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SAGILITY INDIA LIMITED

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IPO Report

03rd Nov '24

Snapshot

Sagility India Ltd provide technology-enabled business solutions and services to clients in the U.S. healthcare industry. Company is a pure-play healthcare focused services provider, and its clients include Payers (U.S. health insurance companies, which finance and reimburse the cost of health services) and Providers (primarily hospitals, physicians, and diagnostic and medical devices companies)

VALUATION

Company is bringing the issue at price band of Rs 28-30 per share at p/e multiple of 56x on FY24 PAT basis.
Company has leadership position in the large and resilient U.S. Payer and Provider solutions market & has domain expertise in healthcare operations, with end-to-end service offerings to Payers and Providers. Company has suite of scalable, technology-enabled services and solutions, supported by proprietary tools and platforms, Company has deep, long-term, expanding client relationships across healthcare Payers and Providers. Company has multi-shore, scalable and flexible delivery model with certified data protection and service standards. Company has experienced management and board, motivated employee base, marquee sponsor support and a sustainability focused culture
Hence looking after all above , we recommend "Subscribe" on issue.

Price Band (Rs./Share)	**28-30**
Opening date of the issue	**05th Nov '2024**
Closing Date of the issue	**07th Nov'2024**
No of shares pre issue	4,68,13,28,413 Eq Shares
Issue Size	Rs 1966-2106 Cr
Offer For Sale	702,199,262 Equity Shares
Face Value (Rs/ share)	Rs 10/share
Employee Discount	Rs 2/share
Bid Lot	500
BIDDING DETAILS	
QIBs (Including Anchor)	75% of the offer (Approx 52,52,24,447 Eq Shares)
Non-Institutional	15% of the offer (Approx 10,5044,889 Eq Shares)
Retail	10% of the offer (Approx 7,00,29,926 Eq Shares)
Employees	19,00,000 Eq Shares
Lead managers	ICICI Securities, IIFL Securities, Jefferies India, JP Morgan India
Registrar to the issue	Link Intime India Pvt. Ltd

WHAT WE LIKE

Leader in the large and resilient U.S. Payer and Provider solutions market

With per capita healthcare expenditure amounting to US$12,555.3 (₹1,048,345.0) in 2022, the U.S. economy was the highest spender on healthcare among leading economies. Healthcare operations expenditure (i.e., expenditure on front and back-office functions to support Payers and Providers) was valued at US$201.1 billion (₹16.8 trillion) in 2023 and is expected to reach approximately US$258.9 billion (₹21.6 trillion based on an exchange rate of US$1 to ₹83.49) in 2028

Domain expertise in healthcare operations, with end-to-end service offerings to Payers and Providers

Company provide technology-enabled services to Payer and Provider clients. This pure-play nature of company's business, together with over 24 years of the Business' experience and the effective use of technology, has helped company build domain expertise in its operations.

Strong financial performance and high margins

The Business has consistently increased the scope of services provided to clients and the number of clients, leading to growth in revenues in prior periods. Company's revenue from operations grew by 9.61% to ₹12,233.28 million for the quarter ended June 30, 2024 from ₹11,160.93 million for the quarter ended June 30, 2023, and by 12.69% to ₹47,535.57 million in Financial Year 2024 from ₹42,184.08 million in Financial Year 2023.

COMPANY BACKGROUND

Company's services to Payers cater to various aspects of their operations including (i) core benefits administration functions such as claims management, enrolment, benefits plan building, premium billing, credentialing, and provider data management and (ii) clinical functions such as utilization management, care management, and population health management. Company's services to Providers include revenue cycle management functions such as financial clearance, medical coding, billing, and accounts receivable follow-up services. Additionally, company also provide some of the services that it provide to Payers to pharmacy benefit managers ("**PBMs**") that manage prescription drugs for Members (i.e., insured persons) under health insurance plans. Company deliver these services leveraging its tools and platforms, as needed, through its capable talent pool from its five global service delivery locations in India, the Philippines, the U.S., Jamaica and Colombia.

Company have been recognized for the quality and scale of its services by industry specialists. Company was ranked as a Leader by Avasant in their Clinical Services Business Process Transformation RadarView report 2023 and as a Leader in Everest's Healthcare Payer Operations PEAK Matrix Assessment 2023.

Company's Predecessor Company commenced providing services to Payer clients in 2000 and gradually increased the scope of services provided to Payers and Providers, and the number of its clients, through organic and inorganic growth. Company was incorporated on July 28, 2021 and it acquired the healthcare services business (the "**Business**") of its Predecessor Company on January 6, 2022. Subsequently, Company acquired the Subsidiaries in March 2024

All of company's clients are located in the U.S. As of June 30, 2024, company's five largest client groups (i.e., client entities together with their affiliates) had an average tenure of 17 years with the Business. As of January 2024, company served five of the top 10 Payers by enrolment in the U.S. Further, during the Financial Years 2024 and 2023 and the quarter ended June 30, 2024, company have added 22 new clients.

In the Financial Year 2024, company helped its Payer clients process 105 million claims and handle over 75 million Member and Provider interactions.

Payer Services

- *Claims Management*. Company manage the claims adjudication processes for Payers. This process involves reviewing and validating claims from Providers against the relevant Member's benefits plan and Provider contracts to ensure that claims are paid accurately and in a timely manner. Company deploy a combination of intelligent automation tools and experienced employees with the aim of driving efficient and accurate processing of claims. Company handle in-patient hospital, outpatient physician, laboratory, surgery, prescription drug/pharmacy, vision and dental claims. Company utilize a smart cognitive extraction solution that extracts content from various documents, thereby reducing manual effort. Further, company offer grievance and appeals solutions that address Provider complaints and appeals. Company utilize artificial intelligence ("**AI**") to identify and prioritize urgent appeals followed by resolution through its experienced claims processors.
- *Payment Integrity*. These services aim to help Payers contain costs by identifying overpayments of claims. Company help verify that the correct amount has been paid by Payers against the claims submitted by healthcare Providers. Company provide this service by leveraging data mining algorithms supplemented by machine-learning (**ML**"**)** based tools. Using company's proprietary technology "Contract Central", company re-price claims based on state-specific guidelines and other contractual provisions to identify overpayment and assist with seeking recovery of those overpayments. The payment integrity service is provided as post-pay (after a claim is paid to a Provider) or pre-pay (once a claim is adjudicated, but the payment has not been made yet). Company utilize predictive analytics tools to identify overpayment as well as cases of fraud, waste and abuse. Company's payment integrity team comprises certified medical coders, credentialed clinicians, data scientists, claims examiners, and auditors.
- *Clinical Management*. Company's clinical management services are aimed at delivering timely and quality clinical care for Members. Company's large team of clinically trained and licensed staff provide these services which help Payers manage the cost of care while ensuring Members receive medically necessary and appropriate care from Providers. Company's clinical services span chronic and complex case management, utilization management and population health management. Company provide utilization management services to its clients across their commercial, Medicare and Medicaid lines of business. These services are highly regulated to ensure that Members get timely and relevant care and to reduce unnecessary high-cost procedures. Company have developed end-to-end capabilities in utilization management which include intake across all channels of requests from Providers and reviewing for medical necessity by clinical staff, for prior authorization and concurrent services such as extension of days in hospitals. Company also further review any appeals by Providers for denial of prior authorizations using company's team of clinicians. Over the years, company have built automations around electronic intake, intelligent clinical decisioning engine and AI, to reduce effort for Providers and for high-cost clinical staff.
- *Other Payer services*. Company also assist Payers onboard new Providers to their networks and manage Provider databases. Onboarding Providers/doctors through a verification process that includes credentialing and maintaining an accurate provider directory in a Payer's network is a regulatory requirement in the U.S. Company assist Payers in this onboarding process by verifying Provider credentials and managing demographic and contract data. Company's services are enabled through its Provider ForwardTM platform. Company also assist Payers with enrolling new Members, configuring and designing benefits plans and managing premium billing and collection.

INVESTMENT RATIONALE	
Suite of scalable, technology-enabled services and solutions, supported by proprietary tools and platforms	Over the years, company have developed a suite of proprietary tools and platforms that enable its services. These proprietary tools and platforms assist in serving the entire spectrum of company's Payer clients' operations and its healthcare Provider clients' revenue cycle management functions. Company leverage various technologies including RPA, analytics and AI.The technology team supporting these technology products and solutions spans product development, client delivery, process optimization, technology consulting and client engagement functions. Company's products and technologies are guided by the domain expertise of its practice leaders to make them relevant to the healthcare industry.
Deep, long-term, expanding client relationships across healthcare Payers and Providers	All of company's clients are Payers and Providers based in the U.S. As of January 2024, company served five of the top 10 Payers by enrolment in the U.S. Company's clients also include one of the largest U.S.-based hospital networks in terms of revenue as of January 2024, three of the top 6 PBMs by claims volume and other large diagnostic laboratories, hospitals, DMEs and radiology companies. As of June 30, 2024, company's five largest client groups had an average tenure of 17 years with the Business. Company have high client stickiness and retention. Due to the sticky nature of its services and solutions, recurring revenues account for a high proportion of company's total revenues. For the Financial Year 2024 and the quarter ended June 30, 2024, company's revenue retention rates (i.e., revenues from existing clients as a percentage of revenues from such clients earned in the previous year / corresponding period in the previous year) were 110.75% and 110.82%, respectively.
Multi-shore, scalable and flexible delivery model with certified data protection and service standards	Company have a multi-shore service delivery model, whereby it provide its services from 31 locationsin five countries (U.S., Colombia, Jamaica, India and the Philippines). As of June 30, 2024, company had 35,858 employees servicing Members across the U.S. In Financial Year 2024, company helped Payers process 105 million claims and handle over 75 million Member and Provider interactions. Company determine the location of service delivery in consultation with its clients, depending upon their requirements. Company follow a flexible work from home model with many of its employees working from home.Company have dedicated leaders for each of its core service lines who are responsible for their respective service lines in each geography. At the same time, company have streamlined its global processes, allowing company to scale its services, as required, and ensure predictable and consistent service delivery.
Experienced management and board, motivated employee base, marquee sponsor support and a sustainability focused culture	Company's Key Managerial Personnel and Senior Management Personnel are positioned across the regions in which company operate, and is experienced across Payer and Provider operations, healthcare, IT services, sales and marketing, outsourcing, and technology transformation. Company's Key Managerial Personnel and Senior Management Personnel have been associated with the Business for an average of 23 years as of June 30, 2024, and have several years of industry experience. Further, three of company's Directors have a combined experience of over 65 years of experience in the healthcare industry as of June 30, 2024.

OBJECTS OF OFFER

The objects of the Offer are to (i) achieve the benefits of listing the Equity Shares on the Stock Exchanges; and (ii) carry out the Offer for Sale of up to 702,199,262 Equity Shares of face value of ₹ 10 each by the Promoter Selling Shareholder. Further, Company expects that the proposed listing of its Equity Shares will enhance company's visibility and brand image as well as provide a public market for the Equity Shares in India

RISKS

The healthcare services industry is highly competitive and if company is unable to compete effectively, it may adversely affect company's business, financial condition and results of operations.

Source:RHP

INDUSTRY OVERVIEW

Trends driving growth in the US healthcare outsourcing market

Healthcare payers and providers are seeking third-party support to gain capabilities that enable them to deal with the challenges such as evolving regulatory landscape, increasing patient expectations, and burdening clinician pressure among others. The following trends list down the drivers behind the outsourcing spends of the healthcare payer and provider enterprises:

• Continued staffing shortages propelling an increased demand for third-party support: As detailed out in the previous section, the US healthcare industry is likely to face an acute shortage of clinical talent. Healthcare providers, when faced with worsening staffing challenges and an ageing population, face far-reaching consequences that not only strain existing clinical talent but also increases the risk of errors. Moreover, the shortage of resources leads to delays in reviewing medical records, assessing medical necessity, and undertaking authorization procedures, leading to suboptimal patient experiences, lower Star ratings and potential revenue loss for payers. As a result, the demand for service providers who can offer skilled talent (e.g., nurses) with domain expertise for services such as clinical management, through a cost-effective delivery model is expected to increase. This will ultimately enable in-house enterprise clinical staff to focus on core care processes, which will positively impact patient care and improve their care journeys.

• Regulatory changes accelerating emphasis on better member engagement: Evolving regulatory changes in the healthcare market are compelling enterprises to enhance their capabilities to remain compliant. For instance, with the end of Public Health Emergency (PHE), states have resumed conducting annual Medicaid eligibility reviews, necessitating assistance with processes such as outreach and member engagement and eligibility verification. Further, despite CMS raising payments for Medicare Advantage Programs by 3.7% in CY 2025, the decrease in effective growth rate along with rising medical inflation could adversely impact the financial health of Medicare Advantage-focused payers. Successfully navigating this complex and evolving regulatory landscape not only requires more resources to focus on administrative processes but also necessitates investments in staff training and technology upgrades, leading to higher operating expenses for healthcare organizations. As a result, healthcare enterprises are expected to increasingly turn to outsourcing service providers who can handle the entire gamut of administrative processes including eligibility verification, member engagement, clinical documentation, prior authorizations, and claims management while staying abreast of regulatory compliances and mitigating the risk of penalties.

Transition to ICD-11 to elevate the requirement for experienced and certified coders for optimal reimbursements: The new coding standard, i.e., ICD–11 coding system has over 55,000 codes to classify diseases, disorders, injuries, and causes of death, compared to the 14,400 in ICD-10, amounting to nearly 4x as many codes as ICD-10, according to the CDC. As countries prepare for this transition, it would bring a plethora of challenges for the healthcare entities in the form of increased administrative work, uptick in the demand of coding talent, higher expenditure on coder training, and need to update technology systems to accommodate the expanded code sets. The healthcare enterprises that are inadequately prepared for this transition may experience an uptick in rejected claims, decrease in operational efficiency, and consequently, a drop in revenue. This serves as an opportunity for service providers to assist healthcare enterprises by coupling certified coding talent with modular and robust technology to ensure comprehensive delivery of services across coding, billing, claims, and multiple other processes.

• Increasing data breaches underscoring the surge in demand for robust data security to ensure compliance and safeguard patient information: According to the U.S. Department of Health and Human Services, there have been over 4,900 healthcare data breaches of 500 or more records that were reported to Office for Civil Rights (OCR) from 2015 to 2024. These breaches have resulted in the exposure or impermissible disclosure of over 520 million healthcare records. Amidst escalating cybersecurity incidents, the healthcare payers and providers are expected to seek outsourcing partners with robust systems and capabilities to bolster their defenses against evolving cyber threats. As a result, the demand for service providers with future-proof systems that can ensure data security, patient privacy, and compliance with industry regulations such as HITECH and HIPPA is anticipated to increase.

Consolidated Financials

(Rs in Mn)

Financials	FY22	FY23	FY24	Q1 FY 2025
Total Revenue (A)	9234.07	42184.08	47535.57	12233.28
Total Expenditure (B)	7338.22	31911.96	36654.67	10293.81
EBIDTA	1895.85	10272.12	10880.90	1939.47
EBIDTA Margin	20.53	24.35	22.89	15.85
Other Income	209.87	176.52	279.47	244.25
Depreciation	1472.10	6443.38	6892.11	1099.87
EBIT	633.62	4005.26	4268.26	1083.85
Interest	652.16	2148.49	1851.45	373.74
PBT	-18.54	1856.77	2416.81	710.11
Share of profit in Asso	0.00	0.00	0.00	0.00
PBIT	-18.54	1856.77	2416.81	710.11
Exceptional	0.00	0.00	0.00	0.00
PBT	-18.54	1856.77	2416.81	710.11
Tax	28.17	421.05	134.15	487.19
PAT	-46.71	1435.72	2282.66	222.92
NPM	20.53	24.35	22.89	15.85
ROE%	-0.12	2.31	3.54	0.29
EPS	-0.05	0.33	0.53	0.05
Eq Cap	19,186.72	19,186.72	42,852.82	46,792.74
Net Worth	40,266.16	62,066.70	64,431.28	76,081.57

(Source: RHP)

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