HEALTHCARE REIMAGINED

Overcoming Adversity with Resilience

TOPICS DISCUSSED INCLUDE:

PANEL:

Bobby Guy, Shareholder, Polsinelli (Moderator)

Dr. Ralph De la Torre, Chairman and CEO, Steward Health

Dr. Christopher W. Kersey, Founder and Managing Partner, Havencrest Capital Management

Casey Leonetti, Managing Director, Bain Capital Private Equity

Jim Moloney, Managing Director and Head of Health Systems M&A, Cain Brothers

This conversation has been lightly edited for length and clarity.

The last few years have taught the healthcare industry tough lessons on the importance of resilience. Now, we're facing a new set of headwinds. Not only do new strains of COVID-19 continue to emerge, but a serious economic downturn could enter the mix. What does that mean for your organization?

Introductions [00:52]

Bobby Guy: To my left is Dr. Ralph De la Torre. He is Chairman and CEO of Steward Health, the largest community health system in New England. He also started several healthcare businesses and one of the first integrated cardiac practices, cardiac protocols for cardiac patients. Next to him is Jim Maloney, Managing Director and Head of Health Systems M&A at Cain Brothers. He has 30 years' experience in M&A and has done many of the largest provider deals in the country. Next to him is Christopher Kersey, the Founding Managing Partner of Havencrest Capital Management out of Dallas. Christopher has a long history in healthcare private equity, and he also serves as an Emeritus Trustee of Johns Hopkins Medicine and the former Chairman of the Board of Johns Hopkins Medicine International. But most importantly, he was a teammate of Pete Sampras on the Prince High School All-American tennis team. And if you talk to him privately, he'll say he schooled Sampras all the time and that's why Sampras went on to become famous. Is that right, Chris?

Christopher Kersey: That's right. Or as I say, my mistake was going to college after high school. I chose the academic route. But it's so rare to be good in professional tennis. It was a real honor to be a part of the tennis world all those years ago.

Bobby Guy: And to his left is Casey Leonetti, Managing Director at Bain Capital Private Equity, and a member of the portfolio group. She focuses on healthcare investments and arrived at Bain after several senior positions at CVS Health.

So, it's been very interesting looking at the current environment, because I've thought for several years that we are in probably the most exciting time, seeing the biggest changes in three generations in healthcare. This year, after the pandemic being a major challenge, we come into many new challenges such as the inflation rate, the specter of a recession, international instability, the pandemic. Lots of things happening, changing reimbursement, and political uncertainty. What does this mean for our healthcare system in the U.S., for providers, for payers, or for leaders?

Current Healthcare Landscape – Surviving and Thriving [03:26]

For the panel: how do you see the current healthcare environment and what does it take to survive and thrive in this market?

Dr. Ralph De la Torre: Thank you for having me. Steward is in a unique position because we have holdings across the United States. We have 40 hospitals and 7,000 physicians spread in diverse areas from Massachusetts, where we are 100% value-based medicine, all risk, all quality-driven, to Utah, which is almost 100% fee-for-service. I'd say answering that question is difficult unless we put it in context. What the pandemic has done can be viewed in two ways: with a macroeconomic view or a microeconomic view. In the macroeconomic view, it has heightened the disparities in healthcare that we knew were in place in the United States and heightened the fact that eventually the government comes in to pay for it no matter what. It always was commercial insurance versus government insurance, Medicare, Medicaid, etc., but what we learned in the pandemic is that the bill always gets floated by the same group of people. How you deal with the disparities in not only healthcare, but in the comorbidities that reside in it, has now come back to the forefront and I think that's going to drive a lot of public policy moving forward around how the commercial insurance interacts with the government insurance, how the wellness is established, how some of those things that we negated now that we're having to pay for it is going to come back on the microeconomic front.

You can talk about different industries other than medicine, but for the brevity of the answer I'm going to focus on hospitals. It's changed the way hospitals conduct care.

For years, a lot of the basic profitable areas of hospitals have been carved out through ASCs, through imaging centers, leaving the hospitals with less and less profitable care. Then what happened during the pandemic is a couple of things. One, the healthcare shortage and then the concomitant costs of capital. So, what does that mean? Again, let me just look at the healthcare shortage. Suddenly, we're in a situation where you must define the problem you're solving for. Anyone says, "there's a shortage of nurses." Well, maybe. But a different way to look at it is that you have to care for the patients you have in a bed and how do you do that effectively? From that perspective, the nursing shortage is not just about recruiting more nurses. It's about managing productivity using predictive labor algorithms to tell you exactly how many nurses you need and not more. It's not staffing at a certain level that may or may not fill the beds. It's about minimizing your length of stay so that your hours per patient days are maximized. Suddenly, you're looking at better utilizing and better matching your labor all the way through. It comes in so many flavors, from predictive analytics to length of stay and all those algorithms to making the throughput of your operating room more rectangular.

Every surgeon in the world wants to operate on Tuesday and Wednesday. I mean, everybody. You ask any healthcare providers and that's what they want to do; they all play golf on Friday, and they're all hungover on Monday. So, it's all about Tuesdays and Wednesdays. It's all about modifying the system so you better utilize every element of your labor, not just necessarily recruiting and training more nurses. I guess the answer to the question is there are a lot of ways the pandemic has changed healthcare, and it goes from something as wide as the macroeconomic impact, these are the socioeconomic disparities, to the microeconomic labor shortages within a hospital. How do you not only shape the supply but also the demand?

Adversity in Healthcare – What Are We Trying to Solve? [08:00]

Casey Leonetti: There are a lot of things Ralph said that are worth building on. Starting with what is the problem we're trying to solve here? You can look at that in a couple of ways. The last several years have brought a lot of adversity into the healthcare system. The COVID pandemic caused a lot of providers to have to solve new problems in order to continue to treat patients. The rising cost of labor, as well as labor shortages, have suddenly made profitable businesses unprofitable and caused constraints on capital at a time when capital is hard. Another problem that's worthy of being solved is, everyone is treating patients, but how are we doing on outcomes? By every measure, if you look at healthcare in the United States, we're spending a lot of money but not

necessarily doing a great job solving outcomes. So, another problem a lot of folks, including investors, are trying to solve, is how do you get better outcomes by providing care and with the system we have? There's a lot of innovation going on right now. There are some motherhood and apple pie answers, like bringing better data and technology to provide more visibility, transparency and better decision making to better outcomes. There's also no one solution to any problem. In times of adversity, we realize how individual businesses, individual humans, individual entities are extremely fragile, but the system can be quite anti-fragile.

How do we strengthen the system so that it can absorb all the headwinds of adversity? One way to think about that is by taking risk, and providers bearing risk so that primary care providers have more accountability for taking care of the whole patient and coordinating care across the whole system to result in a better patient experience, with better navigation through the system where they won't get lost in the cracks and instead will end up with better outcomes and hopefully a lower total cost of care which the provider then benefits from. What many smaller provider groups have realized is that it's too risky to take on that much risk. That's why big insurance companies have been aggregating lives for years and it's hard for providers to do that. How do you create resilience that type of environment so that you can move in the right direction toward what's the problem we're trying to solve? Actual better outcomes. But do so in a way that doesn't make you fragile and allows you to persist through adversity. We need to aggregate groups of providers, creating more systems of providers who can take on risk and partner with each other, which leads to better outcomes.

Resiliency and Private Equity [12:39]

Christopher Kersey: I'd like to answer the resiliency question from a private equity perspective. It's so interesting when you see the tumult in the public capital markets and then you invest as a private equity investor. Charles Dickens started his novel *The Tale of Two Cities* with the phrase, "It was the best of times, it was the worst of times." Now, nothing is a perfect analogy, but it's kind of schizophrenic to see that it's just about the worst of times in the public markets with so much uncertainty and risk factors out there for investors and operators; while simultaneously on the private market side, 2023 could be a real boon for private equity. Nobody knows the future, but 2023 is setting itself up for some interesting times with accelerated deal velocities and an active year of capital deployment.

Furthermore, the take-private scenario for private equity is huge. If you look at the de-SPAC index, the aftermarket performance of all SPACs, it's down 70%. The VC backed IPO index is down 60% on average. The private equity backed IPO index is down 45%. A thousand companies went public in the bull years of 2019 to 2022 with $2.6 trillion in inception value, or initial market capitalization, and the average stock price of all those companies is down 45%. There are so many downtrodden public market companies and it's a tried-and-true strategy for private equity to rummage through the public market companies that have been hammered and recapitalize them, add operating value, tweak the business model, and then sell the companies after a finite holding period. On average, in 2021 and 2022, the average discount to a target company's 52 week high was between 7% and 9% so there's your built-in return if you can add operating value. The point is there are lots of deal opportunities even in this tough environment, and correspondingly we at Havencrest, are looking quite opportunistically at the public as well as private markets. We don't talk about themes that we're going after, but lots of take-private deals are coming I think, followed also by sponsor-to-sponsor deals. There's $1 trillion of private equity dry powder out there, and if you take 20% of that number and apply it to healthcare, you have a lot of dry powder wanting to be deployed in healthcare. Sponsor-to-sponsor deals have risen from half of all PE exits (the historical 20-year average) to two thirds of all PE exits. Net/net: there is a lot of capital out there, there are a lot of funds out there with lots of great investors, so there will be a rise in sponsor-to-sponsor deals in the coming quarters.

Lastly, healthcare valuations persisted in 2022. They were stubbornly and surprisingly high throughout a lot of the last calendar year. Maybe there was 5% or 10% moderation, but my colleagues and I say the B assets remained on the market and the A assets went away. With that kind of valuation moderation, you're still dangerously close to overpaying no matter what you buy. So, valuations are moderating. There's a well-known lag in private equity taking 6 to 9 months to follow the public markets in terms of how valuations move, but if you add up the take-private scenario, the sponsor-to-sponsor scenario, and the valuation scenario, there are going to be a lot of deals in private equity in 2023. That being said, you still have to be careful since there are hot and cold subsectors that we can discuss but I think it's going to be an exciting calendar year.

Resiliency in Big Healthcare [16:33]

Jim Moloney: If you looked at the last two or three years and asked what the sources of resiliency have been to get the healthcare system to this place--and my focus is primarily on the big health systems so lots of nonprofits and large physician groups--there have been three sources. One is incomestatement strength, one is balance sheet strength,

and one is external funding, and you can insert federal government there. Federal government was big in 2020 and 2021. Balance sheets were big in 2022. We saw people take huge drops in their balance sheet cushions to fund operating losses and deal with investment losses. This year must be the income statement. If health systems can't get their income statements right sized and generate positive returns, they're going to be under a lot of pressure. That's in sharp contrast to what we've seen on the physician side. The physicians have been nimbler, and well-managed physician groups have transitioned through this quickly without the balance sheet cushion the health systems had, but with a fair bit of help in 2020 and 2021 from the federal government. So, I think it's about your income statement. The income statement is about volume in healthcare because there's so much operating leverage that you can't manage by reducing, you have to manage by growing and that means stay close to the consumers. Consumerism is going to become increasingly important. You need to be relevant to consumers. You need to manage fluid and dynamic labor forces. You need to talk about purpose a lot because you need to convince the people that work for you to work for you, not because you pay them more, but because you're doing something that's consistent with what they want to accomplish. That is easy to say, but hard to do. I think organizations like Steward that articulate their purpose and have an economic model that can transition into this world through value-based and capitated models are going to be relatively well positioned.

Casey Leonetti: I'd love to build on that point because it's one worth making around not just every employer making their place of work an attractive place to work, but the healthcare industry as a whole attracting talent versus any other industry that people could go into. This is from physicians and nurses all the way down to medical assistance and technicians, bringing healthcare back to why do people get into healthcare beginning with its purpose, its meaning, and the feeling of being supported and rewarded for doing great work. It's an industry challenge that we need to address for the long term both individually and collectively.

Lessons Learned from the Pandemic [19:54]

Bobby Guy: **Let me ask you about the pandemic. We look at the pandemic as taking ten years of healthcare advances and condensing them into a year or two years. What does that mean for us now? What lessons did we learn from the pandemic that we can apply now to get through this hard time?**

Jim Moloney: I don't have the answer yet, but I think we've done what is called a natural experiment in healthcare and there's a lot to be learned from that. There's a lot of data out there that has not yet been deciphered and analyzed, but in an earlier panel there was a question about what happens when you don't screen for cancer. We're going to know the answer to that in two years. What happens when you don't see primary care physicians regularly? We're going to know the answer to that in two years. That has to be a big focus for both public policy and healthcare operations people to figure out what we learn from this.

I do think this is different than the 2008 financial crisis. There was about a decade of financial services consolidation in 2008 and 2009 and what we did is we took financial services from almost 20% of the economy down to 12-14%. That is not going to happen in healthcare. We've put a lot of pressure on healthcare, we've reduced a lot of rules, some things like telehealth were accelerated, but I don't think we've seen big fundamental changes in the way healthcare organizations are operated. There's rich data out there now to help inform us about what could work better, and that will be a challenge to data analysis.

Dr. Ralph De la Torre: I don't know if we've accelerated change, but I think we unmasked the underlying flaws in healthcare, many of which we knew already. The fundamental question, having unmasked them in such a grotesque way, is: are we finally going to do something about it? Are we sick and tired of being ranked with Cuba by the World Health Organization metrics of care despite how much we spend? Fundamentally, are we going to change the way we interact with our healthcare environment and in the way that it interacts with us?

Healthcare is full of nuances. Let me provide an example around value-based medicine. When an insurance company enters value-based medicine, they set a baseline and what you spend is the baseline. So, company X says, yes, I want to enter into this pool, it's going to be value-based and I understand that. Now you're given a budget based on what you've been spending on the group of patients you have.

Now let's take a bank. If you take your average cashier, or your average guard or maintenance person, they live in a poor area. Now, that budget, because they live in a poor area and get reimbursed less than doctors get reimbursed, the budget you're given to take care of that patient is less than the budget you get for taking care of the bank president in a rich community. However, ERISA governs benefits and how costs are applied, which means everybody pays the same. So, what you're actually doing is taking money from the poor and redirecting it to care for the wealthy.

Now, if you're smart and trying to cut and you're trying to figure out the loophole, you know that by targeting the wealthy community in this value-based mechanism, you have

more to cut before you get to the bottom line in the poor community. The very first stage is the people trying to find loopholes and make money in a value-based system that target wealthy communities because they're commercial. They don't target the poor commercial - that's the last. Again, I think there are nuances that we know about but don't want to confront. There's a lot of lessons that Americans hate wellness, and that Americans believe they can eat whatever they want, do whatever they want, and when the wheels fall off the car, someone will fix them. But we're going to pay the price, right? Everyone asks, "Why is American healthcare so expensive?" Well, our wage scale for doctors and nurses is off the chart compared to the rest of the world. And our consumption of high-end tertiary care is astronomically higher than the rest of the world. We're uniquely positioned to reap exactly what we've sown, which is the most expensive healthcare system in the world. Unless we take a step back and say, "Wow, is this going to be enough of an impetus for us to change now?" We've learned nothing. In two years, we will have forgotten everything we learned and everything we saw, and we'll be back here trying to find the next widget that does something meaningless in healthcare but can generate returns for the next five years and we'll all make money.

Casey Leonetti: Isn't it up to us to not let that happen?

Dr. Ralph De la Torre: I've been trying for a decade.

Casey Leonetti: I think COVID accelerated a lot and pointed out all the flaws in our system and it's up to us to fix them. It also exacerbated what we all knew and talked about theoretically, which is the shortage of labor, and which is now front and center because it really taxed our direct patient caregivers. We've asked too much of them, and we continue to ask too much of them. We need to figure out how to make this a better, more sustainable work life for them.

I would also like to highlight something positive that came out of the pandemic. I saw this firsthand in the dialysis industry - we own a dialysis company that I work closely with. Dialysis is an outpatient life sustaining treatment for people whose kidneys have failed, and 80% of individuals who are on dialysis need it three days a week, and they leave their homes to go to a center. They also tend to be from lower socioeconomic backgrounds and they're in end-stage renal disease, which means they typically have multiple chronic conditions. If you think back to the beginning of COVID, the one thing we did know at that time was how much more at risk you were if you had multiple chronic conditions. Yet these individuals had no choice, they had to leave their home every other day to go into the community and get dialysis. As a result, the dialysis industry was forced to come together. They couldn't shut down operations like many other parts of healthcare, instead they had to figure out how to safely continue providing life sustaining treatment. There was excellent partnership across the industry with new communication channels that had never existed before, new partnership models and sharing of resources, figuring out which clinic in a market among competitors is going to be the isolation clinic, and which clinics are not going to be. So new operating models, new forms of communication, new channels of communication, new data sharing agreements all happened, and they were set up in weeks and they were sustained.

The reason this is not just applicable to COVID is two years later, Texas had a freeze that destroyed its infrastructure and power, not just the energy grid, but also the water system, and when water goes, dialysis clinics can't operate. They must completely shut down because that's an essential part of dialysis. Suddenly you had facilities all over Texas unable to provide treatment, not just for a day, but for several days at a time. However, the communication channels, the network across competitors, and the sharing of resources and operating models that existed because of COVID allowed patients to access the necessary treatment they needed during that crisis. Adversity can create resilience and it can create new systems that allow people to treat other unforeseen emergencies and crises over time.

Going back to your point Ralph, I would like to see us take the lessons we learned during COVID as opportunities to solve some of these problems and try to create things that will make us more resilient for the next unforeseen crisis that we face.

Bobby Guy: It's a great point in never letting a good crisis go to waste.

Christopher Kersey: These have been great pandemic-related comments. Let me answer the question briefly to round out my fellow panelists' answers on this topic, again looking at this through the aperture of an investor. A couple of positive themes coming out of the last three years are the implications for telemedicine and telehealth; we've all heard about that, and I am very sanguine on that. We've seen a lot of business models that weren't quite mature enough, that were too nichey, that didn't have the right customer base, but telemedicine, particularly related to behavioral health and some of these other more cerebral general medical specialties is a fertile investment thesis, and I think we're in the early innings of an extra inning baseball game there.

The pandemic also highlighted a rapprochement to pharma services and pharma IT, as well as an appreciation for the robustness of vaccine-related products and services, including site management organizations, patient enrollment business models, and patient engagement platforms for clinical trials. It's a huge industry with a huge addressable market,

and these themes are now engrained in the consciousness of the American electorate and the average American in a way that they weren't before - that dynamic really increases the addressability factor. I also think there are a lot of "partnerable" corporations out there in Big Pharma and Big Biotech land that need to continue to outsource those solutions to private equity, public equity, investors, entrepreneurs, and service providers galore. I'm excited about these post-pandemic investment themes.

But great answers from my fellow panelists and I'm definitely going to remember this one: "Americans hate wellness." Very nice.

Dr. Ralph De la Torre: I want to provide one real life example of something you just mentioned, which is the eICU platform that we have in our hospitals. We were able to rapidly and massively expand our ICU services because we had eICU, which meant just by connecting to machines and having one huge remote mission control, we could provide ICU care from Dallas or from Boston no matter where you were in the United States. Just by modifying the HVAC systems in some medical units, we were able to turn them into intensive care units because we had eICU. Without that telemedicine capability, we would not have been able to do that.

Christopher Kersey: That is so novel and so honorable, namely because it's such a creative approach. At the same time, it is also bucking the trend for primary care and the cerebral medical specialties where you don't need to have a patient-physician encounter that's real time in person. You've taken it to the next level. These kinds of innovations are continuing to take hold. Yes, telemedicine penetration is moderating back to pre-pandemic levels, but things have changed. Things have changed for the good, and I think things have changed permanently.