

HEALTHCARE

CATHERINE ELLIS

Director
212.901.6928
catherine.ellis@navigant.com

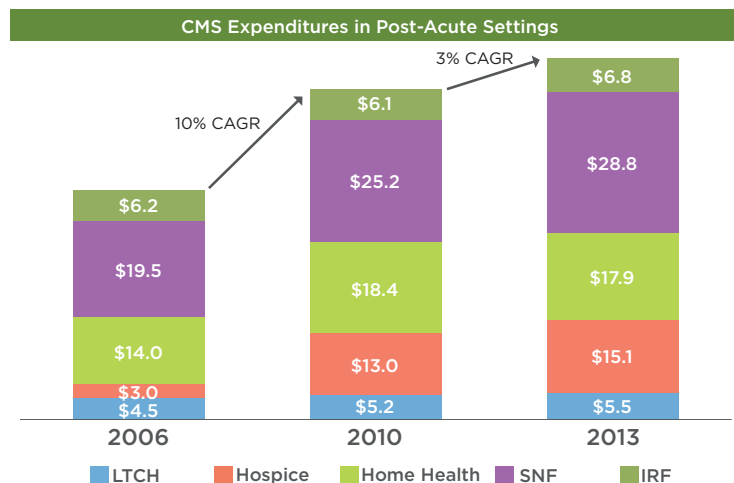
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WINNING IN THE POST-ACUTE MARKETPLACE

Between 2006 and 2010, the Centers for Medicare & Medicaid Services (CMS) expenditures for post-acute care rose by 45 percent with an annual growth rate of approximately 10 percent. The sharp increase in expense was driven by a variety of factors, including the rise in the elderly population and in the chronically ill. Hospitals also played a role, as they worked to discharge patients as early as possible into post-acute settings in response to declining DRG payments. Patient volume is expected to continue to rise, and, by some estimates, the number of Americans needing long-term support services is predicted to more than double by 2050. However, the management and funding of care of these patients is changing significantly.

First, CMS is actively working to contain costs, and annual spending growth dropped to 3 percent between 2010 and 2013. In addition, CMS is instituting quality metrics, similar to those in place in acute settings, to track quality of care. Also, 30-day re-admit penalties have forced hospitals to take a closer look at the journey of their discharged patients and to become increasingly more selective about referrals. In addition, bundled payments, in which reimbursement is paid for an entire episode of care, have further encouraged collaboration between acute and post-acute organizations. Finally, the growth of health systems which contain both acute and post-acute facilities and the consolidation of post-acute facilities into regional and national chains is centralizing management and decision making. On the horizon, accountable care organizations (ACOs) and other types of shared risk systems are experimenting with radically different approaches to care in post-acute settings, particularly in the management of the chronically ill.

Products and services marketed to post-acute settings need to go to market in new ways, if they are to survive these sweeping changes.



CAPTURE THE SYSTEM

Like most industries facing economic constraints, re-organization and consolidation of post-acute institutions has been swift and steady. As of 2013, there were 910 unique integrated delivery networks (IDN) in the United States, and many now include ownership of post-acute institutions. Post-acute facilities and services which are not owned by hospital systems are executing credentialed agreements that outline the mutual expectations of the partnership in order to accommodate risk sharing payment schemes like bundled payments or capitated budgets. And post-acute institutions are also consolidating, creating large regional and national chains which combine skilled nursing, inpatient rehabilitation facilities, nursing homes, and even assisted living accommodations. Kindred Healthcare, for example, has spent the last few years expanding from a focus on skilled nursing facilities to become a broad-based, post-acute provider with a full array of facilities. Taken together, these trends are leading to much more centralized management and decision making and much less diversity of products and protocols across acute and post-acute settings.

For the medical device manufacturer, this means that the key sales call point is likely to cover a large number of institutions and be highly-disciplined in product selection. It is as likely to be located at corporate offices as it is at a provider facility. The decision process may very well be led by non-clinical stakeholders at larger, more powerful and increasingly data-driven IDNs and/or corporate post-acute chains.

In this transition to a business-to-business sales model versus salesperson to clinician, it follows that manufacturers with diversified product lines who can provide servicing and discounts over a wide range of products will be increasingly favored over single-line players. Manufacturers with the heft and influence to impact protocol design will be advantaged, as will product lines that cross both acute and non-acute settings.

INFLUENCE THE INFLUENCERS

CMS is encouraging the development of medical homes in which patients, and particularly chronic patients, are cared for by a primary care physician (PCP) who is supported by a range of professionals from nurse practitioners to dietitians and social workers. The concept is designed to create a tight, trusting relationship between the patient and the medical home staff in order to address the medical, as well as the social and economic issues that often surround these patients and exacerbate their conditions. It follows that these medical-home-associated staff will become very familiar with devices used in the home and will play an increasingly significant role in helping patients select devices that work best for them, be it oxygen concentrators, wound dressings, mobility aides, or glucometers. “Work best” will incorporate patient parameters like user-friendly design, including accommodating poor eyesight, impaired hearing, and limited dexterity. But it will also encompass provider utilities like enhancing compliance, effortlessly sharing and analyzing information, maintaining accuracy in challenging circumstances like movement and temperature change, and providing good value for the investment.

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MONITOR, ANALYZE, COMMUNICATE

Prevention of adverse events is a core concern for post-acute facilities. While the 30-day re-admit to an acute institution is a primary concern, any exacerbation which escalates the care of a patient can reduce quality metrics, which in turn can diminish referrals. Chronically ill, often elderly patients, can decline very quickly, often in the few hours between vitals checks, and certainly in the days between home visits. Devices that can quickly detect and communicate key parameters should be embraced, such as sensors that pick up a developing urinary tract infection, increasing fluid in the lungs, rising respiration rate, or a developing temperature.

Compliance has historically been an issue for the chronically ill, so technologies that improve and monitor compliance, already in place in Pharma, are now being expanded into Medtech. One example is scales that alert home health providers if a congestive heart failure (CHF) patient has not weighed in.

Incorporating these kinds of technologies into device design will ultimately become a requirement of participation in the post-acute space. As an example, Medtronic's Cardiocom division is providing telehealth services to leading post-acute providers like LHC Group. It is building a footprint in post-acute care which will provide insight on device development, and allow it to piggyback onto innovative monitoring technologies, building a footprint in post-acute care which will give it insight in terms of device development, and also provide the scaffold onto which it could piggyback innovative monitoring technologies.

HONE THE PORTFOLIO

As with any change that is underpinned by tightening economics, transformation is moving rapidly across the post-acute landscape and leaving larger, more business savvy institutions in its wake. The scrutiny and selection of products will be brutal, and negotiations tough. Small players will have an increasingly tough time maintaining share, absent proven and significant economic and/or clinical advantage. Price advantage on any one product will be difficult to maintain against those with a larger footprint who can offer an economic advantage across a wider range of products. Large-scale consignment purchasing and just-in-time delivery will be difficult for smaller companies to manage. Medical device manufacturers need to take a hard look at their portfolio of products in the light of this new reality and ask themselves where they can compete effectively and what is required to

optimize their portfolios. Acquisitions which can strengthen and expand product lines should be actively pursued, while moving expeditiously to divest weaker and/or standalone products while they still have value. Wound care, for instance, is an example of a highly-fragmented market with limited clinical evidence on outcomes or value; a number of players are unlikely to fare well in the new environment.

DECIDE: DME OR DTC

Devices used in the home have traditionally flowed through durable medical equipment (DME) dealers. These retailers were,

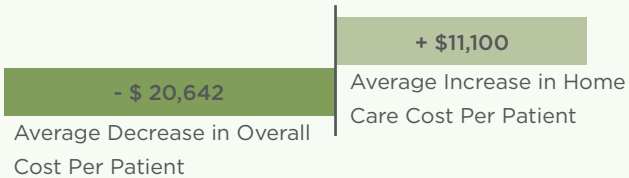
for the most part, local mom and pop stores that maintained relationships with the local clinicians and discharge planners who comprised their referral network. DME dealers also took on the tedious work of dealing with CMS and commercial payers to capture reimbursement. In recent years, CMS has slashed payments for many of these devices, and the DME universe has changed drastically as thousands of dealers have exited the business. Those who remain are consolidating into regional or national players that

are increasingly business savvy in terms of product selection and are aggressively passing the margin squeeze onto device manufacturers. Manufacturers of medical products used in the home are actively looking for ways to increase leverage and protect margins. One option is to sell directly to patients, as Inogen has done with its portable oxygen concentrators. However, this strategy requires building several expensive capabilities, including a sales force to call on clinicians, a distribution network, a reimbursement staff, and a customer service capability. A manufacturer will likely need to have a healthy revenue stream to justify the infrastructure, as well as a set of products that can be easily delivered, simple to operate, and do not require frequent servicing.

Direct sales and distribution is not the only option to preserve margin. Increasingly, patients and their families are more inclined to search advocacy sites and patient blogs to compare and contrast products, and compare and contrast DMEs as well. As more internet savvy and empowered patients age into conditions that require home medical devices, there will be greater opportunity to reach out directly to patients and create pull through, and also to develop private pay markets. Medtech companies with products targeted to the post acute market should study consumer product management, which has decades of experience developing both compelling consumer brands and successful trade strategies.

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VA HOME BASED PRIMARY CARE PROGRAM



Net Average Savings Per Patient: \$9,542



ANTICIPATE THE SECOND CURVE

Patients with chronic conditions such as diabetes, CHF and chronic obstructive pulmonary disease (COPD), represent about 10-20 percent of the CMS population, but account for approximately 70-80 percent of expenditures. Much of the cost burden is driven by expensive, acute care episodes. CMS, the U.S. Department of Veterans Affairs and full-risk systems like Kaiser and Geisinger, are experimenting with ways to reduce the overall cost of care for these individuals by changing the care paradigm. Several of these experiments have demonstrated that increasing the level of care provided in non-acute settings, particularly residential, can result in a significant reduction in acute care expenditures. ACOs, in which a medical home program is often a feature, are also working actively with these patients to increase the care and counseling they receive at the community level. As the U.S. health system moves to the "second curve," or value-based reimbursement, where improved quality, enhanced patient engagement, and lower cost are the key drivers, more and more patients are covered by integrated provider systems which accept capitated payments and shared risk incentives. If the results of these experimental programs hold up, it would suggest that expenditures in products and services targeted to care outside the acute setting will grow, as at-risk provider systems recognize that the increased investment will be more than offset by savings in acute care. There is also likely to be great technological innovation in this space, not just in terms of remote monitoring and diagnostics, but also in terms of mobility aides and robotics to supplement a labor force that is both over-stretched and expensive. Medtech companies that survive the current turmoil in post-acute care should find their efforts rewarded.

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