WHITE PAPER

MARWOOD GROUP

Healthcare Provider Efficiency In The Spotlight

Mark Slomiany PhD, Director of Advisory

The pandemic brought front and center the value of home-based care and telehealth. It also exposed chronic labor shortages and the systematic lag of the healthcare sector to rapidly expand the skilled workforce for the foreseeable business cycle. Herein, we explore the opportunities which recession-driven cost-sensitivity may facilitate the implementation of platforms, service structures and performance improvement to increase provider efficiency while decreasing the impact of labor on bottom line.

TABLE OF CONTENTS

CONTACT INFORMATION

Lee Alvarez
Senior Managing Director
Office: 212-532-3651
lalvarez@marwoodgroup.com

Jennifer Meyers
Managing Director
Office: 212-532-3651
Jmeyers@marwoodgroup.com

Kyle Holmes
Senior Vice President
Office: 212-532-3651
kholmes@marwoodgroup.com

Joshua Benig
Vice President
Office: 212-532-3651
jbenig@marwoodgroup.com

I. Growing Provider Shortages

The U.S. faces provider shortages, from physicians to nurses to pharmacists and ancillary care providers. The Association of American Medical Colleges forecasts a deficit of ~18K–48K primary care physicians and ~21K–77K non-primary care physicians over the next 12 years. This is in addition to a nursing shortage. According to The American Nurses Association, more registered nurse jobs will be available through 2022 than any other profession in the United States. The US Bureau of Labor Statistics projects that more than 275,000 additional nurses are needed from 2020 to 2030. Pharmacists are also in short supply. The Health Resources and Services Administration estimates a pharmacist shortage of between ~18K–57K by 2030. Finally, as discussed in our prior white paper on the substance use disorder space, by 2024 the psychiatrist workforce will have a shortage of between ~14K–31K. with psychologists, social workers, and other mental health workers overextended as well. Given these dire statistics, there is growing interest among investors and operators in efficiency solutions which can increase the ratio of patient to provider, while decreasing time spent by providers on tasks that can be deferred to full automation or partial automation coordination by less-skilled staff, in order to improve bottom line.

II. Inflation-driven Cost Pressures To Providers

In recent years, commercial health insurer per-person spending on hospital and physician services has grown more quickly than analogous spending by the Medicare fee-for-service program. Private insurers on average pay nearly double Medicare rates for hospital services, in a range of 141–259%. The difference between private and Medicare rates was greater for outpatient hospital services, which averaged 264% and 189% of Medicare rates overall, respectively. For physician services, private insurance paid 143% of Medicare rates, on average, ranging from 118-179% of Medicare rates.

While both commercial and Medicare rates are set in advance, these trends as well as the structure through which Medicare is reimbursement is set, indicate greater ability to negotiate higher rates with commercial payors. Thus, higher reimbursement expectations, including increased pressure from labor contracts (typically indexed to CPI), will be disproportionately borne by commercial payors which either will accept the costs or develop cost containment strategies to push back on providers. In the latter case, these negotiations may become more intense as doctors and hospitals contend with inflationary pressures and must consider cost containment strategies of their own. Higher inflation may thus not only widen the gap between public and private reimbursement—forcing physicians to charge more from their private sector clients—but also lead both payors and providers to distribute the pain between cost containment and cost transfer through higher insurance premiums and patient out-of-pocket. This is detailed in our white paper on inflation impacts on the healthcare landscape from March of this year.

III. Approaches To Improved Productivity – Overview

Marwood has identified several themes of investment likely to provide inherent advantages to labor productivity in healthcare services. These include efficiency force-multipliers such as home-based services, digitization and automation of low-value task, and performance improvement efforts including efficiency studies.

IV. Home-Based Services As A Skilled Labor Multiplier

Over the past several years, commercial payors have sought to drive patient volume away from hospitals and toward less costly sites of care, which not only include outpatient facilities but more recently the home. Home-based solutions have not only benefited the payor from lower per-patient cost than center-based care, but offered attractive margins to operators through decreased labor costs.

"The economics are very much aligned for all parties [patient, operator and payor] for patients to be on home dialysis. And clinically the benefits are clear."

- Director, National Dialysis Provider

Dialysis offers a strong case in point. The center-based model for dialysis can achieve only limited gains in efficiency, even with patient retention, as they remain labor-intensive. Daily equipment ramp-up and ramp-down requires a fixed labor component and patient care is bound to a relatively fixed ratio of patient to provider. This presents challenges to operators as the labor market for dialysis-trained nurses has been and will likely remain tight for the foreseeable future. In contrast, home care in dialysis shifts time-intensive tasks from the nurse to the patient and caregiver. After an intensive initial several week training (dialysis modality-dependent), the nurse transitions away from direct contact and toward overseeing and troubleshooting, wherein a single nurse may be responsible for multiple concurrently treated dialysis patients. Notably, commercial payors may reimburse home dialysis at a slightly lower rate. Yet, the margin profiles of home dialysis providers tend to be higher than their center-based colleagues, in part due to a significantly reduced labor component. In addition, with reduced dependence on skilled labor, home-based dialysis providers face more limited exposure to labor costs than their center-based colleagues.

V. Automation

A recent third-party survey of physicians, residents and medical students indicate their expectation that almost a third of their current duties could be automated in 20 years. Alongside the longstanding trend of private equity investing heavily into physician groups, the value of efficiency measures is becoming more acute, as the physician labor shortages places greater emphasis on productivity. Beyond the low-hanging fruit of digital intake forms and appointment scheduling/reminders, automation of patient charting directly into the electronic health record (EHR) and an integrated practice-management system saves time from notes transfer that can better be spent tending to patients or practice oversight. The market for these hardware and software solutions continues to expand years after implementation of EHR requirements.

In the back office, traditional revenue cycle management is being disrupted as artificial intelligence (AI) and digital automation begin to supplement and replace inefficient manual processes or move those processes within the

reach of less-skilled employees. The lowest-hanging fruit of revenue cycle management (RCM) automation is using AI to read, tally and automate the standardized billing codes. Programmed rules-based processes offer the next step in handling specific billings. Future processes in RCM promise to combined AI with machine learning, optical character recognition, and natural language processing, to transform unstructured data, including handwritten notes and voice records to interpret clinical terms, predict billing outcomes, identify potential write-offs, catch human errors (like unbilled procedures), or even write an explanation of benefits.

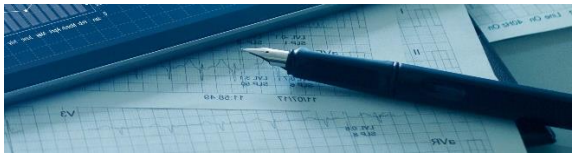
VI. Structural & Operational Performance Improvement

Beyond consolidation opportunities of providers less able to adapt, an increased focus on partnerships will drive efficiencies in such areas as information technology, telehealth and supply chain/procurement. Examples include regional health system partnerships with academic medical centers or teaching hospitals. Partnerships will also help hospitals address infrastructure gaps laid bare by the pandemic such as intensive care unit bed capacity, as well as geographic reach through partnerships with physician groups that are more open to opportunities to reduce their financial risk exposure. On the other hand, divestiture will be just as important, as the growth of telehealth and remote services has reduced the need for a physical footprint. Marwood is active in these strategic considerations and their impact on vendor services ranging from EHR systems to hospital equipment and maintenance.

Investment into efficiency studies offer an additional avenue to optimizing performance and resource allocation. A strategy for long-term financial recovery and cost reduction should be developed alongside a short-term strategy. An analysis of the spend and operational landscape will identify specific opportunities for cost reduction and operational improvement. In this exercise, non-essential projects should be evaluated for postponement or closure. Procurement and contracting initiatives should be evaluated for long-term cost reduction opportunities—such as pricing reduction, product or service conversions—and utilization and waste management. As organizations plan initiatives, it's important to structure decision-making and prioritization. Factors to consider include potential impact, work effort, implementation team, subject matter expertise, organizational risk, governance structure, and timeline. Marwood's Performance Improvement Team is active in assisting operators achieve greater structural and operational efficiency.

VII. Future Considerations

Target analysis in this environment requires an understanding of federal and state regulatory and legislative policies guiding such fields as telehealth, home health and digital enablement, commercial payor perspective on such areas as site-of-care shift and telehealth reimbursement and an understanding the underlying market, in terms of size, growth and landscape. With extensive experience in telehealth, home health and provider automation platforms, Marwood's services connect policy with market dynamics and strategy. In addition, Marwood's performance improvement arm routinely engages clients in operational & financial performance studies including revenue cycle management, cost reduction, integration and strategic plans.



ABOUT THE AUTHOR

Mark Slomiany PhD is a Director of Advisory at The Marwood Group and a former faculty member of the Department of Cardiothoracic Surgery at New York University Langone Health, as well as a former research associate at the Mossavar-Rahmani Center for Business and Government at the Harvard Kennedy School of Government.

ABOUT MARWOOD

Marwood is a leading healthcare advisory, strategy, and research firm that provides comprehensive depth, perspective, and insight to financial sponsors, lenders, healthcare companies, asset managers, and others. We are seasoned professionals from government, industry, academic medicine, healthcare consultancies, and finance with a deep understanding of the influence federal and state policy and politics has on reimbursement and regulation—and how those levers impact business strategy and investment decisions.

DISCLOSURES

The information herein is provided for informational purposes only. The information herein is not intended to be, nor should it be relied upon in any way, as investment advice to any individual person, corporation, or other entity. This information should not be considered a recommendation or advice with respect to any particular stocks, bonds, or securities or any particular industry sectors and makes no recommendation whatsoever as to the purchase, sale, or exchange of securities and investments. The information herein is distributed with the understanding that it does not provide accounting, legal or tax advice and the recipient of the information herein should consult appropriate advisors concerning such matters. Reference herein to any specific commercial products, process, or service by trade name, trademark, manufacturer, or otherwise, does not necessarily constitute or imply its endorsement, recommendation, or favoring by Marwood Group Advisory, LLC ("Marwood").

All information contained herein is provided "as is" without warranty of any kind. While an attempt is made to present appropriate factual data from a variety of sources, no representation or assurances as to the accuracy of information or data published or provided by third parties used or relied upon contained herein is made. Marwood undertakes no obligation to provide the recipient of the information herein with any additional or supplemental information or any update to or correction of the information contained herein. Marwood makes no representations and disclaims all express, implied and statutory warranties of any kind, including any warranties of accuracy, timeliness, completeness, merchantability and fitness for a particular purpose.

Neither Marwood nor its affiliates, nor their respective employees, officers, directors, managers or partners, shall be liable to any other entity or individual for any loss of profits, revenues, trades, data or for any direct, indirect, special, punitive, consequential or incidental loss or damage of any nature arising from any cause whatsoever, even if Marwood has been advised of the possibility of such damage. Marwood and its affiliates, and their respective employees, officers, directors, managers or partners, shall have no liability in tort, contract or otherwise to any third party. The copyright for any material created by the author is reserved. The information herein is proprietary to Marwood. Any duplication or use of such material is not permitted without Marwood's written consent.