended efforts to provide people with coverage, et cetera, that would actually take away our reserves for other things than what they originally intended for. We'll kind of be cooperative in that nature, meet the needs of our members, but also make sure that we're being careful custodians of the resources that are there for our customers and our members when they need it.

Mike Elizondo (23:28):

Final question, Dr. Steve. At this early stage in the crisis, can you, as a health plan CEO and then physician assess for us any lessons learned and changes that you would hope to see implemented for a response to future health care crises?

Dr. Steve Udvarhelyi (23:46):

Yeah, that's a great question. I would say that in many cases, it's a little too early to look back on lessons learned. I think if you listen to Dr. Fauci from the NIH, maybe all of us realize now that we probably wished we'd responded sooner to the virus than we did. Hard to know whether we would've made different decisions with the information that we had at the time. I think there will be a time once we're through the immediate crisis part, we'll look back and share information. I'm hoping that's not too far off, but right now, let's say it's a little too early to really understand exactly how we could have managed this in a different way for a better outcome. By the way, we're not alone in this country. I think the whole world will learn from this in a fundamentally different way.

There are some, I would say, early silver linings on this. First, I think there will be an enduring impact in terms of using telehealth and telemedicine to care for people. I think this crisis has shown us that that's important. I think that moving forward, the delivery system will probably migrate to a much broader use of telemedicine capabilities, which is probably a good thing for all of us. But we'll have an opportunity to do that in it in a more thoughtful and structured way at the end of the crisis. The other

area is as employers, I think we've all learned that we can work remotely at scale much more effectively than we would have thought. I think that's going to have some enduring impacts on how we work and where we work. Again, in the long-term probably beneficial, although prompted by this crisis. Those are two things I think that we've learned as we've responded, but the broader lessons I think are yet to come.

Mike Elizondo (26:20):

I think this is a good place to conclude. Dr. Steve, thank you for your time today and your insights and perspectives on the current crisis? I hope you and your family and the entire Blue Cross and Blue Shield of Louisiana team are and continue to be well, thank you.

Dr. Steve Udvarhelyi (26:35):

Thank you very much. Stay safe.

Public Health & Healthcare in Post-COVID America. Court Houseworth, Cain Brothers

Court Houseworth, Managing Director at Cain Brothers, and Kyle Stern, Managing Partner at Healthscape Advisors, join Dave Johnson to discuss the long-term impact of social determinants on individual and community health, and innovative companies addressing those public health disparities. With COVID-19 continuing to hit the most vulnerable disproportionately, this topic is both timely and urgent.

Court Houseworth (00:00):

You have a more engaged senior, you have a more educated senior and you have a happier consumer, right? And those are the more subjective aspects that underlie those great financial statistics.

Dave Johnson (00:15):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets Incorporated. I'm your host, Dave Johnson, the CEO of 4sight Health and the author of The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I also co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry. This month, our article is titled Public Health and Healthcare in Post-COVID America: Innovative Solutions for a Healthier, More Prosperous Society. In the article, we explore the outsized impact of social determinants on individual and community health.

We also profile companies developing innovative solutions that address health disparities. COVID-19 has magnified the impact and visibility of social determinants on vulnerable populations. A potential silver lining of the COVID crisis is that it gives American society the opportunity to become more proactive in promoting holistic health and wellness. Today, I'll be talking with my two co-authors Court Houseworth and Kyle Stern. Court is a managing director at Cain Brothers and he's co-leader of

the firm's managed care advisory practice. Kyle was a managing partner at HealthScape Advisors. Prior to co-founding HealthScape, Kyle worked at UnitedHealth Group where he was on the OptumHealth executive leadership team. Kyle and his team at HealthScape have joined us this month to do a deep dive on the social determinants of health. Chicago-based HealthScape is part of Convey Health Solutions, a healthcare technology and services company. Welcome to House Calls, gentlemen, where the bankers and in this case, advisors, are always in.

Court Houseworth (02:19):

Thanks, Dave, really appreciate you hosting us today and diving into such an important topic in healthcare.

Kyle Stern (02:28):

Great to be here, Dave.

Dave Johnson (02:29):

Yeah. Well, let's get right to it. Court, why don't you talk to us a little bit about the genesis of this commentary and why are particularly you wanted to dive into the topic of social determinants of health with Kyle and his team?

Court Houseworth (02:47):

Dave as I think about it, increasingly it's recognized that addressing non-clinical factors contribute significantly to improved health outcomes. Social determinants of health have a significant impact on care outcomes and population health. As Cain Brothers works with payers, providers, and other healthcare service organizations, we are seeing a substantial increase in the resources dedicated to addressing such social determinants. Furthermore, like many we're seeing structural changes in reimbursement from fee for service to value that address health needs in a coordinated and cost-effective fashion. Both Cain Brothers had HealthScape deliver market-leading insights and solutions to our respective clients, which are both primarily payer and provider organizations and health care technology companies. We believe collaboration is a powerful tool to serve our clients. As Kyle will share, the HealthScape team provides consulting services to leading healthcare entities. Many of whom overlap with Cain Brothers' clients. Kyle and I thought combining our views and insights on social determinants of health would be interesting and valuable to all of our clients.

Dave Johnson (04:05):

Hey, thanks Court, that was great. We really haven't paid for health and wellness prevention, chronic disease management, and so on. And now we're getting some models that are starting to do that and that in turn is triggering innovation inside the sector. Really interesting. And I know Kyle, you and your team spend a lot of time specifically thinking about the business models and the companies and so on. So why don't you give us a little background on HealthScape?

Kyle Stern (04:35):

Sure, Dave, and thanks again for having us on House Calls. I love talking about the importance of SDoH and some of the advancements that we're seeing out there in the market. A HealthScape Advisors is a management consulting firm. We are solely dedicated to healthcare. We work with both payers and providers so we see both ends of the spectrum and we really help them transform their businesses as they try to navigate our ever-changing healthcare landscape.

Dave Johnson (05:02):

Let's discuss social determinants and why they're so important for health care outcomes and costs. Kyle, maybe why don't we start with you? Could you provide some background on social determinants, the categories, the impact, and just generally how you think about them within the overall health ecosystem?

Kyle Stern (05:23):

Sure, Dave. When we talk about long-term personal health, it is really all about social determinants. Collectively, social determinants is the single most important factor set in one's own health. Now the audience for these House Calls I know is a highly knowledgeable one, but let me just take a second to level set. The social determinants could be broadly broken into six different categories. You have number one, economic stability. This is what's your income level? What debt do you have? Do you have job security or a job? The second factor is your neighborhood. The housing that you have, the transportation that you may have access to, but it's also things like parks and bike paths and playgrounds that may or may not be easily available. The third factor is your education. Do you have a high school diploma? Do you have a college experience? But beyond your grade level, it's also about your health literacy.

The fourth category is food. We have many, many individuals in this country, a significant portion of our populace that is food insecure that do not have access to healthy foods and healthy choices in their community. The fifth factor is your social community context. What support systems do you have? Are you isolated? Are you connected? And what are the means of connectedness? And then that last category is really the healthcare system itself, do you have access to providers? Do you have the ability to get there? Are they quality providers? Do you live in a remote area? If you're in an urban setting, does it take you four buses to get to a provider? All of those factors contribute materially to our health. Study after study have shown that these factors collectively account for over 60% of our long-term health outcome. Outcomes measured by life expectancy, traditional quality of daily life factors, your total health spend, the number of morbidities or HCCs that you have. These are all determined by these factors. Genetics is a distant second and 10% or less of your overall health outcome is actually through clinical interventions.

Dave Johnson (07:47):

That was a really nice job of going through that. And we've known for a while that social determinants have a huge influence on health status and longevity. And we've started to see the concept of death gap where lower income people are often dying 10, 15, even 20 years earlier than people living in wealthier neighborhoods just a few miles away so this isn't really a surprise. But COVID, because of how it's targeting its victims, I think has placed or magnified the impact of social determinants on health status.

Court Houseworth (08:33):

Well, in part to the most vulnerable populations and communities have faced disproportionate impact from the disease. Frankly, experts have been surprised by the degree of the disproportionality. In San Francisco, the low-income population has the highest infection rate in the three largest Bay Area counties. In New York City, Black and Latino residents are dying at twice. The rate of white residents. In Chicago, the racial disparity is even higher with Black residents accounting for 72% of the city's COVID-19 deaths while Black males make up about 29% of the city's population. COVID-19 has exacerbated certain challenges associated with housing and income instability, food insecurity, and socialized isolation. For example, with up to 78% of Americans living paycheck to paycheck, the sudden loss of jobs

have interfered with mortgage and rent payments. In the early going there were widespread shortages of basic food staples in grocery stores and there continues to be an ongoing struggle by food banks to meet the increases in demand. And finally, the shelter-in-place programs have exacerbated the nationwide loneliness epidemic. So we've seen multiple impacts across the country and across the populations.

Dave Johnson (10:04):

Yeah, it's actually kind of scary the way you're laying it out, Court. COVID is actually making many of the conditions that we're already afflicting those in lower-income neighborhoods worse so we could see a compounding effect of the disease with the social determinants, which gets us to the question of how exactly did we get here? It's been over a century since America experienced its last pandemic, the Great Influenza of 1918. In response to that pandemic, the country developed a robust public health infrastructure and in many ways that dramatically improved overall health status throughout the country. Unfortunately, however, investments in public health have withered during the last 30 to 40 years, to the point where there are lots of leaks in our public health infrastructure, which is both limiting our ability to respond to the pandemic, but also has limited our ability to address social determinants in an effective way. So Kyle, why don't we start with you? Where have we gone wrong?

Kyle Stern (11:18):

Dave, that's a great question. Obviously, it's multifactorial. If I were to single out the primary driver, I frankly say it's misaligned incentives. We foundationally have a system that pays for acute clinical intervention. It's very difficult in our system to be rewarded or to collect revenue for health, for positive outcomes, for no episodes of care. Unfortunately, right now our system, and certainly the one over the last 30 years, has been reactive. And what we need to do is we need to be more proactive and particularly proactive around these influential factors that frankly are the largest portion of our outcomes [five 00:12:09], which are the SDoH factors.

Dave Johnson (12:11):

Yeah. One way I've always thought about this is healthcare is the ultimate weak link enterprise. We're only as strong as our weakest link and we're very strong on the treatment side, but we're very weak on the prevention side. And yet, if we could prevent the need for a surgery through chronic disease management, health promotion, any number of things, addressing social determinants, that's a better outcome than having the best surgery by the best surgeon in the best institution in the country. And yet, we pay a lot of money for the latter, which is an inferior outcome than we do the former. I think we're getting some real innovation in the sector. Why don't we just generally talk about the types of organizations addressing social determinants today and what are the barriers that they're confronting in providing effective services? They want to do it, they're organized to do it, but the system is itself isn't really set up to accommodate this type of business model. So what are those barriers?

Court Houseworth (13:25):

What a great question, Dave. We see a broad array of healthcare industry participants addressing the social determinants. Payers, for example, are increasingly investing in housing communities care source. The focus primarily on the Medicaid population has funded digital preschools for lower-income children. And Kaiser has awarded grants to promote education, job training. We've seen hospitals systems do some pretty innovative things. ProMedica in Ohio has addressed food insecurity by building a grocery store for at-risk individuals. From a transportation standpoint, we've seen Lyft and Uber adapt their apps

and services for the healthcare community to provide non-emergency transportation. But to the second part of your question, the obstacles, I think there's really two main obstacles which I see. First is the scale of the problem is enormous and there's just so many competing priorities with limited funding.

And then second, tracking the outcomes and benefits from such initiatives is challenging. There is a early-stage company Unite Us via its digital platform is addressing the latter problem. The company handles external referrals between community services and providers and then tracks each of the patient's outcomes and their journey through care. And so I think that's a big step towards solving the tracking and outcomes part of the issue.

Dave Johnson (15:03):

I guess you can't fight a five-alarm fire with a garden hose, to use an old metaphor. So on the one hand really encouraging that a number of companies are creating really innovative solutions, building grocery stores, using Uber and Lyft for transportation, and so on. On the other hand, those are a drop in the bucket relative to where the main action is as Kyle said in the treatment side of things. But we know down in our bones that addressing social determinants is a major public health issue so we have to do it. Fortunately, the news isn't all bad. Court, as you alluded to, there's been some real innovation addressing social determinants of health. Kyle, could you discuss advances in technology and data primary and preventative care and social support that are underlying the business models of some creative and innovative companies?

Kyle Stern (16:03):

Sure, Dave. And I really think that Court hit the nail on the head. I started in healthcare in 1993, as I now look at healthcare companies investing in housing, healthcare companies helping connect people to jobs, healthcare companies supporting educational programs. It's a wonderful thing. I would not have imagined in 1993 that we would have organizations like CVS and United and Blue Cross plans throughout systems, certainly here in Illinois, investing tens of millions of dollars on these factors that one might think are unrelated, but as we've all come to learn are highly related to the health of the population of individuals they serve so it's very, very exciting. On the technology front, Court mentioned a couple like Unite Us and Healthify. I've been dealing with care management platforms for 20 years and these care platforms are used by registered nurses and other practitioners to help guide individuals through their complex disease states.

And these platforms are very good historically at guiding individuals through the right care steps to treat their illness. But what's been really cool from some of these new companies is that they're integrating with those and a nurse can easily toggle and not just address the clinical pathway for that diabetic, but then immediately connect them to food banks if they're food insecure and nutritional programs and literally down to street level, and then even connect them to a share ride service that will take that individual to that nutritional program education site. And so that's a really interesting new dynamic, these tech platforms and data stores that are interacting with map-based systems to get people to where they need to be. And that's just an exciting example of what we're seeing on the tech side.

Certainly, Court also mentioned Uber, right? They are integrated with nearly every EMR across the country. And they're partnering with plans, Guidewell Florida Blue and hospital systems down in Florida, where they will receive reimbursement because both the payer and the hospital know and it's in their interest to get that patient to and from care cost-effectively and safely. And this non-emergent medical transportation market that Court mentioned is a huge market. And now you have the ability to track that individual all of the mechanisms that Uber and Lyft have.

Dave Johnson (19:01):

Yeah. It's interesting to contemplate what tech is going to do for us. Imagine when 5G is fully online in a couple of years and suddenly a connection point accommodates millions of connections instead of thousands today. But tech is a really important factor in sort of the new wave focusing on primary care like you were describing and giving it its due in the sense of prevention and health promotion. Chicago based Oak Street in Kyle and my hometown here, although they operate across the country, employees, all of those types of techniques to service its clients. We profile Oak Street in our commentary. Court, why don't you tell us a bit about Oak Street, their business model, and what impresses you about them?

Court Houseworth (20:02):

I'd be glad to Dave. Oak Street Health has a private equity-backed company led by CEO Mike Pykosz. The company is focused on full risk, primary care contracting to provide care for Medicare patients, including dual-eligible and patients with complex conditions. Its clinical model involves the primary care focus as Kyle talked about, and they're really focused on longer, more frequent visits, supported by integrated care teams and sophisticated IT tools that are used to develop and carry out individualized care plan. Each of their centers are established in neighborhoods that are underserved. Every center operates under one clinical model for how to treat patients and a common digital IT platform. All of Oak Street patients have complex care needs and are all Medicare patients.

I think Dave, to your question of what's impressive about them is if you look at the results, a 50% reduction in hospital admissions, 52% reduction in emergency department visits, 35% reduction in 30-day readmission rates, and a 90% retention rate with their patients. So the model has proven since it was established a handful of years ago to be very effective. One other note to hit upon is that in the wake of COVID-19, Oak Street introduced remote care model, which includes phone and video-based telehealth visits, COVID-specific resources such as virtual monitoring and a hotline for wellness checks and deliveries to address social determinants of health.

Dave Johnson (22:01):

What's not to like about Oak Street? Lower costs, better outcomes, great client engagement with a tough clientele, and then the adaptability to shift almost overnight their care delivery mechanisms from in-person to virtual. Really, really, really impressive. Hey Kyle, any other innovative companies you'd like to mention?

Kyle Stern (22:28):

There are so many other companies that are out there building great tools and creating some breakthrough technologies that are in a very positive way, deconstructing these social barriers to really good health. And our white paper that will follow this podcast, we'll hit on a number of those companies really in each of the six major categories that we outlined earlier. So I won't spend a ton of time diving deep into these companies, but there's companies like Cityblock and Aunt Bertha and DC Greens and Community Action and Roundtrip and Signify and Rally and Martha's Table and a whole host of others that we hit on and they do great work and food and shelter and transportation, predictive analytics prevention and connecting people to community groups, to prayer groups. And I think that's wonderful but I'll say maybe something slightly different because I think where we're building momentum and there are a lot of players out there, but I think there's three important factors that will ultimately will underlie success.

Number one, the companies that I've mentioned that are successful at partnerships will do well. Complex partnerships. The ones that build the right economic model will be successful. And frankly, the

ones that scale and create repeatability and sustainability will be successful. As we all know, you can't get anything done by yourself in healthcare. It is such a complex ecosystem. You have to be able to create interconnectivity with providers with hospital systems with complex EMRs, you've got to be able to connect with payers and their claim data. And if you're able to do that, you'll be successful. If you frankly have a great widget or a killer app but you're not able to connect and interface with your partners, you ultimately won't succeed. Many companies have tried to come in from the retail sector into the healthcare world and they realized that the fundamental economics are very disjointed and complex.

The consumer, the end person who benefits from the tool or capability often isn't the one that pays for things. And so creating the right online economic model where you're delivering results, not just to the end consumer, but to another constituent and that that constituent is willing and able to fund the mutual success, that's critically important. And that as we all know in the tech world, scale matters and would outscale frankly your program or your service or your platform will ultimately be subsumed by others. And so scale across geographies and scale within geographies matters a lot.

Dave Johnson (25:44):

Yeah. Great response, Kyle. I mean, how could anybody not want to get healthcare from a company named Aunt Bertha, right? But your observation that you need partnerships, you need a value-based economic model, and the ability to scale. I think those are the right factors. And you also note as does President Trump, that healthcare is complicated. So really do need to do it in partnership with others, with the right tools and the right focus. And we have seen in COVID some massive scaling of virtual care and also seeing the benefits of people practicing a top of license and so on. We'll get into this in a moment. But before we do that, let's talk a little bit about the money. My guiding philosophy in healthcare is that we won't fundamentally change the way we deliver care until we changed the way we pay for that care. Court, how does that apply to social determinants of health?

Court Houseworth (26:57):

That's a great question. And Dave, I agree with your philosophy. It's really critical to align incentives in order to fully address the needs of the patients. Unfortunately, healthcare policymakers struggle with preventative care as well as care, which is addressing the social determinants of health that we've talked about today. However, we are seeing flashes of change. CMS regulations now allow health plans to offer supplemental benefits that cover meal delivery rides to the grocery store or a service that makes members' homes environments more conducive to healthy living and that's a real step in the right direction. As we've discussed a patient's social circumstances, including their socioeconomic status, educational attainment, housing status or food security will have a considerable and direct impact on outcomes. After all, if a patient cannot access healthcare resources necessary to manage the illness for themselves, the clinical effectiveness of any care really will decrease over time. So incorporating social determinants of health into value-based purchasing contracts can make the difference between a model that merely incentivizes providers to alter their workflows and one that sustainably lowers costs and improves quality, bringing savings ultimately to all stakeholders.

Dave Johnson (28:33):

Well, the government is focused on this, Court. They're on record is trying to get to, or eliminate fee for service payment for Medicare within the next three to five years. And they've been sort of systematically chipping away at that. It is remarkable though what American companies can do with the

right incentives and maybe in that spirit, Kyle, anything you want to add to what Court has described in terms of incentives and business models and desired outcomes?

Kyle Stern (29:09):

Well, I'm a naturally optimistic person. And I always try to look at the silver lining in things even today's under the most dire situations. And I do think a positive accelerated outgrowth of the situation we find ourselves in with COVID is an accelerating partnership between payers and providers in a baseline structured value-based agreements, right? Large IPAs provider, primary care groups, or other larger organized systems care. They're all seeking ways to partner with risk-bearing entities, to diversify their revenue sources away from solely fee-for-service and into some of these new value-based constructs. It had been on their agenda for some time. We've all been talking about value-based partnerships for years and years. And there have been some rudimentary programs launched and then some sophisticated programs in certain geographies. But there's no doubt in my mind that as a result of COVID, we are seeing an acceleration of very well aligned economic models that promote the right behaviors, that incorporate elements of SDoH in them, but that fundamentally compensate factors within this care environment, including providers for promoting health and value-oriented exercises versus just journey services.

Dave Johnson (30:55):

Yeah. Powered by optimism, Kyle, that's a great way to be. And I think you're right, we need payers and we need providers to be on the same page. And increasingly that's where they have to go for the market is starting to shift. The government is starting to shift. The COVID will be accelerating that change. So with that in mind, last question we are right in the midst of this overwhelming COVID-19 pandemic. And many, I think including all of us believe healthcare will never be the same. I'd like to ask each of you to make a bold prediction regarding the post-COVID healthcare landscape. Court, why don't you go first? What's your bold prediction?

Court Houseworth (31:46):

I'm not sure exactly how bold this is, but I do think that the adoption of telemedicine and virtual care that we've seen over the last several months is going to continue to accelerate among all patients, including commercial, Medicaid, Medicare. The pandemic accelerated the adoption of telemedicine and I expect it to be much more commonplace going forward.

Dave Johnson (32:10):

Great. Thanks, Court. Kyle?

Kyle Stern (32:12):

The only other [inaudible 00:32:13] bold prediction I'd make is there's going to be a tremendous amount of M&A market activity into the next year into 2021 as a result of what's happening. Yeah. I don't think there'll be much activity in the months ahead, but in the quarters of head, there will be. You will have organizations that look to diversify. If they were employer only carrier they'll look to get into Medicaid and Medicare. If they were provider, they may look to secure parts of the health insurance premium. They may look to acquire individuals that maybe were more highly leveraged and haven't come out of this situation as strongly as other organizations.

Dave Johnson (33:02):

Oh, great. Virtual care and more consolidation, all moving toward a better, more efficient healthcare delivery system. That seems like a pretty good place to land. Look for our forthcoming article, Public Health and Healthcare in Post-COVID America. We'll continue to produce thought leadership over these coming months with Cain Brothers, it's more important than ever to look at trends in both the short and long term to get a view of this new world of healthcare and how it's unfolding.

Kyle Stern (33:33):

Dave, one last item. Court and I would both like to extend our thanks to our first responders, to our nurses, our physicians that put their lives at risk each and every day during this crisis.

Dave Johnson (33:46):

Oh, what a great thought. Thank you, Court and Kyle, this has been a fascinating discussion of social determinants of health in the time of COVID-19. To the audience out there, look for our article. All the best.

Podcast: Health Tech to the Rescue: Combatting COVID-19 with Virtual Care and Predictive Analytics

Jill Frew, Managing Director of the healthcare technology practice at Cain Brothers, a division of KeyBanc Capital Markets, discusses how technology companies, many of them start-ups, are helping to meet the vast needs of the U.S. healthcare system in the midst of battling COVID-19.

Dave Johnson (00:03):

I can't believe how many Zoom conversations that we're all doing, and it's not the same as face-to-face. We're even doing it socially. I'm getting better at making cocktails.

Jill Frew (00:14):

One benefit of all this, right? My domestic skills haven't improved. I never had many to start with so the bar was low.

Dave Johnson (00:22):

Well you know, you're out changing the capital markets as we know it in the healthcare tech. So you've got a good excuse.

Jill Frew (00:27):

Yeah, that's what I tell my husband.

Dave Johnson (00:31):

Welcome to House Calls, where we get to talk to senior investment bankers from Cain Brothers, a division of KeyBanc Capital Markets Inc. I'm your host, Dave Johnson, CEO of 4sight Health, and the author of The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I also co-author a monthly thought leadership article with a rotating cast of Cain Brothers senior bankers. In each piece, we do a deep dive on a fascinating sector of the dynamic healthcare industry.

This month our article is titled, Health Tech to the Rescue: Combating COVID-19 with Virtual Care and Predictive Analytics. It's an amazing story of how tech companies, many of them startups, have shown up just in time to support and bolster a health system that's truly under siege. Today, I'll be talking with my co-author on the article, Jill Frew, Managing Director of Cain Brothers.

Jill leads Cain Brothers' Telecare technology practice. She joined the firm in 2006 and has over 25 years of experience advising both public and private companies in a variety of M&A, capital raising, and strategic advisory transactions, including working with organizations like American Well, CVS, GuideWell, RedCard Systems, and UnitedHealth. I love talking to Jill because healthcare tech takes us to such interesting places.

Welcome to House Calls, Jill, where the bankers are always in.

Jill Frew (01:59):

Thanks Dave, really excited about today's discussion.

Dave Johnson (02:01):

Yeah, I think we're going to have some fun. Anyway, back in ancient history, let's say January, when we were finalizing our Cain Bothers editorial calendar for 2020, we decided like we did last year, it would be really timely to write a piece with you about what had come out of the HIMMS conference, which then was scheduled for March. Then as the date got closer, the coronavirus began spreading globally and ultimately led to the cancellation of the HIMMS conference. But it was still an eye-opener when the largest healthcare event in the country canceled.

So flash forward a month to where we are now, and we're all sheltering in place, well, really all over the world. You happen to be in New York City, the epicenter of the COVID pandemic, and the healthcare industry as we know it has been completely disrupted on every level. By the way, not just healthcare, pretty much everything has been disrupted on every level. There's all kinds of new language, flattening the curve, social distancing, PPE. And we're talking more about ICU beds and ventilators than ever before to go along with an economy in absolute free fall. Why don't you give us sort of your personal circumstances and then more broadly the industry as a whole?

Jill Frew (03:14):

Sure. Well, obviously New York has been the epicenter of the crisis. I've been kind of front row seat to this whole experience. Thankfully, the data is improving and the admission rates are coming down. Unfortunately the death rates are still at extraordinary levels. I think we lost over 800 of our residents just yesterday, but the data's looking better. I've watched a lot of the models that everybody has become familiar with and have been relieved to see a lot of improvements on a kind of day-to-day and week-to-week basis. But it's certainly been a life altering event for I think all of us. And in fact, when you mentioned HIMMS, in retrospect, it seems like such an insignificant event, given the magnitude of the issues that we're all now facing really at every level in our life.

Dave Johnson (04:01):

Yeah, right.

Jill Frew (04:02):

And I remember, that was just kind of the beginning of a cascade of events. I remember a couple of days later, the NBA canceled its season. The next thing you know the schools were canceled, a lot of essential

businesses were closing. We're all setting up our home offices and getting familiar with new technology. And I think I knew pretty quickly that life as we knew it was going to change and for, unfortunately, a fairly long period of time. Yeah, it's been quite a change for I think all of us at many levels.

Dave Johnson (04:30):

Yeah. Let's dive into the tech a little bit, and what's been happening there and your perspective as someone who really sort of sees around the corners about what's the promising technology that's coming. But also now can talk about how technology that's been developed and promising for a while is really now getting applied.

So in many areas of healthcare banking business is at a temporary stand still, and in many aspects of the healthcare industry, we're talking about traditional models being suddenly overwhelmed and overturned. You just look at some of the issues related to access and data. But in the healthcare tech sector, the area you focus on, the story has often been the opposite. In our darkest hour it's health tech to the rescue. In the article that you and I wrote, which had that in its title, we talk about a number of companies that are bridging the sudden gaps in healthcare delivery and data transmission. Even so the rapidity of the adoption is really something to behold.

In many industries, if you build a better mousetrap, the world beats a path to your door. In healthcare, it seems you need some type of sword of Damocles hanging over your head, whether it's in the form of sweeping legislation or a crippling global pandemic before the industry moves. But the industry is moving now and in some cases there's almost elastic demand for tech services. Why don't you elaborate on that topic for us, just give us the 60,000 foot view of what you're seeing and how that's starting to play out.

Jill Frew (06:00):

Yeah, be happy to. Yeah, it's unfortunate that it took a pandemic for really consumers to more fully embrace a lot of the digital and virtual tools and technologies that have been available for many years, and for the regulators to reduce some of the barriers that have really limited growth over time post-COVID. And I think as the world in pre-COVID and post-COVID now, I think the utilization and adoption of a lot of these solutions will be a fundamentally different level for a sustained period of time. The coronavirus has just been an extraordinary catalyst for change and something that I think is transforming the healthcare industry right in front of our eyes.

So I don't think there'll be a back to normal. I think once the crisis is over, I think the industry will look quite different and in many ways in a better way.

Dave Johnson (06:45):

Yeah.

Jill Frew (06:46):

And I think the other thing that coronavirus has done is revealed a lot of the inadequacies and gaps in our healthcare system, and the technology for telehealth, which has probably been in the headlines now, obviously in a significant way for the past couple of months. But that's a technology that's existed for, really since almost 2005, at different levels of sophistication and a pretty modest uptake to date. And I think since 2005 till recently, one out of every 150 primary care visits was done through telehealth, and like one of every 5,000 or 10,000 specialists is done through telehealth. And due to the coronavirus it's become mainstream almost overnight. So it's been interesting to see how this has been a catalyst for I think in some ways good change. Unfortunately it took a crisis for it to occur.

Dave Johnson (07:35):

Yeah, and the remarkable thing about telehealth is the way most companies perform telehealth. It's really a replication of a doctor's visit in virtual form, right?

Jill Frew (07:45):

Mm-hmm (affirmative), that's right.

Dave Johnson (07:46):

That they tend to be 18 to 20 minutes long and it's just done in front of a computer rather than in person. We've been so locked into the doctor's office visit that that still predominates. Somebody told me we had a billion visits in ambulatory centers and doctor's offices last year.

Jill Frew (08:04):

Yeah, it really has. And I think just the level of innovation that's come as well. I mean, the traditional telehealth model as you described that everybody was quite familiar with, I think there's a broader universe of solutions that I speak of more as kind of virtual health. And I think as a result of the crisis, we see in some of the more innovative healthcare systems, many of which we work with here at Cain Brothers, developed kind of unique and kind of new use cases for virtual health across some of the different care settings, just urgent care or intensive care or first responders, monitoring. So I think they've been, again, almost kind of a sense of survival have found a way to use the technology in a way to deal with a lot of the issues.

Some of the systems we're seeing using basically telehealth intake programs to minimize contact between patients and providers. I think there's been an extension of kind of telehealth in a traditional sense to more kind of finding ways to virtually interact with healthcare givers and caretakers and the patients in whatever setting they may be in.

Dave Johnson (09:07):

I think, yeah, we've only really scratched the surface. And one of the heroes of our story was this company, Zipnosis, which most people probably haven't heard of, but they've been around for quite a while. So they white label their telemedicine capabilities to health systems and they have different grades of contact depending on the need for the service, but fully 90% of what they do is asynchronous.

So they have logic trees built into the interface between the patient and the computer that asks questions. And then based on the answers, it goes to the next step. And it doesn't take long to identify the symptoms and do a preliminary diagnosis. And then the person finishes up. A note gets sent to a professional caregiver, either a nurse practitioner or a physician. And they have a certain amount of time to get back agreeing with the diagnosis or changing it, and if there is a prescription needed actually filling it.

And the time to do that on average per visit is only a minute and a half. Whereas a typical telemedicine visit would be 18 to 20 minutes. And Zip on March 7th did 700 visits, on March 12th, did 98,000 visits. So maybe you could just talk about the type of potential that technology offers to scale not only quickly, but massively and generate enormous value in the process.

Jill Frew (10:35):

Zipnosis is obviously really uniquely suited as far as their ability to handle the kind of volume of screening required dealing with the pandemic. So just the clinical capacity that that type of model

creates and the ability to provide rapid updates into the field. Not to mention virtual care, which is kind of localized and obviously you're keeping patients out of the clinic. So I do think that's kind of a next generation approach, and it's pretty compelling as far as the benefits that health plan and health system customers can realize as a result.

Dave Johnson (11:06):

Yeah, Jill, are there any other kind of unique models out there like Zipnosis that have the potential to really disrupt the way telemedicine happens? I mean, I'm thinking back a few years when we went to the Tele-ICUs, for example, in bunkers. You could not only run them more cost-effectively from a centralized location. It also meant having real expertise at disposal, time it needed to go and real-time monitoring and lots of times things got missed or mistakes got made. But looking out at the telehealth space generally, what's either here or right around the corner that has the same potential as asynchronous telehealth visit?

Jill Frew (11:49):

I think behavioral, yeah, behavioral, mental health. Typically given the issues that people are going to be facing as the result of this crisis I think there's going to be greater demand, and there's been a lot of interest, a lot of new startup companies that had been focused in that area and more established players like Livongo, who we've worked with have been very successful in mental health solutions, all being done remotely and telephonically and by video.

You mentioned teleICU, Advanced ICU is the company who's a leader in that space too. And again, I think the coronavirus has just put a spotlight on some of those solutions that again, have historically not been mainstream. I think it will become kind of the primary means of delivering that sort of care for a variety of reasons. I think it's more convenient obviously. And a lot of individuals are just more comfortable, I think, doing that in a remote setting versus traveling to, and going to some in-person sessions.

So I think one, the demand for it will grow into, and it's the fact that we've got technologies now and practices and businesses that have been set up to accommodate those people, similar to what we're seeing in kind of the basic kind of primary care mental health setting.

Dave Johnson (13:04):

Let's shift the other half of our focus in the article and then this House Calls podcast on data and the potential for data interoperability, data curation, data storage, to find much more signal in these massive amounts of data that we're collecting and then apply it much more effectively. And COVID has given an opportunity for a lot of companies to think in new and different ways about data, because there's some pretty important questions to answer, ask and answer like, Where's it going to go? How big is going to get? How many people ICU beds we're going to need?

So one of the companies that we profiled in our article is Carrot Health, which has developed a COVID impact risk predictor, and it blends demographic data like age, whether you're male or female and whether or not you're a smoker with disease specific information. And it's kind of scary when we talked to Carrot. They can get so much information from socially available or from commercially available sources that they have individual profiles on every single person in America, including you and me.

Jill Frew (14:11):

Yeah. 215 million adults and 5,000 variables, it's pretty stunning, the data they've been able to collect and kind of centralize.

Dave Johnson (14:19):

Their real businesses is primarily working with payers, but some providers as well, to identify which patients are most at risk for an acute episode based on this combination of demographic and social factors. And they've gotten pretty good at it. And so it's now applying that fairly well-developed concept to COVID and being able to say which areas were at greater risk for a COVID outbreak based on this mix of factors. And then even going to the next stage and looking at ICU bed capacity relative to risk factors and pointing out areas that may be at greater risk of having their capacity overwhelmed. And they're able to do this at a county level.

But maybe you could just talk a little bit about the ability that we're now seeing to develop within these really sophisticated tech companies. And it's not just the Googles of the world but it's a whole host of companies out there, their ability to collect, curate, and apply data in ways that deliver real insight, get data to the frontline people when they need it and the form they need it can be a nudge when it has to be, isolates the signal and it's fun. Anyway, just give us your sort of take on that. I know this is a sector you know well.

Jill Frew (15:29):

Yeah, I mean Carrot's platform, obviously there and other companies that are offering similar solutions, a couple of things that are in tremendous need right now, one, they're helping those payers that you mentioned and health systems drive growth by identifying and targeting the needs of the consumers, of the population, and the relevant geography. So the value prop of these sorts of businesses is pretty extraordinary. I think it's the broader kind of social determinants of health, which has obviously been an area of great interest on the part of payers and health systems, but also the investment community who see that as a real potential game changer and a way to kind of utilize data in new and different ways.

I think healthcare broadly as it relates to data, we haven't had a problem. We generate a tremendous amount of data, probably more than we ever have. It's claims data, clinical data, social determinants of health data, but it isn't gathered or collected or shared in any sort of robust way. And I think the social factors play a huge role in outcome, and health plans and providers often don't have access to this type of data. So there's just a tremendous disconnect as far as getting access to and then being able to apply different sorts of predictive tools and analytics to optimize care.

There's a couple of recent announcements that caught my eye just even this week. ACA and Google announced the National Response Portal, which is an open data platform, which runs on Google Cloud, as you can imagine. And it promotes data sharing about COVID-19 and how it's spreading. And obviously this is an effort to allow hospitals and communities to better prepare and respond. It's updated daily across the US.

And also I saw something this week where AWS announced that it's making available COVID-19 datasets, which is kind of a centralized repository of data and other information regarding the kind of spread of the virus. And a lot of the big tech companies are offering up data assets that they've been able to collect, and in some cases, partnering with large healthcare organizations to allow all of us to benefit since we're all kind of fighting this virus in a significant way.

Dave Johnson (17:43):

Boy, there was so much in there to unpack. The one area I want to kind of hone in on is that idea of a national repository of claims and clinical data. And we've had, as you know, a real problem getting

access to patient data at the record level to companies that can really develop innovative apps and apply them. The ONC and CMS pushing or finalizing the rules for data sharing and data access for patients.

But I mean, if you could just let your brain kind of go free for a moment and imagine how different this crisis might be if we had this type of national registry of source patient data protected, but standardized and accessible so that we could mine it for much more. I mean, imagine how much better the Carrot model might be, for example. Maybe go a little deeper on that.

Jill Frew (18:39):

Yeah. Data assets are kind of prized possessions of a lot of large healthcare systems, whether it's UnitedHealth or any of the large payers that are obviously protective of their data and their ability to do things with their populations that are unique. It gives them, I think in some sense, the competitive advantage or unique capability that maybe they're not quite ready to share. Or you take some of the EMR players, Epic and Cerner, who are sitting on extraordinary amounts of obviously patient data or the PBMs. And I don't know how we ultimately kind of break down those barriers and get organizations like that comfortable to share something that now they feel gives them kind of a unique advantage, or it would give others a different advantage if they were to kind of share it. I think it's still a ways out before people open up the repositories and decentralize that data in a way to benefit the broader population.

Dave Johnson (19:38):

Do you think it happens naturally like it did in the device industry or it's enforced by the government, which is kind of where these new rules are going?

Jill Frew (19:46):

Yeah. I'd like to see it happen naturally. I don't know if that is likely. I suspect there'll be some intervention on the part of the regulators, kind of nudge that along. But I think everybody universally acknowledges the benefits of doing so. So hopefully we'll get there.

Dave Johnson (20:04):

Yeah. It's kind of the simple way I look at it is everybody should have access to source patient data the way companies choose to organize it and so on. It shouldn't be proprietary. Source patient data should be available. You ought to be able to put the feeds in there to get the information drawn out.

Jill Frew (20:21):

Well, importantly, I think the other day we also have our ownership of our own data, right. And it's still a struggle after all these years for all of us to have a medical record that captures our medical history. There's efforts to do that, but I think we all struggle as we, anybody interfaces with the healthcare system is still siloed and difficult on a good day.

Dave Johnson (20:47):

Yeah. And heaven forbid you actually try to go from one system to another system that has a different BHR.

Jill Frew (20:52):

Yeah.

Dave Johnson (20:53):

If we had all of the source data available, then any insights that companies can glean from it could be commercialized, right?

Jill Frew (21:00):

Yes.

Dave Johnson (21:00):

If you figure out a new way to diagnose something or whatever based on data, that capitalism is that's what capitalism does. But we got to create the level playing field so that America's innovation engine really can come to the fore.

Jill Frew (21:12):

Yeah. I mean, a lot of the clients that I work with are selling into either payers or large health systems, and they're, as part of their product or solution are trafficking in massive amounts of data. Some have enough scale where they can start to [inaudible 00:21:29] analytics, benchmarking, et cetera, and commercialize that data on a de-identified basis. But it takes significant scale for that data to become meaningful. So I think that's still the challenge. Even a lot of companies who do have access to some of that data, they take a minimum amount of scale and diversity in that dataset for it to really be a really robust platform for doing analytics.

Dave Johnson (21:51):

Yeah. We know that a lot of AI is a pretty blunt force instrument, right, too, because all it is, is correlation. So unless you've got massive data sets and unless you can narrowly focus them on to solve real problems, you can end up with some weird stuff.

Let's push beyond COVID a little bit and let's assume we're out of it and back to some level of normalcy in the next four, six, nine months, something like that. What happens then? Which technologies ... The genie can't get put back in the bottle. What does the health system begin to look like now that we've had this kind of shock to the system of the pandemic and our response to it?

Jill Frew (22:30):

Yeah. Well, I agree. Hopefully we won't go backwards. I think it will be very different. I think in a good way, healthcare providers, systems, payers will be more efficient than they used to be. There'll be a much greater recognition for the value that technology and data can bring to the overall systems. So I do think again, we'll be kind of in a very fundamentally different place with regards the level of adoption, the comfort on the part of both the consumer, the patient and the provider and relying upon some of these remote technologies.

I'm hopeful that healthcare will begin to look more like the banking industry and that it can be accessible from anywhere. It doesn't have to be something that you get in a hospital or clinic or in some other remote location.

I think there's a lot of lessons that have been learned in a very difficult situation, but I think, hopefully financially it will take some time I think for a lot of the younger technology and startups to kind of get back on their feet, as well as the number of provider groups that have seen their visits drop dramatically, and as a result, these organizations are in a very difficult position financially. But I do think

collectively as an industry, people will emerge stronger, smarter, and with a much greater level of dependency on technology.

Dave Johnson (23:56):

Yeah. Amen to that. So anyway, let's wrap up with one last question, which will involve a bold prediction. So it's a year from now and we've just finished up our summary of the HIMSS conference.

Jill Frew (24:07):

Assuming there's a HIMMS, right?

Dave Johnson (24:08):

Right, right, right. And we've been blown away by whatever. So what's your bold prediction a year from now that those in the healthcare tech world will be focused on and really gushing about?

Jill Frew (24:22):

I do think healthcare at home is concept of being able to get healthcare kind of on-demand at the location of choice. But I think and technology obviously enables that. So I do think whether it's with regard to virtual health, I think payments will become more automated. So people can interface with their health plans or their employers with regard to their financial transactions around healthcare. That'll become more of a PayPal type experience.

So I do think there'll be a much higher level of adoption and acceptance of some of these newer technologies that have been more central to other industries that have adopted them.

Dave Johnson (25:01):

Yeah, yeah. We're at a really interesting moment of potential convergence, like we were in 2007 when the smartphone came out. I hope that's what we're talking about in a year, is how the convergence of new technologies are going to make it easier to build healthcare around individual needs and solve individual problems, and also hopefully cut down on how concentrated chronic diseases and lower income populations. Because one of the things that COVID is doing in its own merciless way is really attacking people with chronic conditions. And the disparities are shocking, how over time, to the extent that virtual care and data and tech generally can create better, more equitable healthcare delivery that's accessible and affordable, amen to that too.

So Jill, as always, this has just been a blast as we go out into the health tech universe and sort of see what's going on. And of course we have the added dimension this time of doing it within our first pandemic crisis in over a century. So thanks again. This was fun. For those of you who haven't read the article, make sure you see it. It's terrific. And Jill's insights and what we've put together are well worth the time reading it. So Jill, thanks again. Stay safe.

Jill Frew (26:16):

You bet. Thanks Dave.

A Fireside Chat w/Beth Mooney, Chairman/CEO of KeyCorp, and Tom Mihaljevic, MD, President & CEO of Cleveland Clinic

Beth Mooney, Chairman and CEO of KeyCorp, and Tom Mihaljevich, President and CEO, Cleveland Clinic, joined Cain Brothers' President Rob Fraiman for a fascinating discussion at Cain Brothers' Annual Healthcare Conference on October 24, 2019.

Dave Johnson (00:05):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets, Inc. Cain Brothers bankers work in some of the most interesting segments of the healthcare industries. They work with organizations and business models that are helping to change American healthcare for the better.

I'm your host, Dave Johnson. I'm also CEO of 4sight Health. I'm a recovering investment banker myself, who discovered late in my career, that I was always meant to be a journalist. I coauthor a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. Each piece becomes an exercise in examining a fascinating segment of the dynamic healthcare landscape.

The focus of our articles and this podcast is on how to make America's fragmented, inefficient and often broken healthcare system more integrated, consolidated, efficient and customer-focus so that it delivers greater value and innovation to the American people.

For this edition of House Calls, we're going to broadcast the conversation from the Cain Brothers Annual Conference from October 2019. It was a great event over two days at the Lotte New York Palace, attended by over 600 executives, investors, and professionals.

On the second day, Cain Brothers CEO, Rob Fraiman, moderated an outstanding discussion between Key Corp Chairman and CEO, Beth Mooney, and the Cleveland Clinic's President and CEO, Tom Mihaljevich. As you'll hear, Rob took this conversation in a fascinating direction right off the bat, focusing on how the two CEOs see healthcare today from an employer's perspective.

My own personal biggest frustration with US healthcare is that self-insured employers like these two companies haven't demanded more value from the healthcare system for the premium prices they pay for coverage. Beth and Tom grappled with this and other issues in a very far ranging and interesting discussion. Let's listen.

Rob Fraiman (02:12):

We're going to kick off the meeting today with a fireside chat that I have the pleasure to moderate with Beth Mooney, the CEO of KeyBanc and with Dr. Tom Mihaljevich, the CEO of the Cleveland Clinic.

Let me first introduce you to Beth Mooney. Beth has been KeyBanc's Chairman and CEO since 2011. Since earlier this year, she's also had the role of the chairman of the board of the Cleveland Clinic. Beth is also a member of the board of directors of AT&T Corporation and Ford Motor Company. Indeed, she's one of the few corporate leaders in America who serves on the board of three Fortune 500 companies. Her role as CEO of Key with over 18,000 employees and a board member of two other companies with several 100,000 employees, while also helping lead one of the most prominent health systems in the world, provides her with a unique vantage point on the US healthcare industry.

Tom Mihaljevich is a physician. He's been the president and the CEO of the Cleveland Clinic since 2018. As you know, the Cleveland Clinic is a $10 billion healthcare system. That includes a main campus in Cleveland, of course, but also has 11 regional hospitals in Ohio, and facilities and physicians in Florida, Nevada, Abu Dhabi, Toronto and soon to be in London. The Cleveland Clinic, of course, is consistently ranked as one of the best hospitals in the world and in the United States in 2018 and 2019.

US News and World Report ranked Cleveland Clinic as the number two hospital in the United States in its best hospitals on a roll. Cleveland Clinic's cardiology program has ranked number one in the nation every year since 1995. They're also a major employer. The clinic employs 66,000 people, including 4,200 physicians and 16,000 nurses. Please join me in welcoming Beth Mooney and Tom Mihaljevich to the stage.

Let's dig in and talk about the healthcare industry. There was a new study that many of us read by the Kaiser Family Foundation that found that for the first time, the annual total cost of employer provided healthcare coverage is now over $20,000 a year. Employers are bearing about 70% of that cost, employees about 30%. Many in the US and many in the industry feel that the average American is actually more concerned about paying for healthcare than they are about actually contracting an illness. How did we get here? What are we going to do or what can we do to relieve this enormous cost burden on the working Americans?

Tom Mihaljevich (04:50):

Well, that's obviously a broad question because it touches so many facets of healthcare the way we live and so on. Let me just try to break it down in probably just a few pieces. One, certainly from the provider standpoint, I think, our responsibility as providers is to change the way that we approach healthcare instead of being there only when patients are able to become much more proactively involved in keeping our patients healthy, and to be involved in their wellness, in their health, and provide a type of a coordinated care that is going to keep them healthy.

On a public healthcare perspective, I think one of the big, big issues in the United States, which is oftentimes under recognized, is that the reason why we're paying so much for healthcare and the discrepancy between the health of the nation and the amount of money that we allocated for healthcare is largely independent from the quality of the hospitals that we have in the United States but it's really, to a much greater extent, determined by social determinants of health.

The health of our nation and people in the United States is really, to substantially great extent, determined by their quality of their housing, quality of the social services, accessibility to the right food. Then, I would say, lastly, I think there are several determinants of health in the United States in particular recently that have skewed the life expectancy in our public healthcare parameters. There's something that we have to deal with more effectively and that's opioid epidemic first and foremost. We're losing 70,000 lives a year, young lives in the United States, something that was unthinkable not such a long time ago. That epidemic, Cologne, has definitely skewed the public healthcare outcomes across the board.

Rob Fraiman (06:56):

Beth, from your perspective as the CEO of Key, but also your insights from your board roles at AT&T and more recently at Ford, what can the corporate world do about rising insurance premiums, about drug price inflation, about hospital and physician price inflation, and ultimately, this cost issue in the healthcare system?

Beth Mooney (07:19):

Thanks, Rob. I will break it down between kind of what our role is, our capacity is to influence the cost structure but more importantly, then as employers, how we design our benefits to optimize health outcomes for our employees, because I think that's increasingly not just a cost-driven analysis, it's about the full wellness of your employees that you want to make sure you have a vital and healthy workforce.

On the cost side, it's very much how you structure your plans, who you partner with, how you create reimbursements. There are all these things we do to try and limit the relative and I'm going to say, increases on an annual basis that the cost of delivery to your employees cost you. I say that because there are many places where the cost curves are actually bending. Healthcare is not one of them. It's a function of how much it's going to go up in any given year.

We have a whole group of people who spend time trying to figure out what is both the optimal structure cost, where we have leverage and how to package that, which we are going to ensure and make available to our employees in every engagement survey we take of our employees. Probably one of the biggest concerns, to your point, is benefits around healthcare. That is a number one employee benefit that we offer. They are concerned about the cost, access and then just clearly understanding because there is not as much transparency as there are many parts of what we do as consumers.

We have done a lot of things to really create wellness benefits that are both good for our employees, but they are hurdles towards things that if you do certain things, you have certain kinds of tests. You submit to a program where you show your walking one person at the bank, put the monitor on their dog, [inaudible 00:09:18] for that but things that really show that you are endeavoring to do a healthy lifestyle and make sure you're doing the things to show your core health, we will give you discounts on your health plans. We give you more reimbursements. We do a variety of things that really encourage people to engage in their health and wellness. Those are very well received.

Then, structurally, we've gone to the high deductible plans. We made that pivot a couple years ago but then we supplement those with HSA accounts that we fund on January 1st every year to try and help offset the costs to our employees. Then, we did what I call the Robin Hood method. We have three tiers of healthcare costs and for the majority of our employees, who make under $100,000 a year, we haven't raised their premiums in over five years but that means you're absorbing it both elsewhere in our employee population and making other tradeoffs in your benefit programs.

This notion of the escalating cost of healthcare, I think employers, it's one of the things we spend in our benefits and our salary packages, perhaps the most time in any years trying to get this right. It's like I said, number one feedback you'll get from your employees is access to healthcare and making sure they understand it. It's affordable. Then, we're all in this together, from a benefit point of view, not just to lower the cost, but to increase the outcomes of wellness for our employees.

Rob Fraiman (10:45):

Tom, let me ask you the same question. As I said in my opening comments, you're in this unique position of being in the business of providing healthcare but you also are a substantial employer. You're one of the largest employers in the state of Ohio. How do you think about that? You're providing care, but you're also paying for care. How do you demand as an employer better value and better outcomes from the huge healthcare investments that you're making?

Tom Mihaljevich (11:12):

This year, we officially became the largest employer in the state of Ohio with 50, a little over 52,000 of our caregivers located in our home state. We have our employee health plan that covers 66,000 employees and their families. By being in this unique position, as you described, being both the employer and a provider of healthcare, we have been able to design the healthcare product that has actually bent the curve, where we are actually spending less than our healthcare for our employees and it's seeing much better healthcare outcomes than what we've traditionally had.

There are two reasons for it. Probably one of the most important reasons is the population that we cover. We cover in continuity. A lot of people who are covered with a variety of different health

plans, from the payer perspective, the population changes, by about 20 to 30% of the population changes every single year. There is a lack of a continuity of coverage. We have that because people are employed by us.

Secondly, we are obviously highly vested into becoming the best place to work in healthcare, meaning we want to keep our own employees, our caregivers healthy. We have designed a lot of innovative healthcare programs and put a lot of effort into engaging our own employees in their own health. 80% of everything that we spend in healthcare is spent for the treatment of chronic diseases or consequences of chronic diseases: diabetes, hypertension, chronic obstructive pulmonary disease.

With these innovative programs, with a longitudinal tracking of our outcomes with the empowerment of our own caregivers to take better ownership in their healthcare, we have been able to bend that curve. Now, we're looking into the ways of how we can extrapolate those learnings on all the patients that we were caring for and we are caring for over two million people.

Rob Fraiman (13:13):

Healthcare is a local business. At the end of the day, it's about care in a given community. I'm sitting with the CEOs of two great Cleveland-based companies. Are there ways that two great companies, one providing, one delivering and paying for care, can innovate and work together to create a new and better model for delivering high value care that won't break the bank? Beth?

Beth Mooney (13:39):

Well, I would start and say that, yes, obviously but I think healthcare is becoming more and more nonlocal. I think some piece of both quality, cost and reach is going to be through care models and I brought this as a prop, this is going to, between data, technology, access, virtual is going to help transform both delivery and cost of care. So I think some piece of what is incumbent on businesses as well as healthcare providers, is to really help figure out how to crack the code on what I call non-space and place-based delivery, as well as trying to make sure we make the physical delivery because there is a portion that will always be physically delivered, make that as efficient as possible.

We, in our industry of banking, have proven that people are willing to do not all, but a lot of their business through a mobile world. I think if we can create incentives and alignment for more virtual care and access in different ways, it will and we could promote it through our employee base that will help accelerate some of these changes in healthcare.

Rob Fraiman (14:53):

Tom, partnerships that the clinic does, whether in Cleveland or frankly in any of your markets with large employers in the market, does it move the needle?

Tom Mihaljevich (15:03):

It doesn't. It does not to the extent that we would like to. I think a lot of our ability to move the needle we've been able to, Beth just as mentioned, to the advances in healthcare and our ability to connect with the larger employers and broader geographies more effectively through technology.

The real problem for pairing large payers with the large providers relates to the scale or insufficient scale of providers. If you take a look at top three or top four best renowned names in healthcare on a provider side, our market share, if you will, is and the size is relatively small. Cleveland Clinic has a market share of half a percent in the United States. We touch, at the best, 1 in 200

Americans. In order for us to directly partner with a large, let's say, national employer, any company, we just simply do not have a footprint or presence.

We can supplement some of that through technology, but not all of it. If we were to take a look at all major contributors in healthcare ecosystem, pharmaceutical, biotech companies is one. Payers is another and then providers is a third, if you were to take a look at their relative role, size and influence, you will see that the providers have a disproportionately small size and influence on a market. As long as that is the case, it is going to really, really be difficult to extrapolate the learnings and quite frankly, to provide the quality of care that a renowned healthcare system stand for to larger number of Americans.

Rob Fraiman (16:45):

Let's stay on this topic of technology. In so many industries, obviously, technology is and will continue to be a disruptor. Some of our panelists yesterday expressed some skepticism about whether and how technology and how quickly it will, in fact, change the game, whether it's AI, data technologies, and so forth, that I think it would be really interesting to talk about, from your perspective, how technology and again, AI, data technologies and mobile technology has changed the financial services industry and what comparisons we should draw or not with the healthcare industry?

Beth Mooney (17:25):

There is one fundamental difference, which is there is a point in the healthcare delivery continuum where you have to be in a room with a doctor and procedures being done. That is a core difference. I think one of the things that in financial services, there are entire countries on the globe that are cashless, their entire banking system is in a mobile device and they have figured out how to make money and the movement of money and goods and everything that you should do in terms of a banking relationship can be done through this.

We have seen in our industry, and I don't think it's disruptive, I think it is evolutionary that we have lots of things. Money is becoming ubiquitous. Friction points of how you do business and being bounded by a physical space in place to transact. You can do so much in self-service in a positive way that we are transforming the delivery of financial services through the use of technology. Every cohort, every age demographic still wants access to a bank at some point in time.

There are these moments of truth in people's lives where they want access to somebody to help inform them make a good decision and give them confidence for what they need to do but when you go down the continuum and then about what are data analytics and AI doing for the industry, and I think AI is still emerging. I think it is more talk than it is yet transforming the landscape.

The data and analytics, across industries and in healthcare, are transforming the business; what you can know about people, the world of connected devices is going to change things particularly in healthcare, but we can mind people's data and know their preferences, how they conduct things. When you think of healthcare versus a hospital, we have floors of people who are PhDs, who are highly sophisticated, who are modeling things. It is not until, I think in healthcare, it's going to be a lot of partnering because to develop these capabilities one off is one I think it will serve us all well if they are interoperable but it's also very, very sophisticated and takes not just the technology but the people to empower it, where it will actually be a meaningful tool.

Rob Fraiman (19:44):

Let's pick up on that word partnering. Tom earlier this week, the Cleveland Clinic announced a partnership with a telehealth company, American Well. Help us to understand that initiative and as well

as other partnering opportunities you're looking at for access, for care delivery, for administration at the Cleveland Clinic. Where are there opportunities, like with American Well?

Tom Mihaljevich (20:08):

Beth and I and members of the board and leadership at the Cleveland Clinic, we oftentimes, we spend a lot of time to understand and determine what is going to be the true unit of success and the legacy that we will leave behind us once we are not in a role that we currently are. We've all agreed that a number of the people we touch with the Cleveland Clinic quality of care is ultimately the legacy that we would like to leave behind. We do believe that we have an ethical imperative to extend the type of care that we know how to provide as many people in need as possible.

That then leads to the answer to your question is the partnership with American Well, gives us a vehicle to scale up of Cleveland Clinic's expertise for in areas of a second opinion to millions of people through a different tool and with a different vehicle. That's the telemedicine platform that American Well has.

American Well has developed a platform that can reach 80 million Americans through their contractual agreements. Cleveland Clinic is powering it with our intellectual professional know how, and that is going to be a vehicle that will allow essentially any American and very many patients throughout the world to access a second opinion easily and will get a quality answer that will determine the future of their healthcare.

Rob Fraiman (21:36):

Let me ask you both about sort of the big three technology players that we see making major investments in healthcare: Amazon, Google and Apple. How do you see or do you see them having an impact on the delivery of care and the cost of care?

Tom Mihaljevich (21:54):

I'll add to that, Microsoft as well.

Rob Fraiman (21:56):

Yeah.

Tom Mihaljevich (21:57):

The answer is yes. Both Beth and I share firm conviction that technology is going to have a very profound effect on our healthcare in a very short time span. Now, I'll just use one example is oncology, cancer care. Cancer care, five years from now and today, is a different entity. It's a different entity because we're using a technology much more effectively to agglomerate a phenomenal amount of data that no human can do on his or her own.

By doing so, all this data, genomic data, proteomic data, and the list goes on and on, allows us to provide a much more tailored therapy for many diseases. They used to be fatal and non-fatal. I no longer take a look at the outcomes, let's say of melanoma, skin cancer, today versus five, six, seven years ago, tremendous shift, largely enabled through technology.

We had the Health Innovation Summit in Cleveland last few days. I spoke with Eric Lefkofsky from Tempus. He's doing exactly that. His companies agglomerating this phenomenal, vast amount of data in cancer care and putting it in a service of our patients and those are phenomenal, transformative, transformative changes that we will be seeing. I will just say that I can see the future when we are going

to have a few or larger healthcare system. They're going to be differentiated, not only by the quality of the talent that they have that is always going to be differentiator, but also by their ability, ability to use the technology to direct and improve the care of our patients.

Rob Fraiman (23:37):

Beth, anything to add to that about the four big technology players and how you see them impacting the-

Beth Mooney (23:44):

Well, a couple of things I would say is that they are transforming many industries right now. They are truly coming into multiple industries. We use the word disruptive, but at the end of the day, they're also transforming in a way that is far more patient/consumer-centric, leveraging technology and data in a way that I think the outcomes are far better than they would have been without these players. I will leave aside whether or not it is a concentration of market power and all that sort of thing. I think it is a net positive to how we are experiencing our world and it will experience healthcare.

Then, I do think it's interesting the way JP Morgan, Amazon and Berkshire Hathaway have come together. I don't yet fully understand how what they've called Haven, which is their healthcare system that they want to take the fact that they have among them hundreds of thousands of employees and figure out a different way to deliver care in a more cost effective without sacrificing quality but there's going to be something that comes out of that that's going to be yet again another pivot in the care models as well as delivery and insurance model.

Rob Fraiman (24:57):

Clearly, one of the major differences for those companies is how they touch the consumer and in healthcare, as we all know, it's a truly unique industry because the buy-sell dynamics that control so many of pretty much every other consumer-facing industry don't exist. The consumer who you serve, Tom, at the Cleveland Clinic doesn't know the price of the service that they are receiving. Of course, they only pay for a portion of it because their employer pays for the balance or their insurer does.

It's been said that many providers, as a result of that, aren't really able to provide the quality and depth and type of service that the consumer is looking for. How do we address that? The Cleveland Clinic has a remarkable brand. How do you address that interaction and the need for a better understanding from the consumer?

Tom Mihaljevich (25:53):

The big challenge in healthcare is that at the beginning of the process of delivering care, we just simply do not know what that process is going to look like. It's difficult to price it upfront. In most other industries, that's a known entity. You know what you're buying and what you're heading into. In particular, for us, in kind of a complex care environment, it is really an impossible task to answer. That's probably one of the big fundamental differences between our industry and other industries when it comes to pricing.

I do believe that the clarity in pricing is going to be easier to overcome for someone to say standardized fragments of care that we provide. I think there's a lot that we can do differently and better but for complex, multidisciplinary team-based care for difficult diseases, it is going to be a really, really difficult hurdle to overcome, no matter which technology we use just because we simply cannot really answer it in a straightforward way.

Rob Fraiman (26:59):

Beth, I'm going to ask you the same question. Obviously, Key but also AT&T and Ford are companies that touch the consumer every day. What can the healthcare industry learn, from all three of those, not just financial services, but also from media and telecom and from the automotive industry about the consumer in healthcare?

Beth Mooney (27:25):

There is a complexity in healthcare because some piece of it is ultimately need-based, based on something that happens in a person's life that they absolutely need a particular care protocol but within the bands of wellness and other things in one of my takeaways is how do you bundle things with intelligence are going to help create outcomes that are more cost effective. If you go in and you do a certain protocol or series of tests together, it could be done more cost effectively and likely create value and health outcomes in healthier patients.

I think across industries, what services or what attributes you bundled together, and by doing so you can make them more cost effective and you will have better outcomes, I think is something that as healthcare providers think through their continuum and delivery that's going to be incredibly important.

Then, in this world of access and convenience, I think the transparency one is difficult for consumers and employers to not have a better sense of the cost and I get that sometimes it's based on you don't know what somebody needs, but then is it you want to walk into a clinic and see the pricing board of, if you have this, it costs you this, if you have that, it costs you Y, and in one of the few industries where you really don't know what the package is going to cost you but I do think there is a real opportunity for some ability for people to understand the costs and the tradeoffs of what they are choosing.

The biggest point of vulnerability in somebody's life is I'm sick and make me well. At that point in time, you really do want people making decisions that are best for you but shorter that, there are probably choices and ways people could stage things through the use of technology and bundling of products and services.

Tom Mihaljevich (29:19):

Just to add to what Beth just mentioned, oftentimes it's interesting to provide a little bit of a context and a scope of complexity, because oftentimes people will start these type of conversations in particularly if they're outside of healthcare, say how in the world can I walk in any type of a service and know exactly what I'm going to pay for whatever I'm asking and you guys in healthcare cannot figure it out.

Just to give you a complexity of the tasks just for an outpatient appointments, there are 20,000 different types of outpatient appointments that a person can schedule at the Cleveland Clinic. Essentially, there are 20,000 service in the outpatient space. You can imagine the menu in a patient's waiting room that's going to have 20,000 items?

Beth Mooney (30:10):

It's not cheaper by the dozen.

Tom Mihaljevich (30:12):

It's not cheaper by the dozen and by the way, you do not know which one of those you're going to fall into and you do not know what are going to be the subsequent choices of 20,000 ramification? The

answer is, we will almost certainly be able to provide some degree of transparency for a large portion of the services that we provide and we should, but there is going to be always a part of the work that we do is going to be really difficult, close to impossible to price upfront.

Beth Mooney (30:43):

Because it's going to be a function of what people need.

Rob Fraiman (30:46):

This morning, earlier, we were talking about value-based models and in particular models for providers that are going at full risk to provide primary care in clinic setting. We have a number of companies here that are in businesses like that. Isn't that sort of the most extreme? Those patients, in fact, don't see a cost ever. They don't see, in many cases, a copay and their provider is at risk for providing the full array of services. How does that fit into the equation and obviously, that's particularly unique relative to a hospital-centric system like the Cleveland Clinic?

Tom Mihaljevich (31:26):

We're not really hospital-centric as people would like to believe. The largest number of our 4,000, four and a half thousand physicians are not hospital-based. They are outpatient-based. 60% of everything that we do is in the outpatient arena. We are the largest number of physicians or any institute is our institute is in a primary care. That is really a big shift that we have undertaken over the last five years. We have moved from 40 primary care physicians to about 450.

That is the size of the shift with an emphasis. What we're really trying to do is to provide a continuous care for our patients and their care continuum is something that we're very passionate about. Value-based care is kind of what we would like to believe at a Cleveland Clinic is something that we've been practicing for the past 100 years, even before the term was coined.

As you know, at a Cleveland Clinic, we do not pay our providers based on the unit of care that they provide. We're all salaried. We're all in a one-year long appointment. We do not have tenures. We're just trying to do what is right for our patients with the means that we have at our disposal for the benefits of our patients. We do not have shareholders. This has been, so to say, the ethos in the organization that has been present since 1921.

Value-based care is a concept that we endorse the concept that we support. The caveat here is we just have to make sure that we understand who is actually getting the value out of value-based care. The way we look at the world, we would like to make sure that that value is actually a value for our patients and from the standpoint of the quality and an experience of care that they're receiving.

Beth Mooney (33:16):

Who gets the value who takes the risk? One of the pieces about the model, going back to what Tom said about you never know what it's going to cost because you don't know what somebody needs, if you guarantee someone access for a year at a certain price that they have been either provided or paid, in the course of that year, if what you need exceeds that which has been paid on your behalf, I think one of the things we all have to understand what are the implications of that both for the person who has the care and need and then what are the risk pool models, it's kind of like creating an insurance model behind the scenes to saying that we're going to receive a million dollars and have this number of patients and somebody may need X and somebody maybe need Y but it's going to average out to be a profitable model but there's a lot of variables in there.

It feels like the people who are providing those models, almost have to think like actuaries and insurance people to understand how they're going to make money because you cannot predict on any one individual that that would be sufficient to cover what they might need in a given year.

Rob Fraiman (34:20):

We've talked about cost. Let's talk about access. As we're heading deep into a political season, the phrase and the concept of Medicare for All has become a profound topic. It was the, I think from minutes or words spoken at the last democratic debate, it was the most discussed subject. How do you think about that and other related universal coverage programs, access programs in the context of where you're heading with the Cleveland Clinic and where you see other providers heading?

Tom Mihaljevich (35:03):

Well, I spoke briefly a few minutes ago about what we stand for. Really, that's an access, access to Cleveland Clinic care. I mean, this is really the motivation. That's what we're really passionate about. We're very much aware of an access issue. I've had the good fortune to live and work in five different countries, in five different healthcare systems. It is really important to understand the difference between having a nominal or declarative access to care and an actually ability to access that care.

I've lived in very many systems where healthcare was free for all. You can always get it, but the lines were very, very long. In practicality, people had difficulties accessing and accessing to the time of their need. I think we have to be careful when we speak about an access what we mean by it. Every time I get into any type of these discussions, we would like to look at the world through a patient's eyes. If you have a right to access healthcare in anytime, anywhere but you cannot really access that right, then right is only declarative. It's not factual.

Then, therefore, our task is to design a system that is going to reconcile those two things. I do believe that people should have access to healthcare. I do believe that this is right but we also do have a responsibility to design a system where the declarative right is going to be translated in actual access to healthcare. I do believe that having a model that balances various aspects of healthcare delivery, whether it's a private government-based and so on is probably the best one.

Beth Mooney (36:52):

Having looked at the financials of a few healthcare systems. Medicare and Medicaid reimbursements don't really cover the cost. It is incumbent on healthcare systems to try and figure out how to think and aspirational goal is to almost get it to break even to a slight profit.

Tom Mihaljevich (37:10):

Correct.

Beth Mooney (37:10):

If that became the entire revenue pool and you didn't have the mix of private pay in there, I think over time, there is a different healthcare system because of what it will be able to find and what it will be able to provide. I'm not sure that if we can't find an ecosystem where we still honor the private payer, the academic piece, we're going to have better healthcare outcomes over time, then I think if you look at something where it's a fixed rate and it's provided by the government, I think that will have implications over time.

Rob Fraiman (37:47):

The inability to finance it by the government and the inability perhaps to provide access. On the other hand, Beth, earlier you talked about as the CEO of Key and as a board member of other large companies, the amount of time and effort that is spent on putting together the benefits package and offering private insurance options and whatnot to your constituents who are employees, in many ways, this movement towards the single payer would obviously relieve the burden of employers, is it realistic or is it what you just said, would might make your life easier in the C-suite but not feasible?

Beth Mooney (38:24):

Yeah, I would tell you, it's feasible. I mean, it would make it simpler. On the other hand, I think as major employers, healthcare is a differentiator for us in how we approach, attract and then retaining high quality talent and our ability to insert into our benefit programs pieces of wellness and services that our employees want and need that, like I said, make them more productive, as well as their quality of life in terms of just the balance between health, office, family needs that we craft into our benefit plans. It takes a lot of time but I also think it correlates with our ability to attract and retain high quality workforce in an era where talent in most any industry is the differentiator.

Rob Fraiman (39:12):

Let's talk about mergers and acquisitions, is there a time that you can see in the next five years, if you look in your crystal ball, where there's a provider in this country that has say, a 10% market share?

Tom Mihaljevich (39:26):

Yes is yes and I do believe that this is going to be inevitable. If we move to, let's say, to great extent to a single payer that is actually going to accelerate that pace substantially. There are eight and a half thousand hospitals in the United States, a large portion of them, if you take a look at their financials, it's not going to look sustainable.

The needs of healthcare in the future that we address is going to be very technologically-driven. We're going to require all of these hospitals to invest a phenomenal amount of money they do not have into technology infrastructure. Needless to say, the regulations and the oversight for all the right reasons is putting a strain to every provider. The answer to your question is absolutely yes. I can see a future in healthcare where we're going to have a few or large centers. They're going to provide us kind of a complex healthcare not unlikely to banking industry. There's always going to be physical bankers. There's going to be a physical hospital. They're not going to disappear.

However, it is going to be really difficult for me to envision that every small town in the United States is going to have 200 to 250 bed hospital. They're going to have a much more asset-light, integrated vehicles for the provision of coordinated care, that care is going to be coordinated with the use of a technology through larger centers that have that technological framework and also have a talent to back it up so that we can have finally the healthcare delivery system that is affordable, that is scalable, and it serves both the needs of our patients and the needs of our society. Yes, the answer is absolutely.

Rob Fraiman (41:12):

You each have been consolidators in the industry. How do you talk with your boards about the long term M&A environment whether it's something that is defensive? How offensive is it, both in healthcare but Beth, I think it is pertinent to talk about those other industries as well?

Beth Mooney (41:38):

I will speak to banking, if I could because I think your analogy that banks and healthcare highly distributed numerous locations, many providers, many banks across the country. I think we're down to 5,000 banks in the United States, different banks. There was a time where it was 12,000 different banks in the United States when I started my career. There has been a consolidation. It is very much a local sport. There is people want their own hospital. They want their own bank.

They do like this notion of trading locally and to a consolidator, you look at it and there is this cost of technology, the cost of investment, the efficiency that can be gained is part of the value equation but resources are finite and it's not just capital, it's time, it's focus, it's priorities that you've set. We did a transaction several years ago of a whole bank acquisition. Somebody asked me this just recently, if I had it to do over again, I would absolutely do it. It was one of those things where, at the end of the day, we made a step change in our performance. We increased our market share. We extended our products set.

It was really a good thing but if I was going to be asked from a banking point of view, would I want to pick up a bunch of small banks, even if it would increase our market share, at some point when I look at our resources and our incremental ability to invest, that takes a lot of time and energy, and is the return there or are you better investing in technological platforms, digital platforms. I think when people start making these tradeoffs, M&A is part of the environment, but to the consolidators, they have to look at it on a continuum of their alternatives for investment, both capital, time and resources. I think that is a complex equation in any industry and will be part of the complexity, I suspect in healthcare overtime.

Tom Mihaljevich (43:33):

For us, our responsibility is to grow responsibly. The week doesn't go by that we did not have a call inviting us to consider partnership merger with a healthcare provider in the United States. This is where we're fortunate enough to be in that position but we also do understand that there are real restriction about our ability to grow at the pace, as I said, that is responsible and that we have to allocate our resources, both intellectual, time, money and people to the type of growth that is going to be most effective.

I do believe the local hospitals, as I mentioned, is going to continue to exist. I do believe that there are going to be certain types of services that we will be able to scale up and extend to other hospitals even though without really owning them. I'll just give you one example of what that could look like. Let's say, all Intensive Care Unit beds at the Cleveland Clinic are being monitored from a single command center bunker. One of the big problems in the United States healthcare and particularly in the rural hospitals in the intensive care units, are just difficult to staff. We do not have enough physicians. We cannot do it. Mental health, huge epidemics of a mental health, we can simply not educate or hire enough psychiatrists to staff every intensive care unit or every emergency room throughout the country. It is just impossible.

Using a telemedicine platform that is going to be able to disseminate the expertise in, let's say mental healthcare from a large renowned center that has that expertise and that that human capital is, I think, the ways to touch many providers in an effective manner without really acquiring them. Yes, I think it's going to be a consolidation, yes to be [inaudible 00:45:30], large centers will grow that will never eliminate the need for local providers but I do believe that there are going to be certain services that those local providers will be able to acquire without really them being acquired by others.

Rob Fraiman (45:45):

Tom, how do you respond to the political discourse that consolidation in the hospital industry, particularly in given markets, reduces competition, and therefore leads to, in fact, price inflation, lack of a competitive environment given your comment about, there may be a provider that has a 10% market share somewhere down the road and the kinds of activities that you've just discussed.

Tom Mihaljevich (46:15):

[inaudible 00:46:15] shares contextually. It's really difficult thing to follow if the largest provider in the United States has half a percent of market share? The largest payers have 20, 30% of market share? How come that payers can grow to be $200 billion cap? That's good. The providers are going to [inaudible 00:46:44] and we're a threat. I don't follow the logic of that.

There is something that I think is very, very important and that is to say that it is absolutely true that the growth of the healthcare systems cannot necessarily translate it historically into the improvements in the quality of care for those who they've covered because most of that growth was in a form of a holding company. People would agglomerate assets, but they wouldn't really integrate it. They wouldn't spread the quality of care and any optimal pathways of care throughout the system. They're not really functioning as an operating company.

From our perspective and there are many others in our industry who are taking the tact, we like to view every presence of a Cleveland Clinic from the standpoint of one Cleveland Clinic, where we stand for the same experience of quality care in every location. We work very, very hard to improve the quality and access to care in every locations and we have seen the improvements in those measures in every hospital that Cleveland Clinic has acquired over the last 10 years.

Rob Fraiman (47:52):

Just got a couple of minutes left, how optimistic or pessimistic should we be? Are you, as a provider of healthcare, as a payer of healthcare, as large employers, about where we're heading over the next five years in this healthcare economy? Beth?

Beth Mooney (48:10):

I don't think you should be a CEO if you're not optimistic because I think in any scenario, you can paint the challenges and you can paint the opportunities but I believe in the resilience of our industry. I believe in the resilience of our country, the quality and the depth, the talent and I believe on the margin, we will always translate into opportunities that give reason and cause for optimism.

Tom Mihaljevich (48:37):

This country has always risen to every challenge. I'm very optimistic. Actually, I'll say there's never been better time in healthcare than it is today. People think about all these are difficult times and I say that compared to which year? People speak about good old times in essence so could you please specify a year or a period when the times were good in healthcare? We've never-

Beth Mooney (49:01):

You rather have melanoma now or melanoma [crosstalk 00:49:03].

Tom Mihaljevich (49:03):

Exactly. Exactly right. I mean, we've never had better...

Beth Mooney (49:08):

Outcomes.

Tom Mihaljevich (49:10):

... better outcomes, greater knowledge, higher quality of people. Probably the most important thing that we all have to understand that the quality of healthcare for the nation, the health of the nation is not solely determined by the quality of their hospitals and I think this entire conversation about healthcare reform, we're speaking about the reform of the payment, people do not realize that, yes, United States allocates relatively large proportions of GDP to healthcare but our allocation to other determinants of health that are much more powerful is actually relatively small; social services housing, affordable food, compared with other western nations relatively small.

When you take a look at the allocations from these budgets for social determinants of health and healthcare, put them on top of each other, United States is in the middle of the pack of the western countries. Yes, France allocates less of their GDP for healthcare, but allocates substantially greater percentage of the GDP for those social services. Therefore, when you take or extrapolate, take a look at public healthcare outcomes, the picture looks differently.

I'll just give you one example and I think this is probably going to illustrate it better, lead poisoning. Beth and I live in Cleveland. Lead poisoning is a huge issue for our communities, for children in our communities. I mean, one hospitalization for a child with a lead poisoning costs more than affordable housing for that child and their families. If you allocate that amount of money in affordable housing, you would eliminate the need for repeated hospitalization, not to speak about the downstream consequences; mental impairment, learning disabilities, inabilities to find job. That's a healthcare reform that we should strive for.

Rob Fraiman (51:12):

Well, I can't think of a better way to end this discussion than your comment, Tom. There's never been a better time to be in healthcare than now. We thank you. Thanks to Beth Mooney, to Tom Mihaljevich. We appreciate your being here. Enjoy your day everybody.

Beth Mooney (51:25):

Thanks to all of you. Have a great day.

Dave Johnson (51:27):

Cain Brothers is an investment bank focused exclusively on healthcare. The bankers at Cain stand apart because of their deep knowledge of the healthcare industry, and their practical know-how when it comes to executing complex transactions in all healthcare sectors. These include healthcare services, medical technology and life sciences.

I'm your host, Dave Johnson. I'm a recovering investment banker who discovered late in my career, I was always meant to be a journalist and maybe even a podcaster. I'm also the CEO of 4Sight Health and the author of two books. The most recent of which is The Customer Revolution in Healthcare, Delivering Kinder, Smarter, Affordable Care for All. I love talking to other revolutionaries who are driving change in the healthcare industries.

Podcast: A Fireside Chat w/Beth Mooney, Chairman/CEO of KeyCorp, and Tom Mihaljevic, MD, President & CEO of Cleveland Clinic

Beth Mooney, Chairman and CEO of KeyCorp, and Tom Mihaljevich, President and CEO, Cleveland Clinic, joined Cain Brothers' President Rob Fraiman for a fascinating discussion at Cain Brothers' Annual Healthcare Conference on October 24, 2019. The three CEOs debated value-based care, the challenges of scaling delivery, and the employers' responsibility in securing better quality, lower-cost healthcare for employees.

David Johnson (00:05):

Welcome to House Calls, where we talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets Inc. Cain Brothers bankers work in some of the most interesting segments of the healthcare industries. They work with organizations and business models that are helping to change American healthcare for the better. I'm your host, Dave Johnson. I'm also CEO of 4sight Health. I'm a recovering investment banker myself, who discovered late in my career that I was always meant to be a journalist. I coauthor a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. Each piece becomes an exercise in examining a fascinating segment of the dynamic healthcare landscape. The focus of our articles and this podcast is on how to make America's fragmented, inefficient, and often broken healthcare system more integrated, consolidated, efficient, and customer focus so that it delivers greater value and innovation to the American people.

For this edition of House Calls, we're going to broadcast a conversation from the Cain Brothers Annual Conference from October, 2019. It was a great event over two days at the Lotte New York Palace attended by over 600 executives, investors, and professionals. On the second day, Cain Brothers' CEO, Rob Fraiman, moderated an outstanding discussion between KeyCorp chairman and CEO, Beth Mooney, and the Cleveland Clinic's president and CEO, Tom Mihaljevic. As you'll hear, Rob took this conversation in a fascinating direction right off the bat, focusing on how the two CEOs see healthcare today from an employer's perspective.

My own personal biggest frustration with US healthcare is that self-insured employers like these two companies haven't demanded more value from the healthcare system for the premium prices they pay for coverage. Beth and Tom grappled with this and other issues in a very far ranging and interesting discussion. Let's listen.

Rob Fraiman (02:12):

We're going to kick off the meeting today with a Fireside Chat that I have the pleasure to moderate with Beth Mooney, the CEO of KeyBanc, and with Dr. Tom Mihaljevic, the CEO of the Cleveland Clinic.

Let me first introduce you to Beth Mooney. Beth has been KeyBanc's chairman and CEO since 2011. And since earlier this year, she's also had the role of the Chairman of the Board of the Cleveland

Clinic. Beth is also a member of the Board of Directors of AT&T Corporation, and Ford Motor Company. Indeed, she's one of the few corporate leaders in America who serves on the board of three Fortune 500 companies. Her role as CEO of Key with over 18,000 employees and a board member of two other companies with several hundred thousand employees while also helping lead one of the most prominent systems in the world provides her with a unique vantage point on the US healthcare industry.

Tom Mihaljevic is a physician. He's been the President and the CEO of the Cleveland Clinic since 2018. As you know, the Cleveland Clinic is a $10 billion healthcare system that includes a main campus in Cleveland of course, but also has 11 regional hospitals in Ohio and facilities and physicians in Florida, Nevada, Abu Dhabi, Toronto, and soon to be in London. The Cleveland Clinic of course is consistently ranked as one of the best hospitals in the world and in the United States in 2018 and 2019. US News & World Report ranks Cleveland Clinic as the number 2 hospital in the United States and its Best Hospitals honor roll. Cleveland Clinics Cardiology Program has ranked number 1 in the nation every year since 1995. They're also a major employer. The clinic employs 66,000 people, including 4,200 physicians and 16,000 nurses. So please join me in welcoming Beth Mooney and Tom Mihaljevic to the stage.

Let's dig in and talk about the healthcare industry. There was a new study that many of us read by the Kaiser Family Foundation that found that for the first time, the annual total cost of employer provided healthcare coverage is now over $20,000 a year. Employers are bearing about 70% of that cost, employees about 30%. And many in the US and many in the industry feel that the average American is actually more concerned about paying for healthcare than they are about actually contracting an illness. How did we get here? And what are we going to do or what can we do to relieve this enormous cost burden on the working Americans?

Tom Mihaljevic (04:50):

Well, that's obviously a broad question because it touches so many facets of healthcare, the way we live, and so on. Let me just try to break it down in probably just a few pieces. One, certainly from the provider standpoint, I think our responsibility as providers is to change the way that we approach healthcare instead of being there only when patients are ill to become much more proactively involved in keeping our patients healthy and to be involved in their wellness and their health and provide a type of a coordinated care that is going to keep them healthy.

On a public health care perspective, I think one of the big, big issues in the United States, which is oftentimes under recognized, is that the reason why we are paying so much for healthcare and the discrepancy between the health of the nation and the amount of money that we allocated for healthcare is largely independent from the quality of the hospitals that we have in the United States. But it's really to much greater extent determined by social determinants of health. The health of our nation and the people in the United States is really to substantially great extent determined by their quality of their housing, quality of the social services, accessibility to the right food.

And then I would say, lastly, I think there are several determinants of health in the United States in particularly recently that have skewed the life expectancy in all public health care parameters that's something that we have to deal with more effective, and that's opioid epidemic first and foremost. We are losing 70,000 lives a year, young lives in the United States. Something that was unthinkable not such a long time ago. That epidemic alone has definitely skewed public healthcare outcomes across the board.

Rob Fraiman (06:56):

Beth, from your perspective as the CEO of Key but also with your insights from your board roles at AT&T and more recently at Ford, what can the corporate world do about rising insurance premiums, about

drug price inflation, about hospital and physician price inflation, and ultimately this cost issue in the healthcare system?

Beth Mooney (07:19):

Thanks, Rob. And I will break it down between kind of what our role is, or capacity is to influence the cost structure, but more importantly then, as employers how we design our benefits to optimize health outcomes for our employees. Because I think that's increasingly not just a cost-driven analysis, it's about the full wellness of your employees that you want to make sure you have a vital and healthy workforce. So on the cost side, it's very much how you structure your plans, who you partner with, how you create reimbursements. There are all these things we do to try and limit the relative, and I'm going to say increases on an annual basis that the cost of delivery to your employees costs you. And I say that because there are many places where the cost curves are actually bending and healthcare is not one of them. It's a function of how much it's going to go up in any given year.

We have a whole group of people who spend time trying to figure out what is both the optimal structure cost, where we have leverage and how to package that, which we are going to ensure and make available to our employees. In every engagement survey we take of our employees, probably one of the biggest concerns to your point is benefits around healthcare. That is a number one employee benefit that we offer. And they are concerned about the cost, access, and then just clearly understanding because there is not as much transparency and as there are in what we do as consumers.

So we have done a lot of things to really create wellness benefits that are both good for our employees, but they are hurdles towards things that if you do certain things, you have certain kinds of tests, you submit to a program where you show your walking one person at the bank, put the monitor on their dog. But we didn't bust him for that. But things that really show that you are endeavoring to do a healthy lifestyle and make sure you're doing the things to show your core health, we will give you discounts on your health plans. We give you more reimbursement. So we do a variety of things that really encourage people to engage in their health and wellness. And those are very well-received.

And then structurally, we've gone to the high deductible plans. We made that pivot a couple of years ago, but then we supplement those with HSA accounts that we fund on January 1st every year to try and help offset the costs to our employees. And then we did what I call the Robin Hood method. We have three tiers of healthcare costs. For the majority of our employees who make under $100,000 a year, we haven't raised their premiums in over five years. But that means you're absorbing it both elsewhere in our employee population and making other trade-offs in your benefit programs. So this notion of the escalating cost of healthcare, I think employers, it's one of the things we spend in our benefits and our salary packages perhaps in the most time in any years trying to get this right. It's like I said, number one, feedback you'll get from your employees is access to healthcare and making sure they understand it, it's affordable, and then we're all in this together from a benefit point of view, not just to lower the cost, but to increase the outcomes of wellness for our employees.

Rob Fraiman (10:45):

Tom, let me ask you the same question. As I said in my opening comments, you're in this unique position of being in the business of providing healthcare, but you also are a substantial employer. You're one of the largest employers in the state of Ohio. How do you think about that? You're providing care, but you're also paying for care. How do you demand as an employer, better value and better outcomes from the huge healthcare investments that you're making [inaudible 00:11:11]?

Tom Mihaljevic (11:11):

Yeah, this year we officially became the largest employer in the state of Ohio with a little over 52,000 of our caregivers located in our home state. We have our employee health plan that covers 66,000 employees and their families. By being in this unique position, as you describe of being both the employer and a provider of healthcare, we have been able to design the healthcare product that has actually bent the curve where we are actually spending less in our healthcare for our employees and seeing much better healthcare outcomes than what we've traditionally had. There are two reasons for it. Probably one of the most important reasons is the population did recover, recover in continuity. A lot of people who are covered with a variety of different health plans from the payer perspective, the population changes by what? 20 to 30% of the population changes every single year. So there is a lack of a continuity of coverage. So we have that because people are employed by us.

And then secondly, we are obviously highly vested into becoming the best place to work in healthcare, meaning we want to keep our own employees, our caregivers healthy so we have designed a lot of innovative healthcare programs and put a lot of effort into engaging our own employees in their own health. 80% of everything that we spend in healthcare is spent for the treatment of chronic diseases or consequences of chronic diseases; diabetes, hypertension, chronic obstructive pulmonary disease. With these innovative programs, with the longitudinal tracking of our outcomes, with the empowerment of our own caregivers to take better ownership in their healthcare, we have been able to bend that curve. And now we're looking into the ways of how can we extrapolate those learnings on all the patients that we were caring for, and we are caring for over 2 million people.

Rob Fraiman (13:13):

Healthcare is a local business. At the end of the day, it's about care in a given community. And I'm sitting with the CEOs of two great Cleveland-based companies. Are there ways that two great companies, one providing, one that delivering and paying for care, can innovate and work together to create a new and better model for delivering high value care that won't break the bank? Beth?

Beth Mooney (13:39):

Well, I would start and say that, yes, obviously. But I think healthcare is becoming more and more non-local. I think some piece of both quality, costs, and reach is going to be through care models. And I brought this as a prop. This is going to between data technology, access virtual is going to help transform both delivery and cost of care. So I think some piece of what is incumbent on businesses as well as healthcare providers is to really help figure out how to crack the code on what I call non-space and place-based delivery, as well as trying to make sure we make the physical delivery of... Because there is a portion that will always be physically delivered, make that as efficient as possible. We, in our industry of banking have proven that people are willing to do not all, but a lot of their business through a mobile world. I think if we can create incentives and alignment for more virtual care and access in different ways, it will. And we could promote it through our employee base that will help accelerate some of these changes in healthcare.

Rob Fraiman (14:53):

Tom, partnerships that the clinic does, whether in Cleveland or frankly in any of your markets with large employers in the market, does it move the needle?

Tom Mihaljevic (15:03):

It doesn't. It does not to the extend that we would like to. I think a lot of our ability to move the needle will be enabled to what Beth just has mentioned, to the advances in healthcare and our ability to

connect with the larger employers in broader geographies more effectively through technology. The real problem for pairing a large payers with the large providers relates to the scale or insufficient scale of providers. If you take a look at top three or top four best renowned names in healthcare on a provider side, our market share, if you will, in size is relatively small. Cleveland Clinic has a market share of 0.5% In the United States, and the best one in 200 Americans. So in order for us to directly partner with the large, let's say national employer, take any company, we just simply do not have a footprint or a presence. So we can supplement some of that through technology, but not all of it.

If we were to take a look at all major contributors in healthcare ecosystem, pharmaceutical biotech companies is one, payers is another, and then providers is the third. If you were to take a look at their relative role size and influence, you will see that the providers have a disproportionately small size and influence on the market. And as long as that is the case, it is going to really, really be difficult to extrapolate to the learning, and quite frankly, to provide the quality of care that a renowned healthcare system stand for to a larger number of Americans.

Rob Fraiman (16:45):

Let's stay on this topic of technology. In so many industries, obviously technology is and will continue to be a disruptor. Some of our panelists yesterday express some skepticism about whether and how technology and how quickly it will in fact change the game, whether it's AI, data technologies, and so forth. Beth, I think it would be really interesting to talk about from your perspective, how technology, and again, AI, data technologies, and mobile technology has changed the financial services industry. What comparisons we should draw or not with the healthcare industry?

Beth Mooney (17:25):

There is one fundamental difference, which is there is a point in the healthcare delivery continuum where you have to be in a room with a doctor and procedure's being done. So that is a core difference. I think one of the things that in financial services, there are entire countries on the globe that are cashless. Their entire banking system is in a mobile device, and they have figured out how to make money and the movement of money and goods in everything that you should do in terms of a banking relationship can be done through this. So we have seen in our industry, and I don't think it's disruptive, I think it is evolutionary that we have lots of things. Money is becoming ubiquitous, friction points of how you do business and being bounded by a physical space in place to transact. You can do so much in self-service in a positive way that we are transforming the delivery of financial services through the use of technology.

Every cohort, every age, demographic, still wants access to a bank at some point in time. There is these moments of truth in people's lives where they want access to somebody to help inform them, make a good decision, and give them confidence for what they need to do. But when you go down the continuum and then about what are data analytics and AI doing for the industry... And I think AI is still emerging, I think it is more talk than it is yet transforming the landscape, but data and analytics across industries and in healthcare are transforming the business. What you can know about people, the world of connected devices is going to change things particularly in healthcare. But we can mine people's data and know their preferences, how they conduct things. And when you think of healthcare versus a hospital, we have floors with people who are PhDs, who are highly sophisticated, who are modeling things, it is not...

I think in healthcare, it's going to be a lot of partnering.Because to develop these capabilities, one, I think it will serve us all well if they are interoperable, but it's also very, very sophisticated and takes not just the technology, but the people to empower it where it will actually be a meaningful tool.

Rob Fraiman (19:44):

So let's pick up on that word partnering. Tom, earlier this week, the Cleveland Clinic announced a partnership with a telehealth company, American Well. Help us to understand that initiative as well as other partnering opportunities you're looking at for access, for care delivery, for administration at the Cleveland Clinic. Where are there opportunities like with American Well?

Tom Mihaljevic (20:08):

Beth and I and the members of our board and leadership at the Cleveland Clinic, we oftentimes spend a lot of time to understand and determine what is going to be the true unit of success and a legacy that we will leave behind us once we are not in the roles that we currently are. And we've all agreed that a number of the people we touch with the Cleveland Clinic quality of care is ultimately the legacy that we would like to leave behind. We do believe that we have an ethical imperative to extend the type of care that we know how to provide to as many people in need as possible. So that then leads to the answer to your question, is the partnership within American Well gives us a vehicle to scale up the Cleveland Clinic's expertise in the areas of a second opinion to millions of people through a different tool and with a different vehicle, and that's the telemedicine platform that American Well has.

American Well has developed a platform that can reach 80 million Americans through their contractual agreements. Cleveland Clinic is pairing it with our intellectual professional know-how. That is going to be a vehicle that will allow essentially any American and very many patients throughout the world to access a second opinion easily, and they will get a quality answer that will determine now the future of their healthcare.

Rob Fraiman (21:36):

Let me ask you both about sort of the big three technology players that we see making major investments in healthcare; Amazon, Google, and Apple. How do you see or do you see them having an impact on the delivery of care and the cost of care?

Tom Mihaljevic (21:54):

I'll add to that Microsoft as well.

Rob Fraiman (21:56):

Yep.

Beth Mooney (21:57):

Mm-hmm (affirmative).

Tom Mihaljevic (21:58):

And the answer is yes. Both Beth and I share from conviction that technology is going to have a very profound effect on our healthcare in a very short time span. I'll just use one, one example is oncology, cancer care. Cancer care, five years from now and today is a different entity. It's a different entity because we're using the technology much more effectively to agglomerate a phenomenal amount of data that no human can do on his or her own. And by doing so, all these data, genomic data, proteomic data, and the list goes on and on, allows us to provide a much more tailored therapy for many diseases. They used to be fatal. They're not fatal any longer. Take a look at the outcomes, let's say of melanoma, skin cancer. Today, versus 5, 6, 7 years ago, tremendous shift, largely enabled through technology.

We had the Health Innovation Summit in Cleveland last few days. I spoke with Eric Lefkofsky from Tempus. He's doing exactly that. His company is agglomerating this phenomenal, vast amount of data in cancer care and putting it in the service of our patients. And those have phenomenal transformative, transformative changes that we will be seeing. I will just say that I can see the future when we are going to have a fewer larger healthcare system. They're going to be differentiated not only by the quality of the talent that they have, that is always going to be differentiator, but also by their ability, ability to use the technology to direct and improve the care of our patients.

Rob Fraiman (23:37):

Beth, anything to add to that about the four big technology players and how you see them impacting the...

Beth Mooney (23:44):

Well, a couple things I would say is that they are transforming many industries right now. They are truly coming into multiple industries. We use the word disruptive. But at the end of the day, they're also transforming in a way that is far more patient/consumer-centric, leveraging technology and data in a way that I think the outcomes are far better than they would have been without these players. I will leave aside whether or not it is a concentration of market power and all that sort of thing. I think it is a net positive to how we are experiencing our world and it will experience healthcare.

And then I do think it's interesting the way JP Morgan, Amazon, and Berkshire Hathaway have come together. I do not yet fully understand what they've called Haven, which is their healthcare system that they want to take the fact that they have among them hundreds of thousands of employees, and figure out a different way to deliver care in a more cost-effective without sacrificing quality. But there's going to be something that comes out of that that's going to be yet again another pivot in the care models as well as delivery in insurance model.

Rob Fraiman (24:57):

Clearly, one of the major differences for those companies is how they touch the consumer. And in healthcare, as we all know, it's a truly unique industry because the buy-sell dynamics that control so many of pretty much every other consumer facing industry don't exist. The consumer who you serve, Tom, at the Cleveland Clinic doesn't know the price of the service that they are receiving. And of course, they only pay for a portion of it because their employer pays for the balance or their insurer does. So it's been said that many providers, as a result of that, aren't really able to provide the quality in-depth and type of service that the consumer is looking for. How do we address that? The Cleveland Clinic has a remarkable brand. How do you address that interaction and the need for a better understanding from the consumer?

Tom Mihaljevic (25:53):

The big challenge in healthcare is that at the beginning of the process of delivering care, we just simply do not know what that process is going to look like so it's difficult to price it upfront. In most other industries, that's a known entity. You know what you're buying and what you're heading into. In particular, for us in a kind of a complex care environment, it is really an impossible task to answer. That's probably one of the big fundamental differences between our industry and other industries when it comes to pricing. I do believe that the clarity in pricing is going to be easier to overcome for some boats, so to say, standardized fragments of care that we provide. I think there's a lot that we can do differently, differently and better. But for complex multidisciplinary team-based care, for difficult diseases it is going

to be a really, really difficult hurdle to overcome no matter which technology we use, just because we simply cannot really answer it in a straightforward way.

Rob Fraiman (26:59):

Beth, I'm going to ask you the same question. Obviously, Key, but also AT&T and Ford are companies that touch the consumer every day. What can the healthcare industry learn from all three of those, not just financial services, but also from media and telecom and from the automotive industry, about the consumer in healthcare?

Beth Mooney (27:25):

There is a complexity in healthcare because some piece of it is ultimately need-based, based on something that happens in a person's life that they absolutely need a particular care or protocol but within the bands of wellness and other things. One of my takeaways is how do you bundle things with intelligence that are going to help create outcomes that are more cost-effective? If you go in and you do a certain protocol or a series of tests together, it could be done more cost-effectively and likely create value in health outcomes and healthier patients. I think across industries, what services or what attributes you bundled together, and by doing so you can make them more cost-effective and you will have better outcome, I think is something that is healthcare providers think through their continuum of delivery that's going to be incredibly important.

And then in this world of access and convenience, I think the transparency one is difficult for consumers and employers to not have a better sense of the cost. And I get that sometimes it's based on, you don't know what somebody needs but then is it you want to walk into a clinic and see the pricing board of, "If you have this, it costs you this. If you have that, it costs you Y." It's one of the few industries where you really don't know what the package is going to cost you. But I do think there is a real opportunity for some ability for people to understand the costs of the trade-offs of what they are choosing. The biggest point of vulnerability in somebody's life is, "I'm sick, and make me well." At that point in time, you really do want people making decisions that are best for you. But short of that, there are probably choices in ways that people could stage things through the use of technology and bundling products and services.

Tom Mihaljevic (29:19):

Just to add to what Beth just mentioned, oftentimes it's interesting to provide a little bit of a context and a scope of complexity because oftentimes people will start these type of conversations in particularly if they're outside of healthcare and say, "How in the world can I walk in any type of a service and know exactly what I'm going to pay for whatever I'm asking and you guys in healthcare cannot figure it out?" Just to give you a complexity of the task, just for an outpatient appointments, there are 20,000 different types of outpatient appointments that a person can schedule at the Cleveland Clinic. Essentially, they're 20,000 services in the outpatient space. Can you imagine the menu in a patient's waiting room that's going to have 20,000 items?

Beth Mooney (30:10):

It's not cheaper by the dozen?

Tom Mihaljevic (30:12):

It's not cheaper by the dozen. By the way, you do not know which one of those you're going to fall into and do not know what are going to be the subsequent choices of 20,000 ramifications. So the answer is,

we will almost certainly be able to provide some degree of transparency for a large portion of the services that we provide and we should, but there is going to be always part of the work that we do is going to be really difficult, close to impossible to price up front.

Beth Mooney (30:45):

Because it's going to be a function of what people [inaudible 00:30:46].

Tom Mihaljevic (30:45):

Right.

Rob Fraiman (30:46):

This morning earlier, we were talking about value-based models, and in particular, models for providers that are going at full risk to provide primary care in clinic setting. And we have a number of companies here that are in businesses like that. Isn't that sort of the most extreme? Those patients, in fact, don't see a cost ever. They don't see, in many cases, a copay, and their provider is at risk for providing the full array of services. How does that fit into the equation? Obviously, that's particularly unique relative to a hospital-centric system like the Cleveland Clinic.

Tom Mihaljevic (31:26):

We're not really hospital-centric as people would like to believe. The largest number of our 4,500 physicians are not hospital-based. They are outpatient-based. So 60% of everything that we do is in the outpatient arena. The largest number of physicians for any institute is our institute, that is in a primary care. And that is really a big shift that we have undertaken over the last five years. We have moved from 40 primary care physicians to about 450. So that is the size of the shift with an emphasis. What we're really trying to do is to provide a continuous care for our patients, and that care continuum is something that we're very passionate about.

Value-based care is kind of what we would like to believe at the Cleveland Clinic is something that we've been practicing for the past 100 years even before the term was coined. As you know, at the Cleveland Clinic, we do not pay our providers based on the unit of care that they provide. We're all salaried. We're all on a one-year long appointment. We do not have 10 years. We are just trying to do what is right for our patients with the means that we have at our disposal for the benefits around patients. We do not have a shareholders. This has been, sad to say, [inaudible 00:32:40] in the organization that has been present since 1921. Value-based care is a concept that we endorse, the concept that we support. The caveat here is we just have to make sure that we understand who is actually getting the value out of value based care. For the way we look at the world, we would like to make sure that that value is actually a value for our patients, and from the standpoint of the quality and an experience of care that they are receiving.

Beth Mooney (33:16):

Who gets the value? Who takes the risk? One of the pieces about the model, going back to what Tom said about you never know what it's going to cost because you don't know what somebody needs, if you guarantee someone access for a year at a certain price that they have been either provided or paid, in the course of that year, if what you need exceeds that which has been paid on your behalf, I think one of the things we all have to understand, what are the implications of that both for the person who has the care need, and then what are the risk pool models?

It's kind of creating an insurance model behind the scenes to saying that, "We're going to receive $1 million and have this number of patients, and somebody may need X and somebody may need Y, but it's going to average out to be a profitable model." But there's a lot of variables in there. So it feels like the people who are providing those models almost have to think like actuaries and insurance people to understand how they're going to make money, because you cannot predict on any one individual that that would be sufficient to cover what they might need in a given year.

Rob Fraiman (34:20):

We've talked about cost. Let's talk about access. As we're heading deep into a political season, the phrase and the concept of Medicare for All has become a profound topic. I think from minitzers words spoken at the last democratic debate, it was the most discussed subject. How do you think about that and other related universal coverage programs, access programs in the context of where you're heading with the Cleveland Clinic and where you see other providers heading?

Tom Mihaljevic (35:03):

Well, I spoke briefly a few minutes ago about what do we stand for, and really that's access to Cleveland Clinic care. I mean, this is really the motivation. That's what we're really passionate about. So we're very much aware of an access issue. I've had a good fortune to live and work in five different countries in five different healthcare systems. It is really important to understand the difference between having a nominal or declarative access to care and an actually ability to access that care. I've lived in very many systems where healthcare was free for all. You can always get it, but the lines were very, very long. And in practicality, people had difficulties accessing it and accessing at the time of their need.

So I think we have to be careful when we speak about an access, what we mean by it. Every time I get into any type of these discussions, we would like to look at the worlds for patient size. If you have a right to access healthcare at anytime, anywhere, but you cannot really access that right, that right is only declarative. It's not factual. So then, therefore, our task is to design a system that is going to reconcile those two things. I do believe that people should have access to healthcare. I do believe that this is right, but we also do have a responsibility to design a system where the declarative right is going to be translated in actual access to healthcare. I do believe that having a model that balances various aspects of healthcare delivery, whether it's a private government based and so on, is probably the best one.

Beth Mooney (36:52):

Having looked at the financials of a few healthcare systems, Medicare and Medicaid reimbursements don't really cover the cost. It is incumbent on healthcare systems to try and figure out how to think in aspirational goal is to almost get it to break it into a slight profit.

Tom Mihaljevic (37:10):

Right.

Beth Mooney (37:10):

So if that became the entire revenue pool and you didn't have the mix of private pay in there, I think over time there is a different healthcare system because of what it will be able to fund and what it will be able to provide. I'm not sure that if we can't find an ecosystem where we still honor the private payer the academic piece, we're going to have better healthcare outcomes over time. Then I think if you look

at something where it's a fixed rate and it's provided by the government, I think that will have implications over time.

Rob Fraiman (37:47):

The inability to finance it by the government and the inability perhaps to provide access. On the other hand, Beth, earlier you talked about, as the CEO of Key and as a board member of other large companies, the amount of time and effort that is spent on putting together the benefits package and offering private insurance options and whatnot to your constituents who are employees. In many ways, this movement towards a single payer would obviously relieve the burden of employers. Is it realistic or is it what you just said? It might make your life easier in the C-suite but not feasible.

Beth Mooney (38:24):

Yeah, I would tell you it's feasible. I mean, it would make it simpler. On the other hand, I think as major employers, healthcare is a differentiator for us on how we approach attracting and retaining high quality talent. And our ability to insert into our benefit programs, pieces of wellness and services that our employees want and need that, like I said, make them more productive as well as their quality of life in terms of just the balance between health, office, family, needs that we craft into our benefit plans, takes a lot of time, but I also think it correlates with our ability to attract and retain high quality workforce in an era where talent in most any industry is the differentiator.

Rob Fraiman (39:12):

Let's talk about mergers and acquisitions. Is there a time that you can see in the next five years, if you look in your crystal ball, where there's a provider in this country that has, say a 10% market share?

Tom Mihaljevic (39:26):

Yes, yes, yes. And I do believe that this is going to be inevitable. If we move to, let's say to great extent to a single payer, that is actually going to accelerate that pace substantially. There are 8,500 hospitals in the United States. A large portion of them, if you take a look at their financials, it's not going to look sustainable. The needs of healthcare in the future that we address is going to be very technologically driven. We're going to require all of those hospitals to invest a phenomenal amount of money that they do not have into technological infrastructure. Needless to say, the regulations and the oversight for all the right reasons is put in a strain to every provider. So the answer to your question is absolutely yes. I can see a future in healthcare world. We're going to have a fewer large centers. They're going to provide this kind of a complex health care, not unlikely to banking industry. There's always going to be a physical bankers. There's going to be a physical hospital. They're not going to disappear.

However, it is going to be really difficult for me to envision that every small town in the United States is going to have 200 to 250 bed hospital. They're going to have a much more asset light integrated vehicles for the provision of coordinated care. That care is going to be coordinated with the use of a technology through larger centers that have that technology that can framework and also have a talent to back it up so that we can have finally the healthcare delivery system that is affordable, that is scalable, and it serves both the needs of our patients and the needs of our society. So, yes, the answer is absolutely.

Rob Fraiman (41:12):

You each have been consolidators in the industry. How do you talk with your boards about the long-term M&A environment whether it's something that is defensive, how offensive is it both in healthcare? But Beth, I think it is pertinent to talk about those other industries as well.

Beth Mooney (41:38):

I will speak to banking if I could, because I think your analogy that banks and healthcare highly distributed numerous locations, many providers, many banks across the country. I think we're down to 5,000 banks in the United States, different banks. There was a time where it was 12,000 different banks in the United States when I started my career. So there has been a consolidation. It is very much a local sport, so there is... People want their own hospital. They want their own bank. They do like this notion of trading locally. And to a consolidator, you look at it, and there is this cost of technology, the cost of investment, the efficiency that can be gained, is part of the value equation. But resources are finite and it's not just capital. It's time, its focus, its priorities that you set.

We did a transaction several years ago of a whole bank acquisition. If I, somebody asked me this just recently, had it to do over again, I would absolutely do it. It was one of those things where at the end of the day, we made a step change. In our performance, we increased our market share. We extended our product set. That was really a good thing. But if I was going to be asked from a banking point of view, would I want to pick up a bunch of small banks even if it would increase our market share, and at some point when I look at our resources and our incremental ability to invest, that takes a lot of time and energy. And is the return there, or are you better invested in technological platforms, digital platforms?

So I think when people start making these trade-offs, M&A is part of the environment. But to the consolidators, they have to look at it on a continuum of their alternatives for investment, both capital, time, and resources. I think that is a complex equation in any industry and will be part of the complexity I suspected in healthcare over time.

Tom Mihaljevic (43:33):

For us, our responsibility is to grow responsibly. The week doesn't go by that we do not have a call inviting us to consider partnership, merger with a healthcare provider in the United States. This is where we're fortunate enough to be in that position, but we also do understand that they're real restriction about our ability to grow at the pace, as I said, that is responsible. And that we have to allocate our resources, both intellectual, time, money, and people to the top of a growth that is going to be most effective.

I do believe the local hospitals has a mission that's going to continue to exist. I do believe that they're going to be certain types of services that we will be able to scale up and extend to other hospitals even without really owning them. And I'll just give you one example of what that could look like. Let's say all intensive care unit beds at the Cleveland Clinic are being monitored from a single command center, bunker. One of the big problems in the United States healthcare particularly in the rural hospitals and intensive care units are just difficult to staff. We do not have enough physicians. We cannot do it. Mental health. Huge epidemics of the mental health. We can simply not educate, hire enough psychiatrists to staff every intensive care unit or every emergency room throughout the country. It is just impossible.

Using a telemedicine platform that is going to be able to disseminate the expertise in let's say mental health care from a large renowned center that has that expertise and that human capital, is I think the ways to touch many providers in an effective manner without really acquiring them. So, yes, I think it's going to be a consolidation. Yes, it will be part of the equation, that large centers would grow

that will never eliminate the need for local providers. But I do believe that there are going to be certain services that those local providers will be able to acquire without really them being acquired by others.

Rob Fraiman (45:45):

Tom, how do you respond to the political discourse that consolidation in the hospital industry and particularly in given markets reduces competition and therefore leads to, in fact, price inflation, lack of a competitive environment? Given your comment about there may be a provider that has a 10% market share somewhere down the road and the kinds of activities that you've just discussed.

Tom Mihaljevic (46:15):

Oh, the reason why I was smiling is just contextually. It's really difficult thing to follow if the largest provider in the United States has a 0.5% Of market share and the largest payers have 20, 30% of market share. How come that the payers can grow to be $200 billion cap, and that's good, and the providers are going to stay as tiny as they are and we're a threat. I don't follow the logic of that. There is something that I think is very, very important, and that is to say that it is absolutely true that the growth of a healthcare systems cannot necessarily translate it historically into the improvements in the quality of care for those who they've covered then, because most of that growth was in a form of a holding company, people with agglomerate assets, but they wouldn't really integrate it. They wouldn't spread the quality of care at any optimal pathways of care throughout the system. So they're not really functioning as an operating company.

From our perspective, and there are many others in our industry who are taking the tact, we like to view every presence of the Cleveland Clinic from a standpoint of one Cleveland Clinic, where we stand for the same experience of quality care in every location. So we work very, very hard to improve the quality and access to care in every locations. We have seen the improvements in those measures in every hospital that Cleveland Clinic has acquired over the last 10 years.

Rob Fraiman (47:51):

We just got a couple of minutes left. How optimistic or pessimistic should we be? And are you, as provider of healthcare, as a payer of healthcare, as large employers, about where we're heading over the next five years in this health care economy? Beth?

Beth Mooney (48:10):

I don't think you should be a CEO if you're not optimistic because I think in any scenario, you can paint the challenges and you can paint the opportunities. But I believe in the resilience of our industry. I believe in the resilience of our country, the quality and the depth of talent. And I believe on the margin, we will always translate into opportunities that give reason and cause for optimism.

Tom Mihaljevic (48:37):

This country has always risen to every challenge so I'm very optimistic. Actually, I would say there's never been better time in healthcare than it is today. Our people think about, "Oh, these are difficult times." And I say to them, "Compared to which year?" When people speak about good old times in this, and so "Could you please specify a year or a period when the times were good in healthcare?" We've never-

Beth Mooney (49:01):

Would you rather have melanoma now or melanoma [crosstalk 00:49:04]?

Tom Mihaljevic (49:03):

Exactly. Exactly right. I mean, we've never had better-

Beth Mooney (49:08):

Outcomes.

Tom Mihaljevic (49:10):

... better outcomes, greater knowledge, higher quality of people. Probably, the most important thing that we all have to understand that the quality of healthcare for the nation, the health of the nation is not solely determined by the quality of their hospitals. I think in this entire conversation about healthcare reform, we're speaking about the reform of the payment. People do not realize that yes, United States allocates relatively large proportions of their GDP to healthcare, but our allocation to other determinants of health that's a much more powerful is actually relatively small. Social services, housing, affordable food. Compared with other Western nations, it's relatively small. When you take a look at the allocations from these budgets for social determinants of health and healthcare, put them on top of each other, United States is in the middle of the pack of the Western countries. So yes, France allocates less of their GDP for healthcare, but allocate substantially greater percentage of their GDP for their social services. And therefore when you take to extrapolate, take a look at a public healthcare outcomes, the picture looks differently.

I'll just give you one example. I think this is probably going to illustrate it better. Lead poisoning. Beth and I live in Cleveland. Lead poisoning is a huge issue for our communities, for children in our communities. I mean, one hospitalization for a child with lead food poisoning costs more than affordable housing for that child and their families. So if you allocated amount of money in affordable housing, you would eliminate the need for repeated hospitalization, not to speak about the downstream consequences; mental impairment, learning disabilities, inabilities to find job. That's a healthcare reform that we should strive for.

Rob Fraiman (51:12):

I can't think of a better way to end this discussion than your comment, Tom. There's never been a better time to be in healthcare than now. So we thank you. Thanks to Beth Mooney and to Tom Mihaljevic.

Tom Mihaljevic (51:12):

Thank you.

Rob Fraiman (51:23):

We appreciate your being here. Enjoy your day everybody.

Beth Mooney (51:25):

Thanks to all of you. Have a great day.

David Johnson (51:27):

Cain Brothers is an investment bank focused exclusively on healthcare. The bankers at Cain stand apart because of their deep knowledge of the healthcare industry and their practical know-how when it

comes to executing complex transactions in all healthcare sectors. These include healthcare services, medical technology, and life sciences.

I'm your host, Dave Johnson. I'm a recovering investment banker who discovered late in my career, I was always meant to be a journalist, and maybe even a podcaster. I'm also the CEO of 4sight Health and the author of two books. The most recent of which is The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I love talking to other revolutionaries who are driving change in the healthcare industries.

Podcast: 2020 Observations and Insights, Healthcare's Recent Trends and Future Direction

Cain Brothers' President, Rob Fraiman, looks back at Healthcare in 2019 and makes some bold predictions for 2020. He also shares the origin of the annual Cain Brothers' College Championship Game Party at the JP Morgan Healthcare Conference in San Francisco.

Dave Johnson (00:05):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, a division of KeyBank Capital Markets Inc. Cain Brothers bankers work in some of the most interesting segments of the healthcare industries. They work with organizations and business models that are helping to change American healthcare for the better. I'm your host, Dave Johnson. I'm also CEO of 4sight Health. I'm a recovering investment banker myself who discovered late in my career that I was always meant to be a journalist. I coauthor a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. Each piece becomes an exercise in examining a fascinating segment of the dynamic healthcare landscape. The focus of our articles and this podcast is on how to make America's fragmented, inefficient, and often broken healthcare system more integrated, consolidated, efficient, and customer focus so that it delivers greater value and innovation to the American people.

We have a great program today. I'll be interviewing Rob Fraiman, the president of Cain Brothers. Rob has been an investment banker for over 30 years. During his impressive career, Rob has led many complex and pathbreaking transactions. These include the conversion and recapitalization of the not-for-profit Caritas Christi Health system into the for-profit Steward Health. He also raised growth capital funding for the DuPage Medical Group through the private equity firms, summit partners. These and many more transactions like them illustrate how Rob and Cain Brothers operate at the cutting edge of capital formation strategies that are reshaping the American healthcare system from the ground up. On a personal note, Rob and I have been friends since college, [inaudible 00:01:58]. He's not only an accomplished banker and leader, he's a jazz aficionados, an avid reader, and a deep thinker on health policy. We regularly have wide ranging and fascinating discussions. I'll expect we'll have another one today. Rob, welcome to House Calls.

Rob Fraiman (02:14):

Thanks Dave. It's great to hear your voice .

Dave Johnson (02:16):

And great to hear your voice. So Rob, we're both just getting back from the JP Morgan Conference or circus in San Francisco. It's always crazy, but it felt even crazier this year than in past years. Let's hold

that part of the conversation for now and talk about the year that we just left, 2019. Throughout the year, Cain Brothers produces a remarkable collection of thought leadership filled with transactions, policy, and market insights. As in past years, we've collected those in a single article with the provocative title, 2019 observations and insights. Here's the provocative part, rising consumerism market and a cloud of dust, just like Woody Hayes. This is always a favorite article of mine because it's a bit like a scavenger hunt. We dig into all of the content from the last year in search of patterns, insights, and clues for what not only happened last year, but what will happen and unfold during the coming year.

So this year, you and I, when we went through this exercise on our three themes around which to categorize all of the 2019 content. They were first, regulatory, policy and financing changes. Second, business model repositioning, especially consolidation. And third, the rising consumerism that's coming into healthcare. So given those themes, let's start with the Big Kahuna Medicare and the rising share of enrollees selecting Medicare Advantage plans. And what's unique about Medicare Advantage plans relative to a regular Medicare is that it shifts care management risks the financial risk of caring for people to the insurance companies that sponsor the plans. Why don't you talk about the impact, this changing insurance dynamic is having on the healthcare marketplace? Who wins, who loses and what are the new business opportunities?

Rob Fraiman (04:21):

Dave, the interesting thing is that, Medicare and MA, Medicare Advantage, in particular actually touches on all three of these themes. It's obviously a policy and regulatory and financing matter. It is having a huge impact on consolidation and new business models coming into the industry. And ultimately it is a consumer business. MA is obviously a great program. And it's clearly better than traditional Medicare for its members given as you mentioned, the broader array of services and the holistic approach to care. It's ironic, in fact, that it's difficult for some retired elderly Americans candidly including my own parents to enroll in MA because of their concern about limiting their network choice. But in any case, we're big believers that the acceleration of MA should continue despite the fact that the law of big numbers will make it harder to achieve the same year over year growth rates over the next five years as we've seen over the last five years.

That said, I think there's a pretty decent chance that we'll get to 45% or maybe even 50% MA penetration in the next five years. But it's going to take a really aggressive implementation and marketing by the payers, the Humana's of the world. And in particular I'd say by the providers, large multi-specialty groups in health systems who are actively trying to move to value based contracts with MA and encouraging their patients to go with their MA offering. So that's who has the opportunity to win. I that in particular we'll see the acceleration of some of the payers like Humana, as I mentioned, continue to partner with providers that can drive MA volumes. And that's certainly a win-win.

Dave Johnson (06:09):

Yeah. Well, before we get into the losers, I just wanted to pick up on this a little bit, Rob. You said we'll get 45% to 50% MA, which may not seem like a big number. But what I've noticed and there aren't many markets like this. But when the percentage of Medicare enrollees gets in and around 50% in places like Minneapolis, Portland, Oregon, Orange County, California, it's a big enough number that the payers and providers need to start vertically integrating to manage the care for these people. And they are having, seeing some visible change in how they organize themselves. Is that something you're seeing as well, or you're seeing companies getting ready for that are interested in the MA space?

Rob Fraiman (06:58):

You bet. And I know that we're going to get into a discussion in a few minutes about consolidation in the industry and MA activity. And I would say that a big part of that is related to exactly that phenomenon that providers or payers, and in some ways use an interchangeably. If they're going to be in the MA program, if they're going to be going at risk, they need to either own, or they need to partner and control the ability to have all of the different aspects of the delivery system under one roof, or certainly under one scheme to provide care.

Dave Johnson (07:38):

I think it was in 2019 I first heard the term, and I don't really like it very much, although it does do justice to what you just said of payviders. But basically, a vertically integrated solution. And I guess what I like about what you're saying is, this is the marketplace's way of fundamentally changing the system bottom up in ways that reward value. If you're only getting a certain amount per member per month for your population, you have to figure out how to manage the group within that budget. And that's what triggers things like free gym memberships, better preventative services, focus on dental care and so on. So feels like vertically integrated providers that can deliver on value can be real winners in the post reform world. So let's talk now about who loses.

Rob Fraiman (08:34):

Look, the losers are going to be those who can't play in that market. It's the insurers who have not developed or successfully marketed their MA product line. It's the fee for service providers who are behind the curve on the shift to value who are still collecting fees. And it's the smaller or lower market share providers who are going to be, if they haven't already been left out of narrower MA network that are being formed. I think those are the folks who are going to lose.

Dave Johnson (09:09):

Yeah. And sort of going along with this is, is a somewhat overbuilt acute care delivery system. Because if we do a better job of prevention and chronic disease management and decanting high cost procedures out of high cost hospitals into lower costs, more convenient ambulatory centers. It feels like there could be a fair amount of disruption in the 2020 decade, which maybe that's good for Cain Brothers because it could mean more consolidation activity. Is that what you see potentially happening?

Rob Fraiman (09:46):

It is what we see. And I think that, look, hospitals, aren't going away and you're right. We will be involved in helping them consolidate, but they have to evolve. There's no question. And one of the ways they're doing it obviously is by acquiring part of physician practices and affiliating with physician practices in as quick and as robust and manner as they possibly can. And that really is the way that they're going to be able to enter into contracts like the ones we're talking about, and ultimately provide that better care at a cost that works.

Dave Johnson (10:22):

And I think most people who try to think about the future, think about it as an iterative progression from where we start today. And yet we know just from looking back over the last 10 or 15 years in a digital age, we've seen the emergence of entirely new types of companies, Facebook, Google, and so on. Healthcare has tended to lag the rest of industry and its application of digital technologies, platforming, going to the cloud and so on, artificial intelligence. Do you see new types of business opportunities

emerging as healthcare begins this progression not only into value, but into operating platforms that start to look a little bit more like the rest of American industry?

Rob Fraiman (11:16):

I do, Dave. And I'd say that some of them are necessarily new, and some of them are. So for instance, in this area, some of the businesses that I love, that I just really feel are part of the solution to our healthcare challenges are older businesses. Like we have a client CareMount Medical, a very large multi-specialty physician group in the Northern Westchester and New York suburbs. Which is a group that's been around for decades. Many, many decades, but has moved to the Medicare Advantage world, the risk world in a way that is going to redefine who they are. So there's an older business that is in the process of transforming itself. But in addition, there are new companies, newer companies that are adhering to the same model, but they're building from the ground up.

And I love some of these businesses that are focused on primary care, clinics that are going fully at risk in MA. Companies like Oak Street Health and Iora, ChenMed and Cano Health down in Florida. These are the companies that are, as I said, undoubtedly part of the solution to our healthcare challenges. Why? Because they're treating patients in a holistic manner, they're doing it inexpensively. They are focused on social determinants because they have to be, and on environmental factors in whatever given market we're talking about. I think that that's where you're going to see a tremendous traction, keeping these patients out of the hospital, out of the high cost settings.

Dave Johnson (12:49):

Yeah. Which gets to the consumerism part of the discussion. The industry as a whole historically has really been able to execute transactions without customers. People go to the doctor, doctor tells us what to do, we do it, and somebody else pays for it. But many of these new models are very consumer centric and companies like Oak Street and ChenMed and Iora work very hard to develop strong customer relationships, know their customers, move forward from that. And it feels like the healthcare is not going to go completely retail, but it will need to develop some consumer muscle and instincts in order to navigate in a world where people will have more choice, there'll be greater transparency. In some ways it won't come as easy to the incumbents as it has up to this point. Are you sort of have that line of thinking as well?

Rob Fraiman (13:46):

I am. I think consumerism is really finally beginning to impact the way companies compete. High deductible plans obviously are causing consumers to think hard about the cost of their prescriptions and of their healthcare services. Obviously mobile devices and ubiquitous apps enable consumers to monitor their health and their utilization in new ways. I think the interesting thing is, technology can actually make health care more human despite the fact that many people think it will remove the human touch. I think that it can enable the healthcare providers and the healthcare payers to become more personalized. So for instance, using AI to deliver faster and more accurate responses instead of making people wait on the phone forever will enable the consumer, the patient to get to the right place in the healthcare system faster.

I also think that, frankly, consumer branding is going to take on a greater importance in the healthcare industry. We've seen it for some time. Whatever city any of us are in major cities that health systems are doing heavy consumer branding, a lot of billboards and so forth. But certainly in major markets like Chicago where you are and New York where I am, there's lots of TV advertising and so forth. And I think we're going to see large companies building national brands. Did Optum take out ads

and last year Super Bowl? It wouldn't surprise me to see a lot more of those kinds of trends growing more rapidly and meaningfully in the healthcare industry.

Dave Johnson (15:13):

On the market side of the equation, Rob, this was another banner year for capital investment. Instead of the mega mergers of recent years, however, we saw more of a wave of consolidation. Could you describe that wave?

Rob Fraiman (15:26):

Sure. There's certainly were some mega mergers. You had to Centene and WellCare and so forth. But we agree there's more activity right now of what we think of as tuck-in acquisitions. Those can be billions of dollars in enterprise value, but typically they're in the hundreds of millions. So what does that say about the healthcare industry today? Well, there's lots of moving pieces. That's what we're talking about on this call. There's this move from fee for service to value. There's an intense need for capital to invest in IT and people to enable that transition as well as for interacting with the consumer, the patient and in a more user-friendly manner. And ultimately the fact that scale really matters in healthcare these days. Whether you're an asset heavy health system, hospital system, or an asset like physician group or ultimate site provider.

Or if you're a medical device company that is selling more and more to GPOs or buyer groups rather than to individuals or even physicians. All of that activity has led the investors, whether they're private equity firms or they're strategic investors to think about how can they move the ball forward. Not wholesale changes that we were seeing in some of these mega mergers, but rather the need to partner with one another. Or if you're a large strategic company, a public company, the opportunity to buy some smaller businesses that in a classic buy versus build scenario.

Dave Johnson (16:59):

Yeah. That partnership of financial and strategic buyers is particularly interesting and that's helping get some bigger and more complex deals done. And I know Cain Brothers is paying attention to that trend and involved in it. Could you give us a few examples of the types of transactions that exemplify the wave that you just described and maybe one or two of these strategic financial transactions that are somewhat new to the marketplace in healthcare at least?

Rob Fraiman (17:33):

Sure. I'd be happy to. The need for growing companies to partner with capital partners with private equity in many cases is part of that wave. Such as when our client Summit Medical Group, large multi-specialty group did both. They did the strategic transaction and a capital transaction. They merged with the large urgent care provider in New York city, CityMD. And the entire entity was recapped by private equity firm, Warburg Pincus. That's a classic example of bringing together those different elements. But a different transaction we weren't involved in was the recently announced a minority equity investment by TPG in Kelsey-Seybold down in Houston. Kelsey-Seybold was looking for a capital partner. They weren't looking for a merger partner. They are in the world that is going through all of these exact changes that we're talking about. And you simply can't do it by self-funding out of cashflow or by reducing physician compensation.

We also see deals like Humana recently buying the hospice pharmacy and benefit manager in Clara. Humana is obviously a $40 or $50 billion market cap company. And in Clara was much, much smaller. But this is a natural fit with be a significant investment that Humana is making in their Curo and

Kindred hospice patient base, which of course fits within their Medicare name. Or similarly, we worked this past year and last year with a client, Steward Health, our client that sold their Medicaid book of business. But the interesting thing about that is this was a book of business in the state of Arizona. And the acquirer was Blue Cross Blue Shield of Arizona. This was a buy versus build decision for the Blue plan because they needed to be a scale Medicaid player in their home state. They obviously have a commercial book of business.

They also have a Medicare book of business, but they weren't in Medicaid. So they acquired 200,000 plus lives from Steward. Lastly, a similar type of transaction but in the provider world, our client Alacare, which was a family owned, privately held business. The largest home healthcare business in the state of Alabama, which was acquired by Encompass Health. Also an Alabama based company, but which did not have a deep array of home care assets in Alabama despite having rehab and other types of assets. So I'd say each of those, Dave, are examples of what, as you called it, that wave, but not mega mergers.

Dave Johnson (20:11):

No, it's really impressive. The range of healthcare transactions that Cain Brothers executes and as president of the company, you get to see it all. But I wonder, could you just deviate a little bit from talking about what's happening in the market. I'm just curious in your role as president, how you think about growing the company and having this breadth of capacity to cover this complex nuanced industry in all of its shapes and sizes? It must be both challenging and invigorating at the same time.

Rob Fraiman (20:49):

It absolutely is. I feel so fortunate to have had the opportunity over the last 16 years to be here and to be the president of the company for the last 11 years. There's lots of really, really great investment banks and advisors and financial advisors out there. What we try to do here is bring a depth of intellectual capital of knowledge of what's happening in the healthcare economy. We are completely agnostic as to whether our clients are a for-profit or not-for-profit. Obviously the US healthcare economy is one that has a tremendous not-for-profit or tax-exempt element to it. We serve those clients in exactly the same way. We have the same dialogue with our large healthcare system tax-exempt healthcare system clients that we do with the for-profit companies.

Similarly, I mentioned the BlueS. In Arizona, we have a dialogue with all those Blues just as we do with the commercial insurers, the for-profit companies. And it's our view that if we can bring to our clients the ability to help them think through some of the trends that we're talking about on this call, and that you've talked about with my colleagues on other House Calls, and engage in the dialogue that crosses over a variety of vertical lines, whether it's by industry sector or as I mentioned by tax status, I think that's something unique that the industry needs. And it certainly has enabled us to grow our business over the last couple of decades.

Dave Johnson (22:26):

And of course, Rob, a big event in the history of Cain Brothers was your merger into keyBank, and being able to have a big money center bank as a partner and in building the business and doing more in different types of transactions and in many ways more complex transactions. I think the audience would really find it interesting to hear from your perspective how you shifted from an independent boutique healthcare bank. Still doing many and most of the same things, but now under the umbrella of a big money center bank. And just talk to us about Key and how that's enabled the firm to grow and develop new capabilities that will take you into the next decade and beyond?

Rob Fraiman (23:17):

Well, look, it's one of those things that I've been advising clients for three decades about what the right time to sell a business is and what the reasons are. And a few years ago, when we started to think about that as it pertains to Cain Brothers, we felt that it might be the right time to find a partner. Why? Well, one reason, a big reason is that we felt that the ability to offer our private equity clients and our corporate clients the access to the capital market was something that would be beneficial. We are a strategic advisory and MA oriented firm at our foundation. But the ability to provide financing to the clients is something that we felt was relevant to them and could continue to enable us to differentiate. That of course fit with what KeyBank was looking for because they have that capability.

Interestingly though, they were also looking to build out their strategic advisory businesses and in particular their mergers and acquisitions advisory business. And that was an important part of the thesis for them. The one other element that I really had no idea until I met the folks at Key several years ago, was that after real estate healthcare, broadly defined healthcare, was the largest asset class within KeyBank, or at least one of the a couple of largest. In other words, the value, the volume of loans that the bank has made to hospitals and physician groups and medical device companies and on and on and on was in the many, many billions and billions of dollars.

And so the ability to bring to those clients or even just some portion of those clients, a strategic advisory business like what we're talking about here that we do really made it a ton of sense. So hopefully we've been able to keep our unique business model intact, but at the same time offer a broader array of capabilities for our clients. And so far, it's been two and a half years, and I have to say it's been a terrific partnership for Key and for my colleagues at Cain Brothers.

Dave Johnson (25:27):

Well, I got to say, if the metric is the attendance at your annual JP Morgan event for the national championship [inaudible 00:25:35] football game, Cain Brothers is doing exceptionally well. It was packed. And so good for you. That gets us into JP Morgan. And like you, I'm probably still processing everything that happened, but what's your overall impression of the conference this year? What did you hear people talking about? Anything surprised you?

Rob Fraiman (26:00):

Candidly, people were talking about what we've been talking about on this call. No surprise there. I would say that the energy that I heard around the conference, the various meetings that I had was as significant and as positive as I've heard it in the last several years. Obviously there was lots of talk about the election and what the impact of the election might be. Of course, none of us can predict that. And that's probably a subject for a whole different House Calls. But there was certainly no lack of interest in talking about where is the pack moving? Where are there opportunities for private equity and strategic investors to move their businesses and their investment theses forward. And I'd say that that was, for me, I always find it to be incredibly exciting and energizing and a little bit exhausting, particularly that football party.

Dave Johnson (27:00):

How many people were there do you think at the party?

Rob Fraiman (27:03):

675 people.

Dave Johnson (27:05):

Oh my goodness.

Rob Fraiman (27:06):

And it's just funny. I'll tell you a very short, funny story. This was our 10th anniversary and the first one was when the Oregon Ducks I think were planning maybe Auburn. And we had a dinner scheduled with a client. It happened to be a client that was based in Oregon for that night. It was just a small dinner to talk, to catch up. And then of course the Ducks get into the college championship games. So the client said, "Gee, do you think we could do the dinner at a place where there's a TV, maybe a sports bar?" So we said, "Gee, that's interesting." This was about two weeks before the event. We said, "Yeah, sure. We can find someplace." And then he said, "Would you mind if we invited a few other people to come along since we're going to be doing in a sports bar?" So that first year we had about 25 people watching the game, and it's grown to become a place to be at the conference.

Dave Johnson (27:57):

Yeah. Well, necessity is the mother of invention. I didn't know that. That's remarkable. And now it's one of the main events during the entire JP Morgan Conference. A couple of years ago, you and I were grabbing breakfast at JP Morgan and I think we were both surprised at how uncrowded the restaurant was, and how quiet the conditions were to have a really nice conversation. And then you look down and there was this little placard there that said, minimum breakfast was a $100 per person. It's some outrageous amount. It really is crazy how much wealth gets spent in and around the conference during the second week in January each year, 200 bucks to run a booth at a dive restaurant, to have a conversation. But did you see anything like that this year?

Rob Fraiman (28:50):

Well, I did, but I'll give you both sides of the story. Our team, we were 25 strong out there. We all stayed at one of the smaller hotels and I won't say the name, but the rates at this hotel were $1,400 a night with a four night minimum. Which is sort of the standard out there. And we held our nose and agreed to do it, have to have someplace to sleep at night. One night I came back to the hotel at 9:00 in the evening, and I walked in and I happened to run into somebody who's a consultant that I know. And I said, "Oh, you're staying at this hotel too." And he said, "Well, I actually just got in. I just got a room." And I said, "How's that? I mean, we signed up nine months ago." And he said, "Well, there's this app called HotelsTonight."

And he said, "I go on it in the morning and I find a place, I'm going to stay that site." And so he had a room for $298 at the same hotel that we had paid five times that for. Now the catch was, was that he could always stay there one night and the next morning you had to take your suitcase and go find a different hotel to stay there. But I thought hard about saying to our bankers for next year, "Listen to me, you'll do this each night and we'll give you the difference or something like that." The cost benefit analysis is a tough one. That said, if you're in a business where you're marketing and meeting with clients and prospective clients, you have to be there. And the efficiency of conducting dozens and dozens and dozens of meetings just off the charts. So I think that's why people keep doing it.

Dave Johnson (30:25):

Yeah. Well, Rob, we're getting near the end of our time together. This has been a blast, but I can't let you go without having you give us your bold prediction for 2020.

Rob Fraiman (30:38):

Okay. I'm going to do two. I'm going to take the liberty. I'll keep it short. I think one is, despite the lack of success of the Blue Cross Blue Shield, North Carolina can be a merger. I think we will see some major consolidation events in the Blue Cross Blue Shield world. As I've mentioned, a scale is critical in health care. And despite the incredibly strong market share positions in each of their home states, many of the Blues are challenged by not having a broad enough service offerings such as MA or Medicaid. They've got lower profit, lower growth, commercial books of business. And frankly, they have an inability to take additional market share. You can't go much higher than 70% or 80%. And I think frankly, the impact of the multi-district litigation is unclear.

Dave Johnson (31:21):

Yeah. The Alabama case.

Rob Fraiman (31:22):

Exactly. But I think that there's a better than even likelihood that ultimately the Blues will be able to compete with one another with their branded service offerings across state lines. So I think you may see some consolidation there in the next year or two. I'd say the other one is that I think it would be really interesting to see a major tax-exempt health system do a conversion to invest their own or go public or partner with private equity. Capital is king. And although the tax-exempt bond markets that you know well from your years as an investment banker are incredibly liquid and low interest rates obviously make debt capital the cheapest capital.

It's not the most flexible capital. And the hospitals and health systems continue to require capital to invest in IT and physician strategies. And that's just more and more difficult to finance with a traditional tax-exempt bonds. So 10 years ago when we represented the old Boston based Catholic system, Caritas Christi, in their conversion to PE ownership as Steward Health Care, I would have bet that there would have been a wave of such conversions. I guess now I'm saying maybe I was a decade early on that. So may be we'll see that happen.

Dave Johnson (32:28):

Well, you were precocious. Well, it's interesting too because there are a lot of strings that come with the tax-exempt financing. Average life, that it has to be used with facilities and so on. The type of investment that I think health companies are going to do is going to be much more oriented toward health and prevention, IT and so on and things that don't lend themselves quite so easily to tax-exempt financing. That may become one of these unexpected nudges to how the system evolves. Really interesting. Actually, both those are really interesting.

Well, Rob, thanks so much. It was a great conversation about healthcare, but I also really appreciated getting you to talk a little bit about what it's like to be president of a very substantial healthcare investment bank and how that roles evolved, how the company's evolved over time. And so thank you. Thank you so much. And for the audience out there, we've got our article coming out. So look for that in the near future along with this podcast, and just stay tuned to Cain Brothers in the insights. They're coming fast and furious all throughout 2020. So Rob, thanks a bunch for being with us today. And we'll talk to you again soon.

Rob Fraiman (33:53):

Thanks Dave, it was my pleasure.

Dave Johnson (33:56):

Cain Brothers is an investment bank focused exclusively on healthcare. The bankers at Cain's stand apart because of their deep knowledge of the healthcare industry and their practical know-how when it comes to executing complex transactions in all healthcare sectors. These include healthcare services, medical technology, and life sciences. I'm your host, Dave Johnson. I'm a recovering investment banker who discovered late in my career I was always meant to be a journalist, and maybe even a podcaster. I'm also the CEO of 4sight Health and the author of two books. The most recent of which is, The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I love talking to other revolutionaries who are driving change in the healthcare industries.

Podcast: Widen the Funnel and Close the Gaps: The Summit-CityMD Combo Sees "Big Apple" Opportunity through Integrated Care Delivery

Cain Brothers' Managing Director, Carsten Beith; Warburg Pincus Managing Director, TJ Carella; and Summit Medical Group CEO, Dr. Jeffrey Le Benger joined Dave Johnson at Cain Brothers' Annual Healthcare Conference on October 23, 2019, to discuss the recent merger between CityMD and Summit Medical Group. The combination of the leading urgent care clinic in New York City with one of the most successful multi-practice physician groups in the nation promises to be a transformative deal for healthcare delivery.

David Johnson (00:05):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, a division of Key Bank Capital Markets Inc. Cain Brothers Bankers work in some of the most interesting segments of the healthcare industries, they work with organizations and business models that are helping to change American healthcare for the better. I'm your host, Dave Johnson, I'm also CEO of foresight health. I'm a recovering investment banker myself who discovered late in my career that I was always meant to be a journalist.

I co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. Each piece becomes an exercise in examining a fascinating segment of the dynamic healthcare landscape. The focus of our articles and this podcast is on how to make America's fragmented, inefficient, and often broken healthcare system, more integrated, consolidated, efficient, and customer focused, so that it delivers greater value and innovation to the American people.

For this edition of House Calls, we're going to broadcast a conversation from the Cain Brothers annual conference from October, 2019. It was a great event over two days at the Lot New York Palace attended by over 600 executives, investors and professionals. On the second day, I facilitated this candid discussion between Cain Brothers, Managing Director Carsten Beith, Warburg Pincus' Managing Director, TJ Carella and Summit Medical Group's CEO, Dr. Jeffrey Le Benger.

Together we talked about one of the most fascinating and impactful mergers in recent years, the joining of CityMD, a leading urgent care company in New York and Long Island with Summit Medical Group, a multi practice physician group based in New Jersey. That combined asset light, consumer-friendly company tells us a lot about the future of healthcare in America. Let's listen.

Let's get to today, our spotlight discussion on the merger between Summit Medical Group with CityMD, which is an entirely new kind of model. A little bit like we were talking about with Steward yesterday, asset light, very focused on customers, with an ability to navigate care to the most opportune and appropriate places. And built around the idea that outcomes matter, customers count and value rules.

And we have just a terrific group of people to cover that with, we've got Carsten, who was one of the bankers that put the deal together, or maybe the banker that put the deal together, Carsten Beith. TJ Carella from Warburg, who wrote the check and you'll see have some very strong intellectual and strategic ideas about why this happened and how it happened. And then Jeffrey Le Benger, who is the CEO of Summit. And we're going to start by just letting each of them tell you a little bit about themselves and then we'll get into it. So why don't you start Jeffrey?

Dr. Jeffrey Le Benger (03:09):

Hi, hello everybody. I am a true New Yorker, I'm from Brooklyn, which I'm very proud of. And I came out to Summit Medical Group in 1989, I'm a head and neck surgeon at Mount Sinai, and I still do practice. I practice on Saturdays and I operate a little bit once a week. My heart has always been on the provider side, taking care of the patient, whatever that might mean. Patient is always first on the provider side.

When I came to the group, we were about 45 providers, and before we did the deal, we were about 950 providers. We run the gambit of every specialty, every ancillary. We really managed the patient to the ambulatory sector, that's how we practice our care. We are in 60, 65% of our revenue and some basis of value within it, especially on the commercial side.

We managed the patient to the lower cost point and we have always been able to manage to the highest quartile of quality in the group, we believe in an all-in-one premise taking care of the patient from cradle. I hate to say grave, but we take care of the patients throughout the entire spectrum of care, even palliative care and cancer care. And we just put up 130,000 square foot inventory cancer site to bring them to an ambulatory sector at a lower cost point.

We are in every payer, we take every payer, we're not out of network and we have very good relationships with the payers. We have good relationships with the systems, we partner with them when we need to, but we are not a system, we don't have beds. We don't drive ancillary to a high course space, we take it to the inventory sector. And for us, it's always has been about the patient, and then we look after the providers at the group.

David Johnson (05:17):

Great, thank you, TJ.

TJ Carella (05:19):

Hi, I'm TJ Carella, I'm lead healthcare partner at Warburg Pincus. For those of you who don't know, Warburg is one of the larger PE operations out there. We have a $65 billion of assets under management offices around the world. We also invest across all categories. Healthcare has been an important sector for us, really since our inception over 50 years ago.

We've been, I would argue a prolific investor invested over $11 billion of equity, our mantra's growth at scale, we love businesses that are fast growing. We love to find that are at inflection points in their growth trajectory, and we love to bring sort of innovation to investing in healthcare and in general. And so we certainly view that in the context of this deal, we made our original investment in CityMD,

which I think people are probably familiar with, given this crowd, but we are at CityMD and the largest urgent care player in the New York Metro area.

And that's something that we'll obviously talk about in the context of the discussion today, but we made that investment about two and a half years ago. It's performed very well and are just really excited to be a part of what is in our view, a very transformational opportunity to bring together two incredible brands and two incredible companies in this Summit CityMD merger.

David Johnson (06:45):

Great, Carsten.

Carsten Beith (06:47):

My name is Carsten Beith, I am a co-head of the health system, M&A Group at Cain Brothers, which you've heard is probably the best and strongest and investment banking firm serving the healthcare industry. And I've been with Cain Brothers 26 years, and my first client was Dean Health System, which was a large, and is a large multi-specialty group practice of fee for service group and have been involved in many transactions in the space, including healthcare partners, DuPage Medical Group.

But I would have to say that culmination really in terms of the potential for transforming healthcare in a major market is what we've seen with Summit and the combination with CityMD. My other task in this engagement in particular, was to try to manage Jeff, which I'm sure TJ is finding out is not that easy. Jeff is a deal maker, actually extraordinary, and I was actually really privilege to work with a client that had a good sense of how to get deals done. This was an extraordinarily complex deal that I'll talk about in a little bit.

David Johnson (07:51):

Well, great. Well, Carsten, why don't we keep it with you? And for those of you in the audience, not as familiar with the details of the transaction, why don't you give us an overview, its proprietary character impact on the market?

Carsten Beith (08:04):

Sure, this transaction followed some other transactions from a structural standpoint. I mean, the way to think about it in its simplest term, it was really the merger of Summit Medical Group and its MSO with CityMD, supported obviously by capital provided by Warburg Pincus. The structure is relatively straight forward from the perspective that these MSO transactions and many of you that are involved in physician transactions are complex, because of the corporate practice of medicine issues.

So it's essentially an MSO, which is fundamentally the business of operating a physician group combined with the physician group itself. This transaction was obviously much more complex than that. By last count, I think there were probably nine different transactions involved. The first was asset transfer of some of the assets in the medical group into the MSO, then there was a stock repurchase.

There was a sale leaseback transaction, there was a management services agreement, there was a pre-close merger, there was a merger with closing, there was a then a significant syndicated loan. So all of that certainly suggest that don't try this at home, unless your spouse is Eric Klein, who was the attorney from Shepard Mullen and-

David Johnson (09:28):

I think Eric spouse is very happy under [crosstalk 00:09:30].

Carsten Beith (09:33):

But needless to say, these transactions are very complex because of the dynamics between physician groups and essentially the business, but fundamentally, at least as we see it, it was pretty unique in the sense that it's kind of a hybrid transaction of a strategic transaction. We've certainly seen particularly with Optum in this space, but it really brought, let's call it the power and the strategic perspectives that TJ, will certainly talk about from private equity.

At the end of the day, this was a transaction that both created the merger of two very interesting platform companies with essentially the capital that allow the shareholders of Summit Medical Group to monetize a portion but not all of their investment in Summit Medical Group. So really an interesting but complex transaction.

David Johnson (10:23):

Great. Well, thank you. That's very helpful. Jeffrey, you take one platform and you put it together with another platform. One platform plus one platform equals five platforms? So tell us from your perspective, the strategic benefit of combining with a CityMD and what is going to allow the combined company to do in terms of really delivering value and care to the citizens in the region?

Dr. Jeffrey Le Benger (10:52):

Before we looked at this deal, we started a management company about six years ago, and I always had my eye on CityMD even before they did their first deal with Summit. I knew Richard Park, I thought he had a great product, in terms of how he ran a care model with an aftercare closing that episodic visit. But it wasn't really-

David Johnson (11:13):

What really appealed to you about that?

Dr. Jeffrey Le Benger (11:14):

It was the quality, it's there quality, the aftercare product, how they took care of their patient on that episode of care. They have a bunch of doctors that sit in an office in Uniondale, New York, that look at every test, every ancillary, I mean, every ancillary test that comes through. And if there's an issue, they triage it and they get back to the patient and they have an algorithm referral on how to refer that patient to that specialist, if it needs to be.

They complete that to get that done, but then they don't know what happens to the patient. I always looked at that as a great growth aspect, in trying to develop the primary care attribution throughout the entire New York metropolitan area. And then when this guy next to me bid out to take them from Summit partners, I couldn't afford them at that time.

We had cash and a management company, but not enough. And I felt all right, let's figure out what we're going to do. And we were growing and we were about that time, about 800 providers in New York, and I mean in New Jersey. And we had our own urgent care model and how we were growing. And then my board came to me and said, "Boy, maybe we want to look at capital and for our growth."

And we were doing really well ourselves, we were running about a 17% EBITDA margin and we were doing pretty well on a management company and increasing share price. I caused them to tell you, "I really didn't want to do it." I came around to looking at getting a partner and I saw the real benefit of

getting a partner. When we decided to do this, I went exclusive immediately with Warburg, because I... You could ask TJ, the first time I met TJ, I threw him out.

TJ Carella (12:59):

It's true, it was five years ago. It took a while.

Dr. Jeffrey Le Benger (13:02):

But then when it came around again and I knew they had CityMD, I really went after this deal with my whole heart, because for me personally, and I convinced the board and the doctor sword at the organization that with us understanding how to grow a multi-specialty group. And we grew from 175 providers, six years ago to over 900 with only a 2% turnover rate within the organization.

Nobody leaves when they come, we have a great culture. It's a culture of family of one in the group. I said, "Let's try to get CityMD, let's take them, let's try to build a primary care attribution across the entire spectrum of the New York metropolitan area, which it's the biggest market in the country. And there is nothing like that." And having over 200 sites in the marketplace where you could...

Urgent care is really primary care, when you extend that to really have a primary care attribution, you really are going to control the healthcare dollar. If you control the quality and the healthcare dollar, I think it makes a real powerful statement.

David Johnson (14:19):

You've used the word attribution, Carsten used the word attribution, that strikes me as saying, you think we're moving more toward risk-based payments and needing vertical integration to manage that risk.

Dr. Jeffrey Le Benger (14:33):

Correct. Everybody talks about what is attribution, I don't want to confuse your audience. I'm growing the primary care base, within that primary care base, there will be attribution, where there'll be some type of value. Now this pay to play all the way to capitation, so somewhere in between, we are in more shared savings going to a full total cost of care product in New Jersey, because we could do that because we have about 300,000 primary care patients, so we could mitigate the risk.

In New York, we're going to have to see how we play in that model and take that model into New York. But I absolutely feel that in the MA world, you could really do something really special, especially if you have the providers. Even though there's a lot of med and pension in this, whatever in the New York market is not growing as quickly as it can, but I still think you could grow an MA product, in the New York and grow on a commercial.

In New York city, you try to get a primary care appointment, you can't, right? I think this is something that the community would want, and if you could offer quality product that really sort of important.

David Johnson (15:45):

Terrific, was it TJ himself, or was it the thought of private equity that-

Dr. Jeffrey Le Benger (15:49):

No, it's TJ himself, I like him. I have an older brother who really tough, so I always wanted a little brother who I could push around.

David Johnson (16:01):

I convinced you of that?

Dr. Jeffrey Le Benger (16:02):

Yes.

David Johnson (16:03):

All right, TJ, whatever it takes, right? Well, TJ-

TJ Carella (16:07):

I'll add on to what Jeff said in terms of this sort of strategic nature of what we're doing and why we're doing it. People sometimes ask me, is this a primary care play? Is this a global capitation play, full risk play? Is it an MA strategy that you're pursuing? And it's a little bit of all of those, but when I kind of try to eliminate the noise, I look at it primarily as an integrated care delivery strategy.

What I mean by that is, there's so many problems around just the handoff in healthcare today, particularly in markets that are more PPO oriented. Those markets where you have commercial populations, who are predominantly interested in access and being seen by the very best specialist, if they have some acute condition. And oftentimes between primary care who operate independently often, or in some other organization and the specialist, there's always that issue of not being able to close the gap, making sure that that referral actually... The visit actually occurred and that the clinical information was shared back.

And there isn't that sort of holistic hand-off and seamless hand-off between different participants in that healthcare ecosystem. And that could be also facility-based reasons why that happens. And so our strategy is really to close those gaps and we'll have one electronic medical record. CityMD has a very unique position in this market. We like to think of it as like the top of the funnel, or if you think of an iceberg, it's above the water line.

This is what CityMD does, it touches a lot of people, but it only takes care of episodic and maybe some crossover primary care needs, but there's this whole under the water iceberg that CityMD doesn't touch. We were successful, and one of the reasons why CityMD is really an interesting business is that it does more than just episodic care. It does a better job than almost all others, we think in the country around making those referrals intelligently and following up, et cetera, but there's still a gap.

And with Summit and Summit's ability to really capture and deliver more healthcare below the water line and go after kind of more of the financial opportunity from the private equity guys perspective, if a commercial patient or member on average spends $5,000 a year on healthcare needs, our CityMD services might represent $300 plus or minus according to a certain visit count that a patient might need in an episodic nature>

But then there's the four or $5,000 that we at CityMD never touched. Summit Medical Group plays in that category, right? They have the ability to manage the vast majority of the healthcare needs of a whole family. And from young children, through adults and elderly, and that ability to do more health care now for more people, it's something that really makes sense for us in terms of the verticalization of what we're trying to do. CityMD touches almost 2 million individuals per year, and we'll have something like 3 million visits this year.

David Johnson (19:31):

3 million.

TJ Carella (19:32):

And summit has the ability to do so much in terms of fulfillment of the healthcare needs of their own population, which is a smaller population because they're in Northern Jersey predominantly. But imagine being able to do all of what they do across that entire population of CityMD patients. And so that's what really excites us, we can't do it alone. I mean, this is an ecosystem where you have to have partnerships with health systems and particularly really partnerships with payers and making sure that we're viewed as the trusted healthcare partner to our patient population above all else.

And so we look at this as an opportunity to serve all of those masters. So it will always be patient first with the highest quality care and the type of healthcare that Summit Medical Group has delivered is absolutely at the highest quality levels in the country that you will find. Serve the provider so that the actual clinician.... There's a huge burnout problem that we all know about around the clinical community across the US.

And part of what our mission is here is to enable our physicians and our clinicians to deliver the care the way that care should be delivered, and to focus on the patients who really need to be focused on. And to kind of help get leverage from our investment in resources and technology and tools and all the great work that Summit's done to have that back office MSO capability to allow them to do what they do best, which is serve the patient needs.

We will serve the payer as well as sort of the third P, which is obviously controlling medical spend downstream. And that's where it gets really interesting, obviously from profit pool perspective, if we're able to, and some it's been hugely successful with this in the Northern New Jersey marketplace. If we're able to bend the cost curve through integrating this care and having that seamless delivery, I think it will really all work out from a bottom line perspective and be a great investment for us.

David Johnson (21:34):

Let's follow up a little bit on that TJ, in the panel yesterday morning, that Todd Rosinski moderated, in response to a question about what are the Amazons, Apples, Googles, Microsofts of the world, how are they going to impact? And sort of the response from the three private equity firms was that they were a little skeptical. They said the healthcare is much more blocking and tackling is what the improvement needs.

And I recently read that something like two thirds of referrals from primary care to specialists are not necessary. And part of it is that primary care doctors have started to specialize. So their ability to be like Dr. Welby and understand 60, 70% what's going on. And Jeffrey mentioned I can't remember what town it was, but the town where the algorithms are, and they look at all the tests and so on.

It just strikes me that your model, the blending of technology with sort of a broader primary care perspective is really what allows you to do such a great job on the aftercare and thereby take that two thirds of referrals that aren't really necessary. And so you've got the one-third that really do need them, and then you can direct them-

Dr. Jeffrey Le Benger (22:50):

If I could take that for a minute, because you can't belittle the effect of the patient seeing their primary care doctor. The digital platform is going to be important. But it's really a hands-on experience now. Unfortunately, primary care is almost going to become almost a data analyst. It will and it's a shame. And then you're going to be referred out to a specialist, right?

And it's not that we're going to go back to a so-called gatekeeper approach, but the primary care is going to control where that referral goes. As I always joke about it, I always think of the book, Doing

the Spice, what's the spice? Is a primary care patient. That's your asset. You have to grow the primary care on the economic side, but I look at it on the quality side, if you really could grow and you get the right chronic management of that patient and you grow that. You could keep them out of the high core specialist and you could keep them out of the hospital very well.

Just think about it, we have 500 CHF visits a year at Summit Medical Group. If you decrease that by 50%, that's 50 that you save emissions, $20,000 per admission. You can just imagine what that means to the healthcare dollar and the cost curve. Like what you were saying on the referral side, now aftercare, what aftercare will do in this merger of bringing this together, is that if you could create a primary care basis, either by digital or by actual being there, you will control the flow of that healthcare dollar.

And by giving those doctors, and this is what we're going to try and do, the efficiencies to care for that patient and the care management needs of that, for that chronic care for that CLPD or for the CHF patient, or that brittle diabetic, you will be able to manage that well, in that primary care setting, either by the digital need. And we're spending a lot of money on the digital platform now to be able to attain that, within the organization or by seeing, and you have to go generational too. Millennial comes to my office and they say, "I Googled it, I want the antibiotic," right?

David Johnson (25:08):

They're usually wearing a vest like that.

Dr. Jeffrey Le Benger (25:09):

You like that? Well, I'm far from being a millennial, but the baby boomer we're dry. They want to be touched and they wanted to be felt, and they want to be seen. So there's a whole cadre of care that you're going to have to have within the platform. And that referral really means a lot of how you control that referral.

David Johnson (25:31):

Well, TJ [inaudible 00:25:32].

TJ Carella (25:32):

My perspective on your question, which is what ,role does technology play? I actually thought you were going to make a different point, which is two thirds of most referrals don't get fulfilled, which is also true. And a lot of those are important referrals that need to be seen-

David Johnson (25:45):

Yeah, you got a false positive and a false negative.

TJ Carella (25:47):

Exactly, exactly. And so I think those are both interesting points to make. The way I think about the digital opportunity as well as the thread is, we have to effectively cannibalize this stuff ourselves that shouldn't be seen in person. There are later acuity issues that can and should be served either via the telephone or via some video interface. And we need to do that to ourselves before someone else does it to us. And if we don't do a to ourselves I'm pretty sure others will do it to us.

And so what I see though is also this under a kind of a bigger framework, which is as an industry, we need to use tools and we need to have these tools drive better value into the system. We have to in

effect, regulate ourselves around this. And everyone talks about operating to the top of your licensure as one way to accomplish that. But very few people actually do it.

And so part of this strategy and thesis is around actually delivering on that promise. So investing in technology tools so we can manage people in the, "Cloud," who can be managed in the cloud and do higher acuity things increasingly in lower cost sites of care. And so what's unique about what we have. We have over 200 plus locations in the New York Metro area. We will have 300 or 400 over the next many years.

And what that enables us to do over time is higher and higher acuity things. As we cannibalize ourselves with the flu issues that can be dealt with remotely via aftercare center or some other telemedicine capability, we'll be able to do higher acuity things to leverage our community footprint that exists out there. You can imagine that a day where dialysis is happening in these clinics, where we're doing infusions in these clinics.

And those are high value things that are sometimes reside today in the hospital, oftentimes reside in the hospital, or in some other higher cost site of care. And that's all part of this kind of long-term strategy by having the footprint into the communities, we're going to be able to serve our patients with all of their healthcare needs, with the exception of the super acute ICU type.

Carsten Beith (28:04):

I mean, I think if you think about what TJ and Jeff are really articulating is that, the reality is this is becoming a healthcare system. It just doesn't own hospitals, right? And you would certainly say that technology is easier to be enabled in an environment where there's a direct impact from the physician who ultimately controls how healthcare is spent.

But I think as we see it and part of the attraction, not only for TJ, but a host of other private equity funds that are looking at this space is really the ability essentially to ultimately sort of control that healthcare spend and to have the systems of care that enable it to be spent effectively.

When we look at it, we think that the hospitals, which if you really think about what hospitals represent in terms of total GNP, it's about 6% of the nation's GNP and the dollars that are essentially spent in hospitals, the opportunity for hospitals to essentially cannibalize themselves with their high cross structures and their high fixed assets and so on is very limited.

We think this type of organization is really transformational because it's asset light. And you heard Dr. Malevich earlier today, describe asset light strategies in Cleveland Clinic moving into asset light. But I think the opportunity to really transform how healthcare is delivered and to reduce the overall cost of healthcare is, this is a much, much better platform and more profound platform than when we look at sort of hospitals being kind of the, let's call it the catalyst for change. Some certainly are, but I would say most of them are just embedded with very high fixed costs.

Dr. Jeffrey Le Benger (29:37):

I just want to add just one thing, the number of primary cares are decreasing in the country. And for us, we will have over two, 300, well, probably have probably over 600 primary cares within our marketplace. It's going to be harder, harder to recruit. You have to go to the APP level and you're going to have to go to the digital platform and you have to get efficiencies within the organization on the digital platform to be able to handle the patient load on the primary care base.

That's a reality that is happening, and when you asked about the digital platform and moving and whatever, you have to bring that into the equation, you have to make it more reasonable, efficient,

and easy for the physician. The pressures on a physician now in the primary care base are huge. They have to do an EHR, they have to add all this data, they have to do all the test box.

People in this audience, don't even understand that, what a test box is. That they could have 100 tasks a day that they have to complete before they could move on to the next day. This has to be efficient in the office and how to manage it and how to take some out of it on the digital platform.

David Johnson (30:50):

It's just you got a lot of pressure on primary care. Carsten, you and I wrote a piece, I don't know, three, four years ago called, Asset Light and Ready about DuPage Medical Group. And I know this has been an area you've focused on for quite a while. Could you just sort of share with the audience, the potential for these asset light models to take volume out of hospitals the right way by delivering the right care at the right time and the right place at the right price?

Carsten Beith (31:18):

Yeah, I mean, look, reality is just that financial incentives drive these kinds of behaviors. And so when we think about asset light, ultimately what you're really talking about, who really controls those lives, right? We go sort of elevated to attributed lives. And so our hospital clients, they're trying to build models where they control those attributed lives as you hear CityMD and Summit has a model designed to control attributed lives.

But the challenge you have in sort of the hospital model, if you will, is that there's a huge cost structure that has to be supported. And so there's a fundamental disconnect between trying to drive volume into the hospital that generates the revenues and controlling the cost of healthcare. That's why we think organizations that are asset light are fundamentally better position ultimately to drive the cost of healthcare down and the total cost of care down.

I mean, we think ultimately it's going to be a challenge for organizations like the Cleveland Clinic and so forth to be successful in a world where they just fundamentally have these high cost structures. And so you look at other industries, does transformation happen with the incumbent sort of transformation happened with the new entries, I would say organizations like Summit CityMD is really a new organization. One that we really haven't seen before.

And I think it's much more likely ultimately to transform healthcare as we think about it. I mean this whole conference has largely been a theme of value-based care and how do you reduce the cost of care and total cost of care and so on? It's just a question of, can the incumbents ultimately change? And I think it's just very difficult.

David Johnson (32:52):

I know we're sort of beating up hospitals a lot and I would say, there is an absolute role for hospitals in the healthcare system. And I think all of us in the room would be much worse off if we didn't have hospitals to be able to do the very important research that's being done particularly in academic centers like those which we have in New York.

And our strategy also involves some very close partnerships with some of these hospitals. And it's really just figuring out the right division of labor. What are we good at? What are they good at? Let's give them more of what they're good at and find ways to have the right appropriate incentives to work together towards this kind of goal of population health at lower costs. I just-

Dr. Jeffrey Le Benger (33:34):

I can take the contrary view.

David Johnson (33:37):

Well, there is a question in the audience that sort of touches on this, and the question is, does Summit Medical need to have physicians located in New York City and Long Island, where CityMD is to achieve the integrated strategy and sort of the... And I think I know where you're going to go with this, but TJ, why don't you start then we can have Jeffrey amplify. It's not only does the Summit need to expand into the New York region, but they're always going to be places where CityMD is that summit isn't. How do you build the networks that work?

TJ Carella (34:12):

I'll keep it brief, because I know Jeff's jumping at the bit here. Our geographies are contiguous overlapping to a certain extent. So we have, I think 15 locations, CityMD has 15 locations in Summit territory probably defined. Summit today, well, is not in New York but active conversations are ongoing to change that. And you're right, this isn't an overnight strategy, where you can immediately have a multi-specialty capability everywhere.

We have a CityMD and nor are we so ambitious to think that's going to be a quick process or even that that's the goal. I mean, for example, there's an ubiquity of specialty, incredible specialty talent in Manhattan, and we're not about to duplicate infrastructure that's already there. We're going to identify pockets where there are a physician shortages of the type of important chronic characteristics that can actually serve our patients well and deliver on the cost advantage.

In some markets, the strategy will be to do a little more like what Summit Medical Group is, more holistic integrated care, where we're kind of employing it all. There will be other sub-markets where it's more in partnership. It could be with a health system that has a lot of specialists and where we have a contractual relationship that works to the benefit of both of us and importantly to the patient.

Dr. Jeffrey Le Benger (35:35):

That's what's nice having a younger, he couldn't say it more eloquently, but this is the whole thesis of our merger. This was the entire thesis. How we're going to handle it in the Boroughs or Manhattan, how we're going to handle it on the island and the low Westchester and continue our strategy about how we're going to grow.

I would tell you that CityMD, 65% of the physician CityMD are ED, and the remaining are family practice, not within and there is a physician in every site. That is primary care period, right? The number one referral out is primary care, the number two referral out is orthopedics. It's not going to be easy, nobody said it would be easy, but to grow primary care and to create what we have in New Jersey on the island will happen.

We went from 170, over six years to 900 and there is a need, and I don't want to sound like a jerk, but there is a need for another option in these marketplaces. Besides the university center, the consolidation of a hospital system the purchase of a payer, of physician practices. There needs to be another option within the region to grow an integrated model. And that's our strategy to achieve that in this marketplace.

David Johnson (37:11):

TJ, another thing that came up in this morning's discussion was Dr. Maholick prediction that within somewhat short time, horizon save five to seven years our health system, and you could read Cleveland Clinic into this will represent 10% of the market share nationwide. Today the clinic's about half or 1%. Do you see this model being scalable into other markets in the country? And how are you thinking about that?

TJ Carella (37:39):

I'd start by saying we have a lot to do here, what we've learned and we've traveled all around the country and met all the sizable groups and different... When you've seen one market you've seen one market, there's different sort of payer dynamics, there are different sort of willingness of patients to engage in more narrow sort of risk-based HMO type strategies in some markets.

Every market's different. We like this market, it's a complicated market, scares a lot of people, keeps kind of competition away, which we think is a good thing. We know this market really well through our respective entities.

David Johnson (38:15):

If you can make it here.

TJ Carella (38:16):

Exactly, I've heard that saying. And we think there's 20 to 30 million people in this geography, which makes it particularly compelling. This market, as I mentioned earlier, it's different. It's not a deep risk market like some markets in Florida or Texas, for example, or California, it's moving in that direction. We believe it will continue to move in that direction, but it will take time for that to evolve.

This is a market where we think having the highest quality medical care at a fair price, which is delivering a total cost of care below the market average, that market average being lifted up by all the big academic medical institutions in this marketplace. We should be able to deliver on that great value proposition to the patient. And this is also an ASL market.

What I mean by that is a self-insured employer market, employers are actively trying to use healthcare benefits as a way to distinguish themselves and to recruit talent and retain talent. And so everyone wants Summit Medical Group in their network. Everyone wants CityMD in their network. If we can deliver on that proposition to the patient, we think everything else sort of solves itself. My winded way of saying, lots of doing this market, I would certainly not preclude going out of market, but every market's different and our strategy might change accordingly.

Dr. Jeffrey Le Benger (39:43):

I might have a little different point on this.

TJ Carella (39:46):

You have points to take over the world.

Dr. Jeffrey Le Benger (39:48):

No, absolutely not. New York City is enough. A New York metropolitan area is enough, but when we started a management company, we wanted to see first, if we could export a clinical model and we're able to do that. We went out to Phoenix and went out to Bend Oregon, and we actually did a deal with Bend through Cain, and go out to Bend.

And these guys were really financially strapped, really big time, because they got a terrible epic implementation. Their shareholders were making half of what their associates were making, and now they have positive cash flow. We really turned around, and they accepted our clinical model. We knew that we could do that with our data analytics. Whether or not we're going to do something as we make our data analytics more robust in the national marketplace is to be seen, but we'll see.

TJ Carella (40:35):

But yes, fair point. We are today in two other markets, Arizona and Bend Oregon.

David Johnson (40:41):

Today, New York tomorrow the world. Well, we're right about at time, but I thought I'd ask each of the panelists to make one bold prediction. So when we're coming back here in five years, 2024 something that'll knock your socks off. Carsten, why don't you-

Carsten Beith (40:58):

I guess, I'll say with beating up the hospital theme, hospitals being a big part of my client base. But I actually think that the hospital industry will be forced into a meaningful change. And I think five years from now, we will see a preponderance of hospital systems either at or in bankruptcy as organizations like this essentially change how healthcare is delivered. And if you really think about it from a hospital perspective, it's all about reducing hospital utilization. With 6% of the GNP, it's a pretty large target with lots of opportunity.

David Johnson (41:35):

Creative disruption.

TJ Carella (41:38):

This is easy Medicare for all, just kidding.

David Johnson (41:44):

What does that mean?

TJ Carella (41:45):

Exactly, it means a lot of different things to a lot of different people. What I do think is that and I'll plug your book, The Consumer Revolution out there. I do think there's been a fundamental shift in how the consumer participates in healthcare. It's a theme that we spend a lot of time thinking about, it's what drove our interest in CityMD to begin with.

And I believe there are going to be some very big consumer centric healthcare brands that don't exist today. Names that you may not have heard of or names that you have heard of, but are on a much different scale. I'd say five years from now, if I had to predict there would be, let's say three, $10 billion plus consumer healthcare brands that are not maybe household names today, but will be in the five-year timeline.

David Johnson (42:35):

Well, Jeffrey as always, you get the last word.

Dr. Jeffrey Le Benger (42:38):

Great. I think this is going to be greater relationships with the payer. I think provider are going to figure out how to create a symbiotic relationship with the payers in this marketplace. And unfortunately the hospitals would take the brunt of it. That's why and my customers are talking about, I think that's what's going to happen in the marketplace.

David Johnson (43:01):

Well, audience, let's thank our panelists for the terrific discussion. Thank you. Cain Brothers is an investment bank focused exclusively on healthcare. The bankers at Cain stand apart because of their deep knowledge of the healthcare industry and their practical know-how when it comes to executing complex transactions in all healthcare sectors, these include healthcare services, medical technology, and life sciences.

I'm your host, Dave Johnson. I'm a recovering investment banker who discovered late in my career I was always meant to be a journalist, and maybe even a podcaster. I'm also the CEO of Foresight Health and the author of two books. The most recent of which is, The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I love talking to other revolutionaries who are driving change in the healthcare industries.

Podcast: Commercializing Breakthrough Drugs in a Value-Based Market

What does it take to bring a breakthrough drug to a value-based market? John Kerins, Director at Cain Brothers, a division of KeyBanc Capital Markets Inc., and David Johnson discuss the intensified need for data, collaboration and communication to bring exceptionally costly but desperately needed therapies to market. They hone in on the growing role of medical affairs and contract commercialization services organizations in meeting the needs of all stakeholders for value.

David Johnson (00:06):

Welcome to house calls, where we get to talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets Inc. Cain Brothers bankers work in some of the most interesting segments of the healthcare industries. They work with organizations and business models that are helping to change American healthcare for the better. I'm your host, Dave Johnson. I'm also CEO of [Forsyth Health 00:00:30]. I'm a recovering investment banker myself who discovered late in my career that I was always meant to be a journalist. I coauthor a monthly thought-leadership article with a rotating cast of senior bankers from Cain Brothers. Each piece becomes an exercise in examining a fascinating segment of the dynamic healthcare landscape. The focus of our articles and this podcast is on how to make America's fragmented, inefficient and often broken healthcare system, more integrated, consolidated, efficient, and customer focused so that it delivers greater value and innovation to the American people.

Today, I'll be interviewing John Kerins, a director in Cain Brothers' Corporate M&A Advisory practice. We'll be talking about what it takes to bring innovative new drugs to market at a time when drug costs can be extremely high, but the payoff can also be transformative for people afflicted by relatively rare conditions or diseases. John joined Cain Brothers in 2015 and has deep expertise in mergers and acquisitions, capital raising and strategic advisory transactions. He's been instrumental in

some notable transactions at Cain with such businesses as RedCard, iCardiac Technologies, Steward Health care system and GuideWell. He's earned a BA from Kenyon College and an MBA from Fordham. hey, John, welcome to, House Calls Where The Bankers Are Always In.

John Kerins (02:01):

Thanks, Dave. Great to be here.

David Johnson (02:03):

It's wonderful to have you on the show and we're going to dive into the most interesting topic today of the rise of contract commercialization organization CCOs. But before we do that, why don't we learn a little bit about you and what drew you into healthcare and your particular segment of investment banking?

John Kerins (02:22):

Sure. I got into banking about 10 years ago after business school. First shop I was at, I was bit of an M&A generalist. Probably spent 50% of my time on healthcare deals just by happenstance. It was an area I had some interest in. I have some family members who worked throughout healthcare and as I thought about making a move to another bank and coming to Cain,, a big part of the calculus for me was, I see real value in specialization. As an investment banker, I think to be able to ride good, thoughtful advice to your client, you need to be able to advise them the complexities of a dealer transaction, but also have real insights about their sub sector and their overall industry. And as I looked at healthcare and I thought about kind of making a career longer-term in healthcare investment banking, I view it as $3 trillion spent pretty inefficiently.

David Johnson (03:19):

That's to say the least. Yeah.

John Kerins (03:22):

And through that, I see real opportunity. A lot of the companies we work with in the middle market are taking costs out of the system or improving outcomes for patients. I also see just a need for on, the provider side, particularly on the, on the hospital system side, a lot of need for consolidation as hospitals need to combine and spread their administrative cost across more patient encounters. There's a lot of tailwinds in the industry, I spend a lot of time across healthcare services, but really have focused more specifically on pharma outsourcing, pharma services over the last four or five years now.

David Johnson (03:57):

Well, great. Thanks John, for that background and pharma outsourcing for those who don't know is an area of tremendous activity and change. The article we wrote together explores the rise of contract commercial organizations. Basically, the types of companies that help both small and large drug companies bring drugs to market. It's a fascinating look, I believe at the way drug development, drug, marketing and payment are evolving as we move toward a marketplace in which players are reluctant to pay for expensive medications unless they demonstrate superior clinical outcomes. So let's set up the scenario here, John. We're talking about some very powerful drugs, potentially curative drugs for really debilitating diseases, but they come with some exceptionally high price tags. What are some example conditions that these new types of drugs, many of them gene therapies, what are some conditions that

the gene therapies can address, and if drawn attention and even scrutiny as this part of the marketplace unfolds?

John Kerins (05:19):

Cell and gene therapy, a very exciting area of pharmaceutical development. A lot of curative therapies that are being developed or have just recently been commercialized, if you went back two or three years ago, you had one approved seller gene therapy on the market. Now I think we're approaching about a dozen, but a number of them have fairly high cost associated with them. So, Novartis has a new product called [Zolgenzam 00:05:47] or Zolgensma, which is a... It treats spinal muscular atrophy, which is a fatal genetic condition that often will kill a child by age two, if it's untreated. It affects a relatively small population. Only one in 10,000 children are afflicted with it and this drug is effective in most patients who take it. It's curative, but it carries with it a fairly high price tag at 2.1 million.

David Johnson (06:21):

Wow.

John Kerins (06:22):

Yeah, and it's certainly received a lot of headlines in the popular press. And I think Novartis has struggled to a certain degree to try to get out there to the market. How they thought about pricing and how... On a relative basis, it's actually a lower cost to the overall healthcare system than the existing drugs that are on the market. But that was a big part of how they went about getting payers to buy off on this $2.1 million price tag. One, you don't have to pay if it doesn't work and two, the price is spread out over four or five-year period. You look at that relative to some of the existing protocols on the market, that really just treat the symptoms, you could spend four or $5 million easily on a patient over a 10 year period where Zolgensma is going to potentially provide a cure for the patient in a single dose.

David Johnson (07:15):

That illustrates very much the challenge that we're addressing. I think 2.1 million is the most any drug manufacturers ever charged for a drug, but it does appear to bring commensurate value, we could probably debate what exactly that constitutes. But boy, you'd think for $2.1 million, they could get a better name for that drug.

John Kerins (07:41):

Agreed. It doesn't roll off the tongue, but it is a pretty amazing product, nonetheless.

David Johnson (07:46):

Yeah. But those features you described, mortgage-like payment mechanisms, essentially money back guarantees or not even money back guarantees, it's you don't pay if the drug doesn't work, are pretty powerful. And therefore the payment is really only going to, or for cases where the drug really does have a curative impact, and we're going to struggle with this as a society because we're set up to pay a lot of money for treatment, much of which doesn't work or is very costly and really doesn't change outcomes. And when we get something like this, that's curative, people are appalled by the price tag at some level. But it's also huge amount of cost avoidance and obviously leads to a dramatically higher quality of life or life at all for the person receiving the treatment. Could you just put these social and economic implications of this type of drug into perspective for us? How do we afford, how do we not afford them? How should we, as a society be looking at this?

John Kerins (09:00):

It's a challenging question. We look at the overall cost on these drugs. The headline price can be quite high as we just discussed, but to cure a patient, there's some other cell and gene therapy products out there that will cure childhood blindness for certain gene abnormalities, so some really exciting therapies. I think the way we need to generally weigh them, I think the framework I use to think about it is, how effective is the product relative to other existing protocols? What's the cost of all the other morbidities for that patient if they aren't cured, if we're just treating their symptoms over a period of 10 or 20 years, versus the cost of potentially curing them in a single dose of a product. It's a difficult equation, but there are health economists and market access experts that are out there that are working within pharma and also outside pharma, that are trying to actually quantify those numbers and look at, what's the longterm survival costs and what are the potential savings associated with some of these new protocols?

David Johnson (10:13):

Yeah. It's also interesting that most of these new breakthrough therapies, particularly the gene based therapies, are for what the industry terms, orphan diseases, diseases that afflict fewer than 200,000 people a year. We don't have the same level of investment going into, I guess, therapies that could address broader need, various types of chronic disease and so on. How do you fold that into this equation to sort of the greater good question. If we can devote billions of dollars to solving a very rare disease, how does that stack up against, I guess, directing the same amount of money to something that could have a bigger impact? And as an industry, we really don't have a way to make those types of value-based judgments, do we?

John Kerins (11:14):

It's a great question. I mean, you look out and you think about these bigger drug needs, whether it be antibiotic resistance and the need to develop new antibiotics, heart disease being a leading cause of death in most developed nations. And you don't see as many dollars in the drug development pipeline focused on antibiotics and statins. I think oftentimes, this issue of comparative effectiveness is sometimes what's driving pharma. Pharma companies are acting rationally, they're looking for areas of growth and a lot of cases, the new statins that are coming on in the market are marginal improvements over the existing protocols. So, if I have a new statin that's going to give me a 2% decrease in my cholesterol, and I want to charge a higher price in the existing protocol, is the PBM formulary going to want to bring me on? Is the payer going to want to pay more for that product? Likely not. And I think in some ways, that dynamic is driving drug companies to look for new therapeutic categories where they can make a significant improvement over the drugs that are being used to treat that ailment today.

David Johnson (12:30):

And from the pharma company's perspective, orphan and specialty drugs are becoming an increasingly large percentage of the overall drug spend and they're for-profit companies, and they're going to follow where the opportunity leads. And that's a nice way to segue into what the FDA is doing on fast track drug approvals and how that's accelerating these new types of drugs, gene-based drugs, specialty drugs, into the marketplace often, or even without the historical level of testing. Could you talk about fast tracking and the implication that's having for the marketplace?

John Kerins (13:12):

Yeah, I think particularly in the oncology field where there's a real need for new therapies, that's caused the FDA to look at different ways to get drugs to market as quickly as possible. We almost had 60 new approvals for the FDA. 73%, or about 43 of those took some type of fast track approval process that was granted by the FDA. Definitely something that's moving the needle in terms of drug development, a lot of new and novel therapies. Your comment earlier about orphan drugs, about 60% of the approvals last year were for orphan indications and about 30% of those approvals for last year were for first-in-class therapies representing-

David Johnson (14:01):

Novel therapies.

John Kerins (14:02):

That's right. Completely novel for that category. There may be existing drugs on the market that are treating symptoms, but this is a drug that actually looks to cure or significantly improve on that disease state.

David Johnson (14:16):

It's very interesting that pharma itself is taking the lead on this discussion of creating new payment mechanisms. The Novartis CEO, Vasant Narasimhan has said, we need new economic models to determine exactly how much a cure represents. It's noteworthy that they're the ones leading the effort and it's probably both a mix of a desire for a better public policy and the reality that society at large is just up in arms against the cost of drug therapies and the burden that's placing increasingly on regular Americans. So could you maybe talk about what the pharma mindset is? I know we've done some of this already, but let's dig into that a bit.

John Kerins (15:06):

Yeah. This is an area where in a period of a lot of partisanship in our political process, a point of bipartisanship is around drug pricing. There's already been a number of congressional hearings this year on the topic, a lot of them focused on generic products that have seen very big price increases in a short amount of time, whether it be insulin, EpiPens, and I do think in the next 12 to 24 months, we could see some type of legislation impacting that. And I think forward-thinking pharmaceutical companies, whether it be large pharma like Novartis or biotechs are very cognizant of how their drug pricing is going to be viewed and they're trying to get ahead of that and looking for ways that they can offer some value based contracting to the market, whether it be the government payers or commercial payers.

Novartis has another interesting product called Entresto that treats congestive heart failure. And part of the reimbursement model there with some payers, is looking at future cardiac events that occur after the patient starts taking the product as well as hospital readmissions after they start taking the product and factoring that in to the overall reimbursement price. Fairly innovative model that's looking more broadly at the total cost of the health service system. Congestive heart failure is one of those areas where we tend to spend a lot as a society. So I think it's an innovative model and one that is largely been well received by payers.

David Johnson (16:45):

Of course. The other thing we know about congestive heart failure, that if people lose weight, exercise and eat better, I'm thinking they can help themselves a lot too.

John Kerins (16:53):

That's right. Larger systemic issues are driving some of the need for these products but it's interesting to see pharma take that kind of approach where they're looking a little bit more holistically about their drugs impact to the total healthcare system.

David Johnson (17:07):

Yeah. And I've interacted enough with leaders of pharma companies to know they're frustrated, often frustrated by their inability to get payers to move more quickly on therapies they believe offer real curative powers. And I think that's led to the rise of the CCOs. So let's dig into them a little bit, and how do they operate? Why is this becoming an outsourcing activity? What does it mean to come up with real-world evidence that, [HEOC 00:17:41] term health economics and outcomes research that often is the sort of crucial metric in determining whether a drug gets... Or whether payers pay for a drug or not. So let's dig into that process a little bit.

John Kerins (17:57):

A lot of this revolves around aggregating data to support a story about why your drug is more effective than the existing protocols on the market and you're making argument both to physicians and providers, as well as payers and PBMs. And so, there's a real need to demonstrate through both the collection of real-world evidence, as well as clinical data that's collected throughout the clinical development process, to show the comparative effectiveness of that new drug in therapy relative to existing protocols. It's an interesting area. We see health economists, clinicians, statisticians, marketers, all coming together to try to one, gather this data, both from the clinical trial process, as well as looking at how are patients reacting to existing therapies in the market. And bringing that or stitching that all together to tell a story, why this drug should be approved to the FDA, but also why payers and PBMs should reimburse for it included in formularies and why ultimately doctors should prescribe it. The messaging is a little bit different to each group, but the collection of all these data sets is really important to telling that story.

David Johnson (19:26):

Well, we're stuck between this barbell of sorts where we've got a need for drug innovation and paying for it and everything that that entails and at the same time, we don't want the pharma industry to engage in profiteering. So generally speaking, some combination of regulatory oversight and market pressures would hope to kind of keep that balance intact. That's what's so intriguing about these CCOs because they exist largely outside the drug development process. Increasingly, companies are outsourcing this function. Some still keep it in-house in a medical affairs unit, but for that to succeed, for that function to succeed, they really have to develop both internal and external credibility, and really can't afford to be misleading the way some marketing tends to be misleading or at least oversell.

Why don't you just talk specifically now about CCOs and how they're emerging and then we'll migrate from that into a discussion of the CCO market. How big is it? How fast is it growing? Who are the big players? What are some interesting companies? How is it consolidating all of those things? So, let's first talk about these companies as they currently exist, why they're coming into being in the way they are, and then talk more broadly about the marketplace. So first, the CCOs themselves.

John Kerins (21:13):

Sure. I guess maybe take a quick step back. If you look at the traditional large pharma organization, and you alluded to this, medical affairs department, they really sit between the clinical drug development

teams and the commercialization, sales and marketing function at big pharma and they're trying to be the scientific group that really kind of is bridging those two worlds.

David Johnson (21:38):

They're between the scientists and the salesman, right?

John Kerins (21:41):

Exactly right. And they bring more of a scientific lens and most of them are clinicians or statisticians, some type of scientists, but they're helping to bridge that wall between the clinical scientist and the sales and marketing teams. And so, fairly natural evolution of what we've seen throughout large pharma, they tend to outsource more and more of these services over time. And so, what we've seen with contract research organizations, as well as contract development and manufacturing organizations, the prevalence of outsourcing in both of those categories has continued to grow over time. I think we're still in the early innings for what I would call broadly kind of commercialization services. So the contract commercialization organizations you alluded to, as well as a lot of commercialization consultancies and boutiques that specialize in certain select aspects of the market.

Part of this is a function of the market itself. In 2008, there were 2000 companies with active drug pipelines, today there's 4,000 companies with active drug pipelines. A lot of those, new entrance to the market are still relatively small, don't have a whole lot of in-house specialized departments. They looked outsource quite a bit of what they do, whether it be on the manufacturing side, the clinical development side, and increasingly on the commercialization front. It's pretty broad spanning in terms of market access, working with payers and PBMs to make a case for why a drug should be on a formulary and what kind of reimbursement it should receive.

Looking at distribution hub services around getting your drug into the market, medical communications, working to craft messages to the clinicians and your marketing message out there to the key opinion leaders in certain therapeutic categories, as well as, then looking at the more traditional kind of marketing agency work that's producing some of the advertising that goes along with these products. Some of this still continues to sit in-house with large pharma, but increasingly, we're seeing a large group of companies that are outsourcing this and kind of a growing field here.

David Johnson (24:03):

Terrific. Really interesting. Well, talk to me about some of the companies you like in this space.

John Kerins (24:09):

Well, I think it's very broad and I think it's very fragmented. $150 billion of spend overall for commercialization services. Only about 16% of that today is outsourced. So you look at some of the bigger groups. Syneos , which is a large CRO, has a contract commercialization organization as one of their divisions. They're certainly a leader in this field. You've got groups like UDG Healthcare, their Ashfield division is very focused on this space. Then you get into some smaller, but nice growing companies that are owned by private equity today. EVERSANA, that's focused both on kind of specialty drug distribution, as well as market access. There's groups like Envision Pharma Group, that's more of a true kind of outsource med affairs team, looking at both medical communications and augmenting existing medical affairs teams, as well as providing a fully outsource medical affairs team for small and emerging biotechs.

Those are just a handful of the companies that we track and look at. What I would say, is beyond that it's a very large group of companies who are outsourced in the space. A lot of them small

consultancies that are very specialized on one particular offering within the space. The three or four I had mentioned before, are tending to build broader platforms where they've got a suite of commercialization services that they could offer to address bringing the product to market from start to finish.

David Johnson (25:46):

Well, this sounds like a market ripe for consolidation. So how are the buyers and the sellers coming together?

John Kerins (25:54):

[Excluding 00:25:54] the consolidation play that you see with some of the larger platforms are acquiring small consultancies, we also see a fair amount of private equity investment in the space, in some cases where they're stitching together three or four companies right out of the gate to try to build a platform. I think there's certainly room for more consolidation. I think just some of the interesting trends, observations that I think about, these are all inherently people businesses, they're professional services organizations. So, looking for organizations that have been good at retaining their talent and have a limited amount of churn, I think is really important in almost any of these specialty areas. Not dissimilar from investment banking or consulting, more traditional management consulting, these groups are all dependent on, in a lot of cases, very highly qualified specialists who serve as consultants.

David Johnson (26:48):

Yeah. So, as you step back and look out three to five years, we've got a dramatic expansion in these expensive complex drugs that potentially cure debilitating diseases, particularly for different types of cancers and other sort of rare conditions. You've got a fragmented industry on the, sort of the commercialization side outside of pharma, you've got growing numbers of drug development companies. What do you think this all looks like in five years and maybe more importantly, will we feel better as a society that when we're paying for these types of therapies, we're paying the right amount?

John Kerins (27:35):

I take an optimistic outlook here. I think that this general framework, I think should be positive for all of us as taxpayers, as well as consumers in the healthcare market. My hope is that it drives best-in-class therapies to market with a reimbursement framework that favors drugs that can really deliver meaningful improvement in patient's lives. That being said, I think we're still very much in the early innings of kind of value-based reimbursement around pharmaceutical products, as well as I think in a unique time where the ability to articulate the efficacy and effectiveness of your drug relative to others, is becoming kind of more and more important. I think those are generally good trends that should favor the consumer or the taxpayer. In terms of the outsourcers are going to be successful in this framework, I do think there's some value to having kind of a suite of services that could help take a small biotech that wants to commercialize their product and really take it from start to finish.

I also think groups who not only know how to analyze and interpret all the data from the real world evidence that's being gathered, but potentially groups who are capable of harvesting their own data sets, building out their own data sets, could be really unique points of differentiation for commercialization companies. We worked with a company at Cain Brothers, advised a company last year called, TARGET PharmaSolutions in the real-world evidence space. They're tracking kind of small populations of patients, four or 5,000 patients that are out taking existing protocols for certain therapies and trying to understand what's most effective and not just pulling EHR data for those patients, but

trying to get the really salient points of physician notes that could be helpful in understanding what's the most effective protocol outdoor. A company like that, coupled with kind of a larger commercialization platform, you could see as being very effective. They're going to bring a unique dataset that's going to help position their clients therapy, and hopefully bring really meaningful insights about what drugs are bringing better value to patients and to payers.

David Johnson (30:03):

Yeah. Well, this is a good place to land, I think John. But your last point really aligns with something we believe very strongly at [Forsyth Health 00:30:12] which is, liberated. Data will actually save lives. That if we can get data in the right form, to the right people, at the right time, they'll make better decisions. That applies in clinical treatments as well as pharmacological treatments. And that we are evolving toward a world where all of us can expect to get the right care, at the right time, in the right place, at the right price and get away from this kind of game playing that goes on right now to maximize payments somewhat irrespective of outcomes. So, I'll be optimistic with you. It's been a fun conversation kind of going through the very complex and evolving world of specialty drug development, gene therapies, and so on.

So, John, thanks very much.

John Kerins (31:06):

You too, take care.

David Johnson (31:08):

We've covered the fascinating subject of bringing new, complex and often very expensive drugs to market and how the marketplace is responding to that challenge. Thanks so much for your time and even more importantly for your insights. Cain Brothers is an investment bank focused exclusively on healthcare. The bankers at Cain stand apart because of their deep knowledge of the healthcare industry and their practical know-how when it comes to executing complex transactions in all healthcare sectors. These include healthcare services, medical technology, and life sciences. I'm your host, Dave Johnson. I'm a recovering investment banker who discovered late in my career I was always meant to be a journalist and maybe even a podcaster. I'm also the CEO of [Forsyth Health 00:31:56] and the author of two books. The most recent of which is, The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I love talking to other revolutionaries who are driving change in the healthcare industries.

Podcast: Mission-Critical Repurposing: Converting Aging Senior Living Properties to Affordable Housing

Bill Pomeranz, Managing Director at Cain Brothers, a division of KeyBanc Capital Markets Inc., and David Johnson dive into the plight of senior living facilities around the country that haven fallen into reduced use, disrepair and abandonment. They look at a conversion process that can benefit sponsors struggling with declining properties by meeting the growing need for moderate-income affordable housing with affiliated healthcare services.

David Johnson (00:05):

Welcome to House Calls, where we get to talk to investment bankers from Cain brothers, a division of KeyBanc Capital Markets, Inc. Cain Brothers bankers work in some of the most interesting segments of the healthcare industries. They work with organizations and business models that are helping to change American healthcare for the better. I'm your host, Dave Johnson. I'm also CEO of 4sight Health. I'm a recovering investment banker myself who discovered late in my career that I was always meant to be a journalist. I co-author a monthly thought leadership article with a rotating cast of senior bankers from Cain Brothers. Each piece becomes an exercise in examining a fascinating segment of the dynamic healthcare landscape. The focus of our articles and this podcast is on how to make America's fragmented, inefficient and often broken healthcare system more integrated, consolidated, efficient, and customer-focused so that it delivers greater value and innovation to the American people.

Today, I'll be interviewing Bill Pomeranz. Bill is a senior banker in Cain Brothers' post-acute care and senior living advisory practices. He has 35 years experience in advising post-acute care providers, continuing care retirement centers and senior living facilities. Bill specializes in negotiating joint ventures between post-acute care providers and hospital systems in order to expedite acute care discharge planning and support population health management. Bill has a B.A. From the University of Illinois and an M.A. From Berkeley. Bill, welcome to House Calls, where the bankers are always in.

Bill Pomeranz (01:51):

Thank you. Glad to be here.

David Johnson (01:53):

Well, I know you've got an interesting background because you've told me about it on more than one occasion, so why don't you share with our audience how you got into healthcare and why you have this particular interest in senior housing?

Bill Pomeranz (02:06):

Well, as a senior in college, I was an economics major, and I was very interested in inner city and rural economic development. What I realized is that inner city and rural areas might not have much disposable income from wages. They had considerable dollars going into those communities in the form of third party vouchers and reimbursement, Medicaid, Medicare, meal programs, Section 8 housing vouchers but a lot of money into these communities. The problem with it was that that money came in and was immediately siphoned out by outside providers. So, the money didn't stay in the community, and money that stays in a community actually recirculates. It continues to circulate. It's called the multiplier effect and it-

David Johnson (02:06):

Yeah, it compounds.

Bill Pomeranz (03:02):

It compounds, and it creates an economics in that area and jobs and jobs that are particularly suited to people who might not have advanced education. When I graduated, I went on to work with the Ford Foundation, and one of our first projects was in Bedford-Stuyvesant where we went ahead and created some large community clinic that was one of the first public HMOs in New York and senior housing and a skilled nursing facility. That resulted in the ability for eight or 900 low-income workers to have jobs and

contracts and home care, skilled nursing aides, which led to the development of a credit union, which then provided money for these people to be able to start businesses and have mortgages.

So, I did that with the Ford Foundation for approximately five, six years both in New York and in other locations in the United States. That took me to the mid-'80s when all of a sudden, these facilities were being built, operated, and people needed to learn how to actually do a good job. It wasn't just the economic model. It was, how do we actually serve the people?

David Johnson (04:17):

Operations, yeah.

Bill Pomeranz (04:18):

How do we do better job? How do we operate?

David Johnson (04:21):

Yeah.

Bill Pomeranz (04:22):

Simultaneous to that, hospital systems in particular were getting interested in senior living and post-acute care as part of a vertical integration strategy where they thought they would make profit and provide good community care in their communities by delving into senior living, and that could have been facility-based, home care based social services. So, I became sort of the one man in the community out there who really knew this area, and so I went from working with the Ford Foundation to establishing my own corporation, own company, where I was working with some of the larger hospital systems. Did that for about 10 years, and then that resulted in a number of tax-exempt bond financings for those hospital systems in the form of senior housing-

David Johnson (05:18):

Sure, sure.

Bill Pomeranz (05:18):

Skilled nursing, post-acute. The banker I was working with at the time said, "You work so hard on that side. Why don't you come over to investment banking side, and you'd be welcome here because you could help from beginning of a project all the way to the financing of the project." So, that's how I got into investment banking.

David Johnson (05:38):

Wow. Well, thank goodness. Your country needed you and still does.

Bill Pomeranz (05:44):

Well, the other thing I noticed, just to add, is that structuring a deal could result in a much lower cost of capital than just trying to beat up on contractors or spend time trying to decide which door to use in a building, that financing just was a much bigger impact on the affordability of a project and the feasibility of a project. So, structuring deals actually had a real purpose, not just providing a check at a construction start.

David Johnson (06:17):

Well, Bill, I'm really glad you mentioned the word affordable because the article we wrote together had the intriguing title of Mission Critical Repurposing, Converting Aging Senior Living Properties to Affordable Housing. In the article, we did a deep dive on a couple of distinct social challenges, which turned out to be interrelated. As you pointed out, with the right innovation and determination, aging senior living centers can become sources for new affordable housing. Could you give us a little bit of your thinking in how you brought these two phenomenon together that the aging of the senior living facilities, that base in the country with this increasing need for affordable housing and why the two problems may actually, when put together, create a solution?

Bill Pomeranz (07:15):

Let me try to be brief but give a little bit of history. In the '50s, '60s, '70s, even into the mid-1980s, most housing that would be called senior living housing or long-term care facilities was provided by nonprofits. They were very much mission driven, or they were oriented towards serving a particular constituency. Could have been religious. It could have been a professional, or it could have been fraternal such as the masons. That was providing a niche and service that was needed, but along in about the mid to late '80s, the private sector entered the senior living market very aggressively. We've seen for basically the last 30 years, the private sector go from being a minor factor in senior living to probably two-thirds to 75% of all senior living in the country now is private sector.

David Johnson (08:22):

What's fueled that growth, the private sector growth? Are they more on top of the market, have better funding?

Bill Pomeranz (08:29):

Well, I think my belief is that it's because the senior living market was basically a social service driven product when it was with the nonprofits. It was trying to be the best old folks home that it could be. The private sector saw that senior living was a very fragmented market with all types of segments within it from the frail elderly to the tennis playing, golfing senior who might still be working. So, they just created a range of products that were more attractive to the marketplace.

David Johnson (09:08):

Right.

Bill Pomeranz (09:10):

The dollars that flowed into that were tremendous. We now have in our marketplace the belief that senior housing is its own category of capital and should be part of a larger investment real estate portfolio.

David Johnson (09:27):

Really interesting. You forgot to or you neglected dimension cocktails at 5:00 and 6:00 at some of these places.

Bill Pomeranz (09:34):

Right. Well, that depends on a lot of things, and those licenses are not always easy to get.

David Johnson (09:41):

Yeah, there you go.

Bill Pomeranz (09:41):

You're right.

David Johnson (09:44):

So, as the industry was going through this transition from as much social service and neighborhood-based to kind of broader customer based, organized around sort of degree of health and activities and interests and so on, what happened to the aging facilities mostly in the inner cities as-

Bill Pomeranz (10:09):

So, what you had is basically a split between those sponsors that understood early on that their senior constituency wanted more upscale product. There was also a rise, I think, in the wealth of seniors in their ability to afford that product, but it's relatively a small segment of the senior population that could afford these upper income communities, but it became the place where everyone was competing. As new product came in from the private sector, the older nonprofits just didn't invest in their communities in the same way that the private sector invested.

Also, the way the nonprofit sector builds senior living and finances senior living is very dependent on tax-exempt bonds. Tax-exempt bonds tend to be very heavy in terms of cash reserves for financing, so you'd often have one to two years of cash reserves to get a credit rating in the tax exempt world. That's the opposite in the for-profit world, where you might have two payrolls worth of cash on the balance sheet, so as your product appreciated, you are continuously harvesting that appreciation and putting a new product or expanding your product, whereas nonprofits, to get their cash up to investment grade levels might wait five, six, eight, 10 years after they did one project to do a follow-up project. So, just the structure of the financing resulted in the nonprofit sector having less money to invest because they were basically harboring it for reserves to get credit ratings. In the meantime, they were becoming less competitive because they weren't putting the money back into their projects.

David Johnson (12:09):

Right. So, that gets us to why we have a supply, I guess, of facilities that are no longer cutting edge, probably have trouble attracting residents, are in some level of decline and maybe even disrepair.

Bill Pomeranz (12:30):

I would also add, David. I think it's an important factor is that neighborhoods also have changed.

David Johnson (12:36):

Sure.

Bill Pomeranz (12:37):

So, even where neighborhoods have stayed middle or upper middle class, they've changed from who lives there. So, most of these projects built '50s through early '80s were pretty much oriented towards an Anglo older adult. As the United States has changed, even as economics had stayed or even gotten better in some of these communities, nonprofits really have not yet figured out how to reach these minority populations, minority, elderly populations. That's ongoing. Some are doing a little better than

others, but it's hard to do that in these mixed communities where many of these minority communities want to have the cultural fit, the food fit, there's just a mismatch, and it's hard to bring in the new populations in these communities while the old constituencies have either faded out, died out or moved away.

David Johnson (13:40):

Yeah. So, they're confronting kind of a Hobbesian choice of sorts, continue trying to keep it going as the market declines or sell probably at higher sale prices, but you offer a different path out that actually meets a chronic need that in many of these same neighborhoods for affordable housing, and we also have the availability of tax credits, various types of tax credits that can support this. So, could you shift our discussion a bit from where we are now with an oversupply of senior living facilities, not-for-profit senior living facilities, mission-led organizations that are really struggling to this new need and how we can take advantage of tax credits and changing market dynamics to repurpose in vital ways these facilities?

Bill Pomeranz (14:40):

So, it's very interesting. A couple things to understand before I get into all the dynamics. We need to talk a little bit about what the definition of affordability means. The definition when we talk about affordable housing and affordable rents and income qualifications, the information that comes out of HUD that sets these standards for what is an affordable level of care or affordable shelter, and I should emphasize we're always talking about shelter here. So, in affordable housing, we're not yet talking about services. We're just talking about providing the basic shelter and the utilities that go along with that shelter. So, those income limits tend to be set against area median income, and those area median incomes tend to be targeted towards working families or individuals, whereas seniors are retired, so you end up with an overlap between what a senior might consider to be middle-class with actually what's affordable.

So, I mentioned that because many of the existing residents already in the communities we're talking about, the aging nonprofit communities, they're already eligible for affordable housing because their incomes, while they think of themselves as middle or moderate, are really in the category of affordable. So, it's an important consideration. It's also important thinking forward that there's income not only for shelter that's available for seniors but that they might have some, because they're qualifying paying rent based on a percentage of their income, they might have some dollars available to actually pay for some services. Most importantly, they're qualified for affordable housing even though they might think of themselves as moderate to middle.

David Johnson (16:43):

So, walk us through a hypothetical example of how we could do one of these conversions.

Bill Pomeranz (16:50):

Okay. So, typically, we're talking about a urban project, almost always an urban project, and I want to stay with urban projects because rural have their own dynamic. So, an urban product is probably in the center core because remember these were built in the '50s, '60s and '70s when most of these constituency groups lived in neighborhoods where they gathered or were grouped, and so buildings were typically built either in those communities or where that population was migrating to. So, maybe the first area of migration.

The good news is those tend to be areas that are now being redeveloped or being rediscovered by the millennials, so economic activity is occurring in these areas. They're usually located near public transportation or other complimentary services that makes life good in these communities, walkable communities, communities with a lot of cultural recreational activity.

David Johnson (18:00):

Well, and enough density too to build services and retail around it, so yeah.

Bill Pomeranz (18:05):

Correct. So, let's take a typical project might be a 150 to 200 units that was some combination of apartment and skilled nursing. So, put a square footage on that. Let's say that's 150 to 200,000 square feet. Well, the value of that building is that it has a structure. Typically, it was a concrete structure, so that means it's reusable. So, you can take that structure, not necessarily the business that's in there now but the structure itself can be evaluated. If it's got decent bones to it, as they say, if it's got decent bones to it, it can be sold to a partnership of which that partnership is both a developer and an investor who wants to buy that property and convert it to affordable or low income housing for the advantage of the tax credits they will receive for making that investment.

I think to your point, because it's in these urban areas, the potential to get maybe even higher density out of these buildings than they historically have has come about from probably three different ways. Most states, over the last 20 years, have created zoning laws that add both higher density allowances for senior projects and for affordable projects. So, in a community that might have land zone for a hundred units, it's typical to see 20% more for seniors and 20% over that for affordable. So, a hundred unit project for a middle income or upper income project could have 140 affordable units based on state and local zoning.

David Johnson (20:06):

That's awesome. That's awesome. Well, we were talking a little bit before the podcast started about social determinants of health, combining shelter and services. The fact that America seems to rediscover this basic truth that human beings are social creatures and when they live in neighborhoods in contact with others, they do better, how do we put together programs that sort of enable people to lead better lives, better, more connected lives, and in the process, actually save Medicare and Medicaid and others that are paying for healthcare real money, and by virtue, investing in sort of the front end, shelter, primary care, behavioral health, and so on, good food, create lives for people that are better and more productive and in the same time, save the overall system money because we're spending less on symptoms and more on root causes of disease?

Bill Pomeranz (21:13):

Well, the problem ... There's a problem there, and the opportunity is that when you group several hundred seniors together, particularly several hundred seniors who might begin to have problems with chronic illness and are becoming higher utilizers of healthcare, when you group them together and you can service them in mass and to economies of scale, the overall system saves money. So, what I mean the overall system, Medicare itself might save money if you can provide economies of scale.

Let's give some examples. Home health care to 200 seniors across a large neighborhood would require, think about it, one worker for every five daily visits. In a congregated setting, that same worker could see eight to 10 patients in the course of a day. So, you save on home care. You literally can view people on a daily basis if they show up for activities or if you're checking on them in their room. Seeing a

person, if you're a trained healthcare professional, you can tell a person who's about to go into distress and maybe-

David Johnson (21:13):

Sure.

Bill Pomeranz (22:32):

... and maybe save a 911 visit, which can cost the system multiple dollars. The problem is that housing is treated separately from healthcare and the tax codes in the housing and mission criteria do not allow for the mandating of the residents being enrolled in any one healthcare plan or any one insurance plan. So, the way that you have to structure this is you bring providers to the site, and hopefully, over time, the seniors see that these providers are a real benefit. Those providers tend to be covered by one or two insurance companies. So, the seniors who have freedom of choice have to enroll into the healthcare program that pay for the providers so that the savings to those healthcare providers makes it worth their time and effort to invest in providing staff to the community, but it takes time, and it's more ... You're selling the benefit as opposed to being able to mandate that the resident also take the insurance.

David Johnson (23:48):

Bill, do you think the more we get full risk capitation, the more we're going to see the type of logical distribution of resources, so that shelter and support and services accompany one another?

Bill Pomeranz (24:04):

I would hope so. I think it's going to have to start with the middle and upper middle class as they're choosing their senior living options and they're choosing between ... I'd love to give the example within my own family where my mother was insured by a particular provider. She's looking at market rate assisted living. Basically, many of them look the same, same granite countertops, same fitness center, all of that, but in one, there was a nurse from her particular healthcare provider who was there three days a week. That nurse had access to her medical records, which tie to her physician. So, for the same $7,500 a month, she might as well go to the facility where she was tied to her healthcare provider, but that was a total freedom of choice.

In affordable housing, the seniors ... I don't know how to put it. In affordable housing, the senior has more freedom of choice in a way then even middle and upper middle income people because you can't mandate this service. So, they have to see that it's a benefit in order to enroll.

David Johnson (25:23):

Yeah. Ballpark. How big an opportunity do you think there is in the country right now to do conversions of these declining non-for-profit? Yeah, go ahead.

Bill Pomeranz (25:33):

Just saw data that indicated last year, there were 200 facilities that nonprofits either closed or basically, I don't want to say gave away, but more or less, gave away.

David Johnson (25:45):

Yeah.

Bill Pomeranz (25:46):

So, there was 200 last year. That's up from about 110 years previously. I think it's important to note that I'm very focused on senior housing and senior housing that's no longer attractive to the middle class, but what we're talking about could also be true for redundant hospitals. You see redundant school systems, school buildings. The concept of conversion to affordable senior housing goes beyond just existing senior housing. I just have noticed that this is an area that we have value. The reason I really think it's important to introduce this to this existing senior housing providers is they want to carry on missions. They want a legacy for these properties that maybe their grandparents on the board started. Now, they're on the board, and they're struggling with what to do.

David Johnson (26:40):

So, they could continue the mission through repurposing either by direct ownership and operations of these new affordable or they could monetize and redirect toward social services or something else that's of a more immediate need to their members.

Bill Pomeranz (26:58):

Correct. I started this for a client who basically wanted to take the money from selling the existing structure and take that money to the community that their constituency has migrated to, so it provided the equity for the next project. That was the first time we ever thought of doing this.

David Johnson (27:20):

Yeah, yeah, yeah. Well, it's an exciting concept. It's probably a good place for us to land the conversation. Bill, any last thoughts you want to leave the audience on this conversion process, the opportunity, what comes out on the other end in terms of better oriented, more holistic shelter and services?

Bill Pomeranz (27:46):

The only thing, I would end with two things regarding mission that for, even for those nonprofits that have moved ahead to do more upscale, as you mentioned, the cocktails at 5:00, but the swimming pools and the 2,000-square foot units, doing mission related housing development can be helpful in two ways. One, serve the constituents as we've talked about, but it also helps justify your tax exempt status. It helps justify your real estate exemption for your new nonprofits where the fees to get in might be higher than any of the proprietary competitors. So, it allows you to go to these various agencies and say we have a mission to serve all seniors, not just those who are upper income. So, I think there's compelling reasons beyond mission but just smart business and strategy.

David Johnson (28:43):

Well, amen to that. We've been talking with Bill Pomeranz today on House Calls regarding a very creative idea that Bill has to repurpose declining senior living facilities into affordable housing and the many ways that that can happen beyond senior living facilities, really any declining facilities to preserve mission, to promote health, to build healthier communities, more productive communities, and to make life better for all of us. So, Bill, thanks for sharing this with the House Calls audience. You've been a great guest, and you've proven once again that the Cain Brothers bankers are always in.

Bill Pomeranz (29:28):

All right. Well, thank you, David. I really appreciate it. It was a lot of fun.

David Johnson (29:32):

Cain Brothers is an investment bank focused exclusively on healthcare. The bankers at Cain stand apart because of their deep knowledge of the healthcare industry and their practical know-how when it comes to executing complex transactions in all healthcare sectors. These include healthcare services, medical technology, and life sciences. I'm your host, Dave Johnson. I'm a recovering investment banker who discovered late in my career, I was always meant to be a journalist and maybe even a podcaster. I'm also the CEO of 4sight Health and the author of two books. The most recent of which is The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All. I love talking to other revolutionaries who are driving change in the healthcare industries.

Podcast: Win-Win Partnerships: Strategics and Sponsors Increasingly Team Up

John Soden, Managing Director at Cain Brothers, a division of KeyBanc Capital Markets Inc., and David Johnson talk about a new breed of innovative partnerships between strategic buyers and private equity sponsors who join forces to execute complex win-win transactions. They discuss the structures of a variety of pioneering deals that have proven effective at achieving beneficial consolidation.

David Johnson (00:05):

Welcome to house calls where we get to talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets. The Cain Brothers bankers are working in some of the most interesting segments of healthcare with organizations and business models that are changing care delivery in the United States. I'm your host, Dave Johnson. I'm also the CEO of 4Sight Health. I'm a recovering investment banker who discovered, I was always meant to be a journalist. We coauthor a monthly thought leadership article with a rotating cast of senior bankers. Each piece becomes an exercise in examining a fascinating segment of the dynamic healthcare landscape.

The focus of our articles in this podcast is on how to make America's fragmented, inefficient, and often broken system more integrated, consolidated, efficient, and customer focus so it delivers greater value and innovation to the American consumers. Today, I'll be interviewing John Soden. John is a managing director at Cain Brothers where he co-leads Cain's medical technology, its advisory practice. John has almost 20 years of experience in medical devices, diagnostics, and life sciences tools. He's earned a BA in economics with honors from Northwestern University. John, welcome to house calls where the bankers are always in.

John Soden (01:27):

Thank you very much. I appreciate the opportunity to do this and enjoy writing the article with you.

David Johnson (01:32):

Let's start by talking about you a bit. What drew you to investment banking and to health healthcare in particular?

John Soden (01:39):

I was an Econ major and permanently focused in industrial organizations of different types of corporate structures and ultimately wrote my honors thesis based on technology joint ventures and what made them work and what made them fall apart in sort of the underlying rationales. So a lot of that complex structuring fed into not only my interest in M&A, but also in this article about private equity and strategic partnerships.

David Johnson (02:07):

Yeah, there sure was a lot of complexity wasn't there. So the article we wrote together is called win-win partnerships, strategics, and PE investors increasingly team up. So strategic investors, largely corporations, and then PE investors, private equity investors. So for our listeners who may not be as versed in the intricacies of finances as you, let's start by talking about why these sorts of partnerships are occurring and why there haven't been very many of them?

John Soden (02:37):

I think fundamentally you have to step back and understand how hard it is to get a deal done to begin with just with one counterparty. And as you add not only multiple counterparties, but different types of counterparties, you have different complexities with different types of counterparties. Public companies, of course, have not only boards to deal with and people within the various layers of management all of whom have conflicting agendas oftentimes in terms of what sort of M&A deal they want to do or what they want to buy. There's always high priority things in the pipeline and lower priority things in the pipeline. And those some shift around as you're going through what could be a five, six month process when selling a company.

And then sponsors, they have investment committees to deal with. There were also contending with cost of capital, as well as trying to understand if they really want to do this deal versus the 10 others that the various partners are currently evaluating. And so when you combine those two things, it's very, very hard to get the two groups coalesce doing anything much less something with very complex governance structure that takes. It's really multiple transactions in one.

David Johnson (03:56):

So let's talk about a sample transaction. You can pick anyone you want. But what struck me when we were working on this together is that you've got a strategic investor corporation that may or may not want an entire part of a company. You've got a PE company that has obviously financial resources, but also various tools and capabilities that they can bring to the party. There's a target that maybe many investors would like to acquire and it's looking for obviously a great price and perhaps a strategic partner so and so. Let's talk about how you take the capabilities of a strategic investor marry them with a private equity investor and then create a transaction structure that gives the strategic what they want, the PE investor what they want and the company that's being acquired what they want.

John Soden (04:51):

Sure. So I think it's important to understand why a strategic would do this. A sponsor will do anything that makes money and they're generally pretty facile with any sort of complex structure. A strategic on the other hand, you would normally expect them just to go in acquire something integrated extract synergies out of it as quickly as possible, and owning it and controlling it is the best way to do that. So there really has to be some driving rationales for them to even contemplate doing something that's more complicated. Some of the things that they look at or reducing overhead costs is they're thinking about what is the most efficient way for this transaction to come in. Sometimes while keeping it

separated actually generates synergies because they may have this synergies near term, or alternatively, it may be diluted to earnings near term.

So anyone going into a private equity transaction is going to get a very big equity stake just for showing up, and to the extent it works out well. They're going to make an incredible amount of money over a relatively short period of time. In this crappy market, that's generally about three years. And so oftentimes, if it's a challenging business that they don't want to integrate and potentially mess up in the process of integrating or to somehow disrupt the momentum if they don't think they have the managerial talent to run it and keep the momentum going, or if it's a high burn company, which usually goes along with high growth rates. They may choose to keep it separate and have a team that's very focused on that particular market or organization really drive it hard until it gets to a point where they can bring it in. They feel stable enough and it's earnings are creative, even if they have to pay more for it longterm, which generally is what happens in these formulate transactions or transactions with formulate exits because the private equity player also has to make money.

David Johnson (07:12):

What about the management side of that arrangement? What usually happens there?

John Soden (07:17):

Sure. There may not be a way to keep the existing management team who's driven the growth in place or to recruit new management to the extent it becomes a division of a larger corporate, which is less interesting and has less direct drive upside associated with the entity being bought for whether it's the existing management team who continues on after the transaction or some new high powered CEO and C-suite that's recruited in.

David Johnson (07:51):

Yeah. It's kind of interesting listening to you explain this because it feels like the strategic investor is really the one that's shaping the transaction and that the PE investor has a lot of obviously funding and capabilities and ability to take risk and so on. And it that kind of morphs around to some extent what the needs of the strategic are so that together they can come up with a more attractive offer and when the deal is. Is that the right way to look at it, John?

John Soden (08:30):

I think it is and I would distill it down further to really for strategic to get involved and to leverage very high cost capital that has a threshold IRR of somewhere between 15% and 25%, depending on who the sponsor is. There's got to be a pretty compelling rationale to do that type of structure. And that rationale has to be strong enough that whoever chooses to partner with them really has to present a working corporate mechanism that achieves what that strategic is trying to either avoid in some cases, or to accomplish in the event that keeping it separate really does help that business grow to a point where it can be absorbed appropriate.

David Johnson (09:22):

Well, let's try to get a little more concrete for our listeners and use a real transaction that you were a part of where you can explain the different roles and how the parts of the acquired company got divided up and how the formulas for exit strategies worked and whether there was leverage. Pick whatever transaction you'd like, but just lay out the different components and why this particular deal came

together. And the strategic was willing, as you said, to absorb the higher funding costs in exchange for other benefits. So why don't you just kind of dig into a real life example for us.

John Soden (10:03):

I tell you, what I'd love to do maybe alternatively is talk about one that's actually coming together silently.

David Johnson (10:11):

Okay. Perfect.

John Soden (10:11):

And because I think that presents a lot of different rationales that many of which don't exist in any one transaction as you look at the precedents that we cited in the article or others that are publicly known. And in this case, we have a target that has a myriad of different businesses inside of it. All of which are relatively high growth, all of which are operated in a semi-entrepreneurial way. And those businesses are somewhat delicate in terms of how they operate. And so a bigger strategic looks at that and says, gee, can we operate at that level? That's a transaction that may very well benefit, whether it's all of those assets or part of it from a financial partner in a discreet management team to oversee them, at least until they get to a point where they're within that individual organization that target itself. They're sufficiently consolidated and synchronize that you can bring it into the bigger organization.

David Johnson (11:20):

Boy, John, that sounds like an inherently complex process.

John Soden (11:24):

I think that's one thing that people worry about, particularly when they buy businesses that have been put together at a high rate or a fast rate by private equity when they go out and do somewhere between three and 20 acquisitions where the private equity firm really does want to disrupt the momentum of those individual businesses. And as a result, they're kept somewhat semi-autonomous underneath the parent organization. So we actually see this situation quite a lot. And it's one of the things were more recently has become in vogue for corporate seating think about partnering with sponsors. And then it's taken a while for sponsors while they've always liked to talk about new structures that take a while for sponsors to actually see it work in a number of different situations many of which we cited.

David Johnson (12:14):

It was fascinating to delve into how the bankers put these deals together and along the way gained PhD level insight into complex deal structuring.

John Soden (12:25):

And to really understand how they're negotiated, how to pull it off and how to protect themselves in those partnership structures, which they're not used to. Most of the private equity players or control interest in their orientation, which allows them to fix things very quickly if they need to whereas being tied at the hip with the big strategic that moves at a different rate and has different priorities, I think scares a lot of people. So it's taken some time for both sides, the corporate side and the sponsor universe to really understand that these things can be done very successful.

So in the present transaction, we also see because you have a very diverse business. There is some businesses that are more strategic and some businesses that while strategic either they're not sort of a perfect hand-in-glove fit, or at least they're not as strategic today as they're going to be three years from now. In which case, the compelling need to integrate them isn't quite there. They may benefit from a more entrepreneurial team or management team that can really drive them hard over those ensuing years to a point where there's a clear fit into the Lego like fit into the parent organization.

So there's a long-term appreciation for what that individual business or business line does for the parent, but the timing just maybe a little bit off today. And so I think that gives rise to a lot of questions about who's really going to take ownership of that business and the interim. Do they have the not only the talent, but also the internal prerogative to really do what they need to do to make it work until it becomes something that really folds into the rest of the business later on and hangs together with the rest of the business.

David Johnson (14:36):

How do companies decide which businesses or business lines to keep independent when they're structuring these complex transactions?

John Soden (14:45):

And the question is to what extent do you actually carve out assets from a diverse asset pool, or do you just keep the whole thing independent and they bring it in at the right time after it's sort of integrated within itself. So we see the situation a lot, and it happens to be relevant to three different situations we're looking at right now because there's a lot of these consolidation plays that are going up for sale. And a lot of in this strategic see a lot alike. At the same time, they're worry of the fact that they may not be fully consolidated they may be diverse and they may not be ready for to take on the whole business or all pieces of the business immediately.

David Johnson (15:32):

So they want to acquire immediately what they like and there is a strategic fit. They may not want to acquire some parts that just don't fit at all. And then there are other parts that at some point may make sense and wouldn't it be great if they could park them somewhere for a while to see what happens.

John Soden (15:47):

Yeah. Yeah. The last two pieces that you mentioned are very, very important and of the several other opportunities that I'm alluding to each of those is resident in two or three. It just depends how big and how diverse those businesses are ultimately. But there is the underlying question of how do you incentivize people to make it work. That's also costly, they just like the private equity cost of capital. You really have to have a very strong rationale to give up those costs. Remember, in order to win an auction, I mean, you have to be the highest payer, of course, and so you're then layering... you're sort of handicapping yourself by taking these costs or employing high cost capital and giving away lots of equity to the management teams. And so you really have to have a strong reason to own those businesses long-term whether it's offensive or defensive. And there has to be great optionality, at least if not, some very obvious upside associated with those businesses that may not be things that you'd like to integrate today.

David Johnson (17:03):

Yeah. Why don't we talk a little bit about the optionality and the different investment timeframes of strategic investors versus private equity investors. I mean, private equity is fairly mercenarian in how it does these things. They want control, they want to be out at a certain time, they're willing to bring their capabilities to bear to advance that idea, but they don't have unlimited patients. So maybe talk a little bit about the various exit strategies, the formulas that come through the various types of put and call options and how the two parties sort of come together given their different perspectives, take advantage of where the perspectives help and then create, I guess, exit strategies when they no longer provide the same level of benefit or it's time to move on for any number of reasons.

John Soden (18:05):

There is typically a put call arrangement in place, and at the very least a quick an option to sell that the sponsor has. And so this will be often structured as an option in years three through five, but rarely beyond a five-year period where the sponsor knows that it can get its money back. And it knows assuming that the business has performed that it can get a fair return relative to any control deal that they could go pursue a solo. And so it's often the case that if you're going to give a sponsor put that you as or one of the CEO of a big corporation who's going to partner with that sponsor. It's going to want an option to buy them out as well at different points in time.

And so that call option also has to allow for the sponsor to make a fair return and factor in the sponsors cost of capital. So these formulas are oftentimes very straightforward, very mathematical. And whether they're at a specific price or at a rolling EBITDA multiple or based on a set IRR to the sponsor. But generally things that need to be clear cut enough that they don't inspire litigation.

David Johnson (19:36):

It's generally litigation's something we all want to avoid. So do you see these partnerships solutions becoming more common for certain types of transactions going forward? If so, why and do you have any predictions for what kind of big deals we'll see in the future?

John Soden (19:54):

I think they're going to become more common just because... For the reasons I mentioned earlier, people will have seen that they actually work. It wasn't that long ago that you saw maybe this predated the Patheon deal, which was a great deal of JLL, but together with world DSM in 2013. Prior to that, it was pretty rare and you've seen people like Welsh Carson do a number of these deals subsequently. Other private equity firms have looked at them and seen what appear to be a potential nightmare actually worked out very well. And some of the firms even pride themselves on being able to orchestrate these deals as a core strategy where they constantly go and look or corporate partners anytime an asset of any type comes up because they may be able to leverage it lower cost of capital of that sponsor. They have a built-in acquire long-term and they have certain expertise in synergies that can be derived from a relationship with that corporate partner during the interim pulling period.

David Johnson (21:11):

You meant the lower cost of capital of the strategic, right?

John Soden (21:15):

Yes, yes. Sorry. And that can take shape in a variety of different ways. But ultimately what a sponsor wants, again, is simply to make money and generate a lot of growth in whatever their holding is and know that they're going to have an exit. Whereas the strategic decision process is a lot more

complicated and the rationales, there's a myriad of rationales why they ultimately might pursue this. Now the question is do or the benefits to each sufficient to that as a partnership that they can actually win against someone else who has. There's another big strategic who has a low cost of capital who's willing to take on call who is a better fit. I actually think more often than not if there is one of those in the hunt, they're going to win. And for sure the seller is going to probably want to go with that party just to limit the complexity involved in getting from an LOI to actually signing closed deal.

Deal risk is always first and foremost in our mind as investment bankers. And I think to someone who's spent a long, long time building a company, building a lot of wealth in the company going through a sale process is suppose a lot of anxiety and the last thing they need in their life is complexity. Unless, of course, they want the best of both worlds and they want some sort of further incentive to continue building the company, which may exist in one of these partnership type of arrangements, similar to how it exists in a private equity arrangement. But perhaps they get a higher price as a result of these partnering sponsors and strategics, or perhaps they get more comfort that the strategic is longer term the right buyer and this is sort of a bridge to that event.

David Johnson (23:20):

Yeah, quite really is a done site. I was intrigued by your description of sort of the sponsor market and how everybody was a little bit afraid of these transactions. And then one or two got done and said, well, if they could do it, we could do it, too. It's a little bit like when Roger Bannister broke the four-minute mile barrier. Suddenly all kinds of people were able to do it. So one last question, John, and one thing I've admired in our interactions as we've talked about transactions is you're always, I think very clear about trying to get the most direct way to the conclusion, which would be a closed deal at a fair price with everybody receiving benefits, the benefits they're seeking.

Einstein had this great quote, "Things should be as simple as possible, but not simpler." And it strikes me that these strategic sponsor win-win partnerships, the way we call them are an example of that. They should be as simple as possible, but not... there's going to be some complexity, no matter what. So, as you're involved in these, what do you do to keep your line of sight clear to only have as much incremental complexity as necessary so that you don't end up creating even more obstacles for yourselves as you're working through these multiplicity of relationships and formularies and governance concerns, and maybe different strategic objectives of the company. How do you keep the train moving forward?

John Soden (24:59):

Yeah, so it's a fascinating question because it's really a two-part question. One is how do you keep the train moving forward and how do you execute these in a way within a sale process where there's a lot of competitive jockeying including between the two parties that may be partners.

David Johnson (25:17):

Keep your enemies close and your friends closer. There you go.

John Soden (25:19):

Yeah. And so the choice of picking a partner is actually quite difficult because you may not want to limit yourself to one party who may or may not ultimately have the highest degree of interest in the asset that you and others are chasing. And so I think there's sort of wheels within wheels in that regard. But to the extent, you have picked a partner and there are clear objectives. The real question to me is when does the strategic want to own the business and what criteria determined when it's the right time? And

that allows the rest of the transaction to sort of take shape around those objectives. They may have near-term objectives as well in terms of minimum earning accretion and how much capital they can deploy, how much capital do they need? The flip side of that question.

And as a result, I think the broad strokes of the transaction can be pulled together fairly quickly under the assumption that the two parties actually trust each other and work well together. In our interview with Welsh Carson, trust was sort of the primary word in what they need as being their advantage since they already had a lot of the relationships, and they had already proven that they had worked well in past transactions with corporate partners. And there are a lot of things that you can't codify on the front end that you're going to have to manage through together. The initial structure may or may not work longer term. Your initial management team may not work longterm and these are quite difficult in Europe. The corporate objectives may change and the interim as well.

And so I think there's a certain social element to this that is always hard to assess on the front end, but comes together fairly quickly. I would also say to the extent corporates can work with people who've already done these transactions and really know the ins and outs of how to what leverage you need to pull, what things you really need to focus on and can get through a high-level set of terms fairly quickly and provide the education that the corporate needs. Because I think the corporate is getting an education from its banker, but it's also getting education from its partner. So having a partner who's very facile with these deals and knows where the potholes are likely to exist both near term and longterm, I think helps to engender a lot of trust and allow these corporates to do something that's actually quite unnatural.

David Johnson (28:21):

An unnatural act that leads to benefits. How about that?

John Soden (28:25):

Yeah. And by the way, as I mentioned on the front end of this call, every corporate knows that joint ventures are a recipe for disaster. The failure rate intentionally or otherwise is quite high. And so any partnership with a financial sponsor is going to be viewed with a pretty jaded eye as a result.

David Johnson (28:45):

Great, John. Well, that's a good place for us to land. We've been talking with John Soden, the co-lead of the medical technology advisory practice at Cain Brothers about this entirely new type of partnership between strategic investors and private equity investors to come up with a deal structure that they can use to acquire a company they want. And it's got lots of complexities as you've heard. So thank you to Cain Brothers, a division of KeyBanc Capital Markets, a member of FINRA and SIPC. Thank you to all the listeners for tuning in, and catch us next time on house calls where the bankers are always in.

Cain Brothers is an investment bank focused exclusively on healthcare. The bankers at Cain stand apart because of their deep knowledge of the healthcare industry and their practical know-how when it comes to executing complex transactions in all healthcare sectors. These include healthcare services, medical technology, and life sciences. I'm your host, Dave Johnson. I'm a recovering investment banker who discovered late in my career. I was always meant to be a journalist and maybe even a podcaster. I'm also the CEO of 4Sight Health and the author of two books. The most recent of which is the customer revolution in healthcare delivering kinder, smarter, affordable care for all. I love talking to other revolutionaries who are driving change in the healthcare industries.

Podcast: Getting Urgent about Urgent Care: Health Systems Go Big on Retail

Wyatt Ritchie, Managing Director at Cain Brothers, a division of KeyBanc Capital Markets Inc., and David Johnson discuss the rise of urgent care clinics that are meeting market demand for convenient, high quality "retail care." They look at how strong partnerships between health systems and entrepreneurial urgent care operators foster success for the urgent care model where barriers to entry remain low, but barriers to success remain high.

David Johnson (00:05):

Welcome to House Calls, where we get to talk to investment bankers from Cain Brothers, a division of KeyBanc Capital Markets. The Cain Brothers bankers are working in some of the most interesting segments of healthcare, with organizations and business models that are changing care delivery in the United States. I'm your host, Dave Johnson. I'm also the CEO of 4sight Health. I'm a recovering investment banker who discovered I was always meant to be a journalist. We coauthor a monthly thought leadership article with a rotating cast of senior bankers. Each piece becomes an exercise in examining a fascinating segment of the dynamic healthcare landscape. The focus of our articles and this podcast is on how to make America's fragmented, inefficient, and often broken system, more integrated, consolidated, efficient, and customer focus. So it delivers greater value and innovation to the American consumers.

Today I'll be interviewing Wyatt Richie who hails from the great state of Iowa. Wyatt is a senior banker focusing on post-acute care and outsource services. He joined Cain in 2010 and has 23 years of experience in advising public and private companies in merger and acquisitions, capital raising and strategic advisory transactions. His recent transactions include the refinancing of senior and subordinated debt for American surgical professionals and the sale of Sentara Healthcare to Kindred Healthcare. Wyatt earned a BA in economics from Saint Olive College and an MBA in finance from the University of Chicago. Wyatt, welcome to House Calls, where the bankers are always in.

Wyatt Ritchie (01:47):

Thank you for having me. It's a pleasure to be on.

David Johnson (01:49):

Why don't we start by having you tell us a little bit about yourself and what drew you both into investment banking and then the healthcare in particular.

Wyatt Ritchie (01:56):

That is a long story. Do we have two hours to talk about it?

David Johnson (01:58):

Yeah. We've got about two minutes.

Wyatt Ritchie (02:02):

I think the more interesting thing is obviously healthcare and the interest in care and investment banking is obviously, it's enjoyable to work with companies dealing with strategic problems and

opportunities. As I reflect back on it. It's probably one of the more complicated industries that we have. And so I think if there's a, one has a level of intellectual curiosity, healthcare is an endlessly fascinating industry to spend time in. And it's clearly an industry that needs a lot of help and needs a lot of learning. And we're probably in a phase where outside industries are starting to have more of an impact on healthcare than they have historically. So it's going to be interesting to see where healthcare goes.

David Johnson (02:44):

So which presidential candidate are you advising on healthcare policy?

Wyatt Ritchie (02:47):

It is interesting, David. That's really not been a topic in presidential politics, in any significant way. So I think that might not be this election cycle, but it's going to quickly become front and center again.

David Johnson (03:02):

The article you wrote together, which by the way, was a lot of fun. You and I wrote together. Getting urgent about urgent care, health systems go big on retail, allowed us to dig into a market oriented aspect of the healthcare delivery platform. So for our listeners, let's just start talking about the emergence of these urgent care practices. How new are they? Why are we starting to see them everywhere? How big an impact are they going to have? How many are around the U.S. and so on. Wyatt, just want you to give us your thumbnail sketch of the urgent care sector and how it's evolving.

Wyatt Ritchie (03:36):

Yeah. Well, it's interesting. I mean, it's not a new sector and I think that urgent care is probably been around 20 or 30 years. What has happened though is it's definitely morphed for a variety of reasons. I think the original emergence of urgent care was really a release valve for people who were going to the emergency room and having the pleasant experience of being in an emergency room. Particularly for those that had the lumps and scrapes and maybe a broken bone, that didn't necessarily need to be in an emergency room. And so I think the original evolution of urgent care was really to fill that niche and do it outside of the hospital. And so now that went along for quite some time. And a lot of it would be primary care physicians or urgent care physicians, or maybe some companies that would start these offices or start these operations.

And maybe they'd open up a few locations. That was original urgent care, if you will. And that's over the last 10 years, maybe a little bit longer though, the businesses definitely evolved. It's still doing the original the tasks that it was intended for. But given the access to primary care and the fracturing of historical patient primary care relationships. But it's also filling a void of acting as a primary care physician. And I'd say, that's where people are getting more interested in health systems are getting more interested as, in that front door, primary care aspect of what urgent care is evolving into.

David Johnson (05:20):

Yeah. So it's really gone from the doc in a box model, which was really just dealing with kind of small routine conditions, more quickly to something that is much more satisfying to a lot of consumers, which is getting whatever they need that's relatively routine, including primary care services, when they want them on their terms. And that's just another example of how consumer purchasing patterns are starting to wreak havoc with the healthcare industry, which has traditionally operated out of these very, and continues to operate under these very large, complicated, centralized, and very expensive locations.

Wyatt Ritchie (06:04):

As you know too, and very provider centric. The consumer has to conform their day around the provider, which for most services that we consume outside of healthcare, as you said, it's when we want it. How we want it. And so those aspects of consumerism are clearly moving into healthcare more dramatic ways than they have historically.

David Johnson (06:28):

Well, I know one thing that struck me, as we were writing these and get to the 30,000 foot view of why private companies are front and center here is, these companies like Go Health and Urgent Team and Physicians Immediate Care, they run a tight operation. I mean, they have the footprints down to the inch. They have the staffing down to the individual.they watch their net promoter scores like a Hawk. They use technology in efficient ways. And when you contrast that to the way that hospitals tend to build facilities and operate them, it's almost like looking at different planets. So maybe you could just talk about how the urgent care business is moving onto main street, and into the malls and so on, pretty much everywhere you turn. And how they're starting to partner with health systems. And how health systems, the smart ones anyway, are beginning to realize, there's no way they can be as good at this particular line of service as these urgent care companies that do nothing but this and how they're starting to find each other?

Wyatt Ritchie (07:40):

Yeah. I mean, it's a good question. Clearly, when you think about cardiac surgery versus coming in for a flu shot or coming in for a quick appointment, the dollars at stake are much different. The margins are different. And so I'll focus on efficiency. And some of the things that you were talking about. Frankly, it's required to be successful financially and it's really required to be successful when it comes to consumer event and environment. And so, as you said, a lot of these companies that have focused on or one operating in an environment where the dollars just aren't as great, you have to be much more precise with cost, particularly staffing. Staffing is usually a big part of it. And you need to be really adept at using technology. Once again, we're now in an environment where you can pretty much order anything you want on your phone. You can track services coming to you or products coming to you.

And so the consumer now is much more oriented, taking more control and more transparency. And as you well know, most of healthcare is not oriented towards transparency nor simplicity. And so I do think that, as you talked about it, these urgent care companies have been taking a lot of the lessons of retail and of other aspects of consumerism and applying them to healthcare in an environment that is small boxes, and low revenue and low reimbursement. And trying to become as absolutely efficient as possible, which is pretty much the exact opposite of what big health systems have generally been focused on. As I said, you said, it's big campuses and it's not efficient because the dollars have been on the system that they could essentially not be focused on efficiencies. And it's oriented towards the physician. When everything's oriented towards their needs and schedule, as opposed to the consumer's needs and scheduling. And so it's just a fundamentally different environment. But if you believe the world's going more towards that retail environment, you've got to figure out ways to capture that without totally reinventing yourself. And that was somewhat the Genesis of our article.

David Johnson (10:16):

Yeah. So why not talk about it from the health system side. And we spent some time interviewing Trinity Health and they're in 75 markets, some huge number of markets. And are pursuing partnerships in several of those markets with urgent care companies. What are you seeing on the other side of that.

And what are the health systems get out of it? And then what are the urgent care companies get out of it? And why are these, sometimes marriages made in heaven and sometimes marriages made in hell, I guess?

Wyatt Ritchie (10:47):

Yeah. Well, I think there's a lot of motivations for health systems to do this. And each one's probably got different priorities in terms of what those motivations are at its basic level. A lot of health systems realize that the emergency room visit is not a particularly pleasant experience for most consumers. Particularly those attractive commercial pay consumers that they're interested in garnering market favor with. And you come in with a broken bone want to get it fixed, but you're sitting there for eight hours. And just about when you're ready to go in for your setting, another more emergent patient comes in and you got to go back into the waiting room. It's just, it's not a great front door from a hospital point of view. And so there's some hospitals are very sensitive to that, in creating an environment that creates a more consumer friendly front door for them. And they see urgent care as part of that.

Others are more focused on broader continuum of care. Wanting to be not only that backend provider of high-end health care services, but move out into the community, have more presence and start interacting with the healthcare consumer earlier in the system. And when you're a primary care patient and build that bond, you overlay that with potentially some systems getting into the risk game and wanting to then become more broadly evolved and involved with healthcare. That's another motivation. So as opposed to just staying on that campus and being the last bastion of high-end specialty care, they're trying to move out and take more control over earlier stages of care and potentially manage risk. And they said that front door, primary care aspect of urgent care is an interesting way to do it. And so that's another aspect of how they think about it.

David Johnson (12:59):

Yeah. Where does branding come into this, both the urgent care brand and the health system brand?

Wyatt Ritchie (13:04):

I would say I've always felt, depends on the health system, but a lot of health systems and local markets have got very good brands and very good reputations. And so we've seen a variety of models where you will use that brand as the lead on an urgent care site. You will see where you co-brand. And then you'll see in other environments where the urgent care provider is the brand in that market. It's still early in the branding game, I think in healthcare. So I'm not sure anyone's got a particularly strong brand on either side, particularly outside of a single market. I'm not sure that there's necessarily a national brand from a provider point of view, that's got any particular strength right now. So I think that's a evolving and there's, I've seen a variety of ways that people have tried to create brand.

David Johnson (14:02):

It does feel like it's still working itself out a bit. Well, I've got this idea. Let me run it by you. That we've moved from an era where hospitals were independent entities. And then in the late '90s, we started to see the formation of health systems. Most of which were holding companies. They started experimenting with this concept of systemness. Many of them have migrated to be more operating companies, and I'm trying to figure out what that means. A lot of it internal, less external. And I think the next evolution is going to be what I would call a platforming company, a little bit like an Amazon. In the sense that, what Amazon does is, it assembles capabilities. Whatever achieves the best product, the

most competitive price with the greatest service for the customer. And they plug and play with partners and subcontractors to make that happen.

And I'm starting to think with healthcare, at least for the companies on the real cutting edge here, they're going to be less concerned about locations and control and ownership, and more concerned about creating a uniform customer experience with a strong brand. So pick your health system, XYZ health system will be your partner in health. There'll be on your phone. You'll have access to them at convenient retail services. If you need something big, you can go to one of their hospitals. But it won't be the heavy facility centric in the future. And if you generally agree with that, and my guess is you probably do, but feel free to disagree. That we're going to see these urgent care companies plug in, in this platform like way, within a seamless network that consumers can interact with 24/7 in whatever ways make the most sense.

Wyatt Ritchie (15:57):

That's an interesting idea, and I can see some applications of it. But one challenge, and I don't think it's an instrumental challenge. But as you know, the interesting thing about healthcare is that, a lot of it is such an intimate act of a surgeon sticking their hands in someone's body in that moment, or seeing you in that patient's office or whatever. That controlling quality, I mean, controlling, what that experience is like. And it's also, there's a lot of labor involved. That it gets a little bit harder to do that than pulling a product off a shelf and putting in a box or picking a vendor. But having said that, I think there's clearly some lessons and I think we need to go more in the direction that you're articulating. So I wouldn't suggest that we should throw our hands up and say, oh, well, we'll never work. Because we do need to integrate this.

We do need to make it more seamless. And I've not seen yet whether it's a health, a payer or a health system do that particularly well. And so maybe it will be a technology platform that does it. But we need to get there. There's no question about that. The redundancy, the waste, the costs that really are not needed, definitely needs to be taken out of the system. And we've got to clearly make the dollar that we spend on healthcare go further than it is now. And that pressure is going to amp up. And something like you're talking about, I do think would help in that. And I do think getting the consumer involved in that. But the paradox of healthcare is, as I said, I mean, scale's important, but it's a very intimate service that's provided, with a lot of labor.

David Johnson (18:01):

I especially feel that way when I'm getting a colonoscopy. One of the more routine diagnostic procedures, and you can get it done for 500 bucks in a physician's office where you take a few Tylenol, or you can pay five grand and get it done in a hospital with an...

Wyatt Ritchie (18:17):

Exactly. I mean, that's where people just shake their head and there's no transparency around that. And that's where we could do much better than we're doing, around just taking out some of those vagaries, which make no sense, and they don't make any sense.

David Johnson (18:34):

Bring it back full circle to where we started. I think as we start to change the way we pay for healthcare. So the more people that are in Medicare advantage types of capitated programs, or people paying full risk bundles in some form or another, that the buyers of healthcare are going to become more diligent in expecting value out of the system. And therefore for routine things, like you can get in an urgent care

center, even if they are some of the traditional primary care services. Why not, if you're Trinity or another health system, partner with companies that can handle that part of the delivery system.

Seamlessly, make sure they're plugged into your electronic medical record. Make sure they've got great engagement with your patients. Make sure you're doing net promoter scores on it? I just think that's where the market part of this will have more and more impact is, on these routine services where we have enormous price variation and really uneven service levels. Companies are coming in, like these urgent care companies we profiled in our piece and are figuring it out. And the question for the health system at large is how do we take these pieces and put them together in ways that really deliver and delight those of us who consume those services?

Wyatt Ritchie (19:56):

I agree with that. I mean, urgent care is one aspect of where we've seen health systems interested in partnerships. And it's a little bit of a variation of your Amazon analogy, but, I do think that we are seeing health systems beyond just urgent care, much more open to bringing in partners and aligning clinically. And then aligning economically to unify, but at the same time to the point we raise, there's expertise out there, that's not residing within the house system that can be brought to bear urgent care. In our example, to create a much better outcome than trying to do it on your own. And so I think that is one way we're seeing the health systems play a role and become that unifying factor is, trying to do partnerships with a variety of different companies, around different clinical aspects of the health system to get to a better outcome. A more efficient outcome. A better consumer experience, et cetera.

David Johnson (21:09):

Well, Wyatt you've got your finger on the pulse of retail health care, post-acute healthcare, some of these areas that are really going through disruptive transformation as, as well as anybody I know. Probably land with this question. But you look out five to 10 years, is healthcare inflation still going to be going up at five to 6%? Will we see twice as many, five times as many of these kinds of retail services? Will there be much more integrated care? Will consumers have a larger role than they have today? Look through your foggy crystal ball and tell us where you think these bottom up retail pressures are going to take the industry in five years. What's it going to look like?

Wyatt Ritchie (21:53):

I have to back to one of the comments I had up front, around presidential politics. There is no question that when you look at the Medicare forecast in terms of expenditures and where we are demographically with the baby boomers, that we are going to very quickly have healthcare, once again, become a front and center issue. Because it's going to put just a tremendous amount of pressure on the federal government budget. And so I think then, it's going to come down to questions about, what is the social contract? How are we going to deal with it? Are we going to what the market deal with it? Which I would argue Medicare advantage is a way that the market's dealing with it, or are we going to have it become, just government's fiat and make those decisions? That's a fundamental question that I'm not sure I've got the polls on. The electorate as to where they would fall on that issue once fully informed.

Being a university of Chicago guy, I mean, I'd sure like to see the market more involved in solving some of those issues. I think it, despite sometimes it can get a little ugly. It clearly gets to, I think the right answer a lot further. And I do to your point that you've raised. And I wholeheartedly believe, I would just love for there to be more consumerism, more transparency injected into healthcare. I think that would go a long way to helping, just at a first blush, eliminate some of these vagaries that we're talking about. The $500 colonoscopy versus the 5,000. I mean, you just think about that apply across a

whole variety of fronts and to my earlier comment, I think we can make the healthcare dollar go a lot further by just dealing with some of that stuff. And information, and motivation and transparency with the consumer would really help deal with that.

David Johnson (24:10):

I call a lot of that behavior, the $5,000 colonoscopy, I call that in-dumbened behavior.

Wyatt Ritchie (24:16):

Yeah, it's true. For whatever reason we chose for healthcare to be employer sponsored benefit and insurance inserts itself into the decision-making process and government on the Medicare side. And so, yeah, it is the one area of our economy. And you think about it's the largest segment of our economy, which consumerism does not have, the market does not have much say in how things get allocated.

David Johnson (24:48):

And I'll end with this. But it's a funny business, right? In the sense that the principals and probably 90% of healthcare transactions really don't interact with customers. You and I go to the doctor, doctor tells us what to do. We do it, and somebody else pays for it. So it severed that buy, sell link and all the signaling that goes back and forth. Well, Wyatt this has been a blast. We've been talking today with Wyatt Richie, a managing director at Cain Brothers, about the emergence of urgent care partnerships with health systems and why that's happening. And what are the implications for healthcare when we actually care about price, and service and outcomes. As I said, why it works for Cain Brothers, which is a division of KeyBanc Capital Markets and a member of FINRA and SIPC. So Wyatt, thank you so much for being with us today.

Wyatt Ritchie (25:43):

David thanks. Always a pleasure.

David Johnson (25:45):

Thank you to all the listeners for tuning in and catch us next time on House Calls, where the bankers are always in. Cain Brothers is an investment bank focused exclusively on healthcare. The bankers at Cain stand apart because of their deep knowledge of the healthcare industry and their practical know-how when it comes to executing complex transactions in all healthcare sectors. These include healthcare services, medical technology and life sciences. I'm your host, Dave Johnson. I'm a recovering investment banker who discovered late in my career I was always meant to be a journalist and maybe even a podcaster. I'm also the CEO of 4sight Health and the author of two books. The most recent of which is, the customer revolution in healthcare, delivering kinder, smarter, affordable care for all. I love talking to other revolutionaries who are driving change in the healthcare industries.