

# Strategic Déjà vu

BY DEXTER W. BRAFF



## Period of Relative Calm to Enhance Diversification in Home Care Industry

**S**trategic initiatives that appear to be good often go bad. Sometimes economic conditions are just wrong, as they were when telemedicine first came to market and cost cutting simply led to reductions in revenue.

But things change and change can radically alter the fate of these initiatives. Under the Prospective Payment System, where managing costs are critical, the economic conditions are now far more hospitable for telemedicine to gain traction in the market. Such is the case in the broad health care service arena, where in light of new market conditions, past strategies du jour are being reconsidered, reconfigured, and re-executed.

### The Managed Care Strategy

When the Clinton Administration unveiled what was then termed Managed Competition, the promise of volume, quick pay, and profits lured many providers to abandon traditional sources of reimbursement, and develop programs and strategies to target the managed care community. Alas, the first incarnation of managed care failed to deliver in virtually all areas; increases in volume, if any, were not substantial

enough to compensate for the discounts providers willingly (and perhaps naively) contracted for, quick pay often deteriorated into no pay, and expected profits turned quickly into losses. At the same time, patients revolted against perceived declines in care and abandoned the plans in droves.

But flash forward to today. With (a) managed care organizations recognizing that the least expensive providers are often not the best, and (b) providers substantially more experienced and more disciplined in negotiating agreements, pricing has risen to substantially more profitable levels. MCOs are increasingly limiting the number of providers they are working with to both streamline administrative oversight, and to deliver on the promise of increased volume in exchange for discounts. Invoices are being processed more quickly. Add to all of this government initiatives to shift dollars from fee for service Medicare to Medicare Managed Care plans – a policy that was jumpstarted by substantial increases in payments to these plans – and we have a market in which strategies to pursue managed care business may be dead-on this time around.

### The Long Term Care – Home Health Continuum

The strategy of blending long term care with home care services to create a seamless continuum of care with multiple access points was extremely popular in the mid 90s. In fact, at its height, some of the most active acquirers of home health agencies were long term care providers. By the end of the 90s however, many of these innovators fell on hard times, bringing the strategy to an abrupt halt. Today, however, many long term care providers are once again looking at, or in the midst of, pursuing continuum of care strategies. What's different now? First, the failure the first time around was not necessarily due to a flaw in the strategy. Rather, some

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other factor came into play, namely the Balanced Budget Act of 1997, which decimated reimbursement for skilled nursing facilities and home health agencies at the same time — a double-whammy that few companies were capable of surviving.

Eight years later, now that both sectors have learned to successfully adapt to their own versions of PPS, the benefits of the continuum model have a real chance to be realized. Furthermore,

with many State Medicaid programs looking to re-balance expenditures from institutional care to community based care, the reimbursement climate is particularly ripe for this type of service combination. Finally, as health care increasingly becomes consumer driven, large, well-known and highly visible long term care providers are likewise increasingly well positioned to leverage their brand identity to capture patients seeking home care alternatives.

### Diversification Strategies

In the immediate aftermath of the Balanced Budget Act of 1997, the industry was abuzz about diversification strategies, particularly private pay services, willing to employ anything to lessen their dependence on Medicare. At the time, it made all the sense in the world. And for the most part, it didn't happen. In retrospect, the reasons are clear. First, post BBA, Medicare focused agencies were fighting for their very survival, faced with the extraordinary challenges of transitioning from traditional cost based reimbursement, to the Interim Payment System, and eventually to the Prospective Payment System, leaving management precious few resources to entertain and develop entirely new business segments. Second, once the industry became comfortable operating under PPS, the zeal to diversify began to wane.

The lack of urgency to diversify further decreased under the Medicare Modernization Act, which called for reimbursement increases through 2006. But we are beginning to sense a shift in strategic thinking. First, given extraordinary mounting federal deficits, many industry insiders believe that we are nearing the tail end of a period of relative reimbursement stability for Medicare home health, re-commencing interest in other services. These services, private pay and hospice, are beginning to attract attention from government watchdogs such as MedPac. However, they appear to have

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several years of goodwill and reimbursement stability to look forward to.

Second, as we have seen, managed care initiatives as well as Chronic Care Improvement Programs are currently being evaluated in demonstration projects and will likely shift patients and substantial dollars from fixed price, Medicare reimbursed, episodic care into competitive, negotiated, and privately contracted services, which, begins to look like private pay. A few innovative thinkers will take advantage of this period of relative calm to develop a more diversified portfolio of services and payers in advance of the next Armageddon, from whichever direction it may come. *dl*

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