Healthcare market proves strong as investors embrace new technological advancements

Our report from the JPMorgan conference

Healthcare Alert

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On the heels of a record-breaking year for private equity fundraising, the healthcare industry is expected to remain strong as cutting-edge technology opens new doors for investors.

That was a key takeaway from a panel moderated by Joshua Kaye, chair of DLA Piper's US Healthcare Sector, on the sidelines of the 2020 JP Morgan Healthcare Conference in San Francisco. The fourth annual panel discussion, "Healthcare M&A exits: who's buying, what are they buying and why?" also discussed trends they are seeing in new technologies entering the healthcare sector, concerns around patient data privacy and the steady rise of incubators and accelerators.

Below are the highlights of the discussion, which featured:

- Robert G. Shepler, Co-Founder and Co-Managing Partner, Telegraph Hill Partners
- Amy Stevens, Executive Vice President of Provider Solutions, AVIA

Joshua Kaye: Telegraph Hill Partners has had a long, successful track record of healthcare investing. Tell us a little about your investment strategy – what areas are you finding attractive at the moment and why?

Bob Shepler: Telegraph Hill Partners is a healthcare-only private equity investment firm. Our current Fund, THP 4, is $255 million in size. We have a total of $900 million under management. We will make 10 to 13 investments in a fund, so in a fund size the size of THP 4, we'll look to invest between $10 million and $40 million in a company. The investment amount does not have to be all at once. While we are healthcare-only, there are overlays to what we will consider. One of the most differentiating criteria is that we avoid situations where there is a profile of a binary outcome. Consequently, we avoid biotech investments. We are very focused on technology and growing our companies through innovation. And we are maniacal about the business model. Does the company have a business model that can generate superior operating results on a reasonable amount of capital? A general description of our investment return profile is three to five times our money in three to six years, with our worst deal getting our money back.

Joshua Kaye: Do most of your deals have a roll equity component? Are you partnering with founders or earlier institutional partners?

Bob Shepler: We are transaction agnostic. We'll do buyouts from large companies, invest growth capital in founder-led innovative companies and recapitalize mature companies that we think can be reinvented. We can be flexible in our terms and often have a founder maintain a significant owner stake post a transaction. While we have co-invested with other institutional investors, we have done less partnering in recent years. It is harder to quickly make critical business decisions when one has to build consensus with other institutional investors. In 14 of our last 16 deals, we've been the majority owner post the transaction.

Joshua Kaye: My understanding is that AVIA partners with health systems to identify and accelerate their adoption of digital healthcare solutions. What does that mean? Who is AVIA partnering with? How does partnering with AVIA truly accelerate healthcare innovation?

Amy Stevens: We are a member network that is comprised of providers, payers and partners. Those partners are often in the broader ecosystem of healthcare, and they include organizations from private equity and banks to the American Hospital Association to EMRs. We have a longitudinal relationship with our members and partners in that we work with them over a period of many years, so we are deep in their strategy shops and their C-suites. We do the work a little differently – if you think about digital, we have some key issues that make it challenging for your actual buyers. For investors, you want that health system to make that decision about your solution better, faster and all in.

So the question is, how do you do that? When I ran health systems, I knew what my outcomes should look like and what the yield should be. But in digital, we don't have that – it's new, untested and often creating fundamentally new types of work or services. In the absence of results data or very early impact data, what you have is professional judgment. That's where we come in. We gather together a group of people who would actually be using the systems you are creating so they have the opportunity to put that professional judgment to work against solutions that are already in the market. This gives us the opportunity to look at capabilities instead of companies. Our underlying value proposition is that we help our members make a better decision faster and with confidence.

Joshua Kaye: From a VC fund perspective, we ended 2019 with a blazing hot fourth quarter in which biotech and other healthcare investments rose as much as 33 percent. Do you see that continuing in 2020? If so, what do you think is driving that perspective?

Bob Shepler: There are no obvious signs of the investment climate having a serious breakdown any time soon. The IPO market for therapeutic companies has remained relatively positive and that has driven optimism, but when that market shuts down, that will have a chilling effect on investor confidence. While we do not directly invest in biotech and pharma companies, we have a number of business-to-business healthcare companies. The positive funding environment for biotech and pharma, our companies' customers, has been beneficial for our companies as well. We do not know when the IPO market will start to shut down, but when it does, it will have ripple effects throughout the healthcare market.

Joshua Kaye: Conventional wisdom has suggested that a winning digital health solution will help health systems or others move the needle on cost, quality and access to care. But many of us remain mystified by the category of digital health and what that means. Can you add any further refinement on what areas

are truly more attractive in this category, particularly for health systems payers or other strategic players in the industry?

Amy Stevens: If you're thinking of the health system category, our version of M&A has often been health systems buying other health systems or health systems buying pieces of the healthcare food chain. We're seeing in that space a trend of failure though. Some of the biggest deals that have been announced or attempted have not come to fruition and we've seen that in markets across the country. We've also seen that the actual results of those M&As are not yielding what was expected.

The M&A world inside of the health system is turning now to ask, "What would differentiate us instead of buying each other?" And the answer is radical automation and digitization. We have to be strong and healthy operationally to survive, particularly against the Big Tech and large non-healthcare disruptors. Automation and digitization sit at the core of what's going on inside of the larger picture of healthcare and healthcare systems.

The three areas where we see people applying tech or needing tech are inside growth, like creating a frictionless experience for those that are expected to use your services; care and care delivery, like determining where to send a patient and not just what the treatment should be; and cost – about 60 percent of all expenses inside the health system are on labor. The US economy has seen that healthcare labor is one of the most driving and consistent labor growth sectors in the US. Of that 60 percent, about 25 percent is spent on labor burden – those mind-numbing tasks that are perfect for automation so employees can focus valuable time elsewhere.

Joshua Kaye: How do you decide to invest in a healthcare platform? Can you share other key metrics?

Bob Shepler: As I mentioned, we avoid binary risk and seek out superior business models. So when looking at companies, we first scrutinize whether the opportunity passes these two criteria. This approach has real-world consequences as to what we will and will not invest in. It's easiest to tell you what we avoid: biotech or pharma companies, early-stage companies, single-product medical device companies, pre-commercial biomarker discovery companies. We also do not invest in facility-related companies. We used to say we would not invest in startups, but as the prices of so many deals skyrocketed, we've done a few, but only after we were convinced there would not be a binary outcome.

What does this leave? A lot. At the highest level, if the company is in healthcare, has a technology focus, has commercial operations and a superior business model, it falls in our bailiwick. The company does not have to be profitable, but it must have a business model that will allow it to get profitable in a reasonable period of time. Fertile areas for us: research tools companies where there is a spectrum of analytics including hardware, software and chemistries; diagnostics where there is a platform technology that can be applied across a portfolio of tests; medical devices where there is already an approved product with a roadmap for future approvals; and contract manufacturers. Healthcare IT is another area where we invest. After assessment of the risk factor and business model, we focus on the targeted market, the technology, IP and the quality of the people involved. We also focus on the deal terms. Once we have a decent handle on these issues, we analyze the return profile to determine if it fits our targets.

Joshua Kaye: How often does a VC fund break up a C-suite or replace individuals?

Bob Shepler: If we are attracted to a company, our perspective is that the founder and management team members are the ones responsible for developing this exciting company. Consequently, we seldom replace a management team. We generally look at the team's experience and functionality. It's much more about continuing to build the team and designing the organization moving forward. Sometimes a founder will want to step down, but in that case, we'll ask him or her to help us find their replacement.

Joshua Kaye: Some would say that health systems continue to be widely underinvesting in such solutions, and their capital commitments pale in comparison to the VC space or what they're willing to potentially pay. How does a health systems approach to evaluating an investment in a solution differ from the traditional venture capital?

Amy Stevens: Health systems *are* extremely invested in any solution they deploy because they ultimately are responsible for the end results (e.g., did a patient get better care? was administrative labor reduced?). But when you think of the question in terms of just financial capital, health systems are very used to investing in the

market; they're just newer at financial investing in specific care and digital solutions. In many cases, health systems cannot close their annual gap to profitability off through their services business (billing for patient services). Their gap is closed by millions coming back from treasury investments.

Joshua Kaye: What are some of the key differences between incubators and accelerators and how does an entrepreneur identify or best pursue one that might be a better fit?

Amy Stevens: We are the lucky recipients of incubators and accelerators. The AVIA network by design looks for solutions that are mature enough and that have at least a couple good proof points of live use out in market. We represent 50 of the largest and most forward-thinking health systems that are willing to try digital solutions in ways that others aren't, but they also aren't willing to turn over the health and safety of their patients or their providers to solutions that are truly not proven.

Incubators tend to be in the idea stage and looking for shared resources – a physical place to show up, coaches, a maker lab, people who can pressure test your idea and help you find an ecosystem to build it. Accelerators already have a use-case established, some level of a business model, some level of a team, $1 million to $5 million already booked and an established senior management team for at least two years. And only two percent of those coming out of an incubator get into an accelerator.

Joshua Kaye: When thinking about a meeting between the executive team and an investment group, what are some missteps you've seen entrepreneurs make that have caused you to shy away?

Bob Shepler: You only get one chance to make a first impression. Your goal in the pitch meeting is to leave the investor excited enough to do more work after the meeting. So structuring the pitch presentation to achieve this end is critical. In terms of how to think about the process, at a macro level, you need to do a good job of education; you need to address why the investment return profile is outsized; but you also you need to address why the risk profile of the investment is manageable. This last point is made in maybe two percent of the pitch meetings and decks we see. All professions have paradigms, and a fundamental one in investing is risk and return. Ask yourself the question: why should any firm turn over $10 million to $40 million to me as steward of this capital? My quick list of points that should be addressed in a pitch book and during a meeting are: Who are you? What is the background of the key managers? How did you/the company get to this point? What is the history? Give a realistic discussion of the market and what would be available to the company over its next one to five years. Review the company's products, their technological advantages and the value/pricing paradigm. Demonstrate there are no significant technological challenges left (avoiding the binary outcome) or review why the challenges left are not insurmountable. What are the growth opportunities and who are the targeted customers? What are the regulatory considerations? Discuss the organization – current and how the organization should be built out and why. Review key milestones that will create value. Assess the competitive landscape. Provide an IP summary. Discuss the business model and provide a one-year relatively detailed projection as well as a summary three-to-five-year projection. Provide a financing history and ownership profile. Finally, indicate the current state of and schedule for the financing process.

Joshua Kaye: In this courtship, it's obviously a binary relationship. While capital is often viewed as the great equalizer, not all investors are created equally. What are a few criteria an entrepreneur may want to consider in determining the right partner or investor?

Bob Shepler: I'd suggest there is a fundamental question to ask before trying to figure out the right VC fund, and that is: is venture funding the right thing for you and your company? In many cases I think the answer is no. So many entrepreneurs invent technologies that will not translate to becoming a VC-backed company having the best outcome for the entrepreneur. I see so many presentations on interesting technologies where the entrepreneur would be best served by avoiding venture capital and finding an alternative way to prove out the technology on a smaller amount of capital so that an exit does not have to be heroic amount to provide a worthwhile return for the entrepreneur. But if venture capital is the right route, high integrity is the most important criteria to find in an investment partner. Experience is next; experience in your sector, experience in building companies that are successful, experience as a successful investor. Having the right "chemistry" with the investment firm's partners is so important. To help figure all this out, make reference calls to portfolio company CEO's to get to the heart of what the VC will be like after an investment is made. CEOs of companies that have been sold or failed are the richest sources of information. One caveat: most early stage VCs have highly technical backgrounds. This is

essential for sorting out the next big thing. Having someone with technical insight and money express enthusiasm for your technology is an exciting proposition. The question is, once the investment has been made, is this person and firm any good at the myriad of things that leads to the creation of a valuable company?

Joshua Kaye: One of the trends we've been hearing about over the last few years is a shift from volume-based to value-based care. Although it hasn't seen much success, do you still expect this trend to continue?

Amy Stevens: All money is at risk. And with value-based care, some money is at risk. How do you take your operations and fundamentally change them so you have a tight, automated set of services that you're providing, that can give you the best yield, no matter what your payer source is? We would not want to be making decisions for patients based on risk.

So because now every dollar is at risk, every portion of the organization needs to be tighter and more efficient. Health systems also need quality, productivity and satisfaction gain.

To achieve this, digital needs to become an asset. Health systems are inefficient operations and the conversion to automation is the only solution left.

Joshua Kaye: From a health systems perspective, is there a control over patient data outside the hospital?

Amy Stevens: We are sitting on one of the richest data sets in the world. We know not just about you, but we know about your next of kin. We know about your propensity for disease, but we don't know enough about your social determinants of health. There are new ways of collecting data where we can look for requests for housing and food and know if that request was filled.

When considering how many nights you've spent in a hospital in comparison to the number of nights you sleep in your home, most of your health data is happening outside the hospital and outside the walls of your caregiver. There are ways to collect that data now so we can be much more predictive, like looking at your grocery receipts and your cell phone usage to assess any underlying health issues.

We can also use data, for instance, to help those with a substance use disorder. Data can predict where you are going to go for your fix and a digital solution can send an electronic ping to a safety net to say, "Please let them know you are in trouble."

Joshua Kaye: With tech giants stepping in with digital health solutions, will the health system ultimately become archaic? If so, how is that influencing venture capital funds?

Bob Shepler: I reflect back on an innovation conference I went to 15 years ago. One of the tracks had the heads of three premier information technology companies. They made grand projections about what each of their firms was going to do in the healthcare space and how it was going to change healthcare. The pain points they identified and the proposed solutions made a lot of sense. But if you compare what they said to what they have actually achieved in the following decade and a half, they have not achieved all that much. Changing healthcare is just very slow-going. In regards to what prominent technology companies are saying, it doesn't affect how we are investing at all. That's not to say they won't make an impact, but we don't think the impact will fall within the investment cycle of our current fund.

Joshua Kaye: From a digital health solution entrepreneur perspective, is this simply the concern around privacy of patient data? Or will the convenience of these technologies ultimately make their way into the health systems and replace the smaller digital entrepreneurs?

Amy Stevens: We see that health systems are cautiously watching what's happening within the big tech side of things. We also see that they aren't thinking of them as direct competitors, but rather stepping back and saying, "We just fundamentally are not going to look the same."

We won't have some of the same assets they have now, nor will we ever. Instead, how do we restructure healthcare going forward? Health systems are looking for ways to reduce the time it takes to schedule an appointment from 96 hours to 24 hours. But if online shopping followed that same timeline, consumers would go nuts. So the expectation that big tech is putting on health systems is starting to create pressure.