Talking Pop Health
Episode 9: Aaron Newman and Hector Torres of FocalPoint Partners

Eric Tower: Hector and Aaron, welcome to Talking Pop Health. To kick things off, why don't you tell us a little bit about yourselves.

Hector Torres: Absolutely, happy to be here. My name is Hector Torres. I'm a Managing Director and co-head of Healthcare Investment Banking at FocalPoint Partners, where we focus on providing comprehensive strategic and financial advisory services to healthcare organizations of all sizes, shapes and types. My background has been one hundred percent dedicated to the healthcare industry within the M&A advisory space, with particular emphasis on working with hospitals and health systems, independent physician groups, and non-acute care providers across the U.S. It's a pleasure to be here today.

Aaron Newman: Excited to be here as well; my name is Aaron Newman, and I am a Healthcare Investment Banking Vice President at FocalPoint Partners. Very similar to Hector, I've spent the entirety of my career as both a consultant, financial advisor with particular M&A expertise in the service of a variety of health care organizations, inclusive of acute care hospitals and health systems, and in the most recent five years, working pon behalf of both single-specialty and multi-specialty physician groups across the country.

Eric Tower: So on this podcast, we've really had a lot of people on who are focused on population health as a care model or as a form of data or a way of interacting among providers. Can we focus a little bit here on why should someone care about pop health more from a strategic concern? I mean if I'm working with St. Elsewhere Health System you know, what, why do I care just as far as how I plan my business and strictly that?

Hector Torres: This is the proverbial question facing health care providers; population health is critical because it represents the foundation for true alignment with the value equation in healthcare and to the long-term sustainability of the industry. Population health enables providers to deliver the highest quality of care, in the appropriate setting of care, at the lowest possible cost. As we look to the evolving healthcare landscape in the U.S., it's not just a question of whether we should be thinking of population health, we absolutely must be thinking about population health, and importaontly, doing so within the context of the capabilities, infrastructure, and capital that will be required to effectively manage the health care needs of patient populations.

Eric Tower: So we've done a lot of work lately with non-for-profit hospitals who have seen really a shift in their business from the inpatient setting to the outpatient setting to provide that lower cost of care that Hector was eluding to and it's really transformed their business in you know, a couple years ago we worked on a project with North Well Health to essentially understand and help them build out their strategic plan for ASCs in Brooklyn, New York which is obviously an emerging population, a lot more affluent population but I think we're going to see a continued – we have seen and continue to see acute care providers across the country really struggle with how do we go from getting our business from an inpatient setting to an outpatient setting and how that's going to impact our financial strategy because it really is. I mean we like to tell a lot of our non-for-profit health care clients it's really a bifurcated market right now with haves and haves not and it's really all based on access and ability to have capital, right? You have your rural health care providers, your smaller systems in suburban and even metro areas that just don't have access to the capital markets that are losing margin and can't make the investment to keep up with information technology and everything that you need to invest in a population health strategy. Then you have your larger systems you know, here are your advocates which is obviously getting bigger and bigger by the second. You have a large balance. You can go to the bond markets and really do everything from a population health investment perspective that's going to enable him – them to skate where the puck is proverbially going.

Eric Tower: Let's be honest. Is this a voluntary transaction or are people – transformation with that --, is this a voluntary transformation or is this something where some people think they have a gun to their head and others, and we all know some, in your niche the large health systems, people who are saying ah we're going to ride it out. Well you know, there sometimes are management teams and boards that just figure you know things are going okay right now. Let's just sort of keep going the way they are. Are people really changing, do they have guns to their head? What's, what's going on out there?

Hector Torres: Healthcare in the United States is certainly very local. The dynamics are very different market to market and even submarket to submarket so it's really about understanding and appreciating those dynamics because those are the ones that are impacting how, as well as the velocity with which organizations need to incorporate population health as a core element of long-term strategy. That being said, all healthcare organizations should be thinking about population health, and being honest in terms of how aligned, or misaligned, their current organizational structure, capabilities and strategic imperatives are in this regard. I do believe there are, and will continue to be differences market to market, and region to region, but it will always be advantageous to position your organization as an effective manager of the health and well-being of the patient populations you serve.

Eric Tower: Well, I've had the opportunity to talk with fairly well-known consultants and thought leaders in the area and a couple of them have told me Eric, this pop health stuff is great but let's be honest. There's really very little at risk for the providers in this case. The way that things are done, you know you could have shared upsides, shared downside, people who are taking cap really are

only doing that within areas where they're very safe. How do you respond to that? I think that's – that's probably more accurate in terms of where the state of affairs is today. They're not. I would certainly agree. What I would say is I think we're going to see the evolution and again, I got back to the velocity of the change with regards to the relevance of population health management become more and more prevalent in, in markets that are already you know living with that dynamic and in others where it's not as relevant or hasn't really been a cornerstone of any material sense. We'll start to see more of it but, but I think that is a fairly accurate assessment, that you know it's really in its, in its nascency or infancy in terms of the overall impact that it would have in a transformative sense to the health care industry as a whole. but I do see it evolving and continuing to evolve in markets where it's already taken.

Aaron Newman: We work on behalf of many of the smaller regional health systems; organizations that have between $300 million and $800 million of net patient service revenue, and these organizations are very challenged from an operating perspective and most of those systems are just worried about improving their margins in operating their businesses and providing the best patient care as possible. Having said that, they don't have the time to even think about population health. Most of these organizations are somewhat stuck in a fee for service midset. And you know when we look at the other end of the spectrum with the haves, even those large, very well-capitalized systems, only a portion of their revenue is in value-based care. I think they're shifting that way and they're doing a lot of experimentation to understand what's the best model to treat patients from a value-based care perspective, but still the majority, vast majority of their revenue streams is just old fashioned fee for service and it's been a very, very slow change.

Hector Torres: Aaron really makes a great point regarding the concept of the haves and the have nots. The pure play example is certainly the hospital and the health system sector, but I think that the haves and the have nots are really across the spectrum of health care provider organizations. A few months ago we were readying a Moody's report stating that the average independent community-based health system has an operating margin of one percent. Now, that is a pretty well-run system because many health system clients we work with actually don't even have a one percent operating margin but to Aaron's earlier point, if you have a one percent operating margin and you've lived historically in a fee-for-service environment and your number one objective as the administrator of that system is to keep whatever wolf is at the door at bay that day whether it's you know, your day's cash on hand or your relationships with your physicians, the last thing that you're going to be focused on is a comprehensive population health strategy. For example, a health system like an Advocate that has the human capital, infrastructure and foresight to think strategically in terms of where is health care going in the long-term, ultimately has the luxury of integrating population health within its organizational strategy. The one percent operating margin independent community hospital that is struggling just to keep the doors open is in a much different position, obviously.

Eric Tower: Well, so this is interesting. I don't want to go too fast and, and I don't want to sit there and ask you a question that makes everything seem like a one size fits all.

Eric Tower: But let's say I'm St. Elsewhere, a one percenter –

Eric Tower: And, and I want to survive as a standalone. You know, and I realize this is one size fits all to some degree but where would you say I begin? I mean how do I, how do I even --

Eric Tower: Approach the world? I might or might not have some in-played physician practices. You know, people are a mixed bag there.

Hector Torres: Yep.

Eric Tower: I might have a home health agency --

Hector Torres: Right.

Eric Tower: You know, probably my contracting capabilities are marginal, my data --

Hector Torres: Hm mm.

Eric Tower: I might not even be able to scrape the data from my physician practices and do anything with it.

Hector Torres: Right.

Eric Tower: You know, where would you – if you were parachuting onto St. Elsewhere and said okay, we need to at least begin to get ready to transform we still want to survive, what would you recommend?

Hector Torres: Yeah, well that's, that's a great question because we parachute into St. Elsewhere every day.

[All laugh]

Hector Torres: We really live in St. Elsewhere, and what we see there day in and day out is thematic. By way of an example, a few weeks ago we were in St. Elsewhere and had a great meeting with the Board of an independent health system that is doing fairly well, but is seeing headwinds in terms of the effects of consolidation in the market, contrasted with their desire to invest in the resources and capabilities of the health care delivery model of the future. Needles to say, they are seeing immense challenges in doing that as an independent organization. So the first thing we do when we're parachuted into St. Elsewhere is we spend a lot of time with Boards, with the C-suite and leadership, and come strictly from a place of seeking to understand rather than being understood. From there, we begin working with them develop an articulation of their organizational goals and objectives, and ultimately arrive of what we call their guiding principles. And that's really almost a mission statement of who and what they are today organizationally and this is across

the entirety of the organization, and who and what they want to be in the future. This is the first step in charting the course for organizational transformation and long-term sustainability. In many cases, an achievable plan for the realization of these guiding principles can be executed upon as an independent organization, in other cases this serves as one of the many indicators that an organization may need to consider a potential partnership or strategic affiliation.

Eric Tower: So I'll throw out a little red meat here

Eric Tower: Why not, right? I assume you're both aware of the New England Journal of Medicine article statin that horizontal mergers in health care don't improve quality and frankly I beg to differ on that point --

Hector Torres: Yep.

Eric Tower: -- with the FTC. but that's just Eric's view of the world.

Hector Torres: Yeah.

Eric Tower: You know, what are you seeing with healthcare M&A generally? I mean they tend to generate a number of positives on paper, but how do organizations make sure that those quality improvements and enhancements really take place? Are you going through guardrails?

Hector Torres: M&A in healthcare has historically largely been driven by the pursuit of the vast array of financial, clinical and strategic synergies that come from being a larger, more well-capitalized organization. The work and rigor necessary to realize these synergistic benefits really comes in the months and years after an M&A deal is completed, and unfortunately, in some instances the synergies that were initially at the core foundation for the pursuit of an M&A transaction become a secondary or tertiary priority after the deal is done.

Aaron Newman: Yeah, I think that was very well-said, Hector. I would just add from a synergies perspective you know there's the Wall Street Journal article, there was obviously the article that you eluded to, Eric, a lot of negative press recently about you know horizontal integration and it may not have the benefits that we really think it is but you know, two benefits that I would like to talk about: one is just you know on the population health theme. In order to effectuate population health management effectively, you need attributable lives, right? And that's why you see a lot of these larger health systems going outside their primary and secondary markets in order to increase their access to attributable lives and pursue population health with a more robust patient population from which substantive data and analytics can be extracted.

Eric Tower: So in other words, to position themselves as a full cap --

Aaron Newman: Yep.

Hector Torres: Yes, exactly.

Eric Tower: Rather than just sort of just skimming off the margins.

Hector Torres: Exactly. I mean in many ways that is what the larger, vertically-integrated managed care organizations are doing on a macro-level. They're really in the population health management business.

Eric Tower: So boiling everything down, are you saying that you need size to provide quality care in the new world?

Hector Torres: In order to maintain market relevance and ultimately attain market indispensability you need size and scale. The days of the independent health care provider in the United States, whether that's the solo practitioner physician or the community-based hospital, are somewhat challenged because of all of the requirements necessary to remain independent.

I'll be a bit more controversial. My thesis is at some point in the future, maybe in 50 years from now, maybe a hundred, we're not going to have the thousands of hospitals and health systems that we have in the United States today. I think we're going to end up with fifty very large integrated health care delivery model organizations that are going to serve the entire continuum of care within their geographic regions or contiguous multi-state regions. There were still be organizations that are also national in scale, but there won't be the thousands of healthcare provider entities we know today.

Aaron Newman: I agree completely with Hector and I think the footprint that we currently have, the bricks and mortar footprint, will be completely transformed and it's beginning to transform obviously will elements such as telemedicine and telehealth. The acute care setting footprint is just overbuilt in this country and the way health care is heading, that will need to change and ultimately I think this is what will drive the cost of care down and also provide better care for patients.

Eric Tower: Let me come at things from a little bit of a cynical aspect.

Hector Torres: Please do.

Aaron Newman: We love cynical.

Eric Tower: So, you know, could it be argued that some of this consolidation is just a response to these big payors who hold the purse strings and the only way the providers respond is by banding together and becoming larger themselves? And you've also got a government that frankly doesn't like regulating fragmented industries. We all know regulating widely fragmented industries takes a lot of resources and, is hard to do.

Especially with consistency. So there are all these pressures, maybe even independent equality they're requiring organizations to go together and I just want to get your thoughts on that.

Hector Torres: If you look at any industry in the United States, there aren't many of them that are as fragmented as health care today. Look at any industry whether it's industrial manufacturing, telecommunications….

Aaron Newman: Airlines!

Hector Torres: Any industry of scale and size has consolidated. Whereas in healthcare, not one organization controls more than two and a half percent of the spend. And I'm using round numbers just to sort of give the concept, but, it's incredible that an industry that is so core and foundational to the U.S. economy and, and so much of a percentage of GDP is spent as a result, is so fragmented and frankly inefficient. Fragmentation and inefficiency are directly correlated.

Eric Tower: Let's look at things from a slightly different perspective, shall we? if I'm a payor in a pop health world, and I've got systems that are capable with attribution taking cap, what am I other than another mouth to feed. I mean, what is my role, right? I mean, is that what is going on with UnitedHealthcare as they see the future? Because right now you've got Humana coming out saying that they're a health care provider with what, an insurance arm or something like that? So all the old lines are getting reshuffled and maybe I'm being too into the, to the payors here, but it's resulting in a rapid transformation.

Hector Torres: It is. Absolutely. In many ways, let me give you a finance analogy. The old insurance business model, the old payor insurance model is really akin to the stockbroker specialist on the floor of the New York Stock Exchange that's literally taking numbers and facilitating sales on a piece of paper and being the intermediary. And today they still have those folks there but they're more out of tradition than anything else because all of that is done electronically, right? in many ways the forward thinking, payor organizations have, have already assimilated to needing to diversify and think holistically and strategically about how do they maintain relevant, their organizational relevance within the entirety of the health care industry food chain.

Eric Tower: Yeah. Exactly. but let's go back to good old St. Elsewhere. You know, which could be listening to this podcast and they'd say, Well, I'm going to bring in Hector and Aaron and they're going to say, throw in the towel! I don't think that's true.

Aaron Newman: No, you know what's interesting about that is, and by the way we get accused of that all the time, so, we're fine. A lot of the times our guidance and advice is actually not that. It is, understanding them financially, strategically, and clinically and contextualizing those three pillars within what's happening more broadly in their market and in the United States. A lot of what we're able to provide them is with is an arm's-length third party view of the health and efficacy of their organization, and in a lot of times our advice is not necessarily a change of control transaction where they have to basically become part of a larger entity, but more around understanding the opportunities for growth and solidification of their market share and market relevance through non-change of control transaction initiatives.

Hector Torres: Let me amplify that approach within the context of population health. Population health and all of the elements that go into being able to do it effectively, are what ultimately informs an organization's desire to want to pursue an affiliation, partnership or change of control transaction. But the thing about that is, and this is why the guiding principles and the work that we do on the front end is critical, population health capabilities can be attained in many ways, and it doesn't always necessarily require an M&A transaction. Depending on the situation, a clinical service line joint venture with a large, integrated health system may be the recommended approach.

Eric Tower: Couldn't you also view joint ventures as the camel's nose under the tent? Because a lot of times you're just cannibalizing your core operations and handing them over to someone else who might or might not have an aligned goal at the end of the day. So if I go and I, let's say I have some ASC joint ventures and I empty out some of my outpatient hospital beds as a consequence. Well over time, you know although it may be the revenues I indirectly control are a little bigger, I'm really losing control of our core function. The ability to provide surgery.

Aaron Newman: Yeah, I think you bring up a great point and it's kind of, goes to the population health point, right, because if it's better for that patient to get the episodal care in an ambulatory service setting that maybe the hospital has a joint venture with, instead of being in the hospital. What's mostly going to cost the health care system less money and also have a better benefit for the patient? It's probably going to be that ASC episode of care instead of keeping that patient in the hospital. I think this shift towards the ambulatory and outpatient settings that lowest cost of care is strategically problematic for many of these acute care providers.

Eric Tower: Certainly. Yeah. Running a hospital is very different than running an ASC, is very different from running a physician practice.

Aaron Newman: It really is. And really, I mean if you're the CEO of a large health system you got to be able to run all of those efficiently and have them be interoperable; that's the alchemy, right? And there are certainly cornerstone organizations that do it exceptionally well and are continuously improving it, but the vast majority of organizations really struggle in this regard.

Eric Tower: Let's assume you're talking to the Board of St. Elsewhere and the CEO of St. Elsewhere. What are three things you would tell them right off the top of your head, right now, that they would want to get their arms around for whatever ends they are achieving, whether it's independence or combining with someone.

Hector Torres: It begins with understanding what are the things that keep them up at night. What they worry about the most. And usually by asking that probing question, you get a lot of insight and intelligence on not just the organization but certainly what's happening within the broader market. So we would first ask the question of what keeps you up at night. What are you really concerned about as you operate this organization and obviously do the best job possible in doing that. That would be question number one. Number two, it would be,

how are you thinking about the health care delivery model that you presently have and the potential deficiencies that you see in it today and most importantly I would say, the potential deficiencies you see in it in the future. And that's a corollary to the first question because usually the things that keep them up at night are the things that they are seeing on the horizon but not necessarily being impacted by today. And the third question is what are you doing about it today, as well as in the future. We advise many organizations to be thinking but in the immediate term in this regard, as well as 10, 15, 20 years down the line.

Eric Tower: Aaron, let's – let's turn to you real quick. a lot of money in private equity right now. And there are a lot of…a lot of established systems are – are partnering with private equity players. do you see this as a good or a bad thing? Or, how – how do you view that from the lens of providing the services you do to some of these systems?

Aaron Newman: Sure. Absolutely. Over the past 4 to 5 years private equity's entry into the healthcare provider market has really accelerated. Today you're witnessing private equity partnerships with both multispecialty and single-specialty physician groups across every market in the U.S. So what's the acute care healthcare provider have to say about all this? Well, you know, if I were in their shoes and if I was in the boardroom and a lot of times we are in that boardroom it – it's really disrupting the way that they're thinking about their strategies on a long-term basis because they're – they're not used to competing a Wall Street type mindset that is really think about profitability and optimized financial performance.

Eric Tower: So, how do you respond to someone say, the FTC is saying well competition is good. isn't this a good thing? We're shaking up the old guard.

Aaron Newman: I think it's definitely a lot more competition in this space and I think it's forcing a lot of the legacy non-for-profit health systems to really rethink their strategic model. Which in my opinion is a good thing. Competition is healthy for the space and, you know, I would rather see healthcare costs be driven down and I think private equity is actually going to do that. It's going take time, right? But, it's going to happen.

Eric Tower: But systems have a lot of fixed costs. I mean these private equity entities are almost by definition very nimble.

Aaron Newman: Right.

Eric Tower: You know, they're coming in late to the game without these legacy costs, and these huge bond debts that are sitting out there; couldn't you say that's unfair?

Aaron Newman: I'm not sure if it's unfair, but if you are a non-for-profit health care system that does have a lot of fixed costs, how are you going to compete in the long term with private equity that is partnering on a much more physician-centric model, whereas the legacy health care system is really overbuilt from a brick and mortar prospective. And, that's driving a lot of unnecessary costs into the

system. So, maybe private equity coming in is going to drive, some of those, bricks and mortar that don't necessarily need to be there out of the system and ultimately keep the cost of care down.

Eric Tower: But I want to go to something here. I'm old enough to remember the old physician practice management companies, and, back then you know, that was all the rage. Today, it's private equity. Arguably built on a somewhat different model and one that requires scale as compared to you know, self-scale that doesn't really exist; is that a correct way to categorize it? Or…

Hector Torres: I think private equity is very different in several ways. Structurally for sure. With the physician practice management companies of the 90's much of the structural consideration was based on pure speculation rather than inherent asset value. The other difference is the level of sophistication with private equity. Private equity firms are very astute in understanding macro trends and assimilating them to investment opportunities within health care in particular. When you have that level of sophistication and discipline being deployed in a differentiated manner relative to how the old PhyCor deals were structured, you ultimately end up in a different, arguably better place.

Aaron Newman: Another difference relative to the old physician practice management deals was that those legacy models didn't properly construct incentive mechanisms for physicians and, one thing that private equity is good at is understanding and aligning incentives. Today private equity understands that when they partner with a urology practice, the assets are ultimately the urologists, and they will want to ensure that those urologists are properly motivated to continue to grow the enterprise on a post-transaction basis.

Eric Tower: So, this might be a little far afield, but since you're touching on this, let's go there. RVUs. Now obviously the solution to the old gee, you're going to get x hundred thousand dollars a year physician…boy we need to keep this doctor productive. We're going to pay you with RVUs, or in some cases adjusted RVUs. Right? Couldn't you argue that this flies in the face of pop health, because it over incentivizes procedures and underweights proper care management?

Aaron Newman: So we completely understand both sides of the argument; some of the more forward thinking physician groups that are entering into partnerships with private equity understand that in order to have a durable clinical enterprise, they can't have a productivity based model that's pushing people to do the wrong sort of things, right? Because ultimately that's going to lead to poor outcomes for the patient and it's not going to be a successful long term investment. The true value comes in sricking the delivate balance of appropriate incentive mechanisms and optimized clinical protocols that are supported and enhanced by robust data analytics.

Eric Tower: So, it's almost a psychological thing in a way, isn't it? You're – you're taking people who are used to being at the top, physicians, and giving them the data to kind of continue their natural competitiveness with each other and, and with their communities. Am I right?

Aaron Newman: Let's look at the bell curve. Let's look at the outcomes. Let's look at everything that goes into your practice and let's analyze it within the context of the broader community of physicians and understand, are your patients truly sicker? Is there a way for you to modulate your practice patterns to get the best possible clinical outcome? The answer may be yes or the answer may be no, but how do you have that conversation with a physician if you don't have the tools that the physician needs to optimize what they do every day. And, that is really a core fundamental aspect of population health management.

Eric Tower: Well, and that's the same argument you hear from health systems in virtually everyone on the health care continuum, you know, if, somehow their outcomes aren't better. Well gee, it's because our populations are more difficult…

Aaron Newman: Right. Or sicker or you know, whatever it is that, you know, and frankly I don't think it comes from a place of maliciousness or a physician being a bad actor. I think they're in there trying to do the right things, in a very challenging environment that's changing every day.

Eric Tower: So, let's talk about nontraditional health care, just real quick. What do you doing around social determinants of health, maybe the use of data that's scraped from non-health care providers and – and insert it into health care record and, you know, at some point I need to have a guest come on and talk about the ins and outs of that because it…

Hector Torres: Yeah. Yeah, we're definitely not that smart. But I – I think it's an important aspect. I mean, it is really a fascinating aspect of our industry. It's very easy to put on your finance hat and – and say, look this is the accretive, dilutive nature of you know, this potential transaction and of course it makes sense to – to pursue it or not pursue it based on that analytical construct, right? But, what's really rewarding I think for us and – and I think our clients really appreciate is that it's really goes beyond that. It's about how does this impact the patient? Because at the end of the day, that is what our mission is. How do we improve the patient's access to care, how do we improve that patient's experience in the delivery and attainment of those health care services and how do we enhance the overall clinical outcome for that patient. Social determinants are fascinating because I think it's an area that has become very prevalent recently and we'll see more of that.

Eric Tower: Well Hector and Aaron, I really appreciate your time. Welcome to FocalPoint. This is your first sort of public appearance through FocalPoint.

Hector Torres: It is and we're really excited to have joined the Healthcare Investment Banking Group and to continue providing best in class comprehensive financial and M&A advisory services to healthcare organizations all over the country.

Aaron Newman: Yeah. It's been a pleasure talking to you today, Eric. we're looking forward to partnering with you further. It always makes the deal easier when you partner with a really good attorney like yourself, who understand the issues from all

perspectives. I think there's a lot of good work we're going to be able to do together in the future.