NEW DAY Healthcare
New way of providing care and doing business - with Honor and Kindness.

CEO Leadership Series: Vol 37

Establishing Sustainable Competitive Differentiation in Home Health

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Key Takeaways

Aligning Ownership Principles with Core Business Mission

Challenges encountered when Burning The Ships to rethink everything, breaking form the norm to develop a great business under private equity ownership

- Contained hold periods and rapid growth expectations mean that the CEOs can often be forced to spend an excessive portion of their time either selling the Company or raising money to acquire
- As valuation expectations grow in a "hot market," the dollars you have to make off of the investment to meet the valuation expectations can cause adverse decision making – e.g., short-sighted cost cutting that impair critical areas such as innovation
- Core principles of a sustainable organization
  - "Burn The Ships" – Rethink Everything
  - Not working with shortsighted partners
  - Only accepting reasonable invest returns
  - Making sure we took good care of capital
  - Keeping our overhead low, investing in bedside care

Establishing Sustainable Competitive Differentiation

New Day has developed several competitive advantages that allow it to offer differentiated care, better attract prospective patients, and expand patient access to lines of business such as Medicare Advantage and Medicaid that were typically hard to operate profitably.

These competitive advantages include:

- Offerings a full continuum of care
- Leverage technology
  - Carelytics
  - Process Automation & Artificial Intelligence
- Virtual operations & care

Full Continuum of Care - Strategic Synergies

- New Day provides a full continuum of home care, which creates meaningful strategic synergies – for example, New Day benefits from a lower patient acquisition cost relative to home health and hospice pure plays by virtue of its personal care service line.
  - The overall strategy is the development of a home care continuum so that we can transition patients over the years, not just episodes, days, or events. The transition of those patients means we have high contact across extended periods of time.
  - We manage a large personal care base where we transition about 6,000 patients a year.
  - Transitioning about 500 per month between our service lines make my patient acquisition cost down to $135, which is one third of what you'd see in home health, and then it's almost eight times lower than the hospice acquisition cost.

Technology - Carelytics

- In order to scale, high contact patient management and engagement across disparate service lines, New Day created its own analytics platform known as Carelytics.
  - With disparate transaction systems, we created a system called Carelytics. We bring in information and data from 17 commercial transaction systems. We stack rank that data, acuity rank the patients that flow into a queue, and we make immediate contact and have triage with baselines.
  - Of that 120,000 people we touch annually, we've got about 11,000 on our average daily census. We're tracking over 80,000 patients. So, 70,000 of them are not on our services. They're in the community and we're tracking them in the community with outbound calling teams, text messages and social media, to identify when they're about to have an incident that might result sin a decline in their health and well being. We have the ability to track patients like non one else in the home care space.

Technology - Automation

- We use automation and artificial intelligence to identify patients. For example, health systems put referrals on Portals, we scrape those portals, identify the payer, get the authorization, and get the verification using AI and multiple IT engines. We deliver to our intake teams, a claim that's ready to go. Those that don't meet our geographic specifications, don't meet our parameters, go back to the portal. We do that in just a matter of minutes.
- Our intake queue is AI aided to process and place all of the information into appropriate electronic medical records, based on payer by the time it gets to our intake people, they've got a fully filled out intake registration form ready for scheduling, that's already authorized. That is literally is done in minutes, and that allows us to process a very high volume of patients from many, many different resources.

Virtual Operations & Care

I've always had a belief that if we don't put dollars in corporate offices, we can put them at the bedside.

- We recruit, hire, onboard, monitor, and supervise all our Texas staff, virtually. We even ship computers and supplies directly to the clinicians home and get them up and running in very short duration. Also, we have 21 corporate leaders at New Day, who all function 100% virtual.
- In Texas, we cover the entire state from one location. We have about 2,000 patients in that state and 900 clinicians. And that virtual model really has to drive a super efficient low-cost delivery mode so we can deliver low cost, high volume care on the front end at the bedside.

Avoiding the M&A Valuation Trap

- We committed to a very focused M&A strategy. We focused on two key areas as the bubble was growing
  - Personal care assets, which are home community-based services assets that tend to trade at a lower multiple and provide activities of daily living for individuals and Hospice assets.
  - Getting a platform that would put us in a position to provide a full continuum of services was our launching criteria and we accomplished this with Phoenix Home Care and Hospice.
- During acquisitions, we do not buy top-shelf performing assets because they are generally priced out of market and we do not buy turnarounds. They are too hard to integrate and turn around. We buy middle-of-the-road performers, inject back-office oversight and overlay of technology and back-office support. We also leave local brands in place because they have established credibility and have market presence.
- We've avoided the leverage problem by not buying top-shelf items. We refused in the bubble. I did not buy a single hospice in the bubble outside of our platform company because the multiples had just gotten nuts.
- We decided to leave locally acquired brands in place and maintain the local cultures.
  - Through my acquisition history, we found that when we relabeled and rebranded companies, we thought we were going to get great traction with national contracts and big payer agreements, and we could put them on our rates. That was not the case; it just does not work that way.
  - What we realized is when we rebranded, all we ever really captured back was the original EBITDA. We really weren't making traction over that five-year period ripping the local brands out, ripping the local cultures out, and starting over by saying we're going to put our brands in.

Background

Scott Herman is the CEO of New Day Healthcare, which is a home care-focused business covering 120,000 patients annually with 7,500 team members across 4 states. A company that you'd think was 20, 30 plus years old was actually formed four years ago, in July of 2020. So it's been an incredibly rapid rise for Scott, and in that period, they've expanded into 29 different locations in Texas, Missouri, Kansas, and Illinois, with over 2 million home visits annually.

I'm sure everybody on this phone is familiar with homecare Care that was once delivered in the hospitals is getting pushed toward the home, and that's what we do in home health, hospice, personal care, private pay, and then we have a pediatric line also. I started early in my career as a paramedic and a nurse in Wichita, Kansas. I was later a flight paramedic, and I entered the home healthcare field about 30 years ago. I lost a coin toss in nursing school, so a firefighter, Lance Flowers, and I were the only two guys in my nursing class. Lance had commandeered the community health segment of our community rotation, and he had the two key areas laid out: outpatient rehab services as well as home health. So, we tossed a coin, he called it, I lost, he took outpatient rehab, and I went to home health.

Having been a paramedic for ten years, I was pretty comfortable with going into homes, assessing what was going on, and evaluating the environment. Once in home care, I realized that this was an industry that should really grow, especially with aging seniors. I looked around, and I saw the people leading the industry were gray-haired, middle- aged men, and I thought, what a great opportunity here. I was still in my late twenties and the industry was still pretty young. I thought, with all these older leaders, I might be able to create a long term career path. Now, I am one of those middle-aged gray-haired men. So, I guess, hopefully, there are people looking at me saying we can do the same things and push things along, and I hope I'm helping identify those people because we want to make sure we take them along. I've been fortunate over the years; I've held nearly every position in the home health business - everything except a home health aide which provides personal care - and those are people we're very, very proud of because we have thousands of them running around today providing care. So, I was able to gather pretty good insight into what's going on in the home. As a nurse, I understand the clinical aspects and having lead some of the larger home care companies in the United States, I see it from front and back office perspectives. I was the president of Harden Home Health and Hospice, Jordan Health Services and I put together the fourth largest company in the country, Elara Caring. We were serving about 65,000 patients on a daily basis. And then in 2019, the market began to shift and it needed a new approach. I started New Day in 2020. My background as a nurse, I get the clinical aspects, and I'm a nurse kind of by accident. I had kids to feed, so I went in that direction. And over the last 30 years, I've been blessed to lead some of the larger companies in the country and create some of the most innovative programs with great teams, many of whom, work with me still today. I have a tremendous team behind me.

Interview

How does New Day differ from other large national home health platforms other than its recency? When you think about Jordan or Harden, how would you differentiate New Day, and how do you plan to continue to differentiate New Day?

The differentiation of New Day really started with market changes I observed, so I will take a step back to give you a brief evolution. In 2019 and 2020, having run some of these large companies, I have sold many of them, and my team has over 150 acquisitions under their belt. I know I should know that number exactly, but it's somewhere between one hundred and 200, and we've done these large rollups, pushed them into large rollups, and then sold them off. I did that five times through private equity channels. And then I noticed, in 2019, something very disturbing was happening, especially as a clinician. Remember, I got into this business to understand why chronically ill seniors are having problems, identify those problems, and intervene. We created tools that increased the values of the companies we've worked for in the private equity segment, which caused them to be very valuable in the market. So, we went through this perpetual cycle at Jordan Health Services for five years and went through three processes. And I was either selling the company or raising money to acquire and sell the company, which wasn't really the basis of what we had driven for. But, the value of the industry had gotten so large that the models for banking these companies became very, very hard to achieve - meaning what you had to do with the company, the dollars you had to make off of an acquisition in order to meet the valuation expectations of the private equity firms, and banks, meant you had to cut in cost, at the expense of innovation and care.

Obviously, we all want to take out cost and create efficiency, but we were getting into having to cut education, innovation, or care. And, the last thing you can do in our market is cut care at the bedside because that's really, kind of a death sentence for you.

So, what I saw really fall away was innovation. We were getting hit with two waves in the home care industry. The first was retiring seniors, and the second was Medicare Advantage enrollment. These two waves hitting an industry that now is failing in innovating because, candidly, home care had become, fat and happy. With turning 65 every eight seconds - that's a stat we all know, 10,000 a day, that we were not doing what we need to do to meet the demand. The second was this wave over the last ten years, which had a substantial impact on our revenue lines, was the adoption of and managed care. We weren't creating the cost efficiencies in the back office that allowed us to put capital at the bedside, and then we were just getting overrun by patients, with an industry that was working on the fringes of solving these problems. There were no real answers. So, I decided to 2020 start a company that was going to "Burn the ships" and rethink everything about home care.

How do we create efficient models to drive care and managed care and then meet these changes and this growth in the industry? We started in July of 2020 but didn't really deploy any meaningful capital until 2021. So, really, about 30 months into this. But, we said by burning the ships that we wanted to create a model that would handle managed AdVantage, a high volume, low margin rapidly growing senior healthcare payer. So, couple of things are making it happen. There was a rush of workers retiring who were very comfortable with managed care plans. They were retiring in COVID, and they were entering these managed care plans, and then enrollment skyrocketed. The first thing we did was say, "okay, let's have a business that doesn't have a corporate office." But before that, I wrote a purpose statement, with some key executives, that said let's do things this way, which is completely different than the way they've been done in previous cycles in the past 20 years of our history, or I'm not going to do anything at all.

This purpose statement focused on not working with shortsighted people, only accepting reasonable returns, making sure we took good care of capital, keeping our overhead low, putting dollars into the bedside, and a few other purpose pieces.

I delivered to these long-term corporate executives who are heavily recruited by our competition what I call, the worst sales pitch in the history of sales pitches. I said, listen, we've got our purpose statement. We want to do something different. No idea if it will work. It's never been done, and we're going to try to do it differently, but here's what I need you to do. I need you to agree to the purpose statement, which they did, and I need you to volunteer your time. Keep track of your hours. I hope to get you paid. If I find a sponsor that will do this with us, I need you to put some of your own money in. Believe it or not, they will say YES! We did find a great sponsor, Kaltroco North America. It's the private family fund of Steve Koltes, one of the co-founders of CVC Capital. He and his family are behind us, with Kaltroco being led by Chief Investment Officer and the best PE partner I've ever worked with, Kenneth Hammond. They put up a big investment, to work on this concept with us. Along with our commercial banking partner First Citizens (formally CIT) we bet big on getting this right. To date we have completed ten acquisitions. We touch ~120,000 patients annually, from 30 with 7,500 team members. We have 21 corporate leaders on the New Day team and we function in a virtual office. I'm sitting in the virtual office today. We were fortunate that, as a startup company, we didn't have a lot of legacy bricks and mortar to deal with, so we didn't have to shift our operating model and expectations. We got to build them, and my executives all work just like I do remotely. We've stuck to that philosophy. I've always had a belief that if we don't put dollars in corporate offices, we can put them at the bedside. One of our theses was to build a virtual model, which we built in Texas. We serve about 2,000 patients in that Texas area with 900 clinicians, completely virtual. We recruit, we hire, we onboard, we monitor, we supervise all virtually, and we even ship computers and supplies directly to the clinician remotely, putting them on our payrolls that are assigned two documents and we e-sign those.

I see the differentiation between the family office and private equity. I imagine that one is much more long-term minded than the other, the way that they're built. I see the differentiation in principles, virtual care and, recently, lower corporate overheads. I want to get into your AI analytics tool and the desire for management to really invest in solutions, but I'm still left with a curious and skeptical mind when it comes to acquisitions. How do you avoid the trap that other aggregators have fallen into over the last five years when faced with the need to acquire in the middle of a bubble storm?

Yeah, thank you for asking that question. We committed to a very focused M&A strategy, and I'm fortunate that my chief development and strategy officer, Matt Griffith, did 50 plus transactions with me at Jordan. Matt's very proficient with home based acquisitions. We focused on two key areas as the bubble was growing, growing; we focused on personal care assets, which are home community-based services assets that tend to trade at a lower multiple and provide activities of daily living for individuals, and we focused on getting a platform that would put us in a position to provide full continuum. We do not shop on top shelf, and we do not buy turnarounds. We buy middle-of-the-road performers, inject back-office oversight in an overlay of technology and back-office support, and lead the local brands in place.

Through my acquisition history, we found that when we relabeled and rebranded companies, we thought we were going to get great traction with national contracts and big payer agreements, and we could put them on our rates. That was not the case; it wasn't the case at all. What we would do is buy an organization, and they'd start the typical hockey stick post-transition acquisition curve of earnings. They'd take that dip and then take off. And what we realized is when we rebranded, all we ever really captured back was the original EBITDA. So, we had over 50 transactions in this space with a massive integration plan, and we were really good at it. We'd integrated a new company in six weeks. We really only got back the EBITDA we purchased, so we really weren't making traction over that five-year period because ripping the local brands out, ripping the local cultures out, and starting over by saying we're going to put our brands in. We didn't get any traction on national contracts. Nobody really does because payers are pretty fragmented also. And so we decided to leave those brands in place, maintain the local cultures, and then we ingrained what we call CPR, it's Connect Promise, and then Reach throughout the organizations that we have so that they all feel the same in some elements, yet they keep their local culture that's been successful for us. We integrate the back offices, and we make almost every acquisition's net benefits positive on day one for us because by keeping my overhead extremely low, all 7,500 of my employees, including part-time, PRN, and full-time, are eligible for benefits, We've avoided the leverage problem by not buying top-shelf items. We refused to over pay in the bubble and keep our powder dry. I did not buy a single hospice in the bubble outside of our platform company because the multiples had just gotten nuts. I wouldn't pay 15, 18, 20 times earnings, that the market was demanding. We manage, with our Carelytics, a large personal care base where we transition, we transition about 6,000 patients a year between home based care businesses, we are about 35% deployed across our footprint.

So about 500 a month between our service lines make my patient acquisition cost 135 bucks, which is a third of what you'd see in home health, and then it's almost eight times lower than the hospice acquisition cost.

It's an interesting stat that I see mentioned by other leading national brands: the cost of patient acquisition relative to peers. So, it's not the first time I've heard that from a high-growth, really well-put-together platform. It's interesting; there's so much packed into that answer that you just gave. It's hard to know where to focus first. It's just so rich in information. Integrating less is not something I hear every day, but there's a lot of logic to what you're saying, and there's also empirical evidence, right? How many acquisitions have you been part of over the last 20 years in this space to be able to reach that conclusion? However, the counterargument that I've seen is that it is difficult to manage 10, 20, or 30 brands versus managing one, right? It can be dilutive. You are developing individual brand strategies for every one of those brands.

No, we're not really developing individual brand strategies. We're keeping brand and contact in the market. The overall strategy is the development of a home care continuum so that we can transition patients over the years, not just episodes, days, or events. The transition of those patients means we have high contact. How do you do that and maintain it? With disparate transaction systems, we created a system called Carelytics. Carelytics is an overlay platform of software that also involves people and processes. And from Carelytics, we're able to intake information from any data system. So, currently, we bring in information and data from 17 different transaction systems. We stack rank that data, we acuity rank the patients, they go into a queue, and we make immediate contact. So of that 120,000 people we touch annually, we've got about 11,000 on our average daily census. We're tracking over 80,000 patients. And so, 70,000 of them are not on our services. They're in the community, we're tracking them in the community, we're outbound calling them, we use text messages and social media to contact them and identify when they're about to have an incident that will impact their health, we have a tracking system that really doesn't exist anywhere else in the home care space.

Does that mean you are agnostic about EMRs and billing systems and happy to have a large ever-growing number of EMRs and billing systems across your portfolio or are you still looking to integrate underneath?

Yes, we are agnostic to EMR's. This means I don't have to convert a transaction system. We do, in some cases; if we bring smaller assets it's easier to grab the information, but it's not necessary. We're agnostic to transaction systems across our portfolio because of our Carelytics overlay.

And that analytics tool. You mentioned when we spoke before that there's an AI component to it. Can you give us some color on that?

You bet there is. We use artificial intelligence to identify payers. For example, health systems put referrals on portals. We scrape those portals, identify the payer, get the authorization, and get the verification all by AI and AI aided programs. We then deliver to our intake teams a patient that's ready to go. Those that don't meet our geographic specifications, don't meet our parameters, go back to the portal.

We do that in just a matter of minutes. We're able to process, and place into our intake queue, and then in our intake queue, we run AI to process and place all of the information, and then by the time it gets to our intake people, they've got a fully filled out intake registration form ready for scheduling that's already authorized.

That literally is done in minutes, and that allows us to process a very high volume of patients from many, many different resources.

The piece we're working on today is how you auto-schedule. That's the hard part. We had 80% of it figured out that 20% is a tough piece, but AI to auto schedule is our next step.

That's fantastic. So you are really developing your tech chops, your tech capabilities as you develop all your other capabilities hand in hand. Very impressive - New Day home care slash health tech business.

Hey, I never wanted to be in the tech business. We've been trying to do things like this predictive modeling for years, and we helped a lot of tech companies develop some of their models around this predictive modeling. I never wanted to be in the business, but their solutions didn't really meet our –the business models differ. So, we ended up in the tech development business.

How large is your tech team?

That's a good question. So internally, full-time folks working is about 12, and then there a lot of outsourced programming stuff we're doing.

New Day 5, 10, 15 years from now, you mentioned home health, hospice, personal care, private pay, pediatric care, the five different states, and the tech initiatives. How does the company differ ten years from now versus where it is today?

Well, I'm not naive to the value we are creating in the market. I lived under this kind of impression that if we had enough scale in the home care field, we could sit down with CMS, and we could just show them our value, and they would just get it. Okay, remember I started in my twenties, so this is an evolution. I believed that with enough scale, we could get the right tables. Fast forward, leading a $1.2 billion dollar company, I was able to sit with CMS and they essentially told us we are a rounding error in the federal budget, and we still are. So, I realized the scale wasn't going to get us there. I decided we needed to develop something that differentiates and can be deployed into a large strategic company or a large scale. Something they can use to change the dynamics of home care. That's what New Day really is. There's not a track on our life cycle and I have no limits on hold time or value production, but I'm not naive. I do know the value of the company, and the value it drives for shareholders once the tech is fully developed, I see a New Day being injected into a large strategic or a payer, which is a basis upon which they can expand these predictive modeling tools and really have an impact on home care.

So it's best-in-class tools that are actually proven efficacy in the marketplace as you scale seamlessly and then bring those tools you are leading with the tools to a large strategic. Does that sound right?

That's probably likely because in order for us to change the paradigm of home care, we'd have to be a $6 billion company, which would make us the largest home care provider, by far. And that just seems like a decade's worth of work. Can it be done? Absolutely. Is that the fastest route to success and deployment of the tools? No, I don't think so. We've already talked with many large strategic companies who are knocking on our door, but we're not doing this until we get it right. I've sold lots of companies and, until it's right, we're going to pass.

That's an interesting goal to have, get to a point of scale where you're influencing CMS and MedPAC. It's interesting. I'm curious about your technology, AI, and other potential; like you said, 10,000 beneficiaries are added to Medicare on a daily basis, transitioning to lower cost of care environments, how much are you deploying remote monitoring, wearables and sort of embracing the transition to the hospital at home as a concept in terms of delivering care, providing care and support, and how does that fit into this very comprehensive multi-entity and entity that you've built?

The first thing you think of regarding mobile technology is telehealth. And I've probably run every telehealth program and failed with most of them. Telehealth is really good at generating data points and collecting clinical data. That all has to be measured and interpreted resulting in actions. That is the part that is really hard, what to do with the data. Most telehealth plans really provide data, dump that on a physician group or other clinician without a path to intervention. That's

not helpful, because it stimulates more questions than answers. Not to mention, nobody paid us for it in home care right now? So, remote technology, we're using geofencing on social media. We're using outbound text messaging and outbound call methodologies, and then we're just implementing a tool that will run AI and talk about patient engagement and patient satisfaction. So those things, but no, we're not using remote vital signs, demographics, fall detectors, or things like that just yet because we really haven't found the tools that integrate and give us useful information what we're trying to do. But currently, the outreach is through social media, text messaging, phone geofencing on Facebook, and other things like that.

Does your Carelytics tool act as your CRM, or are you using a third-party vendor for your patients?

We use third-party known commercial EMR's and upload all that data to Carelytics from 17, now 18, commercial transaction systems. We remain agnostic to the EMR. For example, a large publicly traded company has a set of patients that are not in their core business but are part a capitated agreement they have as an ancillary. We upload their data, put the indicators that they want, kick that back out, and kick it out automatically. Track adverse events, trends and predictively model. We also do email distributions and fax distributions; if that's what a provider wants. We could do that in any form and for any continuum and customize the outputs in any form.

What business line, what system, and what pool of data analytics are the biggest source of frustration for you that you're involved in today? What are the sorts of misbehaving children that keep you most busy? I'm a parent. I have several kids. Some are more work than others.

We view managed care payers as having all the data, and they do have a lot of data and big data sets, but they often don't know what to do with it.

So when we deliver outcomes like reduced hospitalizations on their patients, and this is the methodology to what we got there, falls that were prevented, they're really excited about it, but they don't know what to do with it.

So every managed care company I've ever been in front of, which is nearly all of them, has offered to throw us 5,000 patients in a subset and grab a bunch of data, and eventually, we turn over a bunch of intellectual property that I'm just not really interested in doing. I'm really interested in creating sustainable methodologies to identify these patients, create interventions, showing those interventions, and then demonstrating back to those payers that we cut costs and increased the quality. That takes clinical intervention. My biggest frustration, not necessarily from a data perspective, is really an understanding of capability. That's why we create a functional high-value model that will basically, I think, be the only way managed care payers are going to buy into this...if it's sitting in their queue. If they own it and are executing it, I think payers can then understand it. And that's not that payers don't want to understand it. These are big, complex organizations, and with size comes bureaucracy, and complexity is a byproduct of bureaucracy.

And what about your service lines - where are you focusing most of your efforts in terms of getting it right? What's the hardest line of business that you're in?

Yeah, let me just take a second and talk about our pediatrics. We do PDN care, which is very sick kids that are going to be with us a very long time. So there's a natural evolution of those children to be in some of our more chronic long-term programs around home community-based services. So, there is a full continuum thought process there.

Where we focus our efforts today is the very heavy Medicare Advantage-operated space, especially in Texas. We bought a virtual business in Texas, with the intention of creating a market differentiated business addressing Medicare Advantage growth. Our intention is to create a low-cost delivery model with a very high volume. So, in Texas, we cover the entire state from one location. We have about 2000 patients in that state and 900 clinicians. And that virtual model really has to drive a super efficient low-cost delivery model in the back office, so we can deliver high-cost care on the front end at the bedside. Everybody that's on this call or listens to it is facing wage inflation. So you can't cut clinician wages because you won't have any clinicians, but you can add benefits, you can enhance the systems, you can make them virtual, which, by the way, nurses in particular love, we're doing a vertical integration on a therapy company, and that's a virtual company that they also love it.

A lot of home care groups - small, medium, and large - have seen margin pressure over the last two or three years because of wage inflation. They didn't count on it to be compounded by margin pressure based on increased capital costs and debt costs, to be specific. How are you dealing with that? And maybe also in the context of hiring 7,000 people plus a corporate team. Granted, virtual, normally that kind of ramp-up is expensive, and if it's not measured in terms of higher wages, in order to attract all that talent, it's measured in terms of high turnover because it just takes time to work out who's a keeper and who isn't, which is also a hidden cost. So, have you wrestled through those three challenges over the past two or three years?

I'll answer the margin pressure piece first. So we experienced downward margin pressure, like everyone else, as market has shifted into Medicare Advantage. In the Medicaid space we have actually gotten some support from states in our Medicaid programs. It's not tremendous support, but it is support that they've increased some rates. We've also got some pressure on pass through rules and some regulations there, but this is what we do. COVID really brought out this labor shortage problem, and we had to think of innovative ways to address it. During COVID, we built a remote recruiting & onboarding specialty business within our operations, that we can open in a market with a clinician, and we don't have to lead with bricks and mortar. Not having bricks and mortar in our Texas operation; we are able to build that efficiently but we had to build virtual capability, and develop the online tools to recruit, onboard, train and pay clinicians. With our capability, we can move rapidly. We have a history.

We took over an agency that was just struggling, and we hired a couple of hundred employees literally in four hours. I think we did it in half a day.

We deployed the first half of the day and hired them in four hours because we were able to do these things remotely. So those are helping us with margin compression. Medicare's advantage over our space is a big challenge in terms of reimbursement. So, like everybody else, we're tacking rates, we're talking terms, and we have an entire contracting team that focuses on that. And we're generally in the top two or three payers rate-wise; we're among the top two or three rate-wise in any region that we're in. Our goal is to be top, but we're always in the top two or three, but we're getting market rates. We're all getting paid the same thing. There are no special carve-outs for New Day. To combat that, we had to accept reasonable returns on that patient base. 53% of all Medicare patients in the United States are enrolled in Medicare Advantage plans. Our view is you can't walk away from half the market. You've got to figure out how to manage in that half of the market, and in that half the market, we accept lower gross margins and lower returns, but we make that up in scale as long as those returns are positive and they're in the low double digits, we're taking that business, and it's growing.

I imagine that you are outsourcing to best-in-class, lowest-cost, highest-quality third parties across the board. No large FTE departments in-house.

No large FTE departments. I will tell you that our outsourcing capability is not as extensive as one would think. Most of our outsourcing is in IT development. We're looking at some outsourcing things that we have in-house that will bring us a couple of points of margin back, but our revenue cycle is internal and I'm very protective of revenue cycle. I have some people working me on the economics, things around the revenue cycle, which I'll get to. It's part of being old; you've got some habits that come with it, and I am very protective of revenue cycle. Our coding is still internal, but that's something that can be managed and outsourced in the industry and we are looking into that aspect. But it must prove to have significant gains for me to let that go.

You mentioned payers as a referral partner earlier with regard to automation. I'm wondering if you have any coordinated partnerships with other care delivery platforms or care providers - specialty platforms, hospitals and other provider organizations?

Obviously, we're in several ACOs and preferred provider networks. I don't currently have any capitated agreements across or any hospital at-home agreements. However, I do have a partnership with a hospital-at-home company in North Texas as well as in Missouri. We partly own an ACO in Missouri. However, I do not have special relationships or cost-sharing relationships with large-scale payers at the moment. I'm not seeking those, currently, because I'm very focused on the development of the product, and really, with a team this small and this remote, you've got to keep them focused, and we're laser-focused on driving that value build through the Carelytics piece. We contract with every major payer in the country serving our geography. As I said, we built a full-time contracting team. We built out a palliative care program for one particular payer and customized it for them. Palliative care is something that we do, but this was a little bit more customized for them. I'm not particularly interested in pilot projects with CMS or CMMI because they haven't been vetted, and we have to determine the upside. And I've not entered a capitated program because I'm a sub of a sub, and don't control my share of the reimbursement. The amount of data that it requires to run those effectively is something I believe home care still has to develop. And the objectives that payers want aren't clearly defined. If it's beding in the cost curve, we're already doing that. And if it's really clinical outcomes, hospitalization reductions, we do that and we prove that, but it currently does not drive better rates. But I'm not really willing to enter an at-risk arrangement today because I haven't found a beneficial arrangement I would enter. Today, we're still exploring an at-risk arrangement in a capitated agreement that makes sense.

You've been acutely aware of other home care groups that have entered into everything that you've just described, including tri-party agreements with health systems and nursing home operators to try to close the loop, complete the circle of patient care, acute care followed by post-care, including in that, maybe even a virtual care component to it too. I have to assume that the experiments that you've led and co-led in these other groups have taken place. Why aren't you in love with those partnerships? Why aren't you looking to replicate them as quickly as possible here on New Day? What went wrong?

So, let me back up one step. We do enter multiple nursing home agreements, but we're providers to those facilities, and we're augmenting their services. We have done co-source managed services agreements in the past where it's a unit cost share.

We have done management agreements with large integrated health systems, Memorial Herman down in Houston, and economic models that work in those systems differ tremendously from ours.

The pressure comes when we develop tools and their rates are chopped; our rates are chopped, and the pressure gets pushed down.

We're going to see that across the board in Medicare Advantage plans over the next couple of years as they got chopped by the government. The earnings are down; pressure's going to get pushed down as ACOs hospital at-home programs and capitated programs develop. We'll pick and choose the parts to participate where they make sense because our purpose is to create a differentiated, scalable delivery system that takes care of patients over the years, not just in moments of time. And to do that economically and to be good stewards of the funds that are entrusted to us. Some of these programs are counterintuitive, and by the way, it's not one size fits all. Every program is different. Clearly defining what the parameters of that program are makes sense. I hear large-scale providers say, we do really well in those programs. And then when you really look at it, many of them are not really doing that well. I talked with a large provider who had a 60% statewide market share with a major payer, and they were in multiple partnerships with them across the state of Texas. One day they got a letter that generally said, we're cutting your rates because we think we're paying you too much. So, large scale provider, major market share holder in commercial contracts and several at risk arrangements, slashed without notice and no appeal. That's one example of a market leading innovator, but that does not seem like a real partnership. I will not enter into partnerships for development unless we co-invest. I'm happy to co-invest in technology innovation partnerships and program development, but not just to take an agreement, because I don't want to invest and get a letter out of the blue one day.

That's interesting. So avoid the value trap on acquisitions, avoid the strategic partner trap on just seeking growth for the sake of growth, but always with a focus on sustainability.