Choosing a Successful Post-Acute Business Strategy in Today's Changing Healthcare Environment

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Executive Summary

If you found yourself on March 23, 2010, wondering how your company would fit into the new healthcare environment, you were not alone. The passage of the Patient Protection and Affordable Care Act (ACA) represented the beginning of landmark changes to America's healthcare delivery system. All stakeholders in the healthcare landscape have begun to see a new emphasis on coordinating care, improving quality while reducing costs and managing the chronically ill, high-cost patients that are currently responsible for the majority of total healthcare spending in the United States. According to an AHRQ estimate, 25% of Medicare beneficiaries represented 85% of total spending; more than 75% of these high-cost patients had one or more chronic conditions. This represents an enormous cost, in both human and dollar terms, and one of the main goals of the health reform law was to improve health outcomes while driving down costs, especially for services the federal government considers “low-value” – including home healthcare.

PPACA aimed to drive down healthcare cost by slashing reimbursement rates of providers and encouraging healthcare providers to become more accountable for patients’ care and costs. Post-acute providers are standing at a critical crossroads in terms of their business strategy – they must choose between two pathways, and the decision will have serious ramifications for a company's strategic direction, access to capital and future valuation. Providers ultimately have to choose between becoming a **vendor of services** or becoming a **specialized solutions provider** in managing high cost patients. Although both options feature risks, benefits and opportunities, they represent very different paths for a post-acute business.

Providers who choose to become a **vendor** will essentially continue operating in a fee-for-service environment. They understand that their margins will shrink or disappear, so scaling their businesses to accept much higher volumes on smaller margins is essential. Traditional Medicare home health agencies are an example. Falling margins, exploding Medicaid enrollment and increased relevance in the post-acute care continuum will lead to much higher volumes. Choosing the vendor path means that providers will not only accept running high volume-low margin businesses, but they will be challenged to see any opportunity for valuation expansion, as low margin operations represent a lower rate of return for investors, consequently, access to capital could be an challenge for some providers. Vendors will need to make additional investments and strategic adjustments in order to meet the challenges of this role. Diversifying payer mix, investing in technology to drive efficiencies and acquiring other providers to achieve scale are just a few of the strategies vendor providers will need to consider.

Specialized solutions providers leverage their current competencies to take advantage of opportunities revealed by health reform legislation. These providers either maximize a current capability in their business that allows them to better control the costs of chronically ill patients, or they have made a conscious decision to build or acquire that capability. Home care agencies with care coordination hubs driven by remote monitoring would be a prime example of these kinds of providers. Although solutions providers have a significant opportunity for valuation expansion – in some cases up to 10 times that of a vendor provider – there are also significant challenges. Solutions providers must be willing to reinvent themselves and have a willingness to change their mindset – and potentially the corporate culture – from fee-for-service provider to payer partner willing to own the cost of the patient. This is a strategic shift that many executives have found very difficult to implement.

The leadership of every post-acute provider will face this decision between now and 2013, when the bulk of the reform legislation begins to take effect. Regardless of which path a provider chooses, the decision has serious consequences that require thoughtful consideration of critical issues and the development of a prudent strategy to carry the business forward. Asking serious organizational questions, walking through key considerations and mapping a way forward are critical steps to building this strategy. Once armed with a strategy, providers will be able to better navigate the new healthcare environment and take advantage of the opportunities brought by healthcare reform.

Current Environment: Change is Forcing Providers' Hands

Healthcare costs in the United States are at an all-time high. In 2005, the Congressional Budget Office noted that the US spent nearly $1.9 trillion on healthcare[1]; a mere five years later, that number jumped to $2.6 trillion[2]. Not only is the sheer amount of money spent on healthcare shocking, but so is the rate at which costs are growing – over 2% more per year than growth in gross domestic product. The Congressional Budget Office predicts that if allowed to continue at this rate, by 2040, 1 of every 2 dollars spent in America will be on healthcare[1].

Although there are many theories suggesting specific reasons why costs have ballooned to these levels, research has tracked the bulk of healthcare spending to the burden of chronic disease in the United States. According to an AHRQ estimate, 5% of Medicare fee-for-service beneficiaries accounted for 43% of total spending; 25% of Medicare beneficiaries represented 85% of total spending. Additionally, more than 75% of these high-cost patients had one or more chronic conditions. AHRQ notes that patients with multiple chronic conditions cost up to seven times more to care for than patients with only one chronic condition[3].

With these human and economic burdens in mind, Congress passed the Patient Protection and Affordable Care Act (ACA) in 2010 to tackle the problem of skyrocketing healthcare spending and to help improve overall access to care and health outcomes – especially for the chronically ill. ACA aimed to drive down cost by slashing the reimbursement rates of healthcare providers and encouraging providers to become more accountable for patients' care and costs. Historically, providers did not have accountability for outcomes or costs, and they did not receive incentives or encouragement to coordinate care, especially among chronically ill, high-cost patients.

For post-acute providers, healthcare reform created an entirely different environment and a drastically different marketplace. Although payment reform and changes to reimbursement rates created a dire economic picture for fee-for-service post-acute care, ACA's emphasis on coordination of care also opened up opportunities. These opportunities are not limited to just public payers – opportunities are also materializing with health plans and large employer groups with chronically ill, high-cost patients with similar expenditure ratios. With both risks and opportunities, the post-reform healthcare environment is forcing post-acute providers to ask themselves some serious questions about where they might fit in this new healthcare value continuum[4]. Maintaining the status quo is not possible anymore – with falling margins and a changed care dynamic, providers must soon choose how they will meet the challenges and opportunities presented by health reform.

Case Discussion: One Question, Two Companies, Two Paths to Success

Reading about the public policy theories and philosophies behind the desire to better manage patients with chronic conditions and control healthcare costs is very different from seeing real-life examples of how different post-acute providers approach the challenges and opportunities found in healthcare reform. We worked closely to develop a strategy for two post-acute providers – both home healthcare companies – that faced the same, singular question: Where do we fit into the new healthcare environment? Although both companies took the same steps, used similar processes and underwent the same level of self-scrutiny, the leadership of each company came away with a different answer and a different approach.

COMPANY 1

- Home healthcare company

- Multi-payer mix

- 40% Medicaid programs, 60% Medicare

- Patient mix: Routine care and high percentage of orthopedic patients

- Company has historically defined itself as a sophisticated provider of services to patients at risk of becoming high-cost patients

After Wyatt Matas facilitated a board discussion dissecting the health reform law, the board members realized that their current business was at risk of becoming a low margin business, and that the healthcare system is going to reward providers that can manage high-cost patients.

In order to move up the value continuum, the company would have to invest heavily in clinical, operational and culture changes to build on its capabilities to manage high-cost patients. Management believed that because of the millions that would be enrolling in Medicaid in the next 2-5 years, it was better to leverage the company's current capabilities to meet this demand and minimize additional structural changes.

The company decided to pursue a strategy of reaching a higher level of scale and furthering its efforts to drive efficiencies. Although the board and management realized their margins would fall, the risk of changing their business model at their size was too high.

For this particular company, the appropriate strategy was to be a superior provider in a high volume, low margin business.

The company then instituted an acquisition strategy that increased scale at a faster rate.

COMPANY 2

- Home healthcare company

- Predominantly a traditional Medicare provider

- Robust care management program to lower nursing visits features clinical command center driven by remote monitoring

- Cost of program not reimbursable, but company felt that superior margins and improved satisfaction from patients and referral sources made the investment worthwhile and gave them a competitive advantage

After analyzing the health reform law and realizing it would face falling margins, the company hired Wyatt Matas to evaluate its options of selling, buying other agencies or spinning off its care management model and offering its services to other providers.

Although it enjoyed margins 35% higher than the average home health provider and had a unique care management program, the acquisition market would still view the company as a traditional home health provider and not see the desired valuation premium.

Acquiring underperforming home healthcare companies and integrating its model in them would translate to instant margin and valuation expansion. However, the company was concerned that falling industry margins over the next 5 years would affect EBITDA multiples – as multiples fall, an acquisition strategy's return would decline.

For this particular company, the appropriate strategy was to be a solutions provider.

The company offered to serve as the care management component of the patient-centered medical homes adopted by other providers. Success with physician groups led to developing care coordination solutions for several managed care organizations.

Key Concepts

- Manage falling margins vs. reacting to them
- Capitalize on a company's strengths and maximize its existing capabilities
- Determine strategic options of selling, buying or acquiring expanded capabilities
- Creating a strategy is critical: Every post-acute provider will face this situation

Vendor vs Solutions Provider

In the case discussion, we reviewed two home healthcare providers that chose different pathways after a careful, guided evaluation and discussion of their capabilities and opportunities. Each weighed the risks and benefits of the options they faced and then chose a strategic direction based on a thoughtful review.

Both pathways – vendor and solutions provider – have positives and negatives, and these aspects can be magnified given a provider's specific business model and characteristics.

For a strong home healthcare provider with specific strategies that provide a path to scale, choosing to be a vendor has many benefits, chief of which is the promise of the expanding marketplace. Health reform legislation will cause a huge uptick in Medicaid enrollments among lower- to middle-income Americans who do not receive insurance coverage through an employer or who cannot afford to purchase coverage through a state exchange. Hospitals are quickly realizing the benefits provided by post-acute services, and home care margins will decline to a point where public payers will want to drive more patients into using home care services. This translates to enormous volume for system vendors. The downside is that margins will drop precipitously – some estimates suggest that providers that do not increase efficiencies or scale their businesses will see margins fall from a current average of 16.6% to -6.9% after all of the reimbursement cuts take effect by 2015[5]. Companies that choose the vendor path will see another benefit in the ability to maximize – and capitalize – on what they do best; however, they will need to scale their businesses and drive efficiency if they want to survive on thin margins. For most vendor providers, this means investing heavily in technology, diversifying their payer mix and acquiring smaller agencies to expand capacity. Those providers that have access to capital will have a significant competitive advantage over those that do not. Finally, providers who choose the vendor path will be challenged to see any value expansion, since most investors see lower rates of return for high volume-low margin businesses.

A post-acute provider that chooses the solutions provider path will discover different kinds of risks and benefits. Typically, companies that have an existing innovative competency that allows them to better manage care and control costs – such as care coordination centers that rely on remote monitoring – choose this pathway; companies that may not yet have the capabilities but have committed to building or acquiring them also may choose this direction. The biggest benefit to this approach is that solutions providers tend to be seen as innovators and partners rather than service providers. Because of this perception, they tend to earn a seat at the negotiating table with innovative payers, physician practices and hospitals who are also building cutting-edge solutions and helping shape the healthcare environment – they are essentially helping write the rules as the game is played. Solutions providers also see greater valuations than vendors – in some cases, 5 times higher.

But as with the vendor option, the benefits for solutions providers come with risk. Even the most fluid and innovative companies will find challenges in switching from a fee-for-service provider to a payer partner willing to own the cost of the patient. Historically, the healthcare system has not offered incentives to providers to coordinate care or take on accountability for a patient's outcomes and costs, so this landscape is very new – so new, in fact, that it may require a great deal of internal culture change and talent development to sell these unique solutions to other providers. Even after a complete organizational re-alignment to take an innovative solution out to the marketplace, solutions providers may still wrestle with credibility issues and a silo mentality among payers, hospital systems and other providers. For example, solutions providers will need to continually battle the traditional home healthcare agency label, even when they have or are building a full-fledged innovative solution to manage at-risk patients. Our research has shown that very few companies currently have a fully developed infrastructure to effectively manage high-cost patients across the healthcare continuum. Providers who choose this path must be willing to embark on a journey to reinvent themselves, invest or acquire talent and new competencies and align their interest with the payer and the patient.

Considerations

The leadership team of a post-acute provider must examine many different facets of its business as part of the process to decide whether to become a vendor of services or a solutions provider. Beyond scrutinizing typical "hard" qualities like organizational capabilities and access to capital, leadership teams should also be sure to explore the less-examined "soft" qualities like management and organizational sophistication and the organization's attitude toward innovation, management philosophy, flexibility and willingness to adopt a creative mindset. This spectrum of qualities will affect a provider's decision, as well as the level of success it encounters as it navigates a changed healthcare marketplace. The following matrix provides a brief sketch of some of the organizational aspects every post-acute provider should examine, as well as some of the questions involved in this analysis. We recommend that providers undergo a deeper level of scrutiny and guidance as part of a thorough strategic process.

	VENDOR	SOLUTIONS PROVIDER
OPERATIONAL ASSESSMENT	Strong quality and financial performance based on delivery of current services? Existing capabilities or willingness and ability to make investments in efficiency drivers? Scalable platform to meet expanding volumes?	Existing platform to build a solution? Is your solution market ready? Impact on vendor business line or legacy business model (assuming that the vendor side of the business is not vanishing overnight or ever) Operational and sales capabilities to introduce and service solution
TALENT ASSESSMENT	Management talent capable of running a high volume-low margin business?	Management understands risk of owning the patients' cost? Management talent capable to sell your solution to payers? Buy-in across all levels of staff?
PAYER ASSESSMENT	What does your payer landscape look like? Are there opportunities to diversify payer mix?	What does your payer landscape look like? Are your payers ready to pay for your innovative solution?
ACCESS TO CAPITAL	Source of capital for acquisitions and investment infrastructure?	Source of capital for acquisitions and investment infrastructure? Flexibility of investors or debt providers to evolve business model?

Why these particular aspects? Some of them – such as operational capabilities or payer landscape – are obvious limiting factors for either path. Not all business models are equipped to scale up to handle high volumes on low margins, and since the concept of offering incentives for care coordination is

relatively new to healthcare, not all post-acute providers will have a care coordination model or the infrastructure that is ready to go. Based on quirks of geography and demography, a provider may have booming opportunities among a variable patient and payer mix – or not. These are logical issues to consider, and most leadership teams will likely have fewer challenges examining them as part of the decision process.

But some of the other aspects in this matrix – issues like organizational mindset, level of sophistication, flexibility, openness to innovation and management's level of comfort with a creative, non-traditional approach – are just as important, if not more important, than the logical characteristics. For example, a provider that may not have a care coordination program ready to offer other providers or payers would not be limited by this factor if it had a mindset favoring innovation, access to capital and a managerial passion for building or acquiring cutting-edge capabilities. Some of these "soft" qualities can also be limiting factors in the decision process. By its very nature, healthcare reform has created a new, mercurial landscape that is not only establishing vastly different paradigms and approaches to care and cost management, but it is still being shaped. Inflexible organizations with rigid operational structures and extremely process-oriented leadership teams may struggle to reinvent themselves to fit the solutions provider option; companies that lack a certain level of sophistication or that foster an internal culture that is not congruent with the level of challenges present in the reformed marketplace will struggle to develop or launch a successful strategy. In every case, organizational boards and management teams will need to carefully consider a wide variety of issues to get a clear, complete picture of the best way forward.

Conclusion

The leadership of every post-acute provider will face a major decision between now and 2013, when the bulk of 2010's health reform legislation takes effect. Providers can choose to focus on becoming a vendor of services – essentially specializing in delivering services in a high volume-low margin environment – or becoming a solutions provider, where they leverage a unique capability to provide care solutions for high-cost patients on behalf of other providers and payers. Regardless of which path a provider chooses, the decision has serious consequences that require thoughtful consideration of critical issues and the development of definitive and prudent strategies to carry the business forward. Asking serious organizational questions, walking through key considerations and mapping a way forward are critical steps to building this strategy. Providers armed with a focused strategy will be able to better navigate the new healthcare environment and take advantage of the opportunities brought by healthcare reform.

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