
**Talking Pop Health**
Episode 13: Hector Torres on the health care outlook for 2022
Episode posted: May 5, 2022

Eric Tower: Welcome to Talking Pop Health. My name is Eric Tower, an attorney at Thompson Coburn. Today, I am elated to have our first ever repeat guest, Hector Torres from Focal Point and we're going to be talking about the outlook for 2022 and some recent developments effecting POP Health and health care generally. With that, I'm going to leave it to Hector, here, to introduce himself and give more background.

Hector: Thank you, Eric. Great pleasure to be with you once again. My name is Hector Torres. I'm a managing director and have the pleasure of co-leading the health care investment banking practice at Focal Point Partners, a diversified, global investment banking enterprise with a strategic focus on the health care industry.

Eric: So Hector, I want to get to the elephant in the room. Right upfront if I can. President Biden gave his State of the Union speech a few days ago. And, frankly, he took a whack at private equity in health care. It was focused on the nursing home industry and he made a lot of strong statements about private equity and the damage he feels that it's doing to the industry. I just wanted you to give a few thoughts about what you think about that.

Hector: Yeah, you know, sort of mixed emotions. Certainly there are valid points to the President's speech. convention for institutional capital, right? All institutional capital is seeking return on investment in yield and it's seeking to deploy capital to see that yield in segments of the economy that are ripe for consolidation or improvement, right? Health care happens to be extremely inefficient and segments such as nursing homes, home health and other categories that in the last decade have really become areas of focus for private equity are such because they're ripe for capital infusion in order to address and rectify all the inefficiencies in those market segements. Now does it academically work that way every singular time? The answer's no. We always tell our clients that are considering private equity as a potential partner that private equity isn't for everyone and everything. It tends to be very popular these days and they are driving a lot of the M&A activity but it really comes down to what is that health care organization's goal? What are their strategic objectives? And how could private equity potentially help accelerate, catalyze or influence in a positive way the attainment of those goals. If the health care

industry was absolutely as efficient as, say, the airline industry, which 100 year ago there were at least 50 airlines. Today there are only a handful because it's completely consolidated and arguably become much more efficient than it was 100 years ago. If that was the case in the health care industry, you wouldn't see the prevalence of private equity seeking opportunities to make money by creating efficiencies and economies of a scale within health care.

Eric: My own perspective is he might be gravitating or focusing on a few bad actors. We haven't discussed this. I even discussed that on this podcast before but I've done your work and it was turn arounds. The facilities that my client was acquiring were distressed. And they were distressed for a reason. When they went in they had a lot of stuff they had to fix. I even had the joy of state regulators in many states saying "tell your client not to bother to buy this place because we want to shut down anyway". When you're coming into some of these places and someone's already made up their mind that you're a bad actor, it's real easy not to change your mind and to go back to what you already think you know and then you fail to notice the improvement, the turnaround. The fact is the nursing home industry is a low wage industry. The staff often aren't really happy and --

Hector: I don't know very many people who want to be in a nursing home.

Eric: But let's go a little out of the nursing home industry and look at private equity generally. I read Modern Health care occasionally when the articles land on my desk. Frankly, I don't think it has a lot to say. It's sort of a gossip mag for the health systems. But they're constantly whacking at private equity.

Hector: Yeah.

Eric: When we look at the service line private equity that we're starting to see, that we've seen for a while now, I guess, there's no doubt that it's shaking up the systems and it's shaking up the status quo. Do you have the perception that that is something that's good for everyone? Or do you think that this is something that's undermining how health care is being delivered?

Hector: It's a great question and it's frankly a question that a lot of our clients ask. They typically ask if private equity is good, bad, or whether it is everything we hear and read about. The reality is it's not unlike any industry or any service category. You have variability among the players. The variability is in terms of levels of sophistication, understanding and overall behavior. Are there bad apples? Sure. I mean there are bad apples in every aspect of life and every industry of the economy. But what we find is there is a prevalence and a predominance at least in the last 10 years of private equity firms that are very sophisticated in their

understanding of the health care dynamics and landscape today but more importantly, I think, very attuned to the evolution of the health care ecosystem. We like to think of those private equity investors as being thematically driven. They not only understand the current state of the environment for health care but they also understanding where that proverbial puck is going to be versus where it is today. In those we find to be the most sophisticated and the most in alignment with health care providers, in particular, but all constituencies across the health care continuum in general.

Hector: And once those groups start to really realize and post up big wins and show very early success then you see other early movers of private equity firms say “hey wait a minute there’s something here in this new clinical category, maybe we should do that. Now in dermatology for example, there are now over 50 plus private equity backed platforms. That is what’s driving a lot of the activity and the investment from the private equity community in segments today, like urology, like musculoskeletal care, like otolaryngology and other segments. So it’s a very, very systematic shift in the paradigm today.

Eric: So 25 years ago when I was doing some of this stuff, it was reimbursement-driven. I think for a lot of the private equity now, the ones that are likely to be successful, they’re the ones who are adapting to the reimbursement models that are coming or that are in front of them and other people have been slow to react. By the same token, how do you respond to say a health system that says you know, you’re hauling us out. You’re taking business that we could be doing and you’re flipping it to for-profit and that’s harming communities.

Hector: Honestly it’s not singularly coming from the private equity community in terms of that approach and in terms of the health system’s response. I think that the health system, unfortunately, is facing that on a variety of fronts. You have Optum care which is now the largest employer of physicians in the United States. With regards to Private equity, I don’t want to say that they take a more passive approach because by definition they’re not a passive investor, but private equity is much more attuned and open to saying rather than have a negative or a adversarial dynamic with the local or regional health system, if there are ways to partner through joint ventures, even PSA arrangements or other waysPrivate equity’s saying look, we’re going to grow our footprint, we’re going to grow our ambulatory surgery presence, we’re going to invest in ancillaries, we’re going to invest in data analytics and IT infrastructure to enable value-base care, etc.. But if we can do that in partnership with the hospital and the health system we’re game.

Eric: I think one of the things that I find most interesting is the proposition that private equity gives the physicians. So what they

say is hey, you're not going to be just a referral source. We're going to build our model around you and your patients and we're going to do everything we can with those two constituents in mind. We're going to make money but we're going to do it in a way that is not turning you into just a clog in the machine.

Hector: Yeah.

Eric: I think that resonates with a lot of doctors.

Hector: It resonates supremely. The other thing that can be a little bit of a misnomer is that there's always a negative fantasy around is someone in New York City going to be telling me in Phoenix, Arizona how to practice medicine? The reality is most states you prevent this dynamic by law. As a private equity investor, I can't tell the physician how to execute clinical protocols. That autonomy, that clinical governance in autonomy typically lies 100% on the side of the physician. So now you have the same level of clinical autonomy that you had before you partnered with private equity but depending on the structure of the transaction in partnership with private equity, you've monetized a significant portion of the value of your practice at a premium value and now you have a majority equity partner that has access to a fortitude of capital and, if it's the right partner, has a vision for what are the immediate, intermediate and longer term growth opportunities that we want to pursue in partnership.

Eric: I don't ever talk law in these podcast but I just want to note that there is a court case in California now challenging the models that we commonly see in the private equity.

Hector: Meaning the friendly PC model.

Eric: Yeah, and I'm watching that because it would turn - -

Hector: It would turn the whole industry on its head.

Eric: Yeah, but I don't think it's far for people to kind of say well, we want doctors to own the business but they're really just tools for these legal private equity people in this black box.

Hector: Right.

Eric: That's, to me, a little ludicrous but we'll see that the court thinks. My opinion doesn't matter.

Hector: Exactly.

Eric: What are some evolving models that you're seeing? I could tell you a couple of observations. One thing, please call up and they say hey, we want to do a roll up. And I say what's your model and

it's the old physician practice management, the PPM model from 19 years ago

Eric: We're going to provide back office and negotiate better agreements. And those are people I don't put a lot of effort into talking with because that didn't work so well and I don't see why it would work well now.

Eric: Then, of course, we've got some of these other models that are taking advantage of value-based care. What are you seeing and how are these people approaching their partnership process?

Hector: I would say the current market environment definitely still has a very high degree of optionality sitting from the physician group or any health care services entity that's considering some sort of a sale process or strategic partnership or affiliation. Whether it's selling a minority interest, a majority interest or the whole thing, without a doubt. There's a direct correlation between the success of any partnership and the level of integration of that ownership post-transaction. Meaning, to your point regarding the of evolution and application today. Those deals didn't work because those practices were really loose confederacies. A physician groups that on paper said hey, we're going to get the benefits and all the synergies of being part of a larger national enterprise but we're not really going to integrate at the local, regional or national level in any way, shape or form. You're not going to get the benefit of becoming part of a larger enterprise under that model. We saw it in Physicians Corporation of America. We're seeing it today with models that have a very similar architecture and structure and the physicians sort of call us and say three years into this, we're not getting any benefit. We sort of feel like this rudderless ship sort of left astray. Yeah we're getting a little bit of pick up on our operating expenses and our group purchasing and some of those minor operating expense synergies. Yeah, sure, yes. But beyond that there's really no benefit. I don't want to say carte blanche it never works out. There are a few models that we've seen in that regard that have had some success but you have to integrate clinical, financial operations and strategy. All those elements have to be focused in on thoughtfully in order to really get the benefits of a partnership.

Eric: Well, if you're going to do value-based care.

Hector: Oh without a doubt.

Eric: Then --

Hector: Without a doubt.

Eric: That's an absolute necessity.

Hector: Without a doubt. All of the cables need to be plugged in and they all need to be coming in and brining in information centrally in order for a value-based model to actually effectuate.

Eric: So when you're doing this and I'm going to emphasize I view you as being more on the PE side. But it's important to partner with the systems. Certainly you can't go it alone without them in many instances. What sort of models are they using or approaching or examining in how you're going to partner with systems?

Hector: A lot of the hospitals, I think in the last decade, have realized that when a potential physician group that is in some way, shape or form, affiliated but not necessarily employed by the system, approaches the system, they approach them in a variety of ways but it's typically one of several. Hey, we've been approached by private equity. We think the model's compelling. Can you do something similar because we've had a longstanding relationship with you? Or a derivative of that is okay Mr. Hospital and health system, you want us to become more integrated with you. We explored private equity. It had attributes but at the end of the day we didn't think it was a good fit. But how can you assimilate more to that model versus the legacy models that the hospitals deploy historically which is very simple, become an employee. We'll pay some fair market value purchase price for the value of your enterprise but it always pales in comparison to a for-profit aggregator like private equity. What we've seen and really more so in the last five years is the hospitals being a lot more thoughtful in actual deploying and offering physician entities PE-like models. Whereby they recapitalize on a majority basis the existing physician enterprise but allow the owners, the physicians of that entity to rollover some form of minority equity ownership so they have that proverbial skin in the game and upside. Now there are a lot of variances because the hospital and health system is not an investor, they're not seeking to aggressively invest and grow and not working within a very finite time period like private equity. So there are very different nuances but they have been a little bit more forward thinking overall.

Eric: Is it a problem that there's no pot of gold at the end of the rainbow?

Hector: It's the biggest problem. A lot of the virtue of a private equity investor coming in is the thought process of hey, I can monetize the majority of the equity value in my practice today, rollover a significant amount of that, 25, 35%, whatever that is and in the next two to three years our private equity partner is going to invest, grow and present to the market at the end of their investment horizon an entity that is much more valuable. The physicians are able to realize that second bite at the apple or that second liquidity event and if done right, and we've witnessed this with our clients, most of the time that second liquidity event can

make the first one almost pale in comparison. That's really one of the key appeals and drivers of why private equity has become so compelling. With the hospital and health system you don't have that second bite. They typically end up in some sort of right of first offer or right of first refusal, upon retirement or upon some later date or event but it's never going to realize the economic value that the private equity's second bite at the apple does.

Eric: We touched a little bit on the role of insurers in driving this change. What do you see happening with your insurers and how are they responding to these changes? Are they encouraging it? Are they discouraging it? Because frankly, most health care providers view insurers as the enemy.

Hector: I think they are definitely sort of sitting back a bit and seeing how the evolution takes hold. I don't think they're pro private equity. I don't think they're pro hospital and health system. I think the insurance constituency is pro insurance constituency If they are pro private equity in one regard it's that it's very difficult for even a large independent physician group or really any health care services enterprise to really operate within value-based care at scale. There's so many roadblocks and impediments. First of all, your data analytics and IT infrastructure has to be cutting edge. That's expensive. How do you finance that infrastructure? And beyond just the nuts and bolts of how do we get the infrastructure, there's a human capital element. You can have all the infrastructure, but if you don't have administrators and professionals that know how to operate within a value-based care environment you can lose a lot of money very quickly. It's almost like managing a hedge fund in a way. I think the insurance companies are really gravitating towards private equity partnerships with physician practices and other health care entities where they're bringing that level of expertise, infrastructure and capital to really empower and position these entities to be relevant in value-based care.

Eric: Let's be clear, insurers are also blurring the lines between insurance and provider. They're starting to enter the market themselves.

Hector: Totally.

Eric: Lot of activity in the primary care market at this point.

Hector: A lot of vertical integration.

Eric: It used to be the lines were pretty clear.

Hector: They're pretty gray these days.

Eric: They're very gray right now. We can look at CVS and where they are and you know, they're not a pharmacy. They're not an insurer and they're not a medical provider. They are all three.

Hector: That's right. Even looking at an organization like Amazon and how they've really thought about – look, Amazon isn't going to enter a segment of the U.S. economy unless there's a really compelling market opportunity. That box is checked with health care. I think there was a little bit of a naïve point of view a few years back when they thought well we can just attack health care the same way we've attacked every other industry that we've had success in and I think they've realized, wow, it's really complicated and really challenging, but you will see more and more nontraditional market interests over the next 10 years. Without a doubt.

Eric: And are those models forcing consolidation in scale or is that just sort of the natural outgrowth of how the market is right now?

Hector: I think without a doubt it's forcing it. It's forcing consolidation. There's no way to get the economies of scale in an industry as fragmented as health care; and in particular, health care services. By definition, for example, to be relevant in population health and value-based care, what are the ingredients? Size, scale and market indispensability. You need attributable lives, right, in order to have the profile to be relevant and actually make money in value-based care. And that's one element that's driving consolidation. And we'll see more and more of that over the next decade.

Eric: So are you seeing Covid impact things at this point?

Hector: It's been a fascinating dynamic. Covid has really, if anything, forced independent health care providers to do a lot of soul searching. I can't tell you the number of groups, physician groups in particular, that we've met with, have spoken to and we've had conversations and they've ultimately said you know we really appreciate your insights but we're furiously independent. We don't necessarily need or want to do anything. Having been ravaged by Covid as an independent provider of health care services, those are the groups that are saying what are our strategic alternatives and how does a potential partnership with the hospital with a strategic aggregator or private equity, how will that help ensure our long-term sustainability because that's what it has really comes down to. I think what Covid did was it really addressed and cut at the heart of the weakness inherently of an independent provider of health care services. How do you maintain your workforce? How do you maintain continuity of services? How do you finance your day-to-day operations when a global pandemic effectuates your revenue stream. And how can you sustain that over a prolonged period of time; very difficult. A lot of groups didn't make it and the stronger groups really felt the pain and came out

of that global pandemic in a much weaker state as an organization. I think Covid was a glaring example of all the things we talk about in terms of what are the black swan events that you're not even thinking about, but could systematically change the practice of medicine and the viability of your practice.

Eric: If I've got a group, let's say it's a specialty group. I've got 15 providers and I pick up the phone and I say hey, Hector, what do I need to do? The world is changing. I'm a physician. I'm not a businessperson. What should I do to get ready? What do you tell them?

Hector: I answer their question with a question most of the time and the question is well, what are your goals? What are your objectives? What are the challenges that you foresee in the immediate, intermediate term? What are the differentiating factors that have driven the success of your practice to date as an independent practice? So the first thing that we encourage all of our clients to do and it's difficult because it's usually very hard and they usually don't like what they see but we encourage them to say take a really long, hard look in the mirror as an organization. And be real with yourselves to say what do we do well. What are the things that we do okay, but we could improve a lot and what are the things that are really putting pressure on our sustainability over the longer-term. When they're able to do that, a lot of them come to the realization is, you know we're good at one thing, practicing very high quality medicine. We would love to have every other aspect and feature of our enterprise be at that highest level as our practice of medicine is. How do we do that? Sometimes they can do that independently. Sometimes it's a matter of optimizing your administrative personnel, beefing up your infrastructure and back office and all the things that go into the day-to-day operation of the enterprise but sometimes it's very challenging.

Eric: I think some people, maybe, are under the impression that gee, if we buy an EMR and get a little IT capability, we're good to enter this new world.

Hector: Exactly.

Eric: Do you think that's accurate? To me, one of the key components of a lot of the value-based relationships is care coordination, care management, developing protocols and data so you know exactly how to treat your patients and you're responsible for them even after they leave your office. But what are you seeing around that?

Hector: I'm seeing, frankly, that there is an inverse relationship between what that practice believes they have in terms of capabilities and what they actually have in terms of capabilities. Meaning, when we sit down with a potential client or a new client and say okay, tell us about your financial reporting and controls, for example. Oh

we have an EMR, everything's synched up. Our chief administrative officer, will get you all the information. Well, that's great. We exit that meeting. We jump into the administrator's office and we say ok, so do you have site level financial reporting and controls and can you dissect clinical performance matrixes and KPIs by provider, by subspecialty and they're like we can't even get the clinics to talk to each other. We don't even know, I can't even get you site level KPIs, let alone quarterly or annual financial statements by provider, by site. There's a massive gap between what a lot of the providers believe they have in terms of expertise and capabilities and it's not so much on the capabilities, it's on the expertise. On the human capital side versus what they actual have in day-to-day sort of operational capabilities. A very huge disconnect there.

Eric: So how do you approach that? A lot of them, if they think they're great, how do you get them to see the world? Do you change their view or do you just --

Hector: The worst thing is for that enterprise to continue on this line of thinking of "we're great; we're at the cutting edge and we need nothing in the way of optimization". That is a really, really bad place to be. Most of the time it's really positive for them to come to the realization of "wait a minute, we're not as sophisticated or we're not 'as good as we thought'" because that helps inform their goals and objectives. I know it's sort of a weird dynamic to say finding all these deficiencies is a good thing. It is. Because the worst thing would be to not acknowledge or even realize that those deficiencies are there.

Eric: Is the ultimate goal here to take full risk, take full cap?

Hector: It is eventually. But hasn't' that been the goal for the last 30 years?

Eric: Well it has and there's been some spectacular failures. And I'm sort of waiting for the next wave of failures, to be honest, just based on my observations.

Hector: Yeah.

Eric: But again this draws us back to the insurance industry. If I take full risk as a provider, who needs insurers?

Hector: Exactly. Exactly.

Eric: If I develop the capabilities you're talking about, the data analytics, the back office --

Hector: You become the manage care entity.

Eric: Right.

Hector: In many ways. I think it's a fascinating dynamic from the insurers side because they want value-based care but only up to a certain point. It's like yeah this is great, it's going to save and it's going to fix the health care system and it's going to make the patient experience better. It's going to make access to care better. It's going to make outcomes better. It's going to drive costs down. But we don't want to lose market share to the entities that are doing it at scale eventually if they can take full risk. So, there's sort of a push and a pull there.

Eric: Oh, in a big way. But they have two things. One is they have better insurance license which require some pretty big reserves.

Hector: Correct.

Eric: The second is they've got the broker relationships. The dark secret in health care that that's a black box.

Hector: It is. By design.

Eric: How they're rewarded and how they're incentivized definitely impacts how health care is delivered in this country and no one thinks of that.

Hector: No one. Because it's opaque by design.

Eric: It's not regulated in the slightest.

Hector: Exactly.

Eric: Even the anti-trust side of the insurance industry isn't regulated so there's very little oversight to that.

Hector: Correct.

Eric: What do you see '22 holding for everyone in health care?

Hector: It's been fascinating. The year has begun at such an incredible rate of consolidation and market activity from a mergers and acquisitions perspective that, you know, we usually see a little bit of an air pocket during the holidays and things slow a little bit down and then folks are getting sort of back into the mix of things in early January and come February, things are sort of running at the same clip they were before we went into the holiday season. This year we never saw a break in the action. The only thing we saw was an intensification in both the velocity and volume of dealmaking. We foresee that the level and pacing of dealmaking in the first half of this year will probably intensify to levels that perhaps we haven't seen in a very long time. But we do foresee

that there are a number of variables that could really, really effectuate a slow down,and those variable are likely to be in play in the third and fourth quarter of this year.

Eric: In what sectors do you think, you're expecting those changes? Either increase in volume or decrease.

Hector: I think they'll be a potential slow down within physician practice management across both single specialty and multi-specialty physician groups. We all know the biggest driver of volume of activity and velocity of activity has been private equity. Private equity is really driven by the capital market environment. Private equity funds structure their deals whereby it's like mortgaging a house. They'll put in their own money but they'll really raise the majority of the financing for the transaction by taking out debt. And their ability to actually consummate the transaction at all is driven by the cost of capital of that debt. Conversely, I think that the slow down in private equity investment activity this year creates a lot of opportunities for the other constituents and players in the M&A environment. Meaning I think it's going to create more opportunities for the forward-thinking health systems that are more well capitalized than the smaller, independent, community-based health system whereby the slow down in private equity will create effectively an air pocket for them to have a more relevant seat at the table in having these discussions with those provider-based entities.

Eric: So whereas a lot of them put their activity on pause due to Covid. They were filling in the bottom line. You're expecting Q3, Q4, a lot of more activity out of the systems and maybe, I assume, some of the PE players who were there and fully funded right now, they're going to keep going.

Hector: For sure.

Eric: Are you really talking about the potential for new entrants and some of the smaller players, kind of dropping off and then are you looking at maybe the collapse of some existing players?

Hector: Not necessarily the collapse. The fascinating difference between this hyper-consolidating market environment relative to the one that we saw in the late '90s is the level of sophistication now of all parties is like 4 or 5 standard deviations to the right.

Eric: 1998, yeah.

Hector: The level of sophistication and the acuity of knowledge of the current breed of investors in health care is such that they've underwritten a lot of the risks through the structure of their deals and they're smart enough to know what they don't know and a lot of the good ones have brought in industry advisors to either sit on

| | |
|---|---|
| | the boards of the companies they've invested in or help them as operating partners . |
| Eric: | So any last thoughts for the audience? |
| Hector: | The only constant in our industry, which is fascinating, is change. And that's not necessarily a bad thing if you're forward-thinking, if you're true to the values and the elements that make you what you are as a health care provider. Being thoughtful and realistic with who and what you are today and what you want to be tomorrow, I think that really lends itself to a much more intellectually honest discussion about what are the potential strategic alternatives before us and how should we be thinking about those really to effectuate long term sustainability of our enterprise. |
| Eric: | Well that's great. Well, Hector, thanks for appearing and we'll do it again. |
| Hector: | Awesome. Thank you for having me. |