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HOME HEALTH & HOSPICE
SPRING 2016

IS HOME HEALTH AND HOSPICE ON THE BRINK OF A REVOLUTION?

If you think about it, home care[1] today is a mash-up of providers and services:

For skilled care needed on an intermittent basis, there's Medicare certified home health agencies. But Medicare doesn't cover the paraprofessional and personal care services required between, or after, those episodes. So, for those patients eligible for coverage, there's Medicaid and other state-funded programs. If Medicaid isn't an option, there's private duty, private pay services. And for patients with terminal diagnoses? There's hospice; staffed largely by the same kind of professionals and paraprofessionals deployed by certified agencies.

Each of these programs provides health care services to patients in their homes. But they represent four distinct segments. Why?

Well, you may suggest that intermittent skilled, personal care, and hospice services are hardly the same. Besides, the eligibility, reimbursement, and billing are so different, they have to be kept separate. True enough.

But are differences in eligibility, reimbursement, and billing more a function of the services rendered, or simply an *artifice* of the payor covering them?

Consider this: What if Medicare wasn't *artificially* limited to mostly intermittent skilled services? What if it covered longer term, paraprofessional, and personal care services as well (as many believe it should)? Would two distinct providers emerge from this model, or would we wind up with those with the capacity to offer – and coordinate – the continuum of professional and paraprofessional services?

And what if Medicare didn't draw a distinction between a terminal and non-terminal prognosis? Would hospice stand on its own, or would it emerge as its own clinical pathway among the many managed by our now unconstrained Medicare agency?

And finally, what if health care populations weren't delineated by income level? Would separate Medicaid or state-funded service providers emerge?

To be clear, we're not suggesting that patients with varied clinical needs do not require equally varied combinations of primary and ancillary services. It's merely that if you define a population by geography, resource needs, diagnosis, or pre- vs. post-acute status, these services could potentially be managed by a single provider to **reduce costs**, **improve outcomes**, and increase **patient satisfaction**. Triple aim, anyone?

[1] For the purposes of this report, we will use the term "home care" to refer to all professional and paraprofessional services provided predominately in the home – Certified, Medicaid, Waiver, Private Duty, and Hospice.

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The linchpin to this revolution is a single-payor system. But not necessarily the "Medicare for all" like system bandied about by "the Bern." In fact, we're already on our way to multiple, single-payor systems.

Accountable Care Organizations. Bundled payments. Capitation. Each are designed in one way or another to allocate a ***single*** payment to cover an array of health care services for a ***discreet*** population. Under each, the incentives align to provide the most clinically effective interventions in the least cost setting (like home). So imagine if you could leverage a single management and operating infrastructure and offer a flexible, coordinated, and efficient ***complement of services in the home*** – from short term, clinically intensive care – to longer term recovery, health care maintenance, or end of life care?

You'd have a revolutionary delivery model - one that has already begun to transform home care M&A.

The conventional wisdom of the past was that you could not operate home health and hospice under the same management structure. Today, a seamless blend is now de rigueur. Skilled nursing providers are increasingly eyeing and buying home health and hospice to build out integrated post-acute offerings. Even hospitals, which spent much of the last 15 years unwinding what they wound together during the "great systemization" movement of the 80s and 90s, are coming back to home health to avoid re-hospitalization penalties.

In fact, while "in-sector" buyers previously dominated the M&A scene, over the past 12-18 months the best opportunities The Braff Group has secured for our home health and hospice clients have disproportionately come from "market-adjacent" providers.

And just recently, we've seen Medicaid and private duty services added to the mix. *In February,* **Amedisys** *acquired* **Associated Home Care***, a $28M Boston-area provider of private duty and state-funded services to "improve the continuity of care our patients receive as their clinical needs change between skilled nursing and private duty care over time."* The same month, **St. Joseph Health**, one of the nation's largest not-for-profit health systems, acquired 26 southern California ***franchise*** locations of **Nurse Next Door**, a Vancouver-based franchisor of private duty home care *"to not only provide care in the hospital, but help people stay at home and have that continuum of care."*

So are we on the leading edge of a run on private duty and Medicaid providers – sectors that have long lagged behind home health and hospice deal flow?

We can definitively say maybe. Why the equivocation?

Even absent the aforementioned single-payor golden ticket, providers have been more comfortable adding certified home health and hospice to their suite of offerings vs. private duty and Medicaid.

Compare the services:

The marketing call points are vastly different. Medicare is physician and hospital focused. But Medicaid is frequently divvied out by state agencies. As for private duty, with its consumer-driven focus, there are scant traditional call points, at all, to drop off a box of donuts.

Then there's the culture thing. The vast educational, economic, and professional differences between skilled caregivers and paraprofessionals makes it that more difficult to create a blended, integrated workforce.

And then there is the institutional memory of unfulfilled expectations. After the first round of price cuts in home health, the expectation was that providers would turn to private duty to hedge their risk. Never happened.

So what's it gonna take to move from equivocation to avocation?

Wide adoption of single-payor systems.

And, perhaps, a leap of faith. No guts. No glory.

FOR MORE INSIGHT INTO THE M&A MARKET FOR HOME HEALTH AND HOSPICE AND WHAT IT MAY MEAN TO YOU, CONTACT OUR HOME HEALTH AND HOSPICE TEAM:

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