March 2021

The Transformation of Care Delivery

US Small Mid Cap Growth Team

BNY MELLON | INVESTMENT MANAGEMENT

MELLON

Health care is changing. The forces behind health care have been slowly building for years and are now aligned to bring about an exciting evolution in care delivery. This will impact where we get care, how we get care, how care is delivered and how it is paid for. The new model of health care will not take a single approach across the country. Instead, multiple models will develop in different geographies based on each individual embedded ecosystem as well as customer needs.

This paper continues our series that assesses how the pandemic has shifted trends and themes and explores our journey to determine the future of care delivery. We postulate that there is no single solution to fix US health care, and the changes happening herein are no panacea. Rather, these incremental changes will move the needle on quality and cost of care, creating attractive investment opportunities along the way. We will focus on three areas where we think new approaches are meaningful: primary care, site of care and mobile health care.

Primary Care

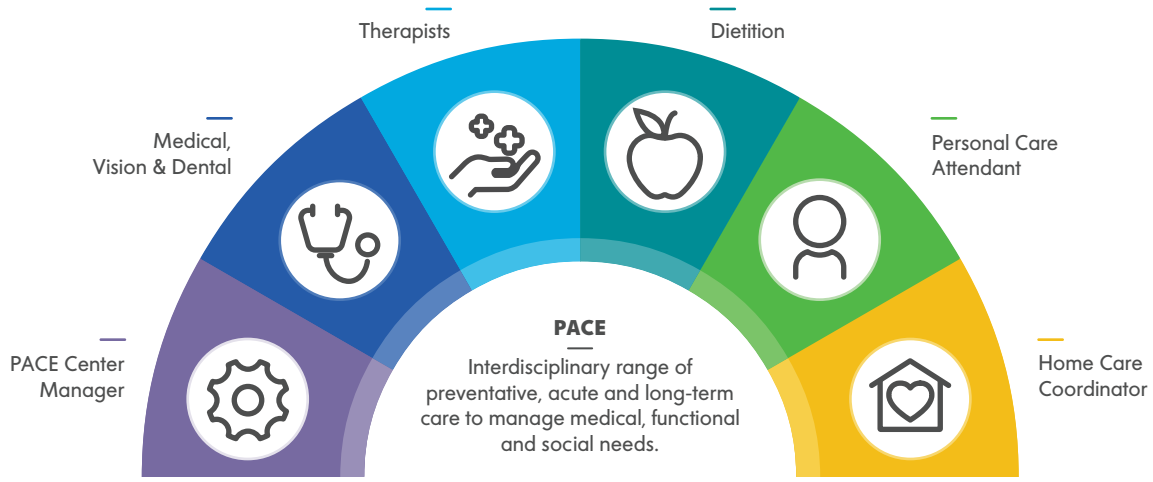
The current US primary care system is part of the problem. Today, most primary care practices are paid on a fee-for-service basis, racking up charges based on the volume of services delivered. This incentive system results in a model where more patients, more services, and more tests all result in more revenue for the provider. But insurance companies want proof of necessity, so primary care physicians spend an inordinate amount of time managing patient records when they could be seeing and treating patients. Additionally, these physicians are not paid for the record keeping and therefore need to see more patients to recoup lost time. This economic model demands high volume and does not allow for the necessary time clinicians need to seek out underlying health issues that may be lurking beneath the surface. Doctors are forced to simply treat the issue at hand, then move to the next exam room.

However, we know that better health and wellness is a result of multiple factors ranging from genetics, environment, diet and exercise, mental health and social determinants, to name a few. Most patients with a chronic condition either have, or will have, multiple chronic conditions. Treating patients on a reactionary basis—fixing the malady of the moment—is a recipe for poor outcomes and higher costs. Discovering and treating health issues earlier almost always results in better results and lower utilization. However in order to do this, physicians need time and resources to probe for health issues that may not be readily apparent. Most importantly, they need an economic model that allows them to do this.

Enter a new approach to primary care. In this model, physicians are paid a fixed monthly fee that is projected to cover a pre-defined set of health care services potentially needed by patients. Physicians are then responsible for downstream costs of care, profiting from the spread between fixed monthly fees and incurred costs. This approach creates an economic incentive for physicians to deliver high-quality preventive care, resulting in healthier patients who utilize fewer resources. Additionally, referring physicians become informed gatekeepers and are now "responsible" for the quality of downstream services. This model of health care should create larger patient flows to providers who deliver higher quality, cost-effective services. The message is simple, reduce downstream costs by improving wellness. While there is risk of physicians simply avoiding referrals to reduce costs, there are some guardrails in place to encourage quality care, thanks to quality reporting and consumer choice. We believe that physicians would prefer to offer high-quality care with a long-term view. These new arrangements provide an economic model that allows doctors to deliver these enhanced services.

The federally sponsored PACE program is a good example of how these models can be successfully applied in the real world. PACE is a substitute for Medicaid when a patient would normally qualify for nursing home-level care. PACE programs are paid a monthly, per member fee and are responsible for all health care needs of member patients. Operators learned that they need to treat the whole patient in order to be successful. While the upfront costs of hiring dietitions, social workers, drivers and therapists can be challenging, the downstream benefits of better health outcomes result in lower health care costs and higher operator profits. Quite simply, if the PACE operator can keep patients out of nursing homes and hospitals, they make money. Operators accomplish this by delivering higher level care on a consistent basis, staying ahead of problems and preventing downstream utilization.

Setting the PACE: An Innovative Model of Care



PACE programs are but one example of the changes underway in primary care delivery. These models are complicated at the start, and the structure can vary significantly as practices take on varying levels of economic risk. While no single formula will take over, the concept is being applied all across the country. Providers are signing contracts with payors ranging from commercial insurers to Medicare and Medicaid, and in some cases, directly with employers. There will be successes and failures, good providers and bad, as well as new bureaucratic hurdles. Most importantly, these new models will prove to be disruptive, changing how care is delivered in the years to come.

Site of Care

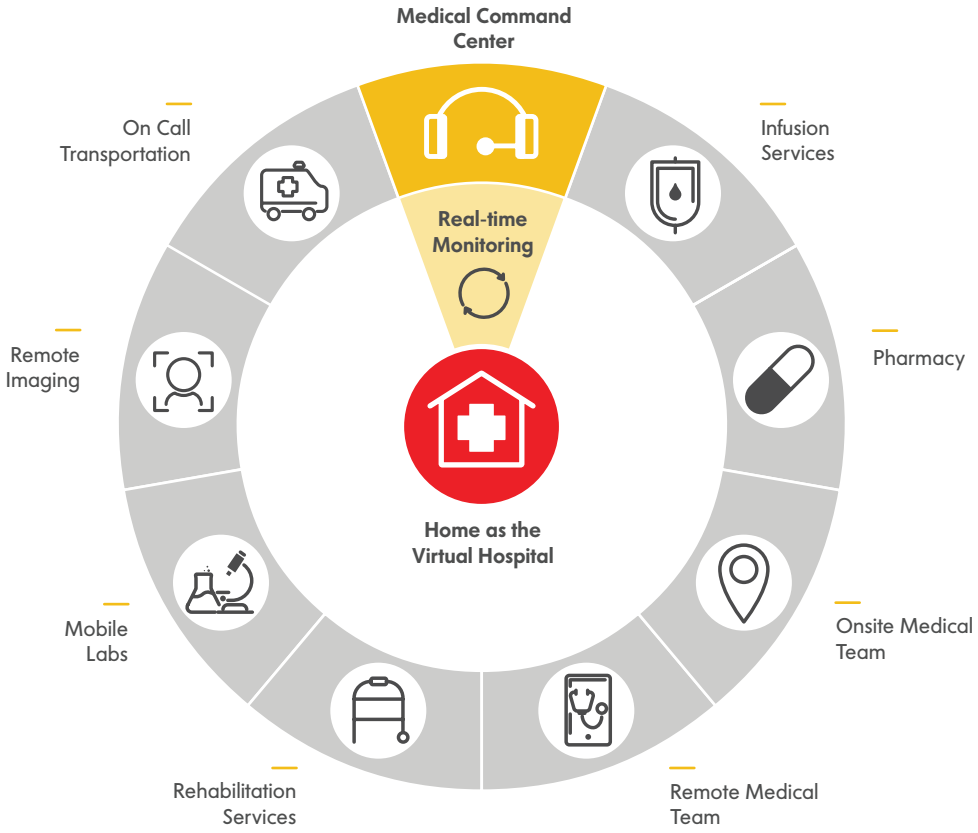
Where we get care will also change. Traditionally, services are delivered in the hospital, doctor office, nursing home and urgent care centers. Moreover, specialist care is delivered in limited locations, often requiring significant travel time. However, providers and insurers are learning that many of these services can be delivered in different settings at lower costs with equivalent or even better outcomes.

Telehealth is the most evident example of this trend as parents are now more frequently video chatting with pediatricians in the middle of the night. This type of service will become ubiquitous, but does not reflect the full power of these platforms. Telehealth will increasingly be used for pre- and post-surgical visits, eliminating the need for office visits. This technology will also be used for in-office specialist consultations, like a dermatology consultation in a primary care office. Additionally, emergency room doctors will consult other physicians via telehealth, negating the need for some transfers. Perhaps most importantly, telehealth will enable other innovations in site of care.

Health care is moving into the home. Driven by technology, consumer preference and innovative service providers, we will increasingly be able to receive care at home—care that goes well beyond a telehealth visit. Providers are offering house calls, and insurers are paying for it. There is also a growing offering of urgent care services in the home, negating the need for a trip to the clinic or emergency room. Other companies are also beginning to offer chronic care services in the home, with frequent visits and outreach for patients with COPD, hypertension and musculoskeletal issues, to name a few. Insurers are learning that, by paying for services in the home, they can keep their members out of higher cost venues. Highlighting this trend is the emergence of skilled nursing at home programs where providers are paid to offer nursing home-level care in a home setting.

Moving even higher in acuity, hospital-level care in the home is becoming a reality, driven by costs and outcomes, and enabled by technology. Leading-edge hospital providers are seeking to discharge patients who normally would have had a lengthy stay in the hospital. In some cases, this may change a four-day stay to a two-day stay but, in other cases, patients can be discharged directly to their home. Patients with diagnoses such as pneumonia, renal failure, respiratory infections and heart failure are just some of the candidates for hospital in home services. The working assumption from these providers is that they can provide an equivalent level of care in a patient's home where they are safer from complications like infection. There is a growing belief that seniors in particular recover faster and more completely in a home setting. Telehealth is a key enabler, as is remote monitoring technology and service providers who provide surveillance and periodic home visits.

Advancing In-home Medical Care: The Clinical Care Model



Beyond the home, health care services are becoming more accessible. Employers are increasingly establishing primary and specialty care on site. Some of the largest retailers in the US are adding a health care offering in, or adjacent to, their existing locations. Independent operators are placing locations in high foot traffic venues normally reserved for traditional retailers. These new offerings are not a repeat of prior efforts to simply add higher acuity services adjacent to a pharmacy counter. These new stores have separate entrances and distinct footprints. The look and feel is akin to high-end retail, and the offerings sometimes include a level of concierge service. Patients can receive primary care, dental, vision and mental health services in the same location. The key element is accessibility and convenience, and these locales frequently target populations who have difficulty attaining care. Lastly, because these are "retail" locations, they will behave as such, approaching marketing and customer service in a manner that will be disruptive to traditional providers.

Mobile Health Care

We are moving to an environment where we can take our health care with us. A confluence of factors are driving novel ways to deliver health care. Faster bandwidth, evolving regulations, payor/provider willingness and consumer preference are enabling these new offerings. These services are app centric and provide varying levels of automated and live service.

Diabetes has been at the front of this curve with multiple companies making inroads. These products connect directly to patients via apps or text, providing real-time feedback on glucose levels, recommended actions, behavioral reminders and motivational support. Other chronic conditions such as hypertension and respiratory illness can be addressed in a similar fashion. The driving principal behind these programs highlights that chronic care requires more frequent, consistent intervention in a format that is easily managed by the patient. The incremental cost to the user is typically zero, with insurers and employers paying for the service. Providers are typically paid on a per-member, per-month basis. While some are taking on capitated risk, contract renewals will be dependent upon continued evidence of lower costs and better outcomes.

One of the fastest growing areas of mobile delivery is mental health. Companies are offering mobile-based care ranging from AI-driven services to immediate connections to licensed therapists. Users have the ability to seek help and support anytime, anywhere – a dramatic improvement over the traditional approach. Using mobile platforms, wait times can be reduced from weeks to minutes.

Physical therapy is a great example of mobile services that can be surprisingly successful. App-based services are now being used to deliver chronic therapy. Location-based therapists are using mobile platforms to deliver hybrid services, reducing the number of on-site visits required for their patients. Some of these apps can provide feedback on proper technique, allowing physical therapists to better leverage their time. Early evidence suggests that patient compliance with prescribed therapy improves, resulting in better outcomes.

Last, and perhaps most impactful, is the emergence of virtual primary care. Providers are building mobile platforms that enable both traditional and direct primary care models in a virtual manner. Patients will join a virtual practice and receive the same services they would if they went to an office-based practice. This approach will improve access to primary care in underserved areas and in demographic populations where mobile care is the preferred venue.

These mobile solutions will not replace traditional on-site care. Rather, we should expect to see increased use of mobile health care designed to supplement traditional offerings and deliver hybrid services to meet patient needs.

Hastening a Health Care Revolution

These changes in health care have been discussed for years, but momentum is now shifting in their favor and accelerating adoption. COVID-19 has further hastened this evolution, highlighting the capabilities of virtual care, while drawing attention to the need for consistent intervention across the full spectrum of an individual's health and wellness. We will see multiple approaches, models and technology. There will inevitably be failures. However the leading-edge players that implement these services will prove to be disruptive at the local level, driving market share shifts and changing consumer expectations. These shifts will provide investment opportunities across next-generation entrants, traditional players willing to disrupt their own models, and downstream service providers who consistently deliver higher value outcomes. An ecosystem of connected devices will become a necessity, and new service models will evolve to support the new care models. The pace of change will appear slow to most observers, but will feel rapid inside health care.

Edward Walter, CFA

Managing Director, Senior Portfolio Manager

Ed is a senior portfolio manager on the Small Mid Cap Equity investment team. He began his career in 1989 at Standish, Ayer & Wood.

Ed has served in various roles, ranging from analyst to portfolio manager, across small-cap, large-cap, value, growth, international and domestic portfolios. In addition, he has covered a wide variety of sectors and industries during his tenure.

Ed has a degree in finance from Villanova University and holds the Chartered Financial Analyst® designation.

Disclosure

Mellon Investments Corporation ("Mellon") is a registered investment advisor and subsidiary of The Bank of New York Mellon Corporation ("BNY Mellon"). Any statements of opinion constitute only current opinions of Mellon, which are subject to change and which Mellon does not undertake to update. This publication or any portion thereof may not be copied or distributed without prior written approval from the firm. Statements are correct as of the date of the material only. This document may not be used for the purpose of an offer or solicitation in any jurisdiction or in any circumstances in which such offer or solicitation is unlawful or not authorized. The information in this publication is for general information only and is not intended to provide specific investment advice or recommendations for any purchase or sale of any specific security. Some information contained herein has been obtained from third party sources that are believed to be reliable, but the information has not been independently verified by Mellon. Mellon makes no representations as to the accuracy or the completeness of such information. No investment strategy or risk management technique can guarantee returns or eliminate risk in any market environment and past performance is no indication of future performance. The indices referred to herein are used for comparative and informational purposes only and have been selected because they are generally considered to be representative of certain markets. Comparisons to indices as benchmarks have limitations because indices have volatility and other material characteristics that may differ from the portfolio, investment or hedge to which they are compared. The providers of the indices referred to herein are not affiliated with Mellon, do not endorse, sponsor, sell or promote the investment strategies or products mentioned herein and they make no representation regarding the advisability of investing in the products and strategies described herein. Please see mellon.com for important index licensing information. CFA® and Chartered Financial Analyst® are registered trademarks owned by CFA Institute.

For more market perspectives and insights from our teams, please visit www.mellon.com.

BNY MELLON | INVESTMENT MANAGEMENT

MELLON

www.mellon.com