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Dissecting A Case Study in Innovation in Provider-Based Healthcare

Soran Health

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Key Takeaways

Public Company Ownership in Provider-Based Healthcare

Innovative healthcare models, especially those involving taking on risk, require meaningful capital, scale and time to mature. This reality lends itself to having a well-resourced capital base, as well as a patient, long-term oriented ownership pool.

When evaluating different ownership models (e.g., public, PE-backed, hospital-backed, independent, etc.) it is critical to evaluate which ownership structure and which specific owner is likely to "score" well in addressing the needs for capital, scale and time to mature.

The additional costs and fluctuations of public markets can make public ownership a suboptimal for innovative care delivery organizations, unless they are more mature in their stage of development.

Payer Partnerships in Provider-Based Healthcare

Expect to see more partnerships between payers and providers – not just in primary care, but also across specialty care - as payers seek to achieve improved star ratings, predictable and improved medical margins, and membership growth and retention.

Payer / provider partnerships are especially attractive for payers when (i) the payer does not have the core competency in-house and (ii) there is an abundance of supply for the particular service in the market. For many payers, primary care is a good example of meeting these criteria.

While payer / provider partnerships can be mutually beneficial, there are areas of potentially divergent priorities to be mindful of. Payers, in the Medical Advantage market in particular, face intense pressure to compete for membership. This has led to strategies such as offering attractive supplemental benefits that can often be non-medical in nature. How these costs are shared between the payer and provider organization can be a source of tension and point where interests may diverge.

The Rising Bar to Success in Value-Based Care

There was a period of time when the critical skillset for a value-based care provider was probably coding. It was billing and coding and having a system that enabled strong processes all the way

from documentation in the clinic to submitting claims. And that was the main driver for success. It's still critical, but we can see the signs certainly over the last year that utilization management to improve outcomes in an effective but cost-efficient way is absolutely critical.

With growing pressure to succeed in utilization management, so-called wraparound solutions are becoming a key area of focus. Wrap around services are bespoke services that meet specific needs, quality ratings, and specialty services linked to utilization and patient engagement.

Soran Health is designed to meet those specific objectives. The Company provides valuable real-time risk stratification and interventional opportunities without the need for EHR, PBM or medical claims data. Soran Health leverages data analytics to help payers identify the lowest cost site-of-service for care appropriate treatment, avoid the need for hospital / ER utilization, and determine high ROI medical & non-medical interventions.

Background

Jason Conger

I'm an attorney by profession, a serial entrepreneur, and a former member of the Oregon House of Representatives. In every role that I've had, I have been drawn to healthcare in some capacity - sometimes as an owner, as an advisor, as a board member, or as an executive. And to me, it's fascinating - both the good and the bad of our US healthcare system. It's become a focus in my life and in my profession. That, of course, led to the partnership with Marlow and two other co-founders and our current healthcare company.

Marlow Hernandez

I'm a physician, and I have always been passionate about making healthcare better. I began my career by founding and developing a more integrated model of primary care at Cano Health, helping hundreds of thousands of people directly and many more indirectly. Our innovations were adopted by many in the marketplace across several states. However, I became frustrated by my inability to continue to innovate. The public and health insurance market also significantly changed for primary care, given runaway medical expenses post-COVID. Therefore, I left Cano in June 2023 and formed Soran Health along with Jason and others to provide specialty healthcare services at home, focusing on patients with advanced care needs.

Interview

For anyone who may not know about Cano, can you give an indication of the size of the company when you were running the business?

Marlow Hernandez

Cano reached about $3 billion in revenues and 170 medical centers up until 2023. After that, I have limited information. They're still fairly scaled, I think, close to about a hundred medical centers or so.

An interesting place to start is on the topic of ownership. We spend a lot of time analyzing the impact of different ownership models on outcomes in healthcare - which work, and what the pros and cons of each are - from hospital ownership to independent, to private equity-backed corporate MSOs. But it's fairly rare that we have the chance to speak with the leadership of a public healthcare company. Cano went public during your tenure and I would be curious to start this conversation by getting your thoughts on the concept of public ownership in provider-based organizations and your experience of what works and what doesn't and how public ownership meshes with these provider-based organizations?

Marlow Hernandez

Public ownership can work. However, the company must have the right capital base and maturity to operate in the public markets. In an industry as complex as healthcare, companies in active growth should wait much longer than their peers in other industries to go public. There's just much more to do for a company in the healthcare sector to be ready for going public more broadly. In terms of ownership, PE can play a beneficial role, and health systems and other strategic investors can benefit the market through consolidation. However, it's all dependent on the model. If the model is related to consolidation, to obtain contractual lift and become more efficient in the performance of services, the cost will increase. The benefit will not be there for the patients and the broader market. It is as simple as that. If the model, however, is to innovate new sites of care and modalities of service within value-based capitated contracts or even fee-for-service contracts that aim to provide more proactive care at lower price points, costs will decrease. So how do you get that? It is a function of how that ownership base views the business, their understanding of the business, and their long-term orientation or lack thereof. It is also related to the incentives for management for the ownership base and the contracts that they negotiate with the payers. With health systems, if you seek contracts that are at the very least tier one type status, for those providers who are able to attain the same or better clinical results at lower press points, whether fee for service or capitated, you are going to get measurably better service and better outcomes.

Jason Conger

I would just echo what Marlow said in a sense. Particularly in value-based care and especially in a risk-taking model, it becomes very complex. The information that you get about claims typically lags quite a bit. So, it takes time to identify real-time trends and respond accordingly. And that, combined with the administrative burden of being a highly regulated industry, let alone if you were a public company where the costs literally become exponentially higher, the need for scale in order to be able to achieve administrative efficiencies and not end up risking too much or being put in a position where you can't understand the risks, especially it calls for some consolidation in risk-taking value-based entities. And so, the need for capital to do that, to build out that kind of infrastructure, is significant and not necessarily easily accessible without institutional capital or once a company matures enough, perhaps accessing the public markets. So, there are good and bad, but as Marlow pointed out, if the consolidation is purely to create pricing leverage or increase volume in a transactional fee-for-service model, that is inherently inflationary. There has to be a system that works, and it has to be set up in a way that you're competing, not just for those types of leverage. It needs to be in a value-based environment where outcomes quality is rewarded, investments are made in prevention instead of investments in driving more volume of procedures or something like that.

A significant number of corporate MSO include provider ownership. And, for those companies, that's a key structural component to align incentives across the different stakeholders. Did your providers at Cano have equity in the business? And if so, what was it like to manage an organization where there's very public information about the market capitalization of the business, decision-making, governance, and business performance results? Did that impact the culture of the organization? What did that feel like to manage?

Jason Conger

Our employed physicians were given equity incentives from the time that Cano was a private company and continuing on as a public company. And that sense of ownership and alignment was very important. The reason that I wanted to jump in and answer this is because the main reason that happened, and through some resistance from our capital partners, was because Marlow insisted on it and thought it was important for all the obvious reasons: the alignment of incentives, but also the reward for performance and the sense of having skin in the game as a key part of the organization, which the providers are. And then with the affiliates, of course, there was always some form of alignment, not necessarily in the sense of direct ownership or equity ownership but by sharing in savings.

Marlow Hernandez

Since December 2016, the majority of Cano has been owned by the PE sponsors, and then the majority has been owned by the PE sponsors, plus those in the public markets. So it's different from what you would see in other MSOs, such as surgery centers or specialty organizations, where close to the majority or more than the majority is owned by the providers. So, it is a different experience to have a relatively small equity stake owned by the providers. Nevertheless, it was much appreciated. I don't think it had an impact other than what Jason mentioned, meaning that important sense of ownership and alignment and continued innovation, doing something greater than yourself for Cano specifically, given that it wasn't as important part of the compensation as it is in other organizations.

Do you expect to see more MSO IPO subject to macro market conditions? As these MSOs become larger, is it a recommended exit option for them to consider? Do you expect to see more of that, or given the complexities that Jason mentioned in healthcare, is this market just not as conducive to IPO exit? Too complicated?

Marlow Hernandez

I think that MSOs can benefit from going public and that kind of exit. It is a question of cost of capital. There are high recurring costs, as Jason mentioned, that private companies don't have, and that needs to be compared to the cost of equity and cost of debt to grow the company and ultimately fulfill the vision.

MSOs need to be in that Golden stage of not too much growth, not too little, having the right infrastructure already in place, and having the right capital base for the longer term.

I think that outside of those specific parameters, which would be highly limited in a space where there's so much complexity and so much current disruption, it is hard to see provider companies be at that stage; it is probably better to go to the bigger sponsor route or the strategic route or just continuing the current ownership structure until you achieve those important building blocks of success in the public markets.

I want to shift to another key topic that we focus on, which is that of strategic partnerships in healthcare. I know Cano had a large partnership with Humana over time that helped the company grow. I would love to hear a little bit more about the nature of that partnership, how it came about, and what it meant to collaborate with a payer on expanding into new locations, new markets, so on and so forth?

Marlow Hernandez

Sure, it's rather simple. Work with Humana and others to build centers in areas where there were large, underserved populations. We partnered with Humana to ensure the necessary short-term resources to make a real difference, meaning be able to serve a meaningful amount of those underserved patients and offer them the integrated, comprehensive, proactive type services that value-based care is all about. So that's a need that continues in the marketplace, albeit primary care is under very significant stress because, as I mentioned, there is a trifecta of post-COVID medical costs continuing to be very high, particularly in Part B, as well as runaway supplemental benefits. And now you have rate changes and some slowness to adapt on the part of the payers. And so, there's a need for solutions that were not as simple as, well, let's stand up more primary care sites and deliver more comprehensive services there. But I do think that there continues to be, and will be, in the future, a significant need for partnerships between payers and providers of many kinds, not just primary care where either physical sites or specific services are rendered in order to meet specific population health objectives. The payers and health systems are smart enough to pay for those and invest in those because, at the end of the day, what they would like to achieve is better star ratings, predictable and improved medical margins, and membership growth and retention. And so you don't do that by the conventional standard of the past.

Jason Conger

Yeah, we had highly productive, very collaborative partnerships with multiple payers. Humana is by far the largest in terms of membership, and we were completely aligned on the things that Marlow mentioned: quality, membership growth, and medical cost. And that worked really, really well. But there's also always a tension between the competition amongst payers, which Marlow also mentioned as an example of supplemental benefits. That was what I'm thinking of when I say supplemental benefits. There are a lot of things that can mean, but what I'm thinking of most recently is a monthly flex card that can be used to buy things like food or pet food or supplies for your house, things like that. Effectively, a debit card and the competition between the payers is largely in the form of benefits in Medicare Advantage. And so that competition drives them to compete on these very things. Those, however, are largely non-medical costs that we had as a primary care provider, that Cano had no control over. This creates tension between the payer's competitive drive and where that cost should be born logically and properly. And that's not completely new. There are other examples I could give of that.

So it's a system where there are a lot of aligned incentives that can work miracles for the patients and the overall system cost.

But then there are some potential tensions between provider and payer that probably need to be thought through and addressed to create a complete alignment where those costs and benefits are reasonably allocated between the parties and no party is bearing costs that are not reasonably appropriate for them and not controllable by them.

Were the partnerships with Humana successful? Did Humana achieve its objectives and the same for Cano Health?

Jason Conger

Well, they were wildly successful and, again, very collaborative, cooperating to identify markets and locations where the need was great and could be addressed well by a partnership between Humana and Cano and, again, other payers as well. And both parties' goals were achieved. Now, in some of the expansion markets that we went into, it takes time for those markets to mature. Think of a single medical center, for example, in a new market where you don't have any strong brand identity or any patient base or things like that; you're going to have a period of time where you automatically have to assume operating expenditure until you achieve your break even and start turning that location profitable. That does take quite a bit of time and can certainly be measured in years. This goes back to some of Marlow's comments about access to capital. Similar to what I was saying about, or what we were saying about MSOs, you need to have reserves, and you need to have realistic expectations about how long you're going to have to invest in a new market in order to have it mature and become pretty predictably profitable after that.

I have one more question about the partnership with Humana. You're both advocates for strong collaboration between payers and providers, and within that spectrum, there are different models. There is the ownership model – United / Optum or Cigna / Evernorth. And then Humana's approach which, at least in this case, was more of a partnership model without ownership. Just curious if you have a point of view on which of those models you advocate for and how you'd compare and contrast the relationship you have with Humana versus the owned model?

Marlow Hernandez

Other payer organizations have pursued this. Yeah, so I would absolutely echo what Jason said in terms of success.

Key objectives were met and exceeded basically everywhere where those partnerships occurred.

Runway or time combined with the inflationary environment and the aforementioned benefits and some of the rate changes put a lot of pressure, particularly on the provider side in this specific case, but there was great success in meeting patient outcome objectives as well as medical margins in such a partnership.

So, the question as to what type of partnership, is it an owned model or is it one where you effectively do some joint venture or one in which you offer some contract concessions? I think it depends on the specific market and objectives, as well as the supply for it in the current market and the core capabilities of the payer wishing to meet those objectives. In the cases where the payer lacks that core competency and does not want to be in it, it makes a lot of sense to do an RFP to have third-parties meet that need in some unique way for them or customized way for them in situations where they do have that core competency. When there's lack of supply or willingness to provide competitive services, then it pushes more toward the owned model. There are, I think, easy examples where you have rural healthcare, and you have healthcare deserts, as it's sometimes called, which could also occur in urban settings, and the payer has little choice but to buy those. The payer just to be careful that it's a core competency and has that worked out internally in the organization. And there are other cases where let's take the primary care example, there's plenty of supply and those that are in value-based care or seeking to do value-based care and are willing to co-invest. Well, that's a great scenario for the payers. So it depends on a range of factors. There is not a silver bullet or a right or wrong answer. The only thing I would say on this one, just talking more medium and long-term and looking out for a healthcare system and fiscal health longer term, we need to ensure that we maintain competitiveness in the marketplace and that we continue to evolve healthcare to providing better patient outcomes at a lower price point. So when you have health systems or others that are consolidating purely to do more volume of services at higher prices per service, that's obviously not in anybody's interest except for that individual entity. It doesn't happen too often, but we are seeing it in some of the specialties, putting pressure overall in the system, we have to watch out for it at the hospital level and so on. With that caveat in mind, most other consolidations, JVs, and investment approaches are moving healthcare in the right direction.

I want to talk a bit about geographic strategy for national MSOs. I think primary care is interesting because it is a specialty that varies meaningfully by geography, both in terms of competitive landscape and reimbursement models. Cano had a chance to expand from its core legacy in Florida to, I believe, eight states across 34 markets. And I think Marlow, you mentioned 170 sites at the company's peak. I would love to get your perspective on comparing performance across these states from a primary care perspective: which were successful, which were unsuccessful, and why?

Marlow Hernandez

We generally enjoyed the same success in markets outside of our home state of Florida markets, like Texas, Nevada, and Illinois. It's generally a function of time in the marketplace, maturity of physical sites, and the state-related intricacies. Some markets just make it a little bit more difficult to get the right contracts in place to then build a critical mass that you need to cover your fixed costs and go from there. But when you look at medical margins and clinical outcomes, which ultimately will be a hundred percent correlated to financial metrics, Cano enjoyed effectively the same success. There were some market-specific elements for us to discuss. For example, Puerto Rico never operated medical centers, it only had an affiliate-type model. In California, we never had an affiliate model; rather, it had medical centers. When you are able to get to critical mass quicker, success comes faster. There are market-specific elements that just make the runway longer, that puts additional pressure. I think there would be several hours of discussion per market to discuss some of that. But to your general question, across some of the largest markets in the country, you have a lot of similarities and the value-based care model where you are offering primary care under an aligned relationship with a payer, and you ensure that you're providing patient centric, proactive, connected care, the model is going to be successful no matter where.

Jason Conger

Yeah, I would add to that when we say MSO, I know it can mean a lot of different things, and I think Marlow and I both look at it through the lens of our experience, which is value-based type contracts. And so we had two different models. One was our ACO Reach, and the other was more traditional, at least for Florida, MSO, and obviously completely different programs. But overall, I think in every case, we think of it as offering limited services, mainly related to trying to help providers make gains in terms of patient outcomes and reducing utilization. And that's through the analysis and delivery of information about their patients, their claims, and various metrics. And that's really it. So, I think Cano did billing for some of its affiliates in Florida, but that was it. We really didn't have a high administrative service-oriented MSO, and our MSO, ACO Reach, or entities were always at risk. So, we think about it in those terms. And scaling state to state is a little bit easier, by the way, with the ACO Reach because the federal rules sort of dictated how that would work state to state in terms of an MSO; a lot of it had to do with the obvious costs and barriers of understanding the regulatory realities in different states. In New York, just to pick a random example, you have to register an entity, which is referred to as an IPA, but you have to register an entity to perform the MSO function that I just described, meaning take the risk. Every state has different rules that are probably threshold considerations, but the ecosystem in which you exist is also really important. And that varies a lot, particularly in, again, I'll pick a random example, but it's an obvious one. The healthcare ecosystem in California, to me, is different than anywhere else, and that's on top of the unique regulatory requirements like having a Knox-Keene license to take risks, which is a very involved and expensive process to obtain that license. However, there are also a lot of intermediaries in the market that already have a significant amount of market power. And so I would say, ultimately, Marlow is right. If you're producing better clinical outcomes and you're accomplishing the ultimate goal...

You can be successful in any market because even though demographics are different and people's habits about accessing the healthcare system are different, all in all, it's not that much different

but the existing ecosystem and the regulatory environment makes it challenging to jump from certain states to other states.

To Marlow's point, I guess it's also a question of timing and patience and how long of a horizon you have to let that play out, which is why I can imagine being in the public markets and having that level of scrutiny would have been at times challenging. Are there any lessons learned or things that you would do differently from a geographic expansion market? Would it be a different expansion strategy? Would it be more acquisitions and less de novo? Would it be a different rate of new market entry? Or do you think that the geographic strategy that was pursued was the right one to replicate?

Jason Conger

Yeah, so I think it was very successful based on the company's original expectations and strategic plan. And in that, as Marlow mentioned, while there were different rates of maturing of the operations in different states and there were different threshold costs to beginning to operate in different states, most of the states by year one or two of operating there were showing good underwriting margins. And so, it wasn't a question of whether we can be successful in those states. It was a question of time and having sufficient membership to generate the revenue that would be necessary to cover all of the fixed costs and the overhead. And so, I think that the strategy was successful with the base assumption that fueling that growth would continue and there would be adequate capital to continue it. And just in general, the strategy involved a little bit of both. As you asked about the difference between acquisitions and de novo centers, the weight was heavier on the acquisitions, and that strategy changed in response to, I would say, investor base pressure after we went public, to emphasize de novos. The difference obviously is that with an acquisition, you are likely putting out more capital in the beginning, but you're also generating cash flow from day one. And with a de novo center, you have a much longer ramp to have positive cash flow. In either scenario, you need capital, but in particular with a lot of de novo centers, especially in new markets, you need a lot of patients and the ability to feed those centers for years until they turn a profit.

The two of you are now partnering again at Soran Health, which is another exciting venture, and I would love to hear a little bit about what you're focused on. I know Soran is in the value-based care ecosystem, so we'd love to hear specifically what the strategy is and how it's different from the value-based care work you did at Cano Health.

Marlow Hernandez

We're very excited about Soran Health, what we've already accomplished, and, in a short amount of time, the idea behind it comes from the critical need to find new ways to address runaway medical costs. We have reached market and industry efficiency frontiers in current care delivery. Primary care organizations, health systems, and payers' needs so-called wraparound solutions are bespoke services that meet specific needs, quality ratings, and specialty services that are linked to utilization and

patient engagement. Soran Health is designed to meet those specific objectives. The only connection between Cano and Soran is that we wish we had a service like Soran Health when we were at Cano. In other words, it's a solution we wish we had. We feel that at Soran, we're doing for healthcare what GPS did for traffic. We are collecting data at Soran that has never been collected, analyzed, or integrated to better direct traffic, to better improve care delivery. So, we're providing valuable real-time risk stratification and interventional opportunities without the need for EHR, PBM or medical claims data. So, those predictive analytics and real-time types of summaries, metrics, and what we call data enrichment, resulting in specific, actionable insights, are informing risk models and care plans. We're already able to show at scale within Florida the improvements to patient engagement, the improvement to medical documentation, to quality ratings, and the link to medical margins. So, I can summarize it as we're turning certain cost centers into profit centers. For example, home health is a cost center for payers and health system providers. We're using software and services so that home health can actually become a profit center by improving documentation, quality ratings, enrollments, and chronic care management and decreasing inappropriate utilization.

Jason Conger

Yeah, I would just chime in. I mean, Marlow covered it, but I feel like I'll give you my opinion about the evolution of value-based care in this respect. There was a period of time when the critical skillset for a value-based care provider was probably coding. It was billing and coding and having a system that enabled that from all the way from documentation in the clinic to submitting claims. And that was the main driver for success.

And it's still critical, but I think we can see the signs certainly over the last year that utilization management to improve outcomes in an effective but cost-efficient way is absolutely critical.

Obviously, the struggles that many healthcare companies are going through have to do with macroeconomic cost overruns, like inflation, but they also have to do with the squeeze on reimbursement and premium amounts. I think that has roots in the need to find ways to control costs. And so, in concept, what Soran is doing is looking for lower-cost sites of care as well as sites of care that can improve access, like the patient's home. So, if you have a home-bound patient, they may struggle to get to a primary care clinic, and then there may be cost-effectiveness

or cost arbitrage in the form of modality. So, if you can use a less expensive, let's say, preventative kind of approach rather than the most expensive intervention where appropriate. Obviously, you should do it. And then the third is delivery or provider personnel, cost-effectiveness, or cost arbitrage. And we're heavily focused on, for example, in our data gathering, finding a way to do it that is as fully predictive and as valuable to create an understanding of population down to individual patient needs without having to bring the patient into a clinic to see a physician unless that is the right way to do it. So for example, if we can have non-providers gather information that will tell us, the payer that we serve, that a patient needs some kind of non-medical intervention and that will have the effect of improving their outcomes, maybe keep them out of the hospital. They're at risk for a fall, and they need a new pair of glasses and that will reduce the risk for them. Then there are high ROI interventions that can be done based on that data. As far as we know, there isn't a systematic attempt to gather the kinds of data we obtain through our operations and then aggregate and analyze to create those kinds of risk stratifications of a population that are real-time and very predictive of, for example, who's the most likely to go to the hospital or to go to hospice care.

Does Soran Health have or plan to have a people-driven component to the business, or is it primarily an IT data analytics offering that you're developing?

Marlow Hernandez

It's both, and we provide full service for those payers who need it. As I mentioned, we work for the payer. We do not provide primary care or continuity of care. What we do is aggregate data that has never been tapped, collected, or integrated for case management action. There are case management actions on the procurement side or another type of enablement that we can directly help provide for these case managers at the payer level and the systems type level so that they can work with the patient's PCP and other providers. But it's about anticipating; it is about not waiting for an ENS alert when a patient already goes to a hospital. It is certainly not waiting for a claim to hit, not waiting for clinical deterioration. Our critical insight, and now we have tons of proof, clinical and financial, is that patients have a certain reserve, and that reserve can be measured through their functional status and nutritional status. By collecting such data along with social determinants of health data and a few others that we have validated, we can create very predictive models and make available actionable insights that, for the first time ever, go into care delivery and can be 30, 60, 90 days ahead of an ENS alert and three, four months ahead of medical claims. Some payers already have more mature care delivery and can collect this data themselves and have networks that can do it for them. Some don't. In situations where they don't, we would provide the staff to collect and make available the data for their case management or care management. In situations where they do have the care delivery and networks, we just provide the application, the technology as a SaaS solution. We do both models.