

Collaborating To Compete

A National Study of Horizontal Networks

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They exist in nearly every state and in some states, there are more than one. Their numbers are increasing and in many areas of the country they are increasing at an accelerated rate. Most are less than two years old but there are some that have been around for more than a decade. Some are large, others small. What are they? Networks! Home Care Horizontal Networks!

Home care networks represent a new dimension, a growing dimension, in the home care field. While they differ in many ways, all were founded for one purpose....to help protect the interest or expand the potential of the home care agencies involved with them. And by all measures, they are rapidly becoming a significant force in the home care field.

But, why have they emerged? Why are so many agencies so interested in them? Why have they captured the interest.....and in many cases the contracts of managed care companies? What is behind the growth of home care networks and what do we know about their successes.....and failures?

The Rationale for Horizontal Networks

We know that one of the major driving forces behind home care networks is the new realities of managed care. Managed care companies are increasingly interested in contracting for services with horizontal networks. They provide managed care companies with an easy answer to the challenge of providing home care services throughout their service area. Networks cover larger geographic areas than any single agency except for the state-wide or national home care companies. From a managed care company's perspective, it is easier to manage, easier to monitor and easier to work with a single entity that covers all or most of its service area rather than having separate contracts with ten, twenty, thirty or more agencies serving the same area.

In Fazzi Associates' national study of managed care companies' expectations of home care (Fazzi and Agoglia, 1996), nearly half of the 50 managed care companies surveyed said that they preferred to contract with networks or agencies who cover national, multi-state or state-wide areas. Less than one-fourth said they prefer to contract with a range of local agencies. In more recent studies conducted by Fazzi Associates for two large state home care associations, these findings were replicated.

The preferences of managed care companies represent a major area of concern for home care agencies. HMO membership grew 14% to 58 million members in 1995, and it is expected to increase to almost 70 million in 1996. The growth rate is expected to vary depending on the area of the country. In the south, where there has been limited managed care penetration up to this point, the growth is expected to be the highest (25.9%), as compared to 18% in the Northeast, 13.3% in the Midwest and 14.1% in the West. And PPO membership grew by 13% to 91 million members in 1995 (AAHP HMO and PPO Trends Report, 1995).

What is particularly noteworthy for home care executives is that the growth of managed care is also expected to heavily impact the Medicare population. In 1994, the number of Medicare beneficiaries in all types of managed care totaled 2,673,522, an increase of 65% from 1987 (NAHC 1995). With states like Arizona (31.0%), California (35.7%) and Pennsylvania (34.5%) leading the way, the growth of Medicare beneficiaries in managed care plans is expected to grow dramatically.

It is clear that in the future, and for some in the near future, managed care will become a major source of referrals for home care agencies. And if an agency hopes to work with managed care companies, it is critical that they be aware of the preferences and biases of managed care companies and, of course, develop appropriate strategies to respond.

Are Networks the Best Option?

But what are the best strategies to ensure market share and continued vitality for home health agencies? What about staying the course and going it alone? According to Steve Boekel, a managed care network consultant, the only single stand alone home care companies that will survive are those with "such a niche within a given market that they really have no competition" (Eli Research, 1995). Boekel's criteria clearly does not apply to many home care companies in the current highly competitive environment.

What about affiliating with a vertical network? Affiliating with vertical networks, at least the right vertical networks, is clearly a viable strategy. The right affiliations certainly can help to ensure that the home care agency receives preferences on referrals from the hospitals and physicians in the vertical network. But for many agencies, there are typically other considerations. Like autonomy, and the ability to ensure referrals from hospitals and physicians from outside of the network.

For many home health leaders, there is another option that is becoming increasingly attractive. It is the strategy of developing or joining a horizontal network. Horizontal networks offer agencies the chance to retain their identity and a great deal of their independence. They provide those providers in the network with access to regional, state-wide or multi-state managed care markets. And, horizontal networks of independent home care providers may have a distinct competitive advantage against national chains if they are able to provide coverage and access for both urban and rural areas in a state or multi-state area (Eli Research, 1995). It is costly for national chains or

managed care companies to build a network of their own to serve the low volume of patients in rural areas.

Another advantage of networks of providers over the national chains, according to Beth Kaplan, Vice President for Network Development at EquipNet, "is the widely held belief that an independently owned company yields a better service level than a national" (Eli Research, 1995). This does not mean, however, that networks can afford to be less conscious about the cost of services. Fazzi Associates' national study about managed care companies' expectations of home care (Fazzi and Agoglia, 1996) found that discussions about quality tend to take place only after it is determined that the home care provider or network can offer services within the cost parameters established by the managed care company.

The Other Side of Networks

The news is not all good, however. As many home care executives have learned, horizontal networks are often easy to define but difficult to develop. In addition to the obvious financial costs to members, there is also some loss of autonomy over decisions such as how care is provided, accreditation requirements, information systems and reporting. Payers want assurances of consistency in the quality and provision of services and relationships with the network. Conflicts often develop when expectations are not clear. Managed care contracts don't always come in as fast as network members were expecting. And in many cases, networks win managed care contracts only to find out that there are very few referrals.

The fact still remains that home care networks offer agencies a true chance to compete and a real chance to obtain contracts that extend far beyond their traditional service area. This has led to a surge of interest by agencies throughout the country. But, with this interest has also come legitimate concerns and questions.

The questions are often the same. What leads to successful networks? What helps to ensure the development of a successful network? What causes networks to fail? Is there an optimal size for networks? What type of financial investment should agencies expect to make? How are conflicts worked out? What are the legal considerations? Clinical? MIS? In short, what can we learn from successful and unsuccessful networks that can help agencies who are now exploring the possibilities of forming a network in their area?

The National Study of Horizontal Networks in Home Care

In order to answer these questions, Fazzi Associates, a national organizational planning, research and training firm that has worked closely with networks throughout the United States, initiated a study of horizontal networks in the home care field. The study was sponsored by five networks in different areas of the country. The specific objectives of this study were to:

- develop a profile of the networks, including organizational structure, corporate status, staffing, and board membership;
- identify types of services being offered through the networks;
- analyze network organizations in terms of how members, providers, and sub-contractors relate to the network;
- assess marketing strategies; and
- summarize how network administrators perceive their experience, including the obstacles they faced, successes they have achieved, and lessons they learned.

To achieve the objectives of the study, Fazzi Associates conducted in-depth telephone surveys with 25 administrators of home health care horizontal networks located in 15 states. Staff at Fazzi Associates developed the questionnaire for the survey with significant input from the study's five sponsors.

Fazzi Associates then identified home health care networks in the country by contacting national, state and regional home care associations, using their extensive list of clients, contacting other home care consultants and researchers, and by making inquiries through on-line home health news groups. Fazzi Associates conducted one and one half to two hour interviews on the telephone with 25 administrators representing some of the best known networks in different regions of the country.

National Study Results

In developing the study and in trying to locate networks that were presently operational, Fazzi Associates concluded that there may be as many as 100 formal networks currently in operation in the country, and most of them are less than two years old. Many more are currently in the informal discussion stages as more and more home care providers conclude that participating in networks is an important strategy to ensure long term survival.

The survey findings indicated that organizational structure and experience varied significantly among the networks. Networks participating in the study had been in existence for anywhere from 5 months to 15 years. 60% formed less than two years ago with 28% being in existence for two to five years and the remaining 12% existing for more than five years (See Table I). The number of board members ranged from 2 to 18. The most common number of Board members was nine.

60%	Less than two years
28%	Two to five years
12%	More than five years

Table I. Length of Time Networks Existed

The number of network members ranged from 2 to 120, with an average of 22 members. Only two networks had more than 40 member agencies. 80% of the networks were

incorporated and they were evenly divided in terms of being for-profit or non-profit corporations. Only three were part of a vertical network.

In terms of services, almost all of the networks covered an extensive geographic area, with two-thirds covering a whole state or multi-state area. All of the networks offered most types of specialized nursing care and a range of other home care programs. (See Table II for examples of services being offered.) About half the networks also planned to add new services that they were not currently offering.

Alzheimer Care	96%
Hospice	96%
Psychiatric Services	76%
Health Prevention	52%

Table II. Percent of Networks Offering Sample of Additional Services

Network administrators were asked about requirements imposed on member agencies. Networks most frequently required accreditation, Medicare certification, and state licensing. They also frequently required adherence to standard clinical protocols and reporting guidelines. Other important requirements were the requirement that network agencies implement some form of quality measurement and improvement process and that they paid dues or some form of financial support of the network.

In addition, a smaller proportion of networks mentioned insurance requirements; adherence to network guidelines and agreement with the network philosophy; management and organizational requirements; service requirements; and referral and utilization requirements. About one-third of the networks had different types of membership, although respondents did not identify different requirements for these different membership classes. Two fifths of the networks reported using providers or subcontractors who were not network members.

Considerations When Forming

Over one-half (59.1%) of the networks utilized market research before or shortly after forming the network. Only four networks used an outside firm for the market research. Nearly two-thirds (63.2%) of the networks conducted informal discussions with potential buyers as part of their initial research.

In terms of funding, networks initially relied on member agency resources. While about two-fifths still relied to some extent on member resources, 40% had implemented membership dues, while 32% had revenue based on a proportion of billing. The median network budget was \$200,000.

Members' investments in their networks to date ranged from \$20,000 to \$4,150,000, with a median of \$125,000. Only three networks reported that gross revenues exceeded the

total investment of members to date. One of the three achieved this return within five months of formation. No differences were found between these three networks and the rest of the networks that would account for this achievement.

Most networks had the same experience as individual agencies in terms of the type of payment system that they had with those managed care companies in which they had contracts. Most of the payment systems (80%) used the traditional fee-for-service system. In many fewer cases, networks were paid on a capitated basis (16%), episodic basis or some hybrid system (16%). Note: Total types of payment systems exceed 100% reflecting the fact that some managed care companies use more than one type of payment system. (See Table III. Types of Payment Systems.)

Fee for Service	80%
Episodic	16%
Capitated	16%
Hybrid or Other:	16%

Table III. Types of Payment Systems Used

Characteristics of the Most Successful Networks

One of the difficult questions to answer was, "How do you define a successful network?" By number of contracts? By length of time in existence? By number of members? By profits? Based on an analysis of the findings and discussions with the leaders of networks throughout the country, we ruled out length of time in existence since most were new. We also ruled out the number of members since some networks, by design, only had a few members. Profits sounded good but since many networks were new, they had initial start-up costs and did not have nor did they project profits this quickly. The one variable that all agreed was important was the number of contracts. Based on our discussions with networks, a successful network was defined as one that had five or more contracts.

We recognized that there were some networks that had fewer than five contracts that were also successful. The five contract benchmark, however, provided a consistent level where Networks tended to report more successes.

Network administrators reported a range from 0 to 25 contracts that they currently had secured. The median number of contracts reported was four.

So what differentiated networks that had five or more contracts with those having four or less? The nine networks in the sample that reported having five or more contracts were significantly more likely to:

- have been in existence for more than two years;
- have conducted market research before forming;
- have a full time network director;
- have an incentive structure for management staff;
- have a budget in excess of the median for the study, \$200,000;
- have a defined marketing budget;
- cover an entire state or multi-state area;
- require reports on services provided from members, providers and subcontractors;
- provide reports on services to buyers;
- provide reports on services to members;
- identify geographic area covered as an important marketing strategy; and,
- use sub-contractors for some of their services or geographic areas.

The consistency among these nine groups strongly suggests that groups interested in forming networks need to look at incorporating many of these goals as part of their development strategy.

Network Problems and Challenges

For agencies exploring the possibilities of forming a network, there is a great deal that can be learned by analyzing some of the challenges many of the networks experienced. Network administrators reported that the biggest challenge in network formation was trying to maintain a focus on common principles and goals while coordinating multiple agencies and covering disparate geographic regions. Specifically, administrators noted that it was particularly challenging to maintain collaborative relationships among member agencies who often competed against each other while developing the infrastructure and programs to meet funders' requirements.

Network administrators also echoed the view that many association CEOs can attest to. It is often extremely challenging trying to manage and quickly move a group of Agency Executives who are used to being in charge and getting their own way. Networks require a certain amount of compromise and collaborative attitudes by its membership.

Administrators also warned that new networks need to maintain an awareness of the costs of developing and marketing the network. Many noted that limited budgets, which most networks had at the outset, inhibited development of an aggressive and well-organized network. They suggested that early identification of and agreement upon revenue sources and financing mechanisms was critical to developing a stable base.

Further, many administrators acknowledged that not having staff committed to network activities weakened network efforts. Some administrators also noted that member agencies needed to be educated regarding the demands of competing in the

managed care market. Many noted that managed care demands were a critical force in shaping the network structure, relationship, and activities.

What was clear was that many of the networks were successful in organizing extensive networks that covered large rural and urban areas and offered a wide range of services. Extensive geographic coverage allowed networks to contract for statewide services. Many networks acknowledged the challenge of developing effective and uniform systems when multiple agencies were working together. Many noted that securing managed care contracts was critical to success. This was a goal toward which many of the networks were still striving.

The Future of Home Care Networks

Networks clearly provide home care agency leaders with options....and challenges. They do provide agencies with a forum for competing in larger arenas. They do respond to managed care companies' need and desire to have contracts with fewer providers who cover larger areas. They also offer agencies the chance to protect market share. But all of this comes with a price.... a financial price and a time and personnel resource price.

One thing is clear. Independent providers cannot afford to stand on the side-lines and wait it out. Not acting is a decision that has serious consequences as well. It is ironic that in the highly competitive home care environment, the best strategy to ensure long term vitality seems to be some form of cooperation with other providers, some of whom were or are competitors in certain markets. Creating flexible and responsive structures to meet the market's needs and the needs of members to make decisions and resolve disagreements is a considerable challenge. A challenge that home care leaders must be willing and ready to meet.

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